

**School of Media, Culture and Creative Arts  
Department of Social Sciences and International Studies**

**Access to health care services among pregnant women in rural  
communities: In-depth case studies from Bagamoyo district in  
Tanzania**

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**This thesis is presented for the Degree of  
Doctor of Philosophy  
of  
Curtin University**

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## Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made.

This thesis contains no material, which has been accepted for the award of any other degree or diploma in any university.

**Human Ethics** (For projects involving human participants/tissue, etc) The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Number # **HR 24/2012**.

This research study was granted ethical clearance on 2<sup>nd</sup> of October 2012 by the National Institute for Medical Research (NIMR), in Tanzania

Signature .....

Date.....

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## **Abstract**

Poor and disadvantaged groups in developing countries, especially in Sub-Saharan Africa, face various barriers to access and use of preventive and curative health services. Women are among the most disadvantaged groups in Tanzania and rural women are most affected because they live far from local and referral hospitals. While the National Health Policy of Tanzania provides free maternal health services for pregnant women, utilisation of the services is still low. This thesis investigates barriers and enablers to access to health care services by pregnant women in rural villages of Kerege, Matumbi, Kiromo and Kitopeni in Bagamoyo district, Tanzania.

The study used a naturalistic ethnographic approach, which focused on intensive listening to the stories and experiences of pregnant respondents and male spouses using in-depth interviews, focus group discussions and observation as methods of data collection. In-depth interviews were conducted with sixteen women and four focus group discussions with thirty two men, and interviews with six health workers were combined with observation at selected government health facilities. The opinions and experiences of health care personnel about the experiences and challenges they perceive as confronting pregnant women and mothers who access health care services were sought.

The thesis identified issues around transport, antenatal care services, child delivery, HIV testing and family planning as of significant importance with regard to access to health care services from study participants' perspectives. The main study findings include: distance, poor road infrastructure, lack of transport, inadequate mode of transportation, costs of transport, lack of equipment and supplies, cost of supplies for delivery, lack of amenities (water and electricity), lack of space and privacy, poor health infrastructure, health care personnel shortage and heavy workload, inadequate funding, social cultural barriers, gender inequality, lack of male participation, inadequate contraception supplies, lack of choice for contraception and lack of training. The thesis provides recommendations to government to assist pregnant women access health care services

easily and conveniently; to help health care personnel execute their work effectively and efficiently; and to devise workable solutions for improving performance of low level health facilities in rural areas. The thesis informs the existing knowledge in both scholarly and applied fields, promotes culturally-sensitive empirical research on access to care, and assists in the enhancement and development of better and/or novel access to health care services.

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## **Abbreviations**

AIDS- Acquired Immunodeficiency Syndrome

AZT- Azidothymidine

CD4- Cluster of Differentiation 4

CHF- Community Health Fund

CHMT- Council Health Management Team

CTC- Care and Treatment Centre

DED- District Executive Director

DMO- District Medical Office

GDP- Gross Domestic Product

HIV- Human Immunodeficiency Virus

HREC Human Research Ethics Committee (Curtin University)

IFAD- International Fund for Agricultural Development

IUD- Intrauterine Device

LUKU- Lipa Umeme Kadiri Unavyotumia meaning 'Pay Electricity as You Use it'

MDGs- Millennium Development Goals

NIMR- National Institute for Medical Research (Tanzania)

NSGRP- National Strategy for Growth and Reduction of Poverty

OHCHR- Office of the High Commissioner for Human Rights

PFP- Pay for Performance

PMTCT- Prevention of Mother-to-Child HIV transmission

TANESCO- Tanzania Electrical Supply Company

TASAF- Tanzania Social Action Fund

UNHCR- United Nations High Commissioner for Human Rights

UNICEF- United Nations Children's Fund

UNFPA- United Nations Population Fund

US- United States

USAID- United States Agency for International Development

UNAIDS- United Nations Programme on HIV/AIDS.

WHO- World Health Organization

## **1. Introduction**

*When I went to see Farida Kombo of Kiromo village for the second time, after she had delivered her child, I had to hire a motorbike to reach the village. En route, we had to pass a certain portion of the road which had turned into a temporary pond due to rain. At first I was hesitant to pass there but the motorbike rider assured me that it was the road they use every day, even during rainy season, and so it was safe. Believing what the native was telling, I crossed the area but we were almost carried away by the water. If it were not for the motorbike rider's skills at manoeuvring, we would have definitely drowned. After that experience, I did not feel secure about returning by the same route. I therefore asked the motorbike rider to use an alternative route if there was one, which he did. Although that road was better, it was still watery, muddy, and the longest route, so it took three times as long to return to the village centre. That incident made me consider what a pregnant woman and/or her relatives would have done if she needed to reach the clinic or be rushed to the health facility for child delivery or due to any complications that come along with pregnancy. What would the family do if they did not have access to transport because of heavy rains flooding roads? Not all people with means of transport like to use their vehicles in such conditions. Barongo (2012)*

### **1.1. Statement of research**

Access to and utilisation of preventive and curative health services among the poor and disadvantaged groups in developing countries, especially in Sub-Saharan Africa, poses various barriers. Women are among the most disadvantaged groups in Tanzania, and rural women are mostly affected because of the long distances to referral hospitals. As in all Sub-Saharan countries, maternal mortality in Tanzania is very high: 578 per 100,000

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live births (National Bureau of Statistics- Tanzania & ORC Macro International Inc., 2005). Statistics from the Tanzania Demographic and Health Survey of 2004/2005 indicate that there is low utilisation of health care services among women in Tanzania for antenatal, intrapartum and postnatal care (National Bureau of Statistics- Tanzania & ORC Macro International Inc., 2005). It is reported that only 14% of pregnant women start ANC during the first trimester as per the national guidelines despite high ANC attendance of 94% (National Bureau of Statistics- Tanzania & ORC Macro International Inc., 2005). Only 47% of all births occur at health facilities and 46% of all births are assisted by a skilled health worker (National Bureau of Statistics- Tanzania & ORC Macro International Inc., 2005). The remaining 53% of births take place at home of which 31% are assisted by relatives, 19% by traditional birth attendants, and 3% are conducted without assistance (National Bureau of Statistics- Tanzania & ORC Macro International Inc., 2005). On postnatal care, it is reported that only 13% were examined within two days of giving birth as recommended, while 83% of women who delivered a live baby outside the health facility did not receive a postnatal check-up (National Bureau of Statistics- Tanzania & ORC Macro International Inc., 2005).

Improvement of maternal health is the fifth Millennium Development Goal of the United Nations to reduce maternal mortality and a goal of the National Strategy for Growth and Reduction of Poverty in Tanzania (United Republic of Tanzania, 2005). To this end, the National Health Policy of Tanzania has announced the provision of free maternal, preventive and curative health services for pregnant women. However, there has been low utilisation of the services by these women (Mpembeni et al., 2007; National Bureau of Statistics- Tanzania and ORC Macro International Inc., 2005; United Republic of Tanzania, 2008a). Although the situation faced by pregnant women in the access and utilisation of health care services in Tanzania is understood to some extent (Mrisho et al., 2007; Mrisho et al., 2009; Kruk, Paczkowski, Mbaruku, Pinho, & Galea, 2009) more detailed localised qualitative studies need to be conducted in order to produce individual and even community perceptions and experiences of the underlying reasons for this; so as to establish mechanisms for creating an enabling environment for access and utilisation of the services among pregnant women living in rural districts.

## **1.2. Research questions and objectives**

The central question of this study was to understand how access to and utilisation of maternal, preventive and curative services among pregnant women living in rural communities in Bagamoyo district in Tanzania are constrained and enabled? This question was explored through the following objectives:

1. To explore barriers to access and barriers to pregnant women's utilisation of maternal, preventive and curative services in government health facilities in Tanzania;
2. To investigate existing enabling environments and mechanisms; and
3. To develop recommendations for improvement of rural pregnant women's access and utilisation of the services.

Within these objectives, the key questions for the study were: what are rural pregnant women's experiences in seeking antenatal, childbirth, postnatal, preventive or curative services in the health care system? Why do many rural pregnant women not use the health services provided? Is the availability of healthcare services a key to access and utilisation of the services? What factors increase/limit access and utilisation of maternal, preventive and curative services among pregnant women living in rural communities? Is there a disparity between the health services provided and the actual needs of the women? What can be done in the rural communities to improve access to and utilisation of these services by pregnant women living in rural communities? How can the voices of rural women be heard?

The aim of this study was to understand why rural pregnant women from their own perceptions and lived experiences do not effectively use the health services provided. Are there existing enabling environments and mechanisms that have been put in place to ensure utilisation of the services? If available, have those mechanisms been able to create enabling environment for access to and utilisation of the services among pregnant women in rural districts? If not, which mechanisms to create enabling environment for access and utilisation of the services among pregnant women living in rural districts can be established to ensure appropriate and high access and utilisation of the services? This

study sought to explore enabling mechanisms that can be used to create and improve rural pregnant women's access and utilisation of services. The outcomes of this study are expected to inform existing knowledge in both scholarly and applied fields, assist in the enhancement and development of better and/or novel approaches to access to health care services, and promote more culturally-sensitive empirical research on access to care.

### **1.3. Background information**

#### **1.3.1. Tanzania**

In this study of access to health care services among pregnant women in rural communities, my study was conducted in Bagamoyo district located in the Coast region in Eastern Tanzania. Tanzania or United Republic of Tanzania (Figure 1.1) is the united nation of Tanganyika (mainland) and Zanzibar which was formed on 26 April 1964 (United Republic of Tanzania, 2015; <http://www.tanzania.go.tz/home/pages/68>). Both Tanganyika and Zanzibar attained their independence from Britain in the early 1960s: Tanganyika gained its independence on 9 December 1961, and Zanzibar became independent on 10 December 1963. Tanzania is the largest country in East Africa (945,000 sq. km) bordering the Indian Ocean on the East; the north is bordered by Kenya and Uganda; the West, by Rwanda, Burundi and the Democratic Republic of Congo; and by Zambia, Malawi and Mozambique in the South (<http://www.tanzania.go.tz/home/pages/68>). As of 2010, both the Tanzania mainland and the Zanzibar Archipelago had an estimated total population of 43.1 million and an average increase of Gross Domestic Product (GDP) of 7% during the period between 2001 and 2010 (<http://www.tanzania.go.tz/home/pages/68>).

In Tanzania, approximately 90 per cent of poor people reside in rural areas, while the workforce of about 80 per cent depends on agriculture as their main source of income

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(IFAD, 2011, 2014). Most of the rural families live in poverty and depend exclusively on food crop production, livestock and/or fishing. The majority of rural poor rely heavily on rain-fed agriculture (Aikaeli, 2010; IFAD, 2014), mostly small scale farming performed by hand hoe (IFAD, 2014). Agriculture in rural areas is also often afflicted by extreme weather and natural disasters, such as drought, leading to poor crop production (IFAD, 2014). Lack of irrigation schemes, infrastructure and market links, unavailability of credit, and inadequate access to public services such as health services, safe drinking water, and education are among other burdens (Aikaeli, 2010).

A report by Hoogeveen and Ruhinduka (2009) demonstrates the level of poverty in household income and expenditure in Tanzania between 2000/1 and 2007. The report showed that almost 90% of Tanzanians had tremendously low levels of household consumption: less than Tanzanian shillings 30,000/= (equivalent to US dollar 17.24) per month during 2001, equating to Tanzanian shilling 58,000/= (US dollar 33.33) in year 2007 rates. Furthermore, approximately 80% consumed less than Tanzanian shillings 20,000/= per month in year 2001 (equating to Tanzanian shillings 38,600/= in year 2007) which is equivalent to US dollars 11.49 and 22.18 respectively. This implies that the level of household consumption was roughly Tanzanian shillings 1,378.57 per day, equivalent to US dollar 0.79. Furthermore, the report shows that despite rural households increasing their incomes by engaging in self-employment unrelated to farming, between 2000/01 and 2007, rural households still had an average monthly income of Tanzanian shillings 32,305 (equivalent to US dollar 18.57) compared to urban households which had between 98,063/= and 108,053/= (equivalent to US dollars 56.36 and 62.10 respectively). Such a level of poverty in household income and expenditure can have a significant influence on access and utilisation of public services including healthcare services. Figure 1.1 below is the map of Tanzania.



Figure 1.1: Map of Tanzania (Maps of the World, 2014)

### 1.3.2. Bagamoyo district

Bagamoyo is one of the six districts of the Pwani Region of Tanzania (Figure 1.2). The district borders Tanga Region on the North, Morogoro Region on the West, the Indian Ocean on the East, and Kinondoni and Kibaha Districts on the South (Mkama et al., 2013). The district capital is Bagamoyo. According to the 2012 Tanzania National

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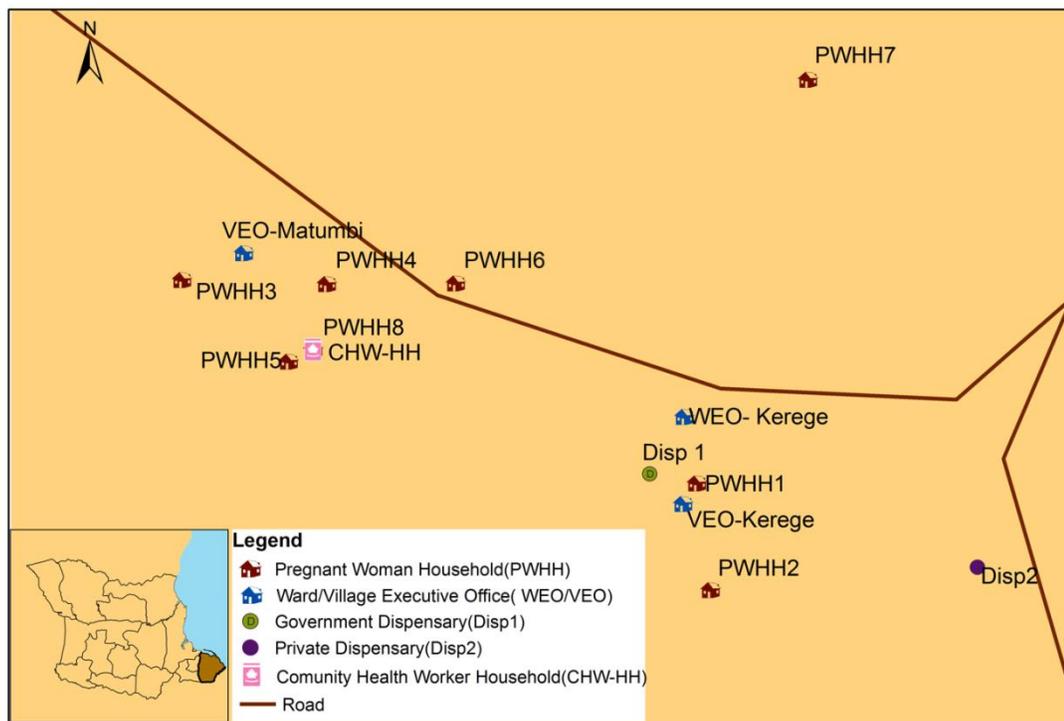
Census, the population of the Bagamoyo District was 311,740 of which 154,198 were males and 157,542 were females (United Republic of Tanzania, 2013a). According to National Bureau of Statistics and Coast Regional Commissioner's Office (2007), Bagamoyo district covers an area of 9,842 square kilometers, and has two parliamentary constituencies namely Bagamoyo and Chalinze (Mkama et al., 2013). Administratively, Bagamoyo district is made up of six divisions, and sixteen wards, eighty two villages and 645 hamlets (Gautum, 2009; Mkama et al., 2013). Bagamoyo district experiences average rainfall of 800 mm as minimum and 1000 as maximum per year (Mkama et al., 2013). Bagamoyo district experiences two main rain seasons: the heavy rainfall season which starts from March to May and the short rain season which starts from October to December every year (Mkama et al., 2013). The main source of income for the inhabitants is subsistence farming and fishing, animal keeping and salt mining (Gautum, 2009, Mkama et al., 2013, Sosovele, 2009). The main food crops for inhabitants include paddy, maize, sorghum, legumes and sweet potatoes while cash crops include cotton, coconut, cashew nuts, sesame and fruits (Mkama et al., 2013). Figure 1.2 below is the map of Bagamoyo.



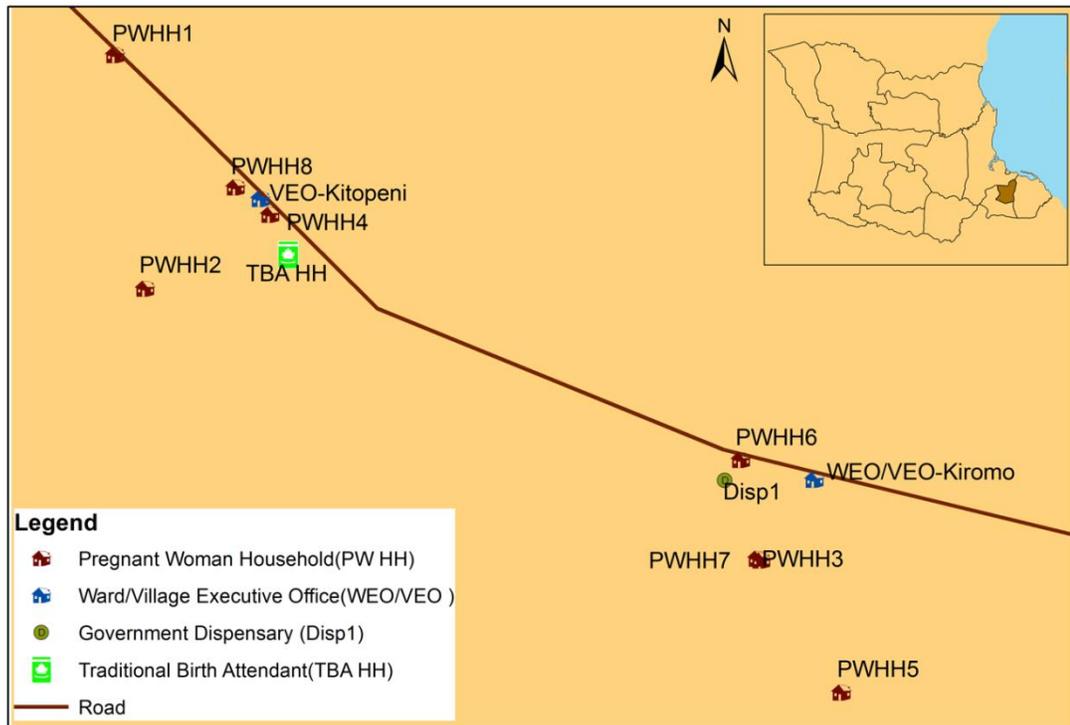
**Figure 1.2: Bagamoyo location map (Weather Forecast, 2015)**

### 1.3.3. Study location

This study was conducted in rural communities of Bagamoyo district in Tanzania, in the wards of Kerege and Kiromo (Figure 1.3 and Figure 1.4). According to the 2013 Tanzania Census General Report, Kiromo ward had a total population of 7,279 of which 3,677(50.5%) are males and 3,602(49.5%) are females, while Kerege ward had a total population of 18,008 of which 8,609(47.8%) are males and 9,399(52.2%) are females (The United Republic of Tanzania, 2013). In Kerege ward, the villages included in the study were Kerege and Matumbi, while in Kiromo ward the villages included were Kiromo and Kitopeni. Figure 1.3 and 1.4 below are the maps of these study areas.



**Figure 1.3: Kerege ward map (Stanley & Sunguruma, 2012).**



**Figure 1.4: Kiromo ward map (Stanley & Sunguruma, 2012)**

My research is an in-depth case study that focuses on access to health care services among pregnant women in rural communities of Bagamoyo District in Tanzania. In particular, I conducted my study in the villages of Kerege and Matumbi which are in Kerege ward, and Kiromo and Kitopeni villages in Kiromo ward. Wards are the lowest government administrative units that represent local government districts. These wards are comprised of several communities, known as villages in rural areas and streets in urban areas. These communities consist of between 7,000 to 36,000 people (United Republic of Tanzania, 2013). The local government (district authorities) in Tanzania was enacted by the Parliament Acts number 7 and 8 of 1982, to establish local government rural authorities and local government urban authorities respectively in the country (United Republic of Tanzania, 1982). The rural and urban authorities are local government districts that have authority in their geographic areas and coordinate the activities of the village and township councils (United Republic of Tanzania, 2014a). While the rural authorities are usually known as district councils, urban authorities are

referred to as city, municipal and town councils (Njunwa, 2005). Both village and township councils have power to make plans and implement functions for their areas according to their needs but are also responsible to their districts for all their daily revenue administration (Njunwa, 2005). My study was therefore conducted in rural communities that are under wards administered by the local government district of Bagamoyo.

#### **1.4. Tanzania health system and maternal health services in Tanzania**

Tanzania developed a national health system at independence in 1961, with the aim of providing the rapidly growing rural population with access to health services (Kwesigabo et al., 2012). The government structured the health system from a lower level of health facility to serve the rapid growing population in rural areas to an upper level of specialised central health facilities. The lower level of health facility is a village-help post providing primary care to community by two or more health workers. The health workers are known as village health workers and are employed by the village governments. These village health workers get a short training in health to enable them to provide health education and care for minor illnesses to community under supervision of the dispensary.

A dispensary is the second lowest level of health care delivery services in the country and caters for between 6,000 and 10,000 people and supervises all the village health posts in its ward (Kwesigabo et al., 2012; United Republic of Tanzania, 2014b). Dispensaries' services include basic laboratory and dental care, outreach programmes, and directly observed therapy for patients with tuberculosis. Other services include provision of maternal and child health care, treating simple medical problems during pregnancy such as anaemia, assisting with normal deliveries (Kwesigabo et al., 2012; United Republic of Tanzania, 2014b). All pregnant women in the village are expected to attend a dispensary as the first stage of health services and may be referred from there to a district hospital which offers additional services including operations not provided at a

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dispensary. A dispensary is often operated by a clinical assistant (a secondary school graduate with 2 years of training in anatomy, physiology, hygiene, diagnostic methods, and treatment of common illnesses, and an enrolled nurse (secondary school graduate with 2 years training in nursing care of minor ailments). A dispensary is supervised by a health centre.

A health centre serves populations of about 50,000 and is run by clinical officers (secondary school graduates with 3 years of basic clinical training) and who are also aided by enrolled nurses. (Kwesigabo et al., 2012; United Republic of Tanzania, 2014b). Health centres usually provide preventive care, reproductive services and minor surgery and usually has 10- 20 beds.

The next level after a health centre is a district hospital. District hospitals provide outpatient and inpatient services that are not available at dispensaries or health centres. The services include laboratory and x-ray diagnostic services, and surgical services including emergency obstetric care. Many of the district hospitals are run by assistant medical officers (AMOs) who are clinical officers with a further 2 years clinical training, and are assisted by clinical officers and enrolled and registered nurses. However, medical doctors also serve in some of the district hospitals. In Tanzania there are 132 districts which are mostly run by a government district hospital while others are non-governmental hospitals and depend on sponsorship from religious organisations to become designated district hospitals and be eligible to receive government subsidies (Kwesigabo et al., 2012).

Next to the district hospital is a regional hospital. A group of several districts usually ranging from 4 to 8 in a region is served by one regional hospital. Currently in Tanzania, there are 18 regional hospitals (Kwesigabo et al., 2012). A regional hospital offers services similar to those at district hospitals but in a larger range and offer more specialised care. The health care personnel include general medical physicians, general surgeons, pediatricians, general and specialised nurses and midwives, as well as public

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health staff coordinating the programmes for preventing and protecting the population from diseases and injuries.

In Tanzania there are four specialised referral hospitals that provide specialised care to regions grouped into four zones. They are also teaching hospitals and two of them are operated by religious based organisations. These hospitals provide complex health care requiring advanced technology and highly skilled personnel.

Provision and access to health care services in Tanzania faces various challenges (United Republic of Tanzania, 2005). Among key issues addressed in the Tanzania National Strategy for Growth and Reduction of Poverty (NSGRP) as main obstacles in provision and access to health care services in Tanzania are long distances to health facilities and inadequate and unaffordable transport systems (United Republic of Tanzania, 2005). One of the major operational targets of the Tanzania NSGRP is 'to ensure effective universal access to quality public services that are affordable and available' by aiming to provide health services within a 5 kilometres radius of all habitations (United Republic of Tanzania, 2005). However, despite these efforts showing that 72% of the population lives within 5 kilometres, about 90% of the population still lives 10 kilometres from a health facility (Mpembeni et al., 2007).

Worldwide, several global and national interventions have demonstrated improvement in women's health and reduction of maternal mortality. The interventions include universal accessibility to comprehensive essential obstetric care, comprehensive antenatal care services and safe blood for obstetric services; provision of reproductive health, family planning services and safe abortion services; women empowerment and male involvement in reproductive issues, strengthening of health system and public private partnership (Wagstaf & Claeson, 2004; Sines, Tinker & Ruben, 2006). Although Tanzania has adopted a number of such efforts to improve women's health, maternal death of women during child birth remains an unresolved challenge. Maternal mortality rate in Tanzania is still very high having an estimate of roughly 21,000 women and girls dying each year due to pregnancy-related complications (AbouZahr & Wardlaw, 2004).

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The report by AbouZahr and Wardlaw (2009) also show that each year approximately another 420,000 Tanzanian women and girls will suffer from disabilities caused by complications during pregnancy and childbirth.

Several studies show that the majority of pregnant women in Tanzania attend antenatal clinics at least once during pregnancy, but only a small proportion of them deliver in health facilities (National Bureau of Statistics & Macro International Inc., 2005). Furthermore, despite a high coverage (94%) of antenatal care and Tanzania having access health facilities closer to rural households than many African countries, more than half of children are delivered at home (National Bureau of Statistics & Macro International Inc., 2005; Lugina, Mlay, & Smith, 2004).

The Tanzanian government, through its country-wide network of well-established health facilities, advocates for every pregnant woman to deliver at health facilities (Mosha, Winani, Wood, Changanalucha, & Ngasala, 2005). In order to promote this goal, the government has even mandated that maternal and child health services, including deliveries, be exempted from fees at any government facility (Mrisho et al., 2007). Yet despite the clear government fee exemption, unexpected health care charges such as paying for or buying some of materials needed for child delivery (such as gloves, cotton wool and razor blades) are very common and considered as normal (Mrisho et al., 2007).

Studies previously conducted mainly focused on access and utilisation of reproductive health services in rural communities in remote areas (Bicego et al., 1997; Mrisho et al., 2007; Mrisho et al., 2009; Kruk et al., 2009; von Both et al., 2006) and the experiences of nomadic populations (Kruger et al., 2011). A number of studies have investigated specific difficulties in the accessibility and utilisation of health services among pregnant women in Tanzania (Bicego et al., 1997; Kruk, Paczkowski, et al., 2009; Mrisho et al., 2007; Mrisho et al., 2009; von Both et al., 2006). A survey by Bicego et al. (1997) conducted in rural Tanzania in 1995, for example, showed that 84% of women who gave birth at home planned to deliver at a health facility but did not do so due to problems related to distance and transport. Other studies show that women are generally positive

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about the utilisation of health services but the major problems have been access to health services due to geographical and economic access as well as staff shortages of and skill birth attendants, and poor or no supplies and equipment (Kruger et al., 2011; Kruk, Paczkowski, et al., 2009; Mrisho et al., 2007; Mrisho et al., 2009; von Both et al., 2006).

It is important to understand the traditional and contemporary role of a traditional birth attendant in Tanzania in relation to difficulties of access and utilisation of health care services. It is estimated that more than 60 million births occur outside formal health institutions each year worldwide of which the majority are attended by traditional birth attendants (United Republic of Tanzania 2007; United Nations International Children's Emergency Fund 2009; Kwesigabo et al., 2012). In rural areas of developing countries, including Tanzania, traditional birth attendants have been used for many years (AMREF, 2015) and experience shows that they usually work in rural, remote and other medically underserved areas. In the past, prior to modern medicine, a traditional birth attendant was an important and reliable person in the community who knew how to deliver a child among other things. As documented by WHO (2010b, p.7), traditional birth midwives, as they are sometimes referred to, *provide basic pregnancy and birthing care and advice based primarily on experience and knowledge acquired informally through the traditions and practices of the communities where they originated*. In most cases, traditional birth attendants do not have the modern equipment to assist a woman with child delivery but work within their resources and environment, making sure as much as possible that a pregnant woman delivers her child safely.

Even with the introduction of modern medicine, communities continue to utilise traditional birth attendants for child delivery due to socio-cultural factors such as the traditional birth attendant's ability to deliver a child safely and provide a level of privacy compared to the modern health care system (Mrisho et al., 2007; Mrisho et al., 2008). Traditional birth attendants are also often regarded as motherly and affectionate (Pfeiffer & Mwaipopo, 2013) and the fact that it is a woman attendant who often delivers the baby makes it comfortable for a pregnant woman, especially for younger women (Mrisho et al., 2007). Further, due to the fact that traditional birth attendants are based in

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communities, they hold a culturally-assigned level of respect and confidence (Pfeiffer & Mwaipopo, 2013). Birth attendants are both geographically and economically accessible (Pfeiffer & Mwaipopo, 2013). Payment is nominal or in kind or and the option of delaying payment may make the birth attendant the preferred option over more modern health care, were payments made upfront.

Utilisation of traditional birth attendants in Tanzania still prevails, particularly in rural areas. The Government of Tanzania recognises the important contribution of traditional birth attendants to communities because of their role in reproductive and maternal health. In fact in many areas, traditional birth attendants are as important as other health care providers, such as village health workers, in bridging the gap between the community and the formal health system (Kruk, Paczkowski, et al., 2009; Mrisho, et al., 2007, 2008). Furthermore, birth attendants have also been used as community-based counsellors and people responsible for monitoring mother and child complications during and after delivery for possible referral (Mrisho, et al., 2007, 2008). However, despite the fact that traditional birth attendants are promoted by the government, their role has been limited to providing counselling on maternal and neonatal health and initiating timely referral to formal health care providers; therefore it does not include attending child delivery (Pfeiffer & Mwaipopo, 2013). Indeed, the Ministry of Health and Social Welfare under the National Road Map Strategic Plan to Accelerate Reduction in Maternal, Neonatal and Child Deaths in Tanzania maintains that child delivery should be performed at a health facility by skilled health workers (Ministry of Health and Social Welfare, 2008). Based on experiences from countries like Malaysia, WHO also acknowledges the existence of traditional birth attendants in many developing countries, and sees the traditional birth attendants as suitable advocates for skilled care who might encourage women to seek assistance from skilled attendants (WHO, 2004). According to WHO (2004, p.1), a skilled attendant is *an accredited health professional- such as a 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 maintains that traditional birth attendants can become an

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important element in a country's safe motherhood strategy and can serve as key partners in increasing the number of live births (Pathmanathan & Liljestrand, 2003; WHO, 2004). Investment in strategies based only on traditional birth attendants has demonstrated historically to cause governments to delay the development and implementation of strategies for ensuring that skilled attendants are available to all women and newborns (WHO, 2004). In conclusion, WHO recommends incorporating traditional birth attendants in strategies for skilled care as an interim step in a longer-term plan for training and providing sufficient skilled attendants.

However, despite ongoing efforts to integrate traditional birth attendants into a safe motherhood strategy (WHO, 2004), experience still shows that most traditional birth attendants handle complicated deliveries themselves and do not follow standards of safety and hygiene procedures (Pfeiffer & Mwaipopo, 2013). Due to unhygienic environments and the use of unsterilised equipment, the work of a traditional birth attendants is often associated with the transmission of infection such as HIV and AIDS, and with the risks of maternal and child death. Nevertheless, communities continue utilising traditional birth attendants. WHO (2004) recognises that there are regions in developing countries where traditional birth attendants are the only source of care available during pregnancy, due to unavoidable circumstances, especially in remote rural areas. Where health facilities are hard to access, traditional birth attendants are relied on for child delivery.

Various studies show that pregnant women living in remote rural areas are sometimes forced to deliver at home or on their way to health care facilities with the assistance of traditional birth attendants, elderly women, relatives, in-laws or neighbours (Izugbara, Ezeh, & Fotso, 2009; Smith, 2008). In developing countries, including Tanzania, traditional birth attendants are important contributors to the delivery of health services in rural and/or remote and hard-to-reach areas (Asghar, 1999; Vyagusa Mubyazi & Masatu, 2013). A report by the United Republic of Tanzania, (2007) under the Ministry of Health and Social Welfare, points out that the high rates of home deliveries are attributed to poor geographical access to health facilities in addition to an absence of functioning

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referral system, inadequate capacity at health facilities in terms of equipment, and the socio-cultural circumstances of pregnant women. Further, one study conducted in rural district of Kasulu in Tanzania by Mbaruku, Msambichaka, Galea, Rockers, and Kruk (2009) indicated that despite many women having given birth at home, pregnant women and their partners had greater trust in health care personnel than traditional birth attendants. Failure to access services was due to systemic barriers and the report recommended interventions aimed at reducing maternal mortality by tackling the systemic problems that prevent women from delivering at health facilities.

Although health education, media and outreach programme promotions on the importance of accessing better health services through clinics in health facilities are widespread in Tanzania, there are still limitations to accessing and utilising health care services. It is therefore realistic to say that the difficult situations that face pregnant women in rural areas may compel them to use traditional birth attendants for child delivery. The barriers to access and utilisation of maternal, preventive and curative services among pregnant women in government health facilities in Tanzania are known. However, the situations faced by pregnant women from their own perspectives and experiences during access and utilisation of health care services in Tanzania are yet to be fully explored.

As a researcher from a medical and health research institution in my country Tanzania, I have past experience of research in health and health care issues. However, I came to realise that despite a substantial body of research, we were not taking into account the perspectives of the actual users of the health care services such as pregnant women, or of providers, at an in-depth level to understand their experiences, opinions and priorities. My prior experience is that such people actively seek to have their voices heard about these issues, but up to now their narratives have not been foregrounded in the discussions which lead to policy making and fiscal decisions. I therefore realised that there was a lack of in-depth understanding of the issues that affect the various stakeholders and this needed to be rectified.

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Reproductive health is one of my main fields of interest in research. I developed an interest in the health care of women due to the fact that in Tanzania, as in any developing country, women, and especially pregnant women, still face various obstacles to access and utilisation of the health care system. Barriers to access and utilisation of health care system in developing countries are due to various socio-economic, political and geographical factors (Acevedo & Hurtado, 1997; Bicego et al., 1997; Bloom, Wypij, & Das Gupta, 2001; Buor, 2004; Celik & Hotchkiss, 2000; Criel, 1998; D'Ambruoso, Abbey, & Hussein, 2005; Ensor & Cooper, 2004; Kruger, Olsen, Mighay, & Ali, 2011; Kruk, Paczkowski et al., 2009; Matsuoka, Aiga, Rasmey, Rathavy, & Okitsu, 2010; Mrisho et al., 2007; Mrisho et al., 2009; Sundari, 1992; Tanner & Vlassof, 1998; Timyan, Brechi, Measham, & Ongunleye, 1993; Walsh, Feifer, Measham, & Gertler, 1993; WHO, 1994, 1996a; von Both, Fleba, Makuwani, Mpembeni, & Jan, 2006; Yanagisawa, Oum, & Wakai, 2006). These studies show that obstacles that make access to and utilisation of these health services difficult for women, particularly rural women include long distances to facilities, lack of adequate transport, unaffordable transport costs, poor quality of health care (including patient and health workers relationships) as well as social relations within the household and community.

However, studies conducted in Tanzania (Bicego et al., 1997; Kruk, Paczkowski, et al., 2009; Mrisho et al., 2007; Mrisho et al., 2009; von Both et al., 2006) have mostly reported the factors affecting women's access and utilisation of health care services rather than describing the lived experiences of women in detail. With this study, I therefore wanted to explore views and experiences of pregnant women and women having babies as they seek health care services in rural Tanzania, by adopting the methodology of listening (Elliott, 2005; Rubin & Rubin, 2005; Somekh & Lewin, 2005). I wanted to hear from these women what this experience is like, how they describe and perceive it, and their actual experiences when wishing to access and during accessing health services. My recognition was that, despite what is known about barriers to access and utilisation of health care services for pregnant women in rural communities in developing countries and specifically in Tanzania, the voices of these women were not being heeded. I therefore wanted to focus on issues of health care access as viewed by

these women who are directly affected by them. The experiences of husbands and partners and the local healthcare personnel were also fundamental to this study because of their roles as main providers of household and health care services respectively, which can have impact on women's access and utilisation of health care services.

My study employed qualitative methods of research, as opposed to quantitative methods, for various reasons. The use of qualitative methods in research enables the researcher to gain different and more complex understandings of various issues from the points of view and perceptions of participants (Denzin & Lincoln, 2000; Malterud, 2001). This study used qualitative methods of research to provide important insights into many factors that affect pregnant women and mothers in their quest for access to and utilisation of health care services. The research will contribute to both to scholarly understandings of issues around access to health care for rural women and to processes of transformation in policy and practices in developing countries in order to better meet the needs of individuals and communities.

### **1.5. Thesis structure**

This thesis is organised into nine chapters and includes appendices. The first chapter provides background information about the study. It introduces the study area and the subject matter. The area of study was in Bagamoyo district in Tanzania in the wards of Kerege and Kiromo. In particular, the study was conducted in the villages of Kerege and Matumbi in Kerege ward, and Kiromo and Kitopeni villages from Kiromo ward. The chapter provides literature review and explains the significance of the study. It also explains the research methods used, including data collection procedures, study population, and study design. The chapter describes in detail the methods of data collection that were used including in-depth interviews, focus group discussion and observation. Further, this chapter also explains how data was analysed, ethical issues addressed, the resources involved, data storage and the duration of the study.

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Chapter two is the literature review. It addresses the issues of reproductive and maternal health worldwide providing in detail information about factors affecting access and utilisation of health care services. It also addresses the significance of this study.

Chapter three is the research methodology. The chapter addresses the methodology used for the study including paradigms, study design, study area, methods of data collection, study participants, sampling, and data analysis and management. It also explains data collection procedures and ethical issues followed, facilities and resources used and data storage.

The findings are presented in the fourth, fifth, sixth, seventh and eighth chapters.

The fourth chapter addresses transport and issues around transport which were of significant importance in the access to and utilisation of health services by groups I interviewed in Kerege, Matumbi, Kiromo and Kitopeni in Bagamoyo district. The chapter recounts and analyses the experiences and perceptions of women (both pregnant and having recently delivered at the time of interviews) of transport when seeking health care services. In order to understand more, I drew on the opinions and experiences of health care personnel about challenges that they perceive confront pregnant women and mothers seeking health services with regard to transport. Further, I also share opinions of men about their experiences related to transport issues when seeking for health care services for and with their partners.

The fifth chapter describes access to antenatal care. It explores the major issues around utilisation of antenatal care services among pregnant women in Kerege, Matumbi, Kiromo and Kitopeni in Bagamoyo district. Particularly, I discuss patterns and reasons for using ante natal care services, from the perspectives of pregnant women and health care personnel. I also discuss the experiences and views of health care personnel on needs of pregnant women including challenges encountered in the process of seeking antenatal care services.

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Chapter sixth explores child delivery at health facilities and its challenges. I wanted to understand critical issues around child delivery in government health facilities from the point of view of pregnant women and women who had just delivered their babies at the time of interviews. I describe and analyse the knowledge of these women about their perceptions and experiences with child delivery. Further, I draw opinions and experiences of health care personnel in relation to the views of these women, by asking them to elaborate on the experiences and challenges that they perceive affect pregnant women and mothers accessing health facilities to deliver their babies.

Chapter seventh discusses rural women's perceptions and experiences of Human Immunodeficiency Virus (HIV) testing. This chapter accounts and analyses the knowledge of women in Kerege, Matumbi, Kiromo and Kitopeni in Bagamoyo district, both antenatal and postnatal at the time of interviews, about HIV testing. I explore their insights and experiences of HIV testing. To understand the women better, I elicit the opinions of health care personnel about issues they perceive as challenging pregnant women and mothers regarding HIV testing when they visit health care services. I also discuss with men their views and opinions about HIV testing.

The eighth chapter explores family planning. In this chapter I discuss issues around family planning as told by pregnant women and women who have had babies in Kerege, Matumbi, Kiromo and Kitopeni villages in Bagamoyo district. From the interviews, I elicit different understandings around family planning. In particular, I draw out issues which were addressed as of significant importance by them within and outside health facilities. I explore deeply about their views and experiences with family planning. As an essential counterpoint, I also ask for opinions of health care personnel about challenges they perceive as confronting pregnant women and mothers who wish to use family planning.

The ninth chapter which is the final chapter draws conclusion from all the chapters. Firstly, it provides summaries of the main issues that arose as of significant importance on access and utilisation of health care among pregnant women. The issues include:

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transport, child delivery, antenatal care, Human Immunodeficiency Virus (HIV) testing, and family planning. Secondly, the chapter provides recommendations that the study sees of significant importance for potential actions to the improvement of access and utilisation of health care services. Lastly, the chapter ends with the overall conclusion.

The appendices section is comprised of research guides which include interview guide in Swahili and English versions, participant's information sheet and consent form, also both in Swahili and English versions, a letter of introduction, ethic clearance letters, letters for permission to conduct research and timeline of the study.

## 2. Literature review

### 2.1. Reproductive and maternal health

According to the United Nations Population Fund (2014) reproductive health is defined as:

*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. (UN Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994, Para 7.2a).*

With the right of access to appropriate health-care services, ensuring access to and utilisation of such services by women will not only prevent reproductive health problems but also solve related problems that occur along with them.

In September 2000, world leaders from 189 United Nations member states endorsed eight goals in what came to be known as the United Nations Millennium Development Goals at the summit held at the United Nations in New York following the adoption of

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the United Nations Millennium Declaration (United Nations Millennium Development Goals, 2000a). The summit Declaration emphasises the observation of freedom, equality (of individuals and nations), solidarity, tolerance, respect for nature and shared responsibility as values and principles of international relations (United Nations General Assembly, 2000). Furthermore, the Declaration also includes the observation of peace, security and disarmament; development and poverty eradication; protection of our common environment; human rights, democracy and good governance; protection of the vulnerable; meeting the special needs of Africa; and strengthening the United Nations. (United Nations General Assembly, 2000).

The eight Millennium Development Goals which were adopted in the summit are as follows: eradication of extreme poverty and hunger; achieving universal primary education; promoting gender equality and empower women; reducing child mortality; improving maternal health; combating HIV/AIDS, malaria and other diseases; ensuring environmental sustainability; and lastly developing a global partnership for development (United Nations Millennium Development Goals, 2000a). Maternal health is, therefore, one of the main issues of public importance around the world. Improvement of maternal health, the fifth of the eight Millennium Development Goals, aims at reducing maternal mortality by three quarters and achieving universal access to reproductive health by year 2015 (United Nations Millennium Development Goals, 2000a). In recognition of the challenges facing women and children around the world, in 2010, world leaders and other influential organisations pledged over \$40 billion in an effort to accelerate the improvement of maternal and child health through health financing, policy strengthening and improvement of health services (United Nations Millennium Development Goals, 2000a). To date, improvement of maternal health is still one of the important agenda items for further acceleration to achieve the Millennium Development Goals. On September 2013, the UN General Assembly proposed commitments to enhance Millennium Development Goals, which include scaling up success, identifying further opportunities including renewing commitment to meeting the Millennium Development Goals (United Nations Millennium Development Goals, 2000a). It is anticipated that a new set of goals will be endorsed in the proposed high-level summit that has been

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planned to be held in September 2015 (United Nations Millennium Development Goals, 2000a).

With this in mind, this study is relevant to the Millennium Development Goals because it focuses on issues of maternal and child health by looking at the real situations affecting women on their quest to accessing and utilising health care services. Accessibility and availability of good quality of service and delivery is important if we are to reduce maternal mortality and improve reproductive health for women. Further, accessibility and availability of good quality services is also crucial if women are to accept and use them. As such, understanding access to and utilisation of health care services from women's own perceptions and experiences is vital to improving maternal health, not only in Tanzania but also in countries that face similar situations.

As part of its Safe Motherhood Initiative (WHO, 1994), WHO also advocates improvement of maternal health services. Of importance here is regular antenatal care to ensure easy identification of a minority of women at increased risk of adverse pregnancy outcomes and to create good relations between women and their health care providers. (WHO, 1994). Antenatal care, if provided appropriately and utilised well, can assist to prevent maternal and perinatal mortality and morbidity (WHO, 1994). WHO also advocates the importance of women attending postnatal care after delivery as vital to ensuring good health and the survival of both mother and child. WHO defines the postnatal period as the period beginning one hour after delivery of the placenta and continuing until six weeks (42 days) after the birth of an infant (WHO, 1998).

According to the United States Agency for International Development (USAID) - funded project, Future Group International (2005), globally over 500,000 women and girls die of complications related to pregnancy and childbirth each year. Of those deaths, over 99 percent occur in developing countries such as Tanzania. The reproductive health of women, therefore, is an issue of public health importance worldwide since maternal mortality is still very high in developing countries and particularly in Sub-Saharan Africa. In 2008, an estimated 358,000 maternal deaths occurred worldwide, of which

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developing countries accounted for 99% (355,000) with Sub-Saharan Africa and South Asia accounting for 87% (313,000) of the deaths (World Health Organization 2010). In Sub-Saharan Africa the lifetime risk of a woman dying due to pregnancy is 1 in 31 compared with 1 in 2100 in U.S (Paxton, and Wardlaw, 2011).

The United Nations High Commissioner for Human Rights (UNHCR) and World Health Organization's (WHO) response has been to lay emphasis on an expectation of access to and use different health services for maternal health which include antenatal, childbirth, postnatal, and emergency obstetric care and any other appropriate health care in connection with such services (UNHCR/ WHO, 2008). However, in many developing countries, and particularly in many rural areas, receipt of pregnancy care has been difficult due to limited access to biomedical health services. Although provision of these services is still inadequate in Sub-Saharan Africa, in addition, problems of access to and utilisation of the services remain significant in these countries (Magadi, Madise, & Rodrigues, 2000; Ndyomugenyi, Neema, & Magnussen, 1998; van Eijk et al. 2006). As a consequence, apart from maternal deaths and high infant mortality (with its concomitant effects on the mother's health), women and girls develop either both short- and long-term disabilities, such as obstetric fistula, ruptured uterus, or pelvic inflammatory disease (Futures Group International, 2005).

### **2.2. Factors affecting access and utilisation of health care**

Access to health care is a complex aspect that has multidimensional issues. These issues, commonly referred to as dimensions of access (Thomas & Penchansky, 1984) are: availability, accessibility, accommodation, affordability and acceptability. Thomas and Penchansky (1984, p. 554-555) describe these dimensions as follows:

*accessibility; the relationship between the location of supply and the location of clients. This includes client's transportation resources, travel time, distance and costs.*

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*availability; the relationship between the volume and type of existing services (and resources) and the clients' volume and type of needs. This refers to adequacy of the supply of physicians, dentists and other providers or facilities such as clinics and hospitals and, of specialized programs such as emergency care and mental health.*

*affordability; the relationship between prices of services and providers' insurance or deposit requirements and the clients income, ability to pay and existing health insurance. Of concern is a client's perception of worth relative to total cost, as well as clients' knowledge of prices, total costs, and possible credit arrangements.*

*acceptability; the relationship between clients' attitudes about personal and practice characteristics of existing providers. The characteristics of the providers' include age, sex, location and type of health facility. They also include providers' religious affiliation and attitudes about acceptable personal characteristics of clients such as ethnicity and patients' source of payment.*

*accommodation; the relationship between the manner in which the supply resources are organized to accept clients. This includes appointment systems, hours of operation, walk in facilities, telephone services and the clients' ability to accommodate this factors.*

The descriptions above demonstrate how these dimensions are closely related to and indivisible from each other. For example, accessibility can determine the use and frequency of use depending on the distance to the health care, while the use of health care may be determined by the availability, acceptability, affordability and accommodation. Accessibility may not be a problem but people may prefer to travel further to access different health care due to finding it more acceptable or

accommodating and hence satisfactory. In other instances, accessibility and availability may have no difference if people are to travel a long distance to reach health care while in other cases health care may be accessible but unavailable in terms of shortages of certain resources and/or services. These dimensions of access to health care are important in understanding various factors related to access to and utilisation of health services among pregnant women and their interrelationships.

### **2.2.1. Distance**

The choice of health care shows to be mostly determined by the proximity of the health services apart from other factors such as: type, costs and quality of health care services, information and cultural barriers (Timyan et al., 1993). Factors such as distance to the nearest government-sponsored clinic therefore relate to the usage or non- usage of biomedical care during pregnancy apart from other factors related to affordability and acceptability of type, quality and cost of health care services (Bicego et al., 1997; Mrisho et al., 2007). Furthermore, transport costs and walking long distances to the nearest government health facility are hindering factors for pregnant women (Acevedo & Hurtado, 1997; Matsuoka et al., 2010). Studies by Acevedo and Hurtado (1997) and Matsuoka et. al. (2010) showed that if health facilities are far from where pregnant women are living, the tendency to delay or even never attend the facilities will be high, as compared to usage if the services are within their reach. It needs to be recognised that distance is relative, and that access is highly dependent on forms of transport, climate, and other environmental factors.

Various studies have documented that availability of transport, physical distance to the facility and the time taken to reach the facility are influences on health-seeking behaviour and health service utilisation (Fatimi & Avan, 2002; Moazam & Lakhani, 1990; Stephenson & Hennink, 2004; Thaddeus & Maine, 1994). Health-seeking behaviour, also known as help-seeking behaviour, can be described as a way people perceive a certain condition or illness to be willing to seek for bio-medical care

(Cornally and McCarthy 2011; Ward, Mertens & Thomas 1997). Health-seeking behaviour is regarded as an important vehicle for exploring and understanding patient delay or prompt action across a variety of health conditions (Cornally & McCarthy, 2011). While some people may readily go for medical treatment, others only seek treatment when in great pain or in advanced stages of an illness. Shaikh and Hatcher (2005) assert that health-seeking behaviour is determined by socio-economic, cultural and political factors. Socio-demographic factors such as cultural beliefs and practices, perception of the cause of illness, disease patterns, levels of education, status of women, gender discrimination, health care, economic and political systems, and environmental conditions greatly influence people's decision to access and use health care services (Chibwana, Mathanga, Chinkhumba, & Campbell, 2009; Fatimi & Avan 2002; Feyisetan, Asa, & Ebigbola, 1997; Katung, 2001; Mwangome, Prentice, Plugge, & Nweneka, 2010; Navaneetham & Dharmalingam, 2002; Shaikh & Hatcher, 2005; Stephenson & Hennink, 2004; Uchudi, 2001). Such factors contribute to the willingness or delay of people to access and use health care services for their family members, or themselves.

### **2.2.2. Past experiences with health services**

Other factors associated with use or non-use of health services include past and ongoing obstetrical experiences and needs for such services (Cocks & Dold, 2000; Walsh et al., 1993; WHO 1994, 1996a) and show that uptake is not necessarily associated with the health facilities being near or within reach. These studies showed that the last experiences of women (or members of their family/community) with health providers or type of service rendered or not rendered in the past may well have an impact on uptake of services, as may socio-cultural factors, such as a local or individual preference for using traditional birth attendants. All these might determine the decision to use or not use the services.

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Various studies show that pregnant women living in remote rural areas are sometimes forced to deliver at home or on their way to health care facilities with the assistance of people such as traditional birth attendants, elderly women, relatives, in-laws or neighbours (Izugbara, Ezeh, & Fotso, 2009; Smith, 2008). The reasons for failure to reach the health facilities are not necessarily due to women's lack of knowledge of health care at appropriate time, but are often associated with distance, unaffordable costs of travel, costs of services, and shortage of skilled health care personnel and supplies, apart from other factors like cultural norms and religious beliefs. (Choguya, 2014; Gabrysch & Campbell, 2009; Izugbara et al., 2009; Mrisho, et al., 2007; Say & Raine, 2007; Smith, 2008, Thaddeus & Maine, 1994; Vyagusa, Mubyazi, & Masatu, 2013). In fact one study conducted in rural district of Kasulu in Tanzania by Mbaruku, Msambichaka, Galea, Rockers, and Kruk (2009) indicated that despite many women having given birth at home, women and their partners had greater trust in health care personnel than in traditional birth attendants.

Various studies have shown that there is an association between utilisation of health care services for delivery and past or current complications (Afsana & Rashid, 2001; Gleit et al. 2003; Mesko et al., 2003; Paul & Rumsey, 2002; Stephenson & Tsui, 2002; Telfer, Rowley, & Walraven, 2002; Yanagisawa, Oum, & Wakai, 2006). A study conducted in rural western Tanzania by Kruk, Mbaruku, et al. (2009) documents the reasons women bypass dispensaries, which are the primary health care facilities in the rural areas for child delivery, to seek care at higher-level quality health facilities. This study discovered that the availability of medical equipment and drugs and the attitude of providers are important contributing factors to women's choice of place of delivery. A study by Atkinson et al. (1999) conducted in Lusaka, Zambia also found many people go to higher level hospitals for primary health care when they are discontented with primary health care services. In their review of maternity referral systems in developing countries, Murray and Pearson (2006) have indicated that the inefficiency of low level of health care facilities and the problem of transport in remote settings contribute to people bypassing those facilities for better and faster health care in hospitals. Better quality of health care and services play an important role in the decision people make to utilise

health facilities. Even a study conducted in Vermont, America established that the experience of place is a more significant indicator of utilisation behaviour than the distance separating individual and health care provider (Nemet & Bailey, 2000).

### **2.2.3. Service costs**

Service costs at the health facilities are another constraining factor on the utilisation of services. Although free health care could mitigate such financial barriers, the vast majority of women and their families in the rural areas cannot afford the attendant costs that go with access to such services. Socio-economic status and the use of health services go hand in hand: the measure of income and wealth plays a significant role in determining the use of health services (Celik & Hotchkiss, 2000, Matsuoka et al., 2010). These studies show that provision of free health care still is not a solution for many women because there are other costs involved, such as transport that may be a hindering factor in the utilisation of the health services.

### **2.2.4. Shortage or lack of appropriate services**

Shortage or lack of appropriate health services is another factor that can determine access and utilisation of health services (Kruk, Paczkowski, et al., 2009). Ensor and Cooper (2004), argue that barriers such as financial, geographical and cultural factors, in combination with the inadequate quality of care within the formal health sector, do affect the demand for care and could be a discouragement of service use. According to Sundari (1992), maternal mortality studies in developing countries have shown that despite the fact that services could be accessible and affordable, still there is a lack of adequate and appropriate health care due to inadequate medical supplies, lack of equipment, personnel, poor patient management and lack of know-how at health facilities, which all contribute to high maternal mortality rates. All these barriers call for changes to health service delivery if the prevention of maternal deaths is to be achieved.

### **2.2.5. Patient and health workers relationships**

Patient and health worker relationships also determine access to and utilisation of health services among pregnant women. A study in rural Cambodia, for example, has shown that the use of abusive language and lack of tolerance by the health workers discouraged pregnant women from using health facilities for delivery (Yanagisawa et al., 2006). Similarly, a study in Ghana showed that women changed their place of delivery and suggested the same to others when they experienced degrading and unacceptable behaviours from health workers (D'Ambruso et al., 2005). In the same studies, staff attitudes and lack of privacy were also factors in the choice of home delivery. The experiences of women with health workers when accessing and utilising such services will contribute to the decisions they make about their continuation of use or non- use (Kruk, Paczkowski, et al., 2009).

### **2.2.6. Woman's position in the household**

In many developing countries, other factors such as a woman's position in household decision making in relation to her spouse or other family members can also affect her use of health services (Bloom et al., 2001; Matsuoka et al., 2010; Tanner & Vlassof, 1998; Timyan et al., 1993). These studies show that within the household, a woman's participation in determining health care priorities is often very limited due to socio economic and cultural factors. Her spouse or other family members may decide where and when she should go for health care and which funds to use, if any. Household income is usually a major determinant of health access and utilisation of health services among the pregnant women. If the household cannot afford the costs required, a pregnant woman and/or her family may resort to self-treatment, seek other alternatives such as traditional healers, birth attendants, or report much too late for care.

### **2.3. Antenatal care**

Since 2002, the Tanzania Ministry of Health and Social Welfare has recommended a four-visit focused antenatal care approach (National Bureau of Statistics- Tanzania and ORC Macro International Inc., 2005; von Both et al., 2006). Pregnant women are advised to start attending antenatal care before the sixteenth week of gestation and services are provided free. However, more than 80% of pregnant women begin attending antenatal care later than 17 weeks of gestation (National Bureau of Statistics- Tanzania & ORC Macro International Inc., 2005; Ministry of Health- Tanzania, 2004]). Further, despite 94% of women making at least one antenatal visit, only 47% give birth with a skilled/trained attendant (National Bureau of Statistics- Tanzania & ORC Macro International Inc., 2005). Studies from a neighbouring country, Uganda, show a similar situation: only a small proportion of pregnant women deliver in health facilities despite the majority attending antenatal clinics at least once during pregnancy (Amooti-Kaguna & Nuwaha, 2000; Hitimana- Lukanika, 1988; Munaaba, 1995; Otim-Adoi, 1981).

A study conducted in Tanzania by Mrisho et al. (2009) found that at antenatal care visits, women are expected to receive services like weight measurement, physical examination, provision of sulphadoxine-pyrimethamine (SP) for malaria, injection (presumably tetanus toxoid immunisation), a blood test for syphilis, counselling for birth preparedness, provision of discount vouchers for government-subsidised insecticide-treated nets to prevent malaria, mebendazole tablets for maternal deworming, iron-folate supplements to prevent anaemia, and specific health education.

### **2.4. Postnatal care**

Provision and utilisation of postnatal care in Tanzania is still at very low levels. Tanzania Demographic and Health Survey (TDHS) data of 2004-5 reports that only 13% of women have the recommended one or more postpartum care visits within two days of delivery, while in some regions the rates are as low as 2%.(National Bureau of Statistics- Tanzania and ORC Macro International Inc., 2005). A study conducted in Tanzania by

Mrisho et al. (2009) demonstrates that despite the fact that postnatal services are still viewed to be both important and routinely provided, these services usually focus more on the child than the mother, unless the mother has a serious problem related to maternal complications. Both mothers and health care providers perceive post natal care important for the baby (Mrisho, et al., 2009). The most common services provided in postnatal care include: weight monitoring, tuberculosis immunisation (BCG), polio vaccination, DPT-1, 2 and 3; and measles vaccination (Mrisho, et al., 2009). Notable is that the services are oriented towards the infant instead of the mother as it is provided under the Expanded Program on Immunization (EPI) in the rural areas. Yet the lack of postnatal care for the mothers could explain why high levels of maternal death persist, and raises questions too about the knowledge of health workers and women themselves about the importance of postnatal care.

## **2.5. Human Immunodeficiency Virus**

HIV testing is another important aspect in the provision of maternal health services in Tanzania. It was explored in this study to ascertain if it has barriers or an enabling environment for access and utilisation of reproductive health services. The government of Tanzania, through its National HIV/AIDS policy under section 1.7 (l) on Principles to guide the National Policy on HIV/AIDS, states that ‘all linked HIV testing must be voluntary, with pre-test and post-test counselling, and all testing for other health conditions must conform to medical ethics, i.e. informed consent’ (United Republic of Tanzania, 2001).

In Tanzania, a provider-initiated HIV testing approach has been recommended (also referred to as *routine or opt-out testing*) as a national strategy for HIV testing and counselling in reproductive and child health settings (United Republic of Tanzania, 2013b). HIV testing is therefore offered as a routine part of reproductive and child health services including antenatal care whereby all women receive HIV testing and counselling (United Republic of Tanzania, 2013b). In order for a client to give informed

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consent, she/he is provided with pre- test information to help her/him make informed decisions (United Republic of Tanzania, 2013b). Informed consent is referred to a process whereby a client is provided with clear and accurate information about HIV testing, including risks and benefits, to ensure that the client understand she/he has the right and opportunity to opt-out of testing (United Republic of Tanzania, 2013b). Opt-out testing means that a client may decline to have the test (United Republic of Tanzania, 2013b). Furthermore, the strategy states that ‘any client or patient who does not give consent for HIV testing and counselling shall still be provided with the best possible care, and may not be denied access to other health services. The decision to decline should be noted in the client’s medical record so that she can be supported and encouraged to test for HIV at subsequent visits to the health facility’ (United Republic of Tanzania, 2013b, p. 26). One of the practice points in the provider- initiated HIV testing approach emphasises that clients should never be pressured or coerced into being tested (United Republic of Tanzania, 2013b, p. 27). However, the approach still points out that a client will continue to be encouraged to have the test even when she/he may have already opted out testing.

WHO and its member countries have taken a strong position against forced testing for HIV and regard it as an invasion of privacy and a violation of human rights (Canadian HIV/AIDS Legal Network, 2007; WHO, 2012). Some studies have shown that making HIV testing compulsory cannot stop HIV from spreading but will rather make people fear testing, especially those who feel they are most likely to be infected (Asante, 2007; WHO, 1992). These studies show that people may avoid testing centres and any other place where they may have to undergo a test, such as antenatal clinics. Further, the same studies have shown that making the HIV test compulsory may even put an unborn child in more danger due to likelihood of pregnant women avoiding antenatal clinics.

Studies from Tanzania, Ivory Coast, Burkina Faso and South Africa have shown that pregnant women, if properly counselled about the benefit of HIV testing, accept HIV testing and return for their results. (Cartoux, Meda, et al., 1998; Cartoux, Msellati et al., 1998; Kilewo et al., 2001; Saba 1999). Nonetheless, a challenge is how much the

country is in a position to provide treatment to HIV-infected people. WHO (2005a) reports high unmet antiretroviral drug (ARV) needs in Sub-Saharan Africa where approximately 4.2 million people in need of treatment were without access to ARV therapy in June 2005. In addition, the report shows that in countries such as the Democratic Republic of the Congo, Ghana and the United Republic of Tanzania, ARV therapy coverage was below 5%. The logic of HIV testing where there is no hope for treatment if needed is challenged (Asante, 2007).

There are also socio-cultural issues surrounding testing for HIV. A study carried out in Botswana and Zambia found that stigma against HIV-positive persons and fear of discrimination were the main reasons for the low uptake of voluntary counselling and testing to prevent mother-to-child transmission of the virus (Nyblade, 2002). Another study done in Tanzania has shown that, even when women go for voluntary HIV testing, they do not disclose their positive HIV serostatus to their sexual partners due to fear of stigma, divorce and violence (Kilewo et al., 2001).

## **2.6. Family planning**

As part of postnatal services, family planning is one of the provisions of maternal and reproductive health services explored in this study to ascertain its accessibility and utilisation among women in Tanzania. Family planning provision is one of the commitments of the Millennium Development Goals (MDGs) to ensure universal access to reproductive health so as to reduce maternal mortality (United Nations Millennium Development Goals, 2000a). The aim of family planning is to enable families to have access to contraception in order for them to plan their families either by delaying, spacing or limiting the number of children they need (Carr, Gates, Mitchell, & Shah, 2012), to improve the health of mothers and children (Razzaque et al., 2005) and to enable them to achieve other social and economic goals (Canning & Schultz, 2012). Studies indicate various beneficial gains of using family planning methods such as improving maternal health (Singh, Wulf, Hussain, Bankole & Sedgh, 2009), saving lives

of children (Graham et al., 2006), reducing mortality (Nour, 2008), empowering women (Kristof & WuDunn, 2009; Schultz & Joshi, 2007), development in education (Bloom & Canning, 2006; Lloyd & Mensch, 2008) and generation of wealth (Barnett & Stein, 1998), reduction of poverty and environmental protection (Canning & Schultz, 2012; Guzmán, George, Gordon, Daniel, & Cecilia, 2009). It is therefore important that women have access to family planning services in order to gain such benefits and improve their own lives and those of their families. However, despite recognition of reproductive rights as fundamental human rights by the International Conference on Population and Development, and the Millennium Development Goal's commitments to reproductive health, still there are unmet needs for family planning (Center for Reproductive Rights and UNFPA, 2010). Authors like Cottingham, Germain and Hunt (2012) advocate the use of human rights to enhance laws and policies and seek government accountability to ensure that people have access to information related to contraception; and ensuring family planning services are available to those in need.

## **2.7. Significance of the study- Implications for policy, delivery or practice**

This was a focused in-depth study with a small purposive sample from one district, rather than a large-scale survey exercise of an entire population. Within the framework of what is known about problems of access and utilisation of maternal, preventive and curative services in rural communities in developing countries, it focused on reproductive healthcare access issues as perceived by those in four rural communities in Bagamoyo district, Tanzania, who are directly affected by them: (recently) pregnant women, their husbands and partners, and the local healthcare professionals. The study provides important insights into many factors that affect pregnant women's access and utilisation of such services. A study by Hankivsky (2008) in Canada shows that health research on women assume that all women, regardless of age, cultural background, geographical location, socio economic status, religion, sexual orientation and other different categories, share exactly the same experiences, views and priorities. In

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addition, Hankivsky's study argues that women's health research also tends to give priority to gender over other key determinants without adequately addressing the interactions between all determinants of health. As a result, the priorities of many vulnerable women are often excluded from mainstream women's health research. With this in mind, and since I wanted to gain a different and more complex understanding of issues around access to health care among pregnant women, it was relevant and important to conduct a small-scale study using qualitative techniques particularly in-depth interviews with women and health care personnel, as well as focus group discussions with men in order to get their experiences, perspectives and priorities. The findings from the study are important to scholarly understandings of issues around access to health care for rural women in developing countries; to processes of transformation in policy and practices in developing countries through revisions, enhancement and the development of new forms of access to health care services; more comprehensively designed empirical research on access to care; and practical models to assist policy makers design programmes that better meet the needs of individuals and communities.

### **3. Research methodology**

Della Porta and Keating (2008) describe methodology as the instruments and techniques that are used to acquire knowledge. It is a set of principles used to carry out research and validate knowledge of a certain subject matter. Different from methods of data collection, methodology is about how methods are used to obtain knowledge of a particular subject matter. According to Noor (2008), the type and features of the research problem determine the choice of methodology. This means that the nature and the purpose of the research are important determinants of which methodology to apply and methods to be used. Methodology is necessary in conducting research because it provides a guide on how to conduct research with a certain field. A methodology enables a researcher to carry out activities using different methods of data collection, such as interviewing and focus group discussion, with different types of participants, and to be able to provide a more contextualised understanding of data from both methods.

Both qualitative and quantitative methodologies are significant in explaining a particular subject and how it is addressed. While on one hand, qualitative research is said to be exploratory, quantitative is said to be conclusive (Bray 2008). These two types of research apply different type of methodologies and it is debatable which methodology is better (Brady & Collier, 2010; Brady, Collier, & Seawright, 2010; King, Keohane, & Verba, 1994). The arguments against qualitative research are based on that fact that qualitative research is limited due to its focus on ‘why and how’ of social life and therefore cannot be representative of the general population while quantitative research is viewed as taking a broader perspective (della Porta & Keating, 2008). Inversely, quantitative research is said to lack deep understanding of social action and therefore qualitative research can deal with questions that quantitative research cannot elucidate (Brady & Collier, 2010). Ulmer and Wilson (2003), for example, argue that there is a need for qualitative results to be supplemented with quantitative findings so as to obtain different views and opinions. However, Corbin and Strauss (2008) make it clear that

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these two research methodologies are not incompatible with each other but are complementary to each other.

Being a qualitative study, my research might not be regarded as representative of the general population. However, it is the nature and the purpose of the research that is the basis of this research and which gives it a scientific validity. Adopting an interpretative approach emanating from ethnography and anthropology, this study is representative in its own way and therefore has a qualitative scientific validity. As Denzin and Lincoln (2000, p.3) elaborate;

*Qualitative research is situated activity that locates the observer in the world. It consists of a set of interpretative practices that make the world visible. These practices transform the world. They turn the world into series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them.*

With that being said, my study provides a deep understanding of perspectives of an individual and groups of people through listening and letting voices of people be heard by means of qualitative research, which could not have otherwise been captured in quantitative research. Qualitative research is a good means of listening and finding ways for people to express themselves and allows voices of people to be heard (Leonard, 2010). The basis of my research is therefore not to provide a representation of the general population, but rather to understand the issues that affect rural Tanzanian pregnant women who try to access and utilise health care services. The importance of this study lies in the fact that it represents the actual situations and conditions rural pregnant women face at health facility, household and community levels as they seek health care services. Despite the small number of sixteen participants included in the

study, as a qualitative study it provides a deep understanding of what women perceive and experience. This understanding is crucial in explaining the day-to-day life of the pregnant women in rural areas, and experiences that would have been unknown if other methods were used. The understanding of perspectives of rural Tanzanian women could be relevant to women living in similar conditions, experiencing the similar environment and facing similar problems.

### 3.1. Paradigms

The study was guided by the interaction theory; Natural Interactionism. This theory was chosen because of its philosophical relevance to this study. According to Denzin (1989, p. 71), the Naturalistic Interactionism is

*the logical method of the symbolic interactionist... demands the researcher actively enter the world of local people so as to render those worlds understandable from the standpoint of a theory that is grounded in the behaviours, languages, definitions, attitudes and feelings of those studied.*

Denzin (1989) views Naturalistic Interactionism as an attempt to enter people's heads, recognising that human engage in 'minded', self reflexive behavior. He states that *humans act in ways that reflect their unfolding and emergent definitions of themselves and the social situations they confront* (Denzin, 1989, p.71). In order for a research project to have a scientific relevance, it must confront these situations of human group life (Blumer, 1969; Mead, 1934)

Adopted from Mead's statement on Social Behaviorism (Mead, 1934), Denzin (1989, p. 71) explains that the term Naturalistic Interactionism *directs the researcher to link the symbol or the attitude with interaction hence the term Symbolic Interactionism.* According to Zardrozny (1959, p. 339) Symbolic Interactionism is

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*an approach to understanding human conduct which is based on the views that the human is primarily an active, goal-seeking person (not merely a responsive organism), that the stimuli toward which he acts are selected and interpreted by him, and that social interaction occurs in terms of these significant symbols.*

The philosophical description of Symbolic Interactionism is based on the stance that in order to understand the empirical world, the determination of problems, concepts, research techniques and theoretical themes should be done by the direct examination of the actual empirical world (Blummer, 1969). The theory expands the understanding of the perspective of scientific inquiry by gathering necessary data through careful and disciplined examination of the world.

Methodologically, the relevance of Natural Interactionism and/ or Symbolic Interactionism in this study lies on the fact that it is a realistic approach that focuses on the scientific study of human group life and human behaviour. By focusing in the natural world of such group and conduct, Blumer (1969, p.47) states that: *it lodges its problems in this natural world, conducts its studies in it, derives its interpretations from such naturalistic studies.* The essence of this theory is that, if it wishes to study a particular behavior it will go to actual people or group of people with particular or similar characters in order to explore, observe, and learn from their conduct and experiences of those particular groups.

The relevance of this theory in this study therefore lies on the fact that in order to understand access and utilisation of health care service among pregnant women in rural communities in Tanzania, it was imperative to interact with pregnant women and other interrelated groups in particular male spouses and health care personnel so as to understand their world. The study therefore focused on intensive listening to the stories and experiences of pregnant respondents, male spouses and health care personnel using a

naturalistic ethnographic approach to explore, observe and learn from their perspectives, conduct and experiences of access and utilisation of the health services.

### **3.2. Study design**

This was a descriptive study encompassing community and health facilities from rural communities in Bagamoyo district, Tanzania. It was a small-scale study which used a naturalistic ethnographic approach, conducted in the communities of Kerege, Matumbi, Kiromo and Kitopeni; two had health facilities (Kerege and Kiromo) and two did not (Matumbi and Kitopeni). The naturalistic ethnographic approach which is a qualitative research approach focused on intensive listening to the stories and experiences of pregnant respondents and male spouses and health care personnel. In-depth interviews, focus group discussions and observation were used as methods of data collection. In-depth interviews with sixteen women, four focus group discussions with thirty two men and in-depth interviews with six health workers were conducted and combined with observation at selected government health facilities.

The aim of my study was to explore issues around access and utilisation of health services among pregnant women from their own perspectives and experiences. In order to meet this aim, it was appropriate that I use an ethnographic approach with the aim of understanding various issues around access and use of health care services from the point of view of women as users of the services, as well as elicit opinions from providers. Bray (2008, p. 300) defines ethnography as

*a naturalistic approach that attempts to work with the society as it is without trying to influence or control it. The goal is to understand behaviour in its habitual context as opposed to an abstract or laboratory setting and to interpret how people give meaning to their experiences.*

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In this study, therefore, ethnographic approaches effected a methodological triangulation, which involves using more than one method to gather data. This method validates data through cross verification from more than two sources (Altrichter, Feldman, Posch, & Somekh, 2008) and enables deep research and the extrapolation of a larger picture. In-depth interviews, focus group discussions and observation were therefore used to explore and identify the determinants of access and use of government health services.

The basis of data collection in an ethnographic approach is the continuous long-term study of an area or group of people; it relies on taking time in order to understand human expressions (Wolcott, 1999; Bray, 2008). Ethnographic approaches are good qualitative methods of data collection because research participants are free to express themselves within very minimal limits. Although ethnography approaches may take long time, they are beneficial to the researcher because, by encouraging the expression of ideas, they can uncover issues of significance that would have otherwise been unknown. Bray (2008) argues that ethnographic approaches allow researchers to ask broad questions eliciting responses in the participant's own words and also assist a researcher to qualify her understanding during the research process through further probing questions.

An ethnographic approach was therefore used to explore the barriers and enablers to access to health care services. Specifically the study sought to explore barriers to access and utilisation of maternal, preventive and curative services among rural pregnant women in government health facilities. The study also sought to investigate enabling mechanisms that can be used to create and improve rural pregnant women's access to and utilisation of these services.

### **3.3. Study area**

The study was conducted in four rural communities: the Kerege, Matumbi, Kiromo and Kitopeni in Bagamoyo district in Tanzania. Bagamoyo district was selected because it is

the district located near an urbanised area and has easy access to Dar es Salaam city, a point of contact with a variety of opportunities and access to reproductive health services. These four selected rural communities also have an easy access to the Bagamoyo District Council and the Dar es Salaam region: Kiromo and Kitopeni villages being closer to Bagamoyo District Council than Kerege and Matumbi villages.

### **3.4. Methods of data collection**

Methods are ways of obtaining data (Bray 2008; della Porta & Keating 2008). The methods are therefore the tools to collect information on a subject matter. This study used interviews; in-depth interviews and focus group discussions with participants as qualitative methods of data collection as well as observations which were conducted at the health facility premises.

#### **3.4.1. Interviews**

Interviews are one of the major methods of collection of data in qualitative research. Punch (2014, p.144) describes interviews as *a very good way of accessing people's perceptions, meanings, definitions of situations and constructions of reality*. Jones (1985, p.46) emphasises the importance of interviews in understanding people from their own perspective by stating that

*for to understand other person's construction of reality, we would do well to ask them (rather than we assume we know merely by observing their overt behavior) and to ask them in such a way that they can tell us in their terms (rather than those imposed rigidly and a priori by ourselves) and in a depth which addresses the rich context that is the substance of their meanings.*

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In the context of qualitative research, interviewing is more than asking and getting answers. Fontana and Frey (2000, p.645-646) elaborate:

*Interviewing includes a wide variety of forms and multiplicity of uses. The most common type of interviewing is individual, face-to-face verbal interchange, but interviewing can also take the form of face-to-face group interviewing, mailed or self-administered questionnaire... It can be used for the purpose of measurement or its scope can be the understanding of an individual or a group perspective. An interview can be a one-time, brief event...or it can take place over multiple lengthy sessions, at times spanning days, as in life history interviewing.*

There is a variety of types of interview styles suitable for different purposes. Punch (2014) concurs with Fontana and Frey (2000) stating that it is important that the type of interviews selected for the study is related to the strategy, purpose and research questions.

Several studies show that interviews are an effective way of gaining deep understanding of a subject matter (Kvale, 1996; Patton, 1990; Smith, Harré, & Langenhove, 1995; Travers, 2009). Consistent interviewing establishes reliability or reveals inconsistencies in the information collected.

According to Wardrop (2015), in this type of ethnographic interview

*the essence of the process is to begin with a framework of issues one wants explored..., from which one develops some open-ended questions to begin the conversation with the participants, and then one constructs ... a dialogical space within which the questions can gradually be introduced, and the participants can use them as a starting point through which to explore their responses to those issues, but also to open up other aspects of those issues or, ... other issues which we as the interviewers*

*had no idea existed. ... The aim, then, is to make audible the silences, to make visible that which is hidden. It is in that way that the narratives can tell the researchers both what they know they need to know, and what they do not yet know they need to know.*

This method demands trust between participant and researcher, and it is often only on second or subsequent interviews or discussion groups that the core data begins to emerge, sometimes told for the first time in a person's life (Fleming, Gaidys, & Robb, 2003; Lather & Smithies, 1997; Patton, 1990; Travers, 2009). As Portelli (2010) has powerfully shown in his work with marginalised Kentucky coalminers, these qualitative interviewing methods enable the engagement of both individuals and community in the research, encouraging them to participate on their terms rather than as subordinate subjects and, therefore, produce deep data which is experientially grounded.

### **3.4.2. Focus group discussions**

The focus group discussion is a type of group interview that involves a researcher interacting with more than one person simultaneously on a certain subject matter. It is a qualitative means of data collection that involves a number of participants, ranging from 6 to 12 people, discussing various topics of a subject matter. The aim of focus group discussion is to gather concentrated discussions that are topics of interest to the researcher (Morgan, 1993). Focus group discussions are advantageous in research due to their capacity to involve a number of people in an interaction. Morgan (1988) also emphasises that *the hallmark of focus groups is the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group*. However Morgan (1993) also cautions that, despite the advantage of focus group discussion in revealing people's deep insights, it may engender a discussion that is less logical, less thoughtful and less organised than anticipated. Additionally, despite the fact that focus group discussions allow people to express their perspectives by sharing

their feelings, opinions and experiences, it can also enable participants to learn from each other.

### **3.4.3. Observations**

Observation as a method is a way of collecting data by watching events as they actually happen at first hand (Denscombe, 2010). It is another type of qualitative research method used to visualise or examine a subject matter. Jamshed (2014) defines observation as a type of qualitative research method that not only includes participants' observations but also encompasses ethnography and research work in the field. In addition to observing something, therefore, observation can also be an account of something heard or noticed. It is an important method in anthropological and sociological research and it uses interviews to understand human behavior and impressions. Mulhall (2003) elaborates that although observation mainly serves to confirm whether what is being said by people is what is actually being done by them, in qualitative research there are reasons for conducting observation which may include: providing insights into interactions between two people and groups; illustrating the whole picture; capturing context/process; and elucidating the influence of the physical environment on the social world. While observation is good at capturing data on people behavior in more natural situations, it is also important in capturing information about physical environment. Observation in research can also assist in validating research results (Gray, 2014). There are two type of observation; participant and non-participant. Participant observation is *a method of data collection in which the investigator uses participation in an area of ongoing social life to observe it* (Lewis-Beck, Bryman, & Liao, 2004). In participant observation, the identity of the observer may be known or concealed to those being studied with the aim of producing an understanding of the group or culture being studied. Denzin (1989, p.157) states that in participant observation

*the participation of the observer may be known to those observed, so that it is clear they are being studied, or the investigator may conceal the*

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*observer identity and attempt to become a 'normal' member of the community, cult, organization, group, tribe, or club being studied.*

Non-participant observation is

*a data collection method used extensively in case study research in which the researcher enters a social system to observe events, activities, and interactions with the aim of gaining a direct understanding of a phenomenon in its natural context (Mills, Durepos, & Wiebe, 2010).*

As a nonparticipant, the observer does not participate directly in the activities being observed. Different from participant observation, non-participant observation adopts a more distant and separate role of involvement in a research setting. The observer may be covert whereby participants are unaware that the observer is doing research, or overt whereby participants understand that the observer is there for research purposes.

Since this was a qualitative study aiming at understanding individuals' perspectives from their own point of view, as well as their experiences, in-depth interviews and focus group discussion, and observation methods of data collection were relevant. This study used these qualitative methods of data collection to examine how access to and utilisation of maternal, preventive and curative services among pregnant women living in rural communities of Bagamoyo District, Tanzania are both constrained and enabled.

### **3.5. Study participants**

#### **3.5.1. Female participants**

I did several in-depth interviews with the same pregnant women over a period of time. The views of women were central to this qualitative study that explores barriers to access and utilisation maternal, preventive and curative services among rural women. Women in Kerege, Matumbi, Kiromo and Kitopeni rural communities of Bagamoyo

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district were purposefully identified (Curtis, Gesler, Smith, & Washburn, 2000). Sixteen women were purposively chosen from the community. I visited a number of households to invite participants for the study in each village after the community leaders had located the potential study participants with the characteristics required. The community leaders informed the participants of a possible visit from me, and provided me with the locations of the participants. I then visited potential participants at their homes, explained to them the purpose of the study, and invited them to participate in the study. I made appointments with those who agreed to participate in the study until I reached the intended number of participants in each village. On the day of the interviews, I provided further details to the women who agreed to participate in the study. When the participants agreed freely to participate, they were interviewed individually at their homes.

In-depth interviews were conducted with sixteen women: four women from the four selected communities of the study. The age range of women interviewed was between twenty and forty two years old. All women had completed standard seven level of primary school education and most of them were peasants, five of them engage in petty trade and three were housewives. All the women interviewed were at least in their second pregnancy or more. The interview guide was used to collect data on background information on socio-economic and demographic aspects, women's experiences in seeking preventive, curative, antenatal, childbirth or postnatal services in the health care system, i.e. reasons for use and/or non-utilisation of the services among pregnant women including the quality of care and services provided from their point of view, as well as enabling environment for improvement and utilisation of these services among pregnant women living in rural communities.

It is important to note that the interviews with individual women were as free as possible, allowing them to speak their minds on anything that they felt important, without censure or reproach. In such an interview space, I heard much that might have not been spoken if the respondents were not given the opportunity. I also listened for

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what the participants were not saying- the silences and elisions that conceal (often) very significant but unarticulated understandings, feelings and ideas.

I had first round and second round of interviews with the women. The second round interview questions were basically based on the questions that needed clarification and/or further inquiry. I manually coded the interviews based on the key issues of my research and developed themes as they emerge accordingly.

### **3.5.2. Male participants**

Four focus group discussions were conducted with thirty two men; eight men from the four selected communities who had been purposively sampled to select those with pregnant wives or partners or those having had pregnant wives or partners for the last twenty four months. The age range of men was between twenty two and fifty five and all had completed standard seven level of primary education. Majority of men: twenty two were peasants, while four engaged in petty trade, four in skilled work and one was a driver. I therefore conducted four focus group discussions, one in each village. The focus group discussions were held, each with a minimum number of six and a maximum number of ten participants. The focus group discussion guide was used to gather information on their perceptions regarding their experience of their partners' access to and utilisation of health services, and their perceptions of the reasons behind the use/non-use of health-care facilities.

### **3.5.3. Health care personnel**

I had in-depth interview with all health care personnel from the two government dispensaries namely Kerege and Kiromo providing antenatal, child delivery, post-natal, preventive and curative services in the selected rural communities in Bagamoyo district. From my experiences as a researcher in health facilities in Tanzania, rural government health facilities usually do not have many health care personnel and these same health care personnel often provide several health services in a facility. This was the case

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during my fieldwork research and therefore, all six health care personnel from both dispensaries: three from each dispensary were included in the study. The health workers had between standard seven level of primary school education and form six level of secondary education. In addition they had training skills in medical attendance, nurse midwifery or clinical medical assistance.

The interview guide was used to gather information about their experiences in the provision of health care services, as well as to elicit their perspectives on women's use of their services including challenges they perceive as confronting pregnant women and mothers who access the services. The information gathered included numbers of women accessing health services; availability of services; adequacy of trained health care personnel; availability of antenatal, childbirth, postnatal, preventive and curative services; drug supply; and infrastructure to perform health-care work efficiently. The health care personnel were also asked to give their views of pregnant women's reasons for using or not using health services. They discussed this in view of their role as health care personnel.

### **3.5.4. Health facilities**

In my study I used non-participant observation to gather data from health facilities. I observed two government health facilities, Kerege and Kiromo dispensaries, of the four selected communities. The aim of the observation was to gain a better understanding of the environment in which dispensary health care personnel operate and their routine needs. I undertook observation to ascertain the interaction of women and health providers, service types required and provided, the adequacy of resources, facilities and surroundings to provide services, and any other circumstances that might have needed attention or follow up.

### **3.6. Sampling**

The study was conducted in four rural communities: the Kerege, Matumbi, Kiromo and Kitopeni in Bagamoyo district in Tanzania. Bagamoyo district was selected because it is the district located near an urbanised area and has easy access to Dar es Salaam city, a point of contact with a variety of opportunities and access to reproductive health services. These four selected rural communities also have an easy access to the Bagamoyo District Council and the Dar es Salaam region: Kiromo and Kitopeni villages being closer to Bagamoyo District Council than Kerege and Matumbi villages. Previous studies on access and utilisation of health care services among women have focused on rural and remote communities with long distance and difficult access to the big cities of Tanzania (Kruk, Paczkowski, et al., 2009; Mrisho et al., 2007; Mrisho et al., 2009).

The study used purposive sampling to select study sites. Four communities were targeted; two with health facilities and another two without such facilities so as to compare access and utilisation of services as well as the reasons for utilisation and non-utilisation of the services. The study areas therefore included two rural communities of Kerege and Kiromo with health facilities and two rural communities of Matumbi and Kitopeni without health facilities. Only government health facilities were included because they are the main health facilities found in and serving the rural communities. Members of these communities live in scattered areas and own small and/or traditional houses built within or near their farms; others live close to each other in areas that are regarded as central locations/towns, for having necessities such shops, schools and village offices. Residents of the Bagamoyo district are almost all Swahili speakers. Swahili is a national and official language in Tanzania (Ali, 2014).

Tanzania has four main climate seasons. The dry season starts in January and ends in March followed by the heavy and long rainy season from March to June. The short and windy rain season begins in June and ends in August; September to December is the short rainy season (United Republic of Tanzania, 2004). Despite the four seasons, Tanzania has been experiencing climatic changes which manifests as weather which

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does not follow this appropriate trend of the seasons. The rainy and dry seasons are the two important seasons for these communities because the rainy season is when community members spend most of their time farming subsistence and low value food crops, fishing and mariculture (prawn and seaweed farming); the dry season is the period for food harvesting, relaxation and celebrations. The dry season is, therefore, the best season for conducting research studies because participants are available to interact. I had anticipated beginning my research around August when the weather was still dry, despite it being the short and windy rain season, but due to delays in getting my ethics clearance in Tanzania, I had to start my interviews in November. During this period, Bagamoyo and particularly my study villages were experiencing short but heavy rainfall which ruined the roads, making some of them impassable by any means of transport and others passable only by motorbikes.

The communities for the study were selected after discussion with Council Health Management Team (CHMT) on the overall situation and trends in access and use of reproductive health services by pregnant women in the rural communities of Bagamoyo district. I also consulted with district leaders to suggest with two villages with and two villages without health facilities to include in the study.

Community members from the four identified rural communities at the district level were invited to participate in the study. Purposive sampling was used to locate potential participants with the characteristics required for the study. The potential participants were then informed of a possible visit. Sixteen women, thirty two men and six health workers were therefore selected to be included in the study. Only those who agreed to participate were included in the study. The main study population was women from Kerege, Matumbi, Kiromo and Kitopeni rural communities in Bagamoyo district, Tanzania. Specifically, the study targeted women of reproductive age who were pregnant and were already due to starting/ had started attending antenatal clinic. The women were three months pregnant or more, and women with pregnancy history not exceeding twenty four months from when the study was carried out for easy recall and not below eighteen years old of age.

The study also included men (partners and husbands) with pregnant wives or partners, or who have had history of having pregnant wives or partners in the last 24 months. It is important to note that these men were not the partners or husbands of the interviewed women. I chose other men in order to avoid bias which could have been contributed by women who I had already spoken to, sharing information with their partners. These men provided their perceptions and experience of access to and use of health facilities. Men's views were important in ascertaining the reasons for women's use or non-use of the health services.

Health care personnel from Kerege and Kiromo government health facilities which provide services to the four selected rural communities were included. These health care personnel also provided their opinions on women's use of and access to their services. Since they are the main providers of the services in rural communities, obtaining their points of view was vital. All respondents in this study were eighteen years of age or older.

### **3.7. Data collection procedures**

Procedures for selection of villages for the study in Bagamoyo district began at the district level. After receiving my clearance to conduct medical research in Tanzania, I wrote and submitted a letter to the District Executive Director (DED) of the Bagamoyo District Council in Coast Region, attached with the clearance certificate to apply for permission, to conduct my research in the district. I also submitted a copy to the District Medical Officer in Bagamoyo District Council. Selection of villages for the study was made after some discussion and agreement with the Council Health Management Team and based on information provided to me.

After I selected the villages to include in the study, the District Medical Officer, a member of the Health Council Management Team, informed me that they would write

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me official letters to take to the community leaders of the selected villages, allowing me to conduct my research. The District Medical Officer informed me that they would notify me when the letters were ready for collection. On 19 November 2012, I collected my letters from the District Medical Office to submit to Village Executive Office, Ward Executive Office and health facility in-charges at the villages for my study.

Upon receiving the introductory letters to the study areas, I went to visit the villages and met with the community leaders and health facility in-charges to introduce myself and the research I would be conducting in their villages. At the ward level in Kerege and Kiromo, I met with Ward Executive Officers. At village level, I met with Village Executive Officers, secretary, hamlet or street leaders. At the dispensary level in Kerege and Kiromo I met with health facility in-charges at that time. On 19 November 2012, I paid a courtesy call to the Kerege Ward Executive Officer. I also visited the Kerege dispensary and met with a health facility in-charge, clinical officers and a nurse midwife. Similarly, on 20 November 2012, I paid a courtesy call to Kiromo Ward Executive Officer, the Kiromo Village Executive Officer and the Kitopeni Village Executive Officer. On 20 November 2012, I met with the acting health facility in-charge of Kiromo Dispensary and a nurse assistant. On 21 November 2012, I paid a courtesy call to Kerege Village Executive Officer and Matumbi Village Executive Officer. While introducing myself at each village, I submitted the letter to the Village Executive Officers and health facility in-charges that I received from the District Medical Office.

At each village, I explained to community leaders the purpose of the research and gave details of the characteristics of intended study participants. After discussion, community leaders informed me that they would share the information with their community members. They asked me to return after a few days to visit potential participants and plan for my interviews. The community leaders then located potential study participants with the characteristics required and informed them of a possible visit. After some few days I went back to the villages and the community leaders provided me with the locations of the potential study participants. I spent between one to two weeks locating, visiting and inviting potential participants for the study. I then visited potential

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participants individually at their homes, explained to them the purpose of the study, and invited them to participate in the study. With those who agreed I made appointments and informed them that I would provide further details on the day of the interviews. I followed the same procedure in each village until I reached the intended number of my study participants.

On the designated appointment dates, I visited the study participants and invited them individually to participate in the study. Between 23 November 2012 and 10 December 2012, I conducted my first round of interviews, which included in-depth interviews with pregnant women, focus group discussions with male partners/husbands, and in-depth interviews with health care personnel and observation at the health facilities. From 10 April 2013 to 21 June 2013 I did my second round of interviews with the pregnant women to follow up after they had delivered their babies. Particularly, I wanted to know how they were doing since the first round of interviews, if they went to deliver their babies where they first told me they would, and if they faced any problems reaching the health facilities, while at the health facilities, or on their way back.

I conducted all the interviews and focus group discussions myself and in the language of the participants, and my language, *Swahili*. I audio recorded all the interviews, transcribed them in Swahili, and later translated all the interviews into English. I assigned pseudonyms names to all participants in order to protect their confidentiality.

The experience from the field was remarkable. Throughout my journey, all my study participants were very cooperative. The participants and especially pregnant women unveiled to me their experiences and shared with me their views and understandings on issues that they felt were of significant importance in access and utilisation health care services as are discussed in the following chapters.

### **3.8. Data management and analysis**

In my study, a thematic analysis of data was used to come up with categories for data presentation (Guest, MacQueen, & Namey, 2012). According to Guest, MacQueen, and Namey, 2012 According to Guest, MacQueen, and Namey, 2012, p.10) thematic analyses *require more involvement and interpretation from the researcher... move beyond counting explicit words or phrases and focus on identifying and describing both implicit and explicit ideas within the data, that is, themes. Codes are then typically developed to represent the identified themes and applied or linked to raw data as summary markers for later analysis.* I used thematic analysis because of its ability to capture the complexities of meaning within a textual data set.

The field work data was transcribed in Swahili the language used during interview. The transcription was done by listening to the audio recorder used to gather the data while typing on the computer. The data was then translated into English for analysis. Analysis and management of data was done manually. This involved looking at the translated data and field notes, making notes and sorting the data into categories, types and relationships of meaning to look for consistencies, differences in order to produce themes. After reviewing translated data and field notes, issues which emerged as prominent from research findings about women access to health care were selected and presented as the main themes for result presentation and discussion. The data was presented in the selected themes in form of narratives and discussion.

I therefore analysed the data from the in-depth interviews, focus group discussions and observation using qualitative thematic analysis and triangulation by locating core themes and making comparisons. Responses from health care personnel were compared with responses from the women and men at community levels to identify factors related to the access and utilisation of the health services. The data was also triangulated with the data from the health facilities and my observations of the health facilities. This method of triangulation ensured credibility and validity of the results (O'Donoghue & Punch, 2003) by verifying information sought as well as identifying inconsistencies in

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perspectives on health service utilisation. After analysis, the main themes that emerged from the findings and selected for presentation and discussion included transport and its issues, antenatal care services, child delivery at health facilities and its challenges, perceptions and experiences of HIV testing, and utilisation of family planning.

I had sufficient facilities and resources at Curtin University which included access to a computer, printer, email and internet, a workstation, library and inter-library facilities and allowances for photocopying, telephone and consumables to facilitate completion of this research. The research required me to purchase an audiotape-recording device suitable for recording interviews and focus group discussions.

The collected data, other than freely available documents, is stored in a locked cabinet in the School of Social Sciences for a period of five years. I used the data for the purpose of this research and it was and is only accessible to me and my supervisor. The electronic data is stored in the main Curtin University computer server with a password. Upon submission and acceptance of the thesis, data and thesis held on the main Curtin University computer server will be deleted.

### **3.9. Ethics**

At Curtin University, ethics approval category A with application number 4238 was sought from the Curtin University Human Research Ethics Committee (HREC) and I received protocol approval HR 24/2012. In Tanzania, the national ethical approval for the proposed study was sought from the National Institute for Medical Research (NIMR), Tanzania. At the district level, the proposal was discussed with the district's Council Health Management Team (CHMT) and after consultation, two villages with and two villages without health facilities were selected for the study.

The intention for the study was then shared among the four rural community leaders and permission was sought to conduct the study. Communal oral consent was sought during

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village meetings and individual written consent was obtained from the women of reproductive age who were currently pregnant women and those who were pregnant for the last two years, husbands/ male partners and health care personnel after the researcher had explained to them the aims and objectives of the study and they voluntarily agreed to participate in the study. (Kvale, 1996).

Procedures, risks and benefits of participating in the study and the right to withdraw from the study at any time were explained. A chance to ask for clarifications about aspects that were not clear was given to those who agreed to participate in the study. Before the interviews, I explained to each participant individually the aim of the study and informed them that participation in the research was voluntary. I made it clear that there would be no sanctions or negative consequences if they declined to participate, or participated and then later decided to withdraw. I provided the participants with all the necessary information about the research, including information on confidentiality and anonymity as provided in the research information sheet. I gave each study participant an information sheet and an informed consent sheet. These were read by the participant and/or read out loud by me if the participant requested me to do so. I then gave each participant a chance to ask questions and seek clarification. Once the participant understood and agreed to participate in the study, s/he signed and/or put her/his thumbprint on the consent form. Each participant received a copy of their consent form which was signed/ marked by them to keep. I did not encounter participants who were not willing to sign the consent form; those who could not read were willing to use thumbprint. Confidentiality of the data and anonymity of the participants was strictly observed by ensuring the use of codes for all personal names. The postal and email addresses and telephone numbers of myself and my supervisor were provided to all participants for easy contact at any time. The contact details of the Curtin HREC were also on all information sheets and informed consent forms. These were all offered in both English and Swahili.

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An audio recorder device was used to record interviews and focus-group discussions. Prior to recording any discussion, permission to use a recorder was sought and obtained from every individual participant. Permission was also sought to use a camera to capture important matters deemed relevant to my study, particularly at the health facilities. I also took notes apart from using the audio recorder. My access to government health facilities was permitted by the Tanzania Ministry of Health and Social Welfare. I obtained ethical clearance from the National Institute for Medical Research (NIMR) where I am a Senior Research Scientist. This body has the sole mandate to provide clearance needed for conducting research in health and medical fields in Tanzania.

In Tanzania, the National Institute for Medical Research (NIMR) is a government institution that has the mandate to approve all medical and health-related research - conducted in the country. After review of proposed research programmes/studies, NIMR provides researchers with national ethics approvals, which allow researchers to carry out their studies in the country. All medical and health research to be conducted in districts has to be reported in advance to the District Medical Office of the district concerned. Past abuses have meant that ethics and access for researchers have been tightened and are closely monitored. I received my clearance certificate to conduct medical research in Tanzania dated 2 October 2012 in November 2012.

In my thesis I have not used the real names of all study participants to protect their identities, but instead have used pseudonyms. For the same reasons, I have also avoided using the work designation of the health care personnel I interviewed at the health facilities. Therefore in the thesis, pseudonymous names of the women participants are followed by only the village name in brackets; of the health care personnel are followed by the dispensary name and the word *dispensary* in brackets; and of the males are followed by the word *focus group discussion* and only the village name in brackets.

## 4. Transport and its issues

*The problem ... is the hospital is too far. For example, you can get labour pains... [There is a delay] even getting a motorbike from the time you call it until it comes to pick you up because the place itself is distant. Sometimes it can happen at midnight; now you call a motorbike and sometimes, you are about to deliver a baby. It becomes a problem. To tell the truth [showing sadness], pregnant women... have a difficult time. The transport issue is a nuisance. Paulina Joseph (Kerege).*

This chapter explores transport as an issue critical to accessing and utilising health services, as discussed by each group interviewed in Kerege, Matumbi, Kiromo and Kitopeni in Bagamoyo district. In particular, issues identified and discussed of significant importance were drawn from interviews with pregnant women, health care personnel and men. Significantly, I was interested in understanding the extent to which transport was an essential component in pregnant women accessing and using health care services. This chapter reveals the experiences of transport that pregnant women encounter while seeking health care services, during pregnancy and/or after delivery.

There is substantial literature that accounts for various problems of transport which pregnant women experience while attempting to access and use health care services, but much of that is limited to survey studies that deal with a large number of research participants rather than in-depth case studies that deal with a single person or a group of people to explore a topic in a more detailed manner. Several studies have discussed geographic and other impediments to the access to health care services such as travel distance, conditions of the roads, transport, the time at which transport is required, and costs, all of which influence utilisation of health care services (Arcury et al., 2005; Choguya & Bose, 2014; Gabrysch & Campbell, 2009; Izugbara et al., 2009; Kowalewski, Mujinja, & Jahn, 2002; McGrail & Humphreys, 2009; Nabukera et al., 2006; Nemet & Bailey, 2000; Parkhurst, Rahman, & Ssenooba, 2006; Say & Raine, 2007; Smith, 2008; Stock, 1983; Timyan, Brechi, Measham, & Ongunleye, 1993:

Thaddeus & Maine, 1994). These barriers influence and impact on health outcomes in pregnancy, and birth, and the transmission of infections such as HIV/AIDS, adversely influencing mother and child mortality (Acharya & Cleland 2000; Rahman, Mosley, Ahmed, & Akhter, 2008; Tanser, Gijssbertsen, & Herbst, 2006; Thaddeus & Maine, 1994).

This chapter recounts the views and knowledge of women, both pregnant and having recently delivered at the time of interviews, of their transport experiences while accessing health care services. In particular the women discuss the significance of transport as well problems related to distance and isolation, transport costs, type and time of transport available, and the opening hours of health facilities.

The opinions and experiences of health care personnel about the challenges they perceive confront pregnant women and mothers is a significant point of examination. I also include the opinions and experiences of male partners regarding the issue of transport as they seek health care services with their pregnant spouses.

#### **4.1. The significance of transport to Bagamoyo hospital**

*During delivery you go to the dispensary where you attended ante natal clinic and deliver there if you have no problems. However, if you have problems, the nurse will tell you that she cannot help you, let us go to Bagamoyo. You leave together with her to Bagamoyo. At Bagamoyo hospital, she will either hand you over or wait with you until you deliver.*

Veronica Chonde (Matumbi).

Bagamoyo hospital, as the central major hospital for this region, is the location to which pregnant women with complicated related pregnancy problems are told to go, and are sometimes taken to, although often not by formal hospital transport. Veronica, a pregnant woman, told me about the ways in which this might be organised. A number of

#### Chapter four: Transport and its issues

options were possible: *With a car, but you are the one to rent it, or the family for example your husband or your relatives, because there is no health facility transport.*

Issues can arise unexpectedly, as Farida Kombo (Kiromo) found;

*I delivered my child by normal birth here at Kiromo but after delivery I got problems. I delivered at around 11 in the morning but after staying for about two to three minutes I shed a lot of blood until I passed out. I was therefore taken by a car to Bagamoyo hospital where I was given blood.*

When I asked Farida which car she used, and if they called an ambulance for her since she delivered at the dispensary and problems occurred while she was still under their supervision. She said to me: *No way. We rented a car, a taxi, ourselves up to Bagamoyo. I rented it with my own money.* I could hear sadness in Farida's voice when she said that to me. The distance in this instance was about 8 kilometres. Farida lamented to me that she used 5,000 Tanzanian shillings equivalent to 2.87 US dollars to pay for transport to go to the hospital for further management.

Pregnant women expressed their discontent at how pregnant women have to travel by motorbike, public transport or rented car instead of by ambulance during the day if they are in intense pain or on developing complications after delivery at the government dispensaries as indicated by Farida. From Farida's account, two major issues emerge. The first concern is the costs of transport that come along with unexpected referral to a health facility, which can have an impact on a family. Women I had informal conversations with who were not study participants in the studied villages, told me that for an ordinary family in the village, this amount of money is a lot to use at once for transport. They told me that such amount of money, if used well, could feed a small family for at least 5 days. A second issue is the danger a woman is put in using non-hospital transport while still in the management of health care personnel. Clearly, delivering at a government health facility like a dispensary does not guarantee a person government transport, such as an ambulance, even if she is still under its care. A woman

## Chapter four: Transport and its issues

who has just delivered or is a few hours after delivery is still vulnerable to complications and is usually closely monitored at the health facility for hours or days. Taking a taxi or public transport while she may need a close monitoring, care and assistance places a woman at risk. Furthermore, not all women or their families have money for either private or public transport to the hospital, putting a woman at risk of delay in getting appropriate services, complications to her condition, or even death.

Various studies have indicated that transport and the condition of roads has an influence on the public's utilisation of health care facilities (Gage, 2007; Gage & Calixte, 2006; Gleit, Goldman, & Rodriguez, 2003). In developing countries particularly, the effect of distance are intense, particularly because the lack of transport and poor roads result in an escalation of the cost of attending health facilities (Bhuiya, Bhuiya, & Chowdhury, 1995; Islam & Tahir, 2002; Noorali, Stephen, & Rahber, 1999). Lack of tarmac/ bitumen on roads in rural areas of Tanzania is also a contributing factor for poor conditions of the roads especially during rainy seasons.

When I went to see Paulina Joseph (Kerege) for her second interview, it had rained for some few days consecutively and therefore the roads were difficult to pass in a normal private car. I therefore had to hire a private motorbike (popular transport used in the village nowadays) to get there. Although it was not raining at the time, the roads were impassable and the motorbike driver had frequently to pass across people's farming fields.

Transport was identified as an essential component in accessing the services by pregnant women, most specifically by those who live far from health facilities and who are unable to walk any distance unassisted. Most of the women in the study told me they depended on health services within their area of domicile but that did not mean that they were all able to reach the services with/without means of transportation. The most accessible health facilities were government health facilities at the level of a dispensary.

## Chapter four: Transport and its issues

Women in Kerege and Matumbi villages depend on Kerege government dispensary while those in Kiromo and Kitopeni villages depend on Kiromo government dispensary. Women told me that the most accessible means of transport to health services was public transport i.e. buses which pass along the villages in Bagamoyo road, mainly privately owned. Women also use motorbikes, as well as private cars, especially late at night when public transport is not available. In recent years, motorbikes in Tanzania have become popular in cities and rural areas. They are widely preferred by many people because the cost of hiring them is less than public and private vehicle transport, especially during the day. Furthermore, they are a means of transport commonly available and easily accessible in rural areas, especially during the night. Most of the motorbikes are parked by those who ride them within the busy vicinity of the rural areas waiting for passengers and, in the evening, are available for hiring within local households. When I spoke to women and men in focus group discussions they told that most of the motorbikes are not owned by those who ride them but by *rich* people from the cities who buy them and bring them to the rural areas. The owners give them to mostly young people for them to run as a small business. Respondents told me that rich people may be people who are originally from rural areas; who have bought land and/or built houses in those villages; and who sometimes may be relatives of some of the motorbike riders. Very few of the riders owned the motorbikes they rode.

However, the women further told me that availability of private transport, such as private cars and motorbikes, is still poor in other areas, given the location where a pregnant woman resides and the condition of the woman seeking transport. In such a situation, a pregnant woman may not be able to reach a health care facility due to the inability to walk the long distance. The situation becomes worse if labour begins during the night when transport is less available. Thaddeus and Maine (1994) have indicated that in such a situation, the likelihood of a pregnant woman failing to reach a distant health care facility and the possibility of a woman with serious complications dying on the way is very high.

## Chapter four: Transport and its issues

Even with available transport, some areas become unreachable during rainy seasons because roads are impassable. When I went to see Farida Kombo of Kiromo village for the second time after she had delivered her child I had to hire a motorbike to reach her. When we were going to her house we had to pass on a certain portion of the road that had turned into a temporary pond due to rain. At first I was hesitant to pass but the motorbike rider assured me that it was the road they use every day, even during the rainy season and so it was safe. Believing my driver, I crossed the area with him but we were almost carried away by the water. If it were not for the motorbike rider's skills we would have definitely drowned. After that experience, I did not feel safe returning by the same route. I therefore asked the motorbike rider to use an alternative route, which he did. Although that road was better, it was still watery, muddy and a route three times longer than the one we first took. That incident made me contemplate what a pregnant woman and/or her relatives would have done if she had needed to reach the clinic or to be rushed to the health facility for confinement or due to complications. What would a family do if they did not have access to transport because, with heavy rains ruining roads, not all riders were willing to use their vehicles?

Dependency on public transport in rural areas of Tanzania is still high due to the low socio economic status of people, which makes it impossible for them to afford or acquire a personal means of transport. Such a situation is prevalent in developing countries where many people still walk long distances because a motor vehicle is a luxurious item and therefore few have such transport available to them (Ojanuga & Gilbert, 1992). A study conducted in rural Nigeria by Stock (1983) discovered that distance from a health care facility tends to quickly reduce use of health care facilities.

### **4.2. Distance/ Isolation**

*The dispensary is very far, pregnant women walk a long distance to for services. Not all women or families have enough income to afford*

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*transport costs to go to health facilities.* Samson Kiango (Focus group discussion- Matumbi)

The issues of distance and isolation were also raised by male participants whose views reflected on the burden and costs pregnant women and their families or relatives face when seeking health care services. This indicates that the conditions for accessing health care facilities are as yet unfavourable. A large proportion of the population has to walk a long distance to reach the nearest health facility, and not all villages have their own government dispensaries. Mustafa Sallu (Focus group discussion- Matumbi) told me: *There is no dispensary in this village; therefore pregnant women have to walk a long distance if their families cannot afford the costs of transport.*

From my study experience, I observed that some households in the villages are isolated and the distance from the homes to the nearest health facility is more than the recommended 5 kilometres radius of all habitations (United Republic of Tanzania, 2005). Further, in other areas, transport is not even available, let alone the money needed for unexpected trips. Therefore, pregnant women are forced to walk long distances if they wish to use the services. In such situations, there is a high possibility of non-utilisation of services. Studies conducted in rural Guatemala and rural Cambodia indicated that if health facilities are very far from where pregnant women live, a tendency to delay or even never attend facilities is high, as opposed to when services are easily within reach (Acevedo & Hurtado 1997; Matsuoka, Aiga, Rasmey, Rathavy, & Okitsu, 2010). Other qualitative studies conducted in Uganda, India, Nepal, Vietnam and Ghana (Amooti-Kaguna & Nuwaha, 2000; D'Ambruoso, Abbey, & Hussein, 2005; Duong, Binns, & Lee, 2004; Griffiths & Stephenson, 2001; Mesko et al., 2003), concur that distance from health care facilities is a hindering factor for pregnant women, especially when labour begins during the night when transport is less readily available.

The problem of distance and isolation manifested itself even where transport could possibly be accessible but securing proper of type of transport for a pregnant woman or a mother, and delays could not be avoided. Women told me to have experienced delays in

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getting transport and the proper type of transport at the appropriate time due to distance involved and especially during the night, as described and referred to by Paulina Joseph as *a problem* in the interview I cited earlier.

What Paulina refers to as *a problem* is a pregnant or labouring woman's vulnerability on a motorbike. She may no longer be able to board a motorbike and may put herself and her unborn child at risk if she uses that mode of transport. Due to poor conditions of the roads, particularly in the rural areas, it becomes unsafe to even use a motorbike at the best of times. Frequently, motorbike riders refuse to carry a pregnant woman in labour because they cannot handle a pregnant woman on the motorbike and they know that she may not be able to tolerate the discomfort of the roads in her condition. Women, especially in rural areas, likely use a motorbike only because it is an affordable means of transport. In some areas it is the only available means of transport, especially late at night.

Several studies conducted in multiple low-income settings show that poor geographic access (distance, poor conditions and transport problems) is one of the barriers of women's use of health facilities for maternal health services (Kowalewski et al., 2002; Nabukera et al., 2006; Parkhurst et al., 2006; Thaddeus & Maine, 1994; Wong, Li, Burris, & Xiang, 1995). A study conducted by Fan and Habibov (2009) in Tajikistan indicated that lack of health facilities within points of population habitations and long distance travel to the nearest health care facility are strongly and negatively associated with maternal health care utilisation. The United Republic of Tanzania (2007) also highlights long- distance to a health facility and lack of transport as among the major barriers to access to health service access in Tanzania.

The problem of distance and isolation affects the utilisation of health services if a pregnant woman lives far away from the health facilities, no immediate transport is available, and/or they cannot afford transport costs. Zuhura Husein (Kitopeni) elaborates:

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*Here women get problems like this: the hospital is very far. For example you can get contractions... now here, as you can see, it is far. Even to get a motorbike is difficult, and until you get it to come and take you, you find that there are delays because the place is far, enh [stressing her point]. Transport for pregnant women here is a big problem.*

In other instances, women told me long distances from health facilities forces women to resort to alternatives for child delivery, such as home delivery or using traditional birth attendants, despite awareness of the importance of visiting health care facilities during and after their pregnancy. The World Health Organization (WHO) (2004) defines the term traditional birth attendant as *traditional, independent (of the health system), informally trained and community-based providers of care during pregnancy, childbirth and the postnatal period* (p. 8). Women told me that there are pregnant women in villages who do not use health facilities for the services required by a pregnant woman until they are about to deliver, or only when they develop complications; or they go to traditional birth attendants to deliver their children because of the distance from their homes to health facilities or their inability to afford transport costs. Habiba Juma (Kerege) gives an example of an incident she saw at their dispensary:

*The other day, there was a pregnant woman who delivered at home. She brought her child here bleeding profusely at our dispensary, she lost the child. Then we came to hear that a traditional birth attendant delivered her child and that the child's umbilical cord was wrongly cut and therefore she lost her child.*

When I asked if she thinks the problem was her delivering to a traditional birth attendant, Habiba said: *No, I think that was an accident ... some women deliver their children with traditional birth attendants because they live far away from the dispensaries.* In such incidents resulting in death, there are no legal consequences for the parents or the traditional birth attendants. Usually, no disciplinary actions are taken by the health facilities or government for failure to go to the health facility for child

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delivery. Further, upon reaching a health facility after infant mortality incurred at home, a woman will still be provided with all necessary medical assistance and support to ensure that she returns to good health. Delay in reaching a health facility directly affects the woman who may lose her child or develop complications detrimental to her future maternal health, as well as risking her own life.

In some areas, transport during the day was available and accessible to some women but the distance and costs incurred were the respondents' major concern. Both women and men told me that they recognised the importance of visiting health care facilities during and after their pregnancy but the travel distance to the nearest available facility was a major challenge. On average, a woman would need to travel four times to a health facility during her pregnancy. WHO and the Tanzanian government both recommend a minimum of four antenatal care visits for a woman with a normal pregnancy: she is expected to attend antenatal care once during the first and second trimesters, and go for two visits in the third trimester. (Tanzania Ministry of Health and Social Welfare, 2002; Villar et al., 2001; WHO, 2014a). However, health care personnel suggest that, a pregnant woman may have more than four visits, depending on her condition.

The first antenatal visit usually determines how many subsequent visits a pregnant woman will need. Lincetto, Mothebesoane-Anoh, Gomez, and Munjanja (2014) observe that the aim of the first antenatal care visit is to identify pregnant women needing the normal four antenatal visits from those needing more visits and special attention. Furthermore, as respondents indicated, they are often required to make more visits to health facilities due to a lack of equipment at the health facility to perform the blood tests for which a woman visits for her antenatal clinic. Due to lack of equipment, a woman may be referred to another health facility, which means travelling away from her place of domicile. After taking the tests, a woman is often required to return for her results another day.

Having seen the problems of distance and isolation in accessing health care services among pregnant women, I determined that living close to health facilities promotes

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utilisation of the services. Pregnant women in Bagamoyo who lived close to the health facilities had no complaints about accessing and utilising the health services. Apart from having to travel to Bagamoyo hospital for blood tests, these women told me that health facilities were within reach and they could walk to clinic visits. The women told me they use transport to take them to their nearby health facility for child delivery only when their conditions worsen while still at home. When asked where she expected to deliver her child, Stella Mbwilo (Kerege) said: *At the moment I have no other place than in our village dispensary. If they fail that is when I will go to Bagamoyo. Here, it is very close.* Stella indicates here that she prefers to utilise the health facility that is within her reach due to convenience and that her rural areas dispensary is her primary health care facility. She has trust in her dispensary and understands that in case of any emergency or complications she will be referred to a higher level of health facility, in this case Bagamoyo hospital. Studies conducted in Kenya, by Magadi, Madise, and Rodrigues (2000), Tamil Nadu in South India by Nielsen, Liljestrand, Thilsted, Joseph, and Hedegaard (2001) and rural Guatemala by Gleit et al. (2003), have indicated that women who live in the vicinity of health facilities are more likely to make more antenatal care visits than those who reside far away. Likewise, in rural Nepal (Mesko et al., 2003), rural South Africa (Myer & Harrison, 2003) and rural Zimbabwe (Mathole, Lindmark, Majoko, & Ahlberg, 2004), distance to health care facilities has shown to be a limitation to utilisation of antenatal care.

Alternatively, there were pregnant women who did not consider distance a barrier to accessing to health facilities. Other women told me that their priority was to go to Bagamoyo hospital for delivery for various reasons, such as past complications with their pregnancies, a good experience with the hospital in the past, or believing that a big hospital is safer, has more equipment, and better services. As Mwajuma Rajabu (Matumbi) said to me: *I have planned to go to Bagamoyo hospital because at Kerege they do not have other equipment. What is taking me to Bagamoyo is the equipment and services.* A Tanzanian study by Leonard, Mliga, and Mariam (2002) revealed that patients are willing to travel to distant service providers if they offer better care for severe illness.

Despite the difficulties in transport, my study indicates that pregnant and post-partum women are aware of and are drawn to good quality services due to their hygienic and safety standards. They understand the importance of delivering children at health facilities under well-trained health personnel. However, barriers such as poor infrastructure system networks and distance mean that they are sometimes forced to be attended to by the local people with local training, such as traditional birth attendants within their communities.

### **4.3. Cost of transport**

*Health services in this village are very far. To take a pregnant woman here up to Kiromo or to Bagamoyo hospital is very expensive... I think the government should think of having health facilities in all villages.*

Musa Haji (Focus group discussion- Kitopeni)

Pregnant women, the male partners, and health care personnel told me that the high cost of transport is a barrier to access and utilisation of services among pregnant women. Although health services are supposed to be free of charge for pregnant women, respondents informed me of hidden costs involved while seeking care. As Mwajuma Rajabu (Matumbi) told me with regard to costs due to long distance to health facilities and given her health problems:

*I incurred costs. I saw that it was far to go on foot and therefore I decided to board a bus. It was three hundred shillings; it is the costs that I cannot afford. You know it is now difficult to get money; it is hard to have money. The six hundred shillings I used pained me. It would have been better if the dispensary was a bit closer because where it is now is very far, we get problems. I get tired to walk on foot some other time and*

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*my feet hurt. Like me, I have feet problems, the feet hurt. I cannot walk on foot over a long distance.*

Pregnant women, health care personnel, and the spouses of pregnant women told me that for most community members, these costs are too high and unaffordable. Public transport passing by rural villages along the main road of Bagamoyo costs Tanzania shillings 300 one way, which is equivalent to US dollar \$0.17 and Tanzania shillings 1,000 which is equivalent to US dollar \$0.57 by bus and by a motor bike respectively. Further, they told me that transport costs vary depending on where someone was coming from and going and therefore could sometimes cost much more. Studies done in Turkey by Celik and Hotchkiss (2000) and in rural Cambodia by Matsuoka et al. (2010) have argued that socio economic status plays a significant role in determining the utilisation of health services. Studies conducted in Africa have shown that apart from place of residence, socio- economic status is a significant determinant of maternal health care use (Magadi, Zulu, & Brockerhoff, 1993; McCray, 2004) and costs (Nwakoby, 1994). Therefore, the provision of free health care is still not sufficient to encourage many women to utilise the standard services because other costs, like transport costs, are themselves barriers to access.

It is important to note that long distance travel is not the only barrier to the utilisation of health care services: the costs that come along with travel, and the cost of medicines and supplies as well as other official and non- official fees requested at health care facilities make it even more expensive to reach and/or utilise the services (Thaddeus & Maine, 1994; United Republic of Tanzania, 2005). Studies conducted in Pakistan have revealed that cost is one of the main deterrents in seeking appropriate health care ((Fatimi & Avan, 2002; Government of Pakistan, 1993; Stephenson & Hennink, 2004). People not only incur the cost of fares to health care facilities but also other costs that attend a visit to the health care facilities, such as consultation fees and the cost of medicines (Shaikh & Hatcher, 2005). The problem is that, these costs are way beyond their ability to pay.

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Since Bagamoyo hospital is the main government referral hospital in the district, all pregnant women from the district government dispensaries and health centres who experience complications are referred there. An ambulance from Bagamoyo hospital is readily available and therefore relatives are advised to save for transport at their own costs to save the lives of a mother and a child/ children. As health care personnel narrates an ordeal that occurred at their dispensary:

*There was another time we got a woman who had a problem of retained placenta....The pregnant woman delivered her children here in our dispensary. She had multiple pregnancy; twins. That woman arrived at our dispensary already wanting to push a baby. On trying to push we find out she had twins. We tried our best; the first child came out but very tired. Meanwhile we had already called to request for transport and were told the ambulance had gone to Muhimbili [National Hospital] and so we were advised to call the driver so that he can come to the dispensary on his way back. We tried to trace him in vain because when he drives the ambulance he usually switches off his phone. By the time we got him he was on his way back from Muhimbili, and the girl had already delivered her first and second child but had lost her first child and the placenta continued to retain. At that time we were still waiting for the ambulance and her relatives were still looking for transport everywhere. Luckily, her relatives got a car; a pick up before the ambulance came. When they had already left that is when the ambulance arrived...You really feel stressed out and exhausted because the girl bled badly until you get confused on how to help her. We get challenges here sometimes until you fail to know what you should do. Even in our normal routine activities with the outpatient department, the challenges are the same, a person could come with a cut bleeding in the night and you do not have even a single stitch, you look at the patient bleeding, what do you do?! Salama Waziri (Kerege dispensary)*

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Pregnant women and male partners told me that a pregnant woman's transport to Bagamoyo hospital in Bagamoyo is often a personal responsibility. As Veronica Chonde (Matumbi) told me:

*The major costs here are transport costs if you cannot walk due to your pregnancy. You are expected to afford these costs, now your problems are your own, the nurse cannot give you a thousand shillings to go to attend clinic next month [showing disagreement].*

When asked what would happen if someone could not afford transport, Veronica said: *No you have to. The car is a personal responsibility; you rent it.*

The costs in this instance are unavoidable. As Zuwena Hemed (Kiromo) told me:

*You know you can plan to deliver you child here because it is near; here you can walk on foot or look for a motorbike to take you the dispensary. However, it is possible that your illness is the work of God; it is possible you may not deliver as you normally do and therefore told to go to the district (Bagamoyo). It is not possible the dispensary does not have the capacity to assist you of... let us say they take you to district because there is no transport. There is no ambulance; this service is not available here. Therefore it is a must for you yourself to have your own savings to keep so that if you see that there is nothing to be done, find a car to take you to the district; therefore they [dispensary staff] emphasise that we keep savings at home because you cannot call someone's car to take you free of charge; therefore you have to have money.*

Zuwena, who attended Kiromo dispensary for her clinic, had no previous problems and had expected to deliver her child at Kiromo. Unfortunately, when she developed complications during her delivery visit at Kiromo dispensary, she was sent to Bagamoyo hospital. When asked if transport was called for her, Zuwena said: *They do not have that*

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*capability, I used my own money to go to Bagamoyo; I boarded normal public transport; fortunately I had saved money in case of emergency.*

Given the familiarity of such situations, health workers told me that they emphasise saving money for emergency from the first ante-natal visit since availability of ambulances is often scarce. They told me that *a personal plan* for child delivery specific to pregnant women has been introduced in both dispensaries to allay the problem of being unable to afford emergency transport. In this personal plan, pregnant women are informed by health care personnel to prepare themselves for delivery when they start attending the clinic; preparation includes saving money for emergencies such as transport. Sophia Taji (Kiromo dispensary) explained:

*A personal plan is a plan whereby we inform pregnant women when they come to the clinic to prepare themselves for delivery by saving money because you can come here and it becomes impossible to deliver here. We will tell you, you have to go to Bagamoyo and us, we do not have transport. You will therefore find your own transport and if you have money you will pay and go.*

When asked who established this plan Sophia said: *it is a government plan; a personal plan for child delivery.*

The problem of transport costs also manifested itself in the absence of necessary equipment for doing different tests, such as blood tests, among pregnant women at the dispensary level, which required women to travel to other health facilities for the services. Stella Mbwilo (Kerege) narrated to me:

*Other times some tests are available but others are not available. For example, a test for measuring the amount of blood you have enh: you go there and you are told you must do that test. They even want to know if you have enough blood on the day of delivery; if you do not, they find a*

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*way for you to have enough blood, you see? So you can go there and be told that test is not available and you have to go to a government hospital or other hospital to do the test. Now you find that you incur costs.*

Men told me lack of testing equipment at their local dispensaries forced them to take their pregnant women to Bagamoyo for tests which resulted in unplanned costs. Abbas Fumo (Focus group discussion- Matumbi) describes:

*Our dispensary does not cater for the needs of pregnant women and even other patients. For example equipment for testing blood test, stomach are not available, therefore when pregnant women need to do tests or we fall sick we are written a note by a health worker to go to Bagamoyo. You incur costs that you would not if the equipment were available here.*

In all villages, pregnant women told me that at all times they were required to go for tests to Bagamoyo hospital which cost them unnecessary travel, time and money. They stated that health care personnel informed them that the tests are mandatory and important to their safety and that of their unborn babies. Respondents pleaded with the government to make the tests available at dispensaries to avoid unnecessary travel to Bagamoyo. As Farida Kombo (Kiromo) said to me:

*A challenge we have here is the lack of equipment for testing. We get problems; when we want to blood test we have to go to Bagamoyo, to test sugar we go to Bagamoyo... but if they could bring those testing services nearby here it would be good.*

Health care personnel admit to the situation in hand, as Salama Waziri (Kerege dispensary) explains:

*The equipment we have here are for the level of dispensary. However, at the moment we do not have a laboratory and so we cannot do other tests.*

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*For example, we do not have equipment for testing; blood group, amount of blood and protein in urine. We therefore tell them to go to Bagamoyo hospital and then return back to the dispensary for clinical records.*

Similar to what health care personnel told me, a study by Kwesigabo et al. (2012) established that health care facilities in Tanzania, including dispensaries, face shortages of medical equipment, poor transport and weak communication infrastructure among other impediments.

When I talked to health care personnel, they told me that they felt sympathy for the women; they pleaded for important services to be brought to dispensaries to reduce the disturbances and costs the pregnant endure. Upendo Saburi (Kerege dispensary) pleads: *We ask the government to bring us important testing equipment such as hemoglobin testing equipment to avoid the trouble of sending women to Bagamoyo to get tested.*

Although health care personnel in both Kerege and Kiromo dispensaries sympathise with pregnant women about the lack of transport at the dispensary level, they are also affected when they are in the process of executing their duties. They expressed their concern at how lack of transport, including unreliable transport for referral within health facilities, affects their provision of services to pregnant women and children.

Health care personnel incurred transports costs several times due to the failure of the district office to provide electricity and/ or gas to operate the fridges that store vaccinations at dispensaries in time. As Shani Uledi (Kiromo dispensary) explains

*Electricity to run the dispensary is being paid for by the District Executive Officer but they do not pay on time. For example right now electricity is unavailable; therefore we will have to take these vaccinations to a nearby village. When we want to use them we go and fetch them and after work we return them to that village again until we get our own electricity back. This is the biggest disturbance to us because*

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*we do not even have our own transport as you know with dispensaries; we depend on boarding public transport.*

Health care personnel told me that they personally incurred costs in the form of bus fares, always from their own money and it is not refunded. When asked who pays for the transport of vaccinations, Shani said:

*Ourselves, we are not paid by anybody. We take from our own pocket, we depend on ourselves, we transport them, and return them back. And it is not that you go one route only. For example if the vaccinations are in Zinga (another village), you will wake up in the morning, you will go and take them and bring them, and when you finish vaccinating you return them and return back.*

From Kerege dispensary Upendo Saburi also explained how delays in getting the electricity on time cost them transport money:

*There are things when finished it becomes a major problem. For example we have not received money for buying gas up until now; therefore we take these vaccinations to a neighbouring village with a dispensary. However, if we find that even the dispensary we want to keep the vaccinations does not have power or gas, we are obliged to take them to the district at our own costs, and there they do not ask how we manage the costs.*

Delay in getting electricity in time leading to incurring transport costs is common in all government dispensaries. Wahida Pandu-Kiromo dispensary receives electricity but not always in time. When I asked what staff do with the vaccinations if they run out of electricity, she said to me:

*We have no other means than carry those vaccinations and take them the nearest dispensary, and very often we take them to Zinga dispensary. And since our employer is the same, if they also run out of electricity and we still have electricity, they bring theirs here. This is a big disturbance.*

#### **4.4. Form of transport**

At the first interview with Latifa Issa (Matumbi), she invited me to sit under a mango tree a little bit away from her house, where I found her and her female friend sitting and talking. When I said I wanted to have a private talk with her, her friend said goodbye to us and left. Then an interesting thing happened. Her husband who was at that time inside came out to sit with us and wanted to know why I was visiting them and wanted to talk to his wife. I explained to him, together with his wife, the intention of the visit. Once he understood, he gave me a go ahead to speak to her and left to go back inside to house, but still insisted that if there was anything I would further like to know he would be around and ready to help. The concern of the husband about his wife having conversation with me indicated the authority he has as the man of the house to know what was going on and also demonstrated his protective attitude to his wife. We started our talk around 2.54 in the afternoon.

*When I went to deliver... we had to sit on one motorbike, the two of us; my husband and I on our way there ... on our way back with a child, I held my baby while my husband carried the stuff. You know, during difficult times you have to force things. Latifa Issa (Matumbi)*

Transport safety and comfort are elements that a pregnant woman would expect when travelling anywhere, especially to a health facility. Further, precaution and care are of importance when she is in pain and needs to be transported to a health facility. Women in the study told me that they experienced discomfort while travelling to health facilities, especially during the night when a motorbike is the sole means of transport available.

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Pregnant women, male partners, and health care personnel told me that pregnant women or their relatives will often either board public transport if a pregnant woman is not in a critical condition, or hire a private car or motorbike to access services. While motorbikes were cheapest and most affordable means of transport they are also the most uncomfortable form of transport. Affordability and availability were the main factors influencing the type of transport pregnant women used to travel to health facilities. Pregnant women told me that they have experienced difficulties in securing transport to go health facilities, especially when their conditions intensify. Lack of transport was also the major factor in women opting for delivery alternatives.

I was curious to know from Paulina about motorbikes transporting pregnant women, so I asked her how a pregnant woman sits on a motorbike, and she had this to say to me:

*That is the problem... when you think about it, for example if it happens past midnight; you have no option than calling a motorbike; what do you do? You use it, or sometimes you are almost about to deliver a child then it becomes very difficult. Transport [feeling sad]... pregnant women... we are doomed.*

Pregnant women told me that they were ready to use any available or affordable transport in order to access health services. They are ready to risk their lives to reach health services, which they believe and/or know are appropriate and beneficial for their safety and that of their children. Zuhura Husein (Kitopeni) narrated to me her experience of her previous pregnancy:

*I boarded a lorry and went to the hospital, I paid them 5,000 shillings. I had to board the lorry because I got sick in the night, at ten o'clock. I reached [hospital] at around eleven and twelve o'clock I delivered. The lorry was just passing by and we asked them.*

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When I asked her how she managed to board in a lorry with her condition, Zuhura said:

*They helped me board [meaning the people who were escorting her] and we went to the hospital; then I paid the driver 5,000 shillings [equivalent of US dollar \$2.87]. It was in the night; buses were not running.*

The readiness of pregnant women to use health facilities is a good indicator of an improvement in maternal health care but the fact that safety to accessing such services is not regarded as a primary concern is alarming.

My study in Bagamoyo district established that bus fare for a return trip to a local government dispensary ranged between Tanzania shillings 600/= and about Tanzania shillings 2,000/= to Bagamoyo district hospital, equivalent to US dollars 0.34 and 1.15 respectively. On the other hand, I was informed that private transport was between Tanzanian shillings 5,000/= to go to a local dispensary and Tanzanian shillings 20,000/= to go to Bagamoyo district hospital, equivalent to US dollars 2.87 and 11.49 respectively. Given the low levels of household income in Tanzania (Hoogeveen & Ruhinduka, 2009); bus travel is therefore very expensive. It is often impossible for an ordinary rural woman or family who depend solely on agriculture to use Tanzania shillings 5,000 [enough to feed a small family for at least 5 days under normal circumstances] for transport to a dispensary during pregnancy. Unanticipated transport costs include referral when an ambulance is not accessible, costs for purchasing additional delivery items (as will be detailed in chapter six) if already used at the dispensary level, transport costs for returning home after delivery, and household maintenance costs. Apart from the mentioned costs, women may be burdened with the cost of drugs and medical supplies which should be available at the dispensary but may not be, due to delay from the government, or to the volume of patients in rural areas.

At the second interview, Mwajuma Rajabu (Matumbi) looked cheerful, as opposed to the previous time. She welcomed me happily. I found her sitting on the veranda of the house, cooking. She had her pot of porridge on top of three cooking stones, known as

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*mafiga* with fire sticks (known as *kuni*) burning under them. She asked her young daughter to continue cooking so that she could talk to me. On the side of veranda there was a mat which she offered me. We started our conversation around two o'clock in the afternoon. In the midst of the interview, her newborn started to cry inside the house and she asked her daughter, who had finished cooking, to go bring him. The girl brought the baby boy and gave him to her mother, who started breastfeeding him and asked me to continue with our conversation.

*When I started getting labour pains and we were preparing to go to the hospital, my bottle [waters] broke. Every time they called a motorbike to carry me they refused because I could not walk. They had to call a traditional birth attendant to help me because I could not walk. I did not plan for the traditional birth attendant to deliver my child; I had planned to deliver my child at the hospital. I had to, [use an attendant] because when the problems happened I had no other option.* Mwajuma Rajabu (Matumbi).

This narrative corroborates the findings of Wong et al. (1995) who conducted a study in two rural counties in Yunnan, China: although some women want to deliver their children in a hospital and agree that hospitals births are best, they found themselves delivering at home due to unavoidable circumstances, lack of transport being among them.

For Mwajuma, distance was not a problem but rather the type of transport available, affordable and appropriate to her condition at that time. This case shows that long distance and isolation from health care facilities affects the use of health services. The problem is even worse if a pregnant woman is in difficult state of health, without appropriate transport, or without sufficient funds to pay for transport. A study by Myer and Harrison (2003) conducted in rural South Africa showed that the high cost of transportation to prenatal care facilities in rural and even urban settings significantly

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reduces the number of visits and forces delay in seeking care, even if care is comprehensive and universally free of charge.

When I went to visit Faraja Hassan (Matumbi) for an interview, I found her sitting outside her house on a local sewn mat known as *mkeka* in the shade of a tree with her daughter of about four years old. They were just finishing their breakfast: black tea and some boiled cassava. It was around 12.35 in the afternoon. Faraja invited me to sit with her on a mat and apologised that they had just finished their meal. I said it was okay. Faraja was knowledgeable on various issues regarding women's health but lacked the confidence to speak. I had to keep on encouraging her to feel free and talk to me. She later slowly started to open up and felt free to talk until we finished our conversation. After finishing the interview she told me that she was scared to talk because she did not know that I was going to ask her just *normal things*. To her, *normal things* were issues that she could understand and share her experiences.

Interestingly, when I asked her how the problem of transport could be solved, Faraja had a recommendation for the government: *What I see as needing help here is, if they could bring us a health facility transport. At Kerege dispensary there is no transport and there is nothing going on.* Amiri Siwatu (Focus group discussion- Kiromo) elaborates, saying: *The Government should provide us with health facility transport so that when a pregnant woman has an emergency, she can immediately be rushed to the district.* The current situation often requires pregnant women and/or their relatives to secure transport while receiving services at the dispensaries. They call for the government to consider solving the problem by providing stationed transport at the level of dispensaries

However, it remains unclear whether these suggestions are feasible. Health care personnel told me that the structure of the health system in Tanzania does not allocate transport at dispensary level. In the case of emergencies or referrals, it becomes even more difficult to assist pregnant women because the dispensaries have to depend on an ambulance from Bagamoyo hospital which is sometimes not readily available. They also told me the other problem was lack of health centres within their localities, which could

have reduced the difficulties of provision of services and the lack of equipment for testing. As Salama Waziri (Kerege dispensary) said:

*In our village and even other villages there are no health centres, which would have reduced the problem of transport to Bagamoyo district and even the congestion of patients in the dispensary. You find that health centres are located in very remote villages where people are very few. I recommend such services be available here, where there are many patients, so that even those in remote villages can be brought here when they are sick.*

#### **4.5. Time of day**

*...There was a young woman who was very short, basically a child of sixteen years old who was pregnant. We had already informed and educated her mother from the first day of her visit to the clinic this girl could not deliver her child at the dispensary because she was too tiny and very short; therefore when she starts to get labour pains, please rush her to the hospital...One day around eleven or twelve o'clock in the night I heard people knocking on my door. When I came out, I found the girl in great labour pains. When I went to examine her, the birth canal had already opened. When I asked her mother why they brought her here, she said she was not home when labour pains started in the afternoon and therefore everyone at home was waiting for her to come back. I told them I was going to examine her but even if the birth canal had already opened, please go find transport; and that whenever we got it we would take her to the hospital. Her sisters wandered looking for transport until four o'clock in the morning when they got a car. When the car arrived I told them to wait so that I examine her again. The baby's head was already visible, the girl was in great pain, and she tried to push but she*

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*could not deliver the child. I told relatives to let the car wait; maybe God would help us.... After a lot of suffering, she finally delivered the child but the child had already died. You basically know a situation like this will end as it did because of lack of transport. Situations like these happen to us a lot. Salama Waziri (Kerege dispensary).*

The narration above describes a scenario whereby a pregnant woman, her relatives and health care personnel found themselves in a difficult situation in a middle of the night due to lack of transport. One could say that it was the negligence of the family for not taking the pregnant woman to the hospital as they were told. However, the case of who makes decision at the family level also plays an important role in women's access to transport and health care services. Health care personnel played their role, giving advice to the pregnant woman on where to go for delivery, given her condition. The reasons for delays and the decision to take her to the dispensary instead can never be clearly known. Perhaps the onset of labour pains made the family worry that they would not reach Bagamoyo hospital on time; perhaps it was the unavailability of transport to Bagamoyo at that time of need or the absence of the family decision-maker who would escort the pregnant woman to the health facility.

Women told me that securing transport to health facilities, especially during the night, is difficult and access depends on where someone is staying; in remote locations it is difficult or even impossible to get transport to go to the dispensaries late at night. They said that it becomes even more difficult when one is referred to go to Bagamoyo hospital because dispensaries do not have their own transport. Pregnant women are often forced to look for a car or motorbike to hire but their success depends on the time of day and vehicle availability. Women regarded daytime as the easiest, most reliable and safest time to go to the health facilities.

My first interview with Bahati Selemani (Kitopeni) took place around three o'clock in the afternoon at her house. The house was surrounded with so many trees which made the area seem dark but cool. Bahati was sitting on torn woven mat known as *mkeka* on

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the veranda outside her hut with her two children. She welcomed me and indicated to me to sit on a trunk of a tree nearby her. She told me she has six children, and was currently married and living with her third husband. Her second husband had died in the previous year and they had had a son together. After he died there was a disagreement between her and her late husband's family about who should inherit their house. Bahati told me the house which she built with her husband through small scale tomato farming was sold so that she and her husband's extended family could all get their share. With nowhere to stay, she met the man who is now her partner. Bahati told me that she has a daughter with her current husband and the pregnancy she was carrying was his. When I asked Bahati Selemani (Kitopeni), about her experience with transport, she said:

*We suffer a lot because of transport problems. You may fall ill at midnight ... when transport is not available. You as a pregnant woman have to face problems; perhaps call a traditional birth attendant who may live far from your home. Transport is in fact the biggest problem here. I am grateful I started having labour pains around six o'clock in the morning and had my own strength when I left home. I therefore was able to reach the hospital fast and deliver at 8.00 in the morning.*

What I heard from women is that lack of public or private transport, especially during the night, was a major problem, even when the cost was affordable. Furthermore, at the level of the dispensary, the difficulties and expense of securing an ambulance made access difficult. In this sense, access and utilisation of health care services by pregnant women is not caused by their unwillingness to use the services but by circumstantial factors beyond their control. A study by Silal, Penn- Kekana, Harris, Birch, and McIntyre (2012), which was conducted in South Africa, indicated that failure to access and use maternal health services in rural areas was related to lack of public transport during the night and difficulties in getting an ambulances, coupled with the inability to afford private transport.

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Health care personnel at the dispensary level acknowledge the problem of transport to be significant to pregnant women and their families. While they agree that these problems were not women's fault, they said other difficulties were caused by the women themselves for not adhering to advice given to them earlier on. Judith Saburi (Kerege dispensary) gives an example:

*You know some pregnant women do not want to adhere to advice. There was a pregnant woman who was advised from the very beginning to go to Bagamoyo hospital for delivery due to her condition. However, she did not do that; instead when she got contractions, she was brought here and failed to deliver; therefore the baby died... the whole night we were struggling to get transport to send her to Bagamoyo.*

Health care personnel even told me of instances where some pregnant women come to the health facilities on the day of delivery having no clinic card. It is important to understand the reasons for the delay in attendance or non-attendance at clinics and why pregnant women still go to deliver at health facilities despite not having received antenatal care. Reasons could stem from the issue of transport and other factors related to it, as revealed by this study.

### **4.6. Limited working hours**

Almost all pregnant women, male partners, and health care personnel agree that delivering a child at a health facility is best, due to the assurance of getting good care and treatment when needed. However, some pregnant women faced problems finding and affording transport at the time of delivery, especially when they expect to deliver their children at a nearby dispensary but go into labour at night when the dispensary is closed and are thus forced to go to the Bagamoyo hospital. The women told me that the limited opening times necessitate them to look for transport to take them to the hospital.

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I asked Stella Mbwilo (Kerege), what happens when a pregnant mother arrives at the dispensary at 3.00 pm and fails to deliver her child until 4.00pm, when the dispensary closes. She said:

*They will continue to wait; they can tell you they will wait until five o'clock in the evening, when five o'clock or six o'clock reaches they will tell start telling you to prepare yourselves to go to Bagamoyo, no discussion. Whatever you say 'please help us...' they will not get into a discussion.*

On being asked whether a pregnant woman will get service if she arrives after 4.00pm or in the night, Stella further said:

*They receive her, they will stay with her, and examine her while checking the time. If they see that the time is running out, the same happens: 'go to Bagamoyo'. They are told go to Bagamoyo even in the night; when it reaches 3.00am or 4.00am even if you got there at 8.00pm, they tell you to prepare yourselves to take her to Bagamoyo because here we have failed. I do not know what they are scared of.*

Men, on the other hand, regarded lack or denial of services during the night from dispensaries as being due to health care personnel being irresponsible. As Issa Faraji (Focus group discussion- Kerege) puts it:

*Preparations for a pregnant woman here at our dispensary are very poor. I think nurses or doctors do not know their job well. At other times when you arrive there, let us say during the night, those who are present do not know their responsibilities. This leads to a person with a pregnant woman deciding to look for transport to take her to Bagamoyo. Last year a pregnant woman went to the dispensary and knocked at the door of the*

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*health care personnel but she did not come out. This led to her relatives taking her to a traditional birth attendant... it is the biggest problem.*

However, this assertion was refuted by women, and by health care personnel at both health facilities, particularly Kerege dispensary, who said although the dispensaries usually close after working hours, health care personnel are always readily available and helpful, even past midnight, if a pregnant woman comes for delivery to the dispensary because staff live within the dispensary compound. Salama Waziri (Kerege dispensary) had this to say:

*Here, even when a pregnant woman comes at 2.00 in the morning for delivery, she will be taken care of because health care personnel live within the dispensary compound. The only problem is for those who develop complications and need to be admitted and/or to be referred to Bagamoyo.*

Health care personnel said that they are forced to provide services to pregnant women even after working hours not only due to fact that they live within dispensary compound, but also it is unethical to deny service to a pregnant woman in labour who comes late in the night when they able to assist. Salama Waziri (Kerege dispensary) further explained:

*...The contributing factor is because we are living here...people know that they can come at any time and get service as opposed to other places where you find there are not enough houses for staff or perhaps the staff live far from the dispensary. But here, even when a person comes past midnight and knocks at the door, we come out and give them service... We cannot just leave a pregnant woman to suffer when we are able to help. The three of us live here except for one who did not get a house.*

Pregnant women acknowledged that health care personnel work late to provide services to pregnant women, even after working hours. Asha Zuberi (Kerege) said:

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*At our dispensary, whatever time you go, if you knock the door they will help you. The doctors have their own house there, so whatever time you knock they help you.*

Depending on who escorts a pregnant woman to the health facilities, the argument put forward by men may or may not have some truth in it since the pregnant women themselves said they do not experience refusal of services no matter when they go to the dispensaries. Men told me that the decision to take a pregnant woman to Bagamoyo hospital or elsewhere is made by the health care personnel themselves, but it is not clear if men know or are informed or even ask why the health personnel make that decision. Take an example of what Mustafa Sallu (Focus group discussion- Matumbi) said:

*On average, pregnant women get all the required services and advice at the dispensaries but there is one problem: a pregnant woman can go there for delivery but as you know our dispensaries are different from big hospitals. It is possible that you have taken your patient at the dispensary with a belief that she will be taken care of there and that is final. When you get there that is when you are asked which number is that pregnancy? First pregnancy? Okay, prepare yourself to go to Bagamoyo. Aah [stunned], prepare yourself? But have you examined her? You need to examine her because even if it is her first pregnancy, it is not true that all women have small uteruses eh? However, our specialists assume that first pregnancy is difficult; they straight away want you to go where? To the district. Now this is also a problem because you have to incur transport costs to take her there.*

On the same topic, pregnant women seemed to be more informed than men of the reasons for health care personnel recommending the place of delivery. As Zuwena Hemed (Kiromo) explains:

*At our dispensary they do not accept a first time pregnant woman to deliver there because she does not have experience....Normally they do not receive a person with a first pregnancy there because you find that some of them are scared because they [first time mothers] do not understand the process... the main thing that makes them refer you to the district is if you have a first pregnancy and therefore are inexperienced, or you have complications.*

From what I heard from women, health care personnel are readily available to them whenever they go to health facilities, even outside of normal working hours. Only first pregnancies or complicated deliveries are referred to hospital. That women told me that health care personnel assist them outside working hours and are readily available to help indicates that staff are devoted and committed to helping women, even when they are not paid to do so.

The fact that health care services are provided free of charge to pregnant women, could encourage women to use them, even after hours. As such, health care personnel find themselves in the situation where they cannot refuse to help the women just because they turn up late at night. With this in mind, it is important that the government acknowledges the role of health care providers, in rural areas particularly, in saving the lives of mothers and children. Studies have shown that a failure to effectively implement policies, such as free health care for pregnant women and children under five years old, was associated with a decline in the morale of health care personnel and an increased workload due to high demand not matching an increase in resources (Chopra, Daviaud, Pattinson, Fonn, & Lawn, 2009; Gilson & McIntyre, 2005; McIntyre & Klugman, 2003).

#### **4.7. Conclusion**

The problem of transport in relation to access and utilisation of health care services was very evident in the Bagamoyo villages of Kerege, Matumbi, Kiromo and Kitopeni.

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Pregnant women and male partners disclosed how problems of transport such as distance, isolation, costs, form of transport and time of day, affect pregnant women and their relatives when attending antenatal clinics, going for delivery and being referred to hospital. While pregnant women in rural areas can be blamed for delays and/or non-attendance at antenatal clinic or for coming to deliver at the health facilities without having attended antenatal care, many of these issues are directly or indirectly related to the problems of transport. While we see the logic of health care personnel emphasising the importance of pregnant women attending antenatal clinics, the pregnant woman's need for accessible health services should be the given attention it deserves. To me, the women seemed to understand the importance of seeking care support from health care facilities, but issues related to geographic accessibility and financial capacity are major hindering factors in pregnant women accessing and using health care services. In the view of this research, bringing health facilities closer to targeted people for services and looking for permanent solutions to transport problems are pertinent recommendations (Mubyazi et al., 2010).

On the other hand, health care personnel were equally affected, particularly by the difficulties of securing ambulances for emergencies/referrals to the Bagamoyo hospital, the main referral hospital in the region. The issue of transport needs to be re-visited to establish what support can be given to dispensaries in order to save lives of women and children. The study showed that unreliable transport, particularly the lack of ambulance services for emergency referrals, was one of the main problems facing women and health care personnel.

The provision of necessary and reliable equipment for testing and storage at the dispensary level and/or upgrading of dispensaries to health centres so that they can provide the services needed at the village level could ease unnecessary travel disturbances and costs, as well as saving time lost and the costs incurred by the health care personnel who must travel to other dispensaries to collect and return the vaccinations required by pregnant women and children for immunisation. In general, the

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lives of many pregnant women and children can be saved if the transport and communication networks are improved.

This study has clearly revealed that health care personnel at the dispensary level are the sole health care providers. Despite having ordinary hours of work, they continue tirelessly during non-working hours and even at night. However, their devotion is not recognised: they do not receive overtime or any incentives from the government. The fact that they are living within the dispensary locale may be taken for granted, making them work around the clock. They cannot leave a pregnant woman to suffer or die because she has gone to the dispensary after working hours and are obligated to assist. However, just like any other human beings, these personnel need proper rest and time of their own and/or with their families so that their bodies can re-energise; without rest they cannot continue to execute their services efficiently. With this in mind, health care personnel need to be considered and compensated for the extra effort and time they put into their work serving communities. Hiring extra personnel and introducing incentives are some remedies that should be considered to alleviate pressure on dispensary staff. The Tanzanian government needs to take appropriate measures, such as reviewing rural and health care infrastructure, in order to develop feasible plans and policies that cater for communities' needs and ensure health care personnel can efficiently execute their work and to maximise the use of health services.

## 5. Antenatal care services

*I go there because when you get there they examine you, they check how your baby is positioned, how he is, and also there are free nets given to pregnant women to protect them from diseases. There are also tablets which they give for prevention, prevention for the baby who is in the womb because they say sometimes if you do not use those medicines a child can be born with defects; therefore they help. Paulina Joseph (Kerege)*

This chapter explores the major issues around utilisation of antenatal care services among pregnant women in Kerege, Matumbi, Kiromo and Kitopeni villages in Bagamoyo district. In particular, I discuss the patterns of and reasons for utilisation of antenatal care services from the perspectives of pregnant women and health care personnel.

The aim of antenatal care services or antenatal clinics is to ensure a pregnant woman has access to services that support her and her unborn child's safety and health through the provision of necessary care and monitoring. The services include early detection of problems related to pregnancy, provision of health education and services on danger signs and symptoms needing immediate assistance from health care providers, and provision of health promotion and preventive services, ((USAID, 2007; WHO/ UNICEF, 2003). Ebrahim (1990) explains the importance of the antenatal clinic in promoting maternal and foetal health and in the supervision of normal pregnancies. He maintains that the aim of antenatal care is to ensure good health in the expectant mother, to enable her to have a normal delivery and a healthy baby, and to teach the art of childcare. Other studies show that antenatal care services are essential because of their preventive services, diagnosis and treatment of complications during pregnancy, provision of information to promote the use of skilled attendants at birth, and emergency obstetric

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care when required (Gloyd, Chai, & Mercer, 2001; Renkert & Nutbeam, 2001, WHO, 2004a).

Several other studies have also shown that antenatal care is the most important way to reduce maternal morbidity and mortality (Adam et al., 2005; Campbell & Graham, 2006; Ekman, Pathmanathan, & Liljestrang, 2008; McCaw-Binns, La Grenade, & Ashley, 2007; Pittrof, Campbell, & Filippi 2002; WHO/UNICEF, 2003). Other studies have suggested that antenatal care, as a vital entry point to maternal care, is a useful means of distributing antimalarial drugs, iron and folic acid tablets, as well as promoting birth preparedness and readiness for unpredictable obstetric complications. (Campbell & Graham, 2006; Carroli, Rooney, & Villar, 2001; McDonagh, 1996).

This chapter accounts and analyses the knowledge of pregnant women and mothers with at the time of interviews about their views and experiences of antenatal care within health facilities. I explore in-depth women's perceptions and experiences with antenatal care. Specific discussion focuses on women's reasons for using antenatal care services, ranging from their knowledge about the importance and benefits of the services, to past experiences with the services, or with pregnancy problems and/or complications. I also draw on the opinions, experiences and views of health care personnel about their experiences with pregnant women and mothers seeking antenatal care.

### **5.1. Pregnant women's reasons for attending antenatal care services**

*I go there for ante natal clinic because they provide us with various services which are good for me and the child. They test us for malaria, [blood] pressure, HIV, and they give us vaccinations, and malaria medicines. Asha Zuberi (Kerege)*

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In my first round of interviews, respondents in all villages of Kerege, Matumbi, Kiromo and Kitopeni told me their various reasons for attending antenatal care services, most of which were centred on ensuring their safety and that of their unborn babies. Pregnant women acknowledged to me that they used antenatal care services because of the perceived importance of these services to their health and the health of their babies. Women seemed to be knowledgeable about the beneficial services they receive when they go for antenatal care. As USAID (2007) indicates, among the services that women should get from antenatal care are detection, prevention and treatment of anaemia, malaria, tuberculosis and sexual transmitted infection including HIV/AIDS. Other reasons for women attending antenatal care were the monitoring of the unborn child for birth weight, and provision of vaccines against diseases.

Health care services and professionals themselves acknowledge that antenatal care services are vital for pregnant women for a number of reasons ranging from knowing the health and growth of a child; prevention and treatment of various diseases; and for preparations of childbirth, to mention but a few (Carroli, et al. 2001; Ebrahim, 1990). Furthermore, a study conducted in in North Maharashtra, India by Mumbare and Rege (2011) indicates that utilisation of antenatal care services is vital because it reduces the risks of maternal morbidity and mortality.

### **5.1.1. Health status knowledge**

*You cannot just stay at home without checking your health if you are pregnant because that is how they [health care personnel] will know the development of your child. It is important to know your health as a pregnant woman because if they see you with problems they will tell you that you are sick or the child is wrongly positioned... Clinics for pregnant women are very important for the child who is in the womb and for the mother herself. Pili Kassim (Kitopeni).*

Pregnant women informed me that they attend antenatal care services because they get to know their status and that of their unborn child, including the position of the child in the womb, through physical examination of their body. They told me that knowing the status of their health and that of their child puts them at ease. They knew if their pregnancy was developing well and if not, health care personnel can assist in finding a solution to any problem they may have.

### **5.1.2. Testing, prevention and treatment**

When I met Habiba Juma (Kerege) for the first interview she was on the side of the major Bagamoyo road preparing some fried fish for her business. I had gone to her house and found her husband who said she was on the road doing her business for the day. He had offered to go find and bring her home but I refused because I did not want to disrupt her activities. I therefore went to meet her at the roadside to plan an interview session. We talked for a little while and I told her my intentions. When I offered her a possibility of meeting her on another day, she told me we could still do the interview straight away. She told me that her young sister, who I saw there, could continue working while she accompanied me to her house to talk. We left for her house and had our interview at around one o'clock and forty minutes in the afternoon. At home she offered me a local sewn mat known as 'mkeka' on which we sat together to talk. Habiba gave me her view about antenatal care:

*What I like about going to antenatal clinic is, we get all the tests; for example if you go to the clinic, they examine the stomach, they test us for malaria enh [confirming if I was listening], we get tablets, we get tested for HIV.*

Testing, prevention and treatment of various diseases such as malaria, gonorrhoea, syphilis and anaemia were among the main reasons that my pregnant respondents attend antenatal care services. The women told me that attending antenatal care services

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assured them of treatment for any diseases they might have. They also told me that testing for Human Immunodeficiency Virus was another reason for attending antenatal services because they would be given medications to boost their immunity and protect their unborn child.

While testing for various diseases and deficiencies were perceived by pregnant women as important reasons to attend antenatal care services, of more importance was the fact of preventative and curative treatments would be available and provided to them. Veronica Chonde (Matumbi) explained to me:

*...you know, if you go there they will first they examine your pregnancy, second if you are sick and explain to them your problems they examine and do tests and give you treatment... they examine you, they give you your card, and give you vaccinations required.*

Bahati Selemani (Kitopeni) also told me:

*I go to antenatal care clinic because when you reach there they check your blood and the amount of blood you have. They also check our blood for HIV, syphilis, gono [gonorrhoea]. What I like is when they find you are sick they will treat you. They also give us medicines; to prevent us from getting malaria, to increase the amount of blood in the body, vitamin B tablets, vaccinations and nets.*

Similarly, Pili Kassim (Kitopeni) also told me that:

*I go for antenatal care because when you go to start the clinic, they provide you with services such as checking your pressure, testing for HIV and syphilis, and examining your pregnancy... testing the amount of blood... The test for knowing the amount of blood of blood is very important so that you can deliver your child safely...*

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Pili further elaborated on the benefit of attending antenatal care clinic.

*The good thing about antenatal care clinic is they tell you to come whenever you feel sick and after testing you they give you medicines. For example if they test you and find you with UTI [urinary tract infection] they will treat you. They also give you tablets to prevent you from contracting malaria, they give you tablets to increase the amount of blood and they give you tablets for worms [pause]...they give you all that is needed.*

Furaha Ally (Kiromo) spoke about her own experience by saying:

*To tell the truth I go the antenatal care clinic services because there are many things that are done and given to you. For example they test us for malaria, they give us tablets for blood, treat us for syphilis, and we are given nets, eh?... Myself I have already done some tests and been given those tablets to increase the amount of blood, they gave me syphilis tablets and a net. I like to go to ante natal clinic because it ensures me of the safety of my child. For example when I went to the clinic today,...they gave me tablets for worms and I will go back to the clinic after one month to know my status.*

As I listened to women, I realised that most of them were well informed of what tests and treatments are provided at antenatal care: an indication as to why they seek and use the services. WHO recommends testing and treatment of various infections such as syphilis, HIV, and detection of warning signs during pregnancy that may require special attention (Lincetto, Mothebesoane-Anoh, Gomez, & Munjanja, 2014; WHO, 2014b). Since education is one of the essential elements of antenatal care (Lincetto et al., 2014), it could arguably be said that women's awareness of the importance and benefits of antenatal care is due to the education provided during antenatal care visits.

On prevention of diseases, Faraja Hassan (Matumbi) told me: *I go there because they give us services like vaccinations and malaria tablets and bed nets to prevent us from getting sick.* Women indicated to me that they knew that antenatal services are readily available and beneficial to them. Preventive measures for diseases such as malaria, HIV, anaemia and tetanus are among the kinds of care provided in antenatal clinics (Nyamtema et al., 2012). The fact that they could get a free discount voucher for mosquito nets before and after delivery was much appreciated. One net costs 500 Tanzanian shillings (equivalent to 0.38 cents in US dollar), considerably less than the normal price, which ranges from 3,000 to 4,000 Tanzanian shillings per net (1.77 to 2.36 US dollars) and very reasonable. Women told me that they are thankful to be considered for a discount in bed nets because the amount that they save could provide meals for their family for up to three days.

The provision of delivery packs was another bonus for using antenatal care services, as Bahati Selemani (Kitopeni) told me: *These days when you reach nine months there are delivery packs that we are given; inside them there is cotton wool, syringe, razor blade, scissors and pampers.*

### **5.1.3. Antenatal education**

Pregnant women told me that another reason for attending antenatal care services is the advice they receive from health care personnel about various issues concerning their health, prevention and treatment of various diseases. Paulina Joseph (Kerege) described to me:

*We use these services because they give us advice and when you are advised about something you must act on it. You can be advised to use certain medication for example; the medications for preventing your child from diseases like malaria or worms so that when a child is born he*

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*does not get such diseases. You cannot just ignore that, you have to follow their advice.*

Furthermore, Paulina also told me:

*I like the way they advise us, they tell us how the child is positioned. Sometimes if the baby is wrongly positioned, they find a way to position the child back to normal while continuing to give you advice. If they check you and find that the child is positioned well, they can tell you that you can deliver your child there at the dispensary, and if it is impossible they can refer you to a bigger hospital.*

Sharing the view that advice given to pregnant women who attend antenatal care clinic is important and advantageous to them, Furaha Ally (Kiromo) said to me:

*You know, the good thing is when I go there, they test my BP [blood pressure]; therefore if I have any changes I know. If the BP is high they will tell me right away, if it is low they will tell me too. If it is high they will tell me not to eat salty things; therefore I take precautions. Furaha Ally (Kiromo).*

Paulina demonstrated her understanding of the clinic-issued mosquito nets: *Even these nets which we are given: we know that when a person gets bitten by mosquito she will later get malaria which to a pregnant woman is very dangerous.*

It is important to note that often women put all their faith and trust into health professionals, literally putting their lives and that of their children into the health professionals' hands. It is therefore important that the advice they receive is well founded on evidence. Similar to my findings above, Thomas, Golding and Peters (1991) point out that antenatal care clinics are sources of advice and reassurance to pregnant women. Sound advice and information related to well-being in pregnancy, child delivery

and after-delivery care including that of a baby are central to provision of antenatal care service to women (Lincetto et al., 2014).

#### **5.1.4. Referral assurance**

*What I like about going for antenatal clinic is... in the treatment, when you feel sick like the stomach is hurting, if you go there [pauses to think]...for example myself, one time I had a difficult pregnancy; I went there and they advised me to start clinic early to get a clinic card so that if my condition worsen they could take me to a hospital for further management. Habiba Juma (Kerege)*

Referral is one of the major factors informing women's attendance of antenatal care services. Pregnant women informed me that attending antenatal care clinic gives them assurance of referral to a larger hospital in case they develop problems or complications while in the hands of health care personnel. Similarly, a study done in rural South Africa found that women attend antenatal care in order to have the assurance of delivering a child in a hospital if need arise, since they will already been listed in the health system (Myer & Harrison, 2003).

Further, a study conducted in Zaire by Dujardin, Clarysse, Criel, De Brouwere, and Wangata (1995) showed that compliance or non-compliance of women with referral advice provided during antenatal care period was closely associated with the woman's perception of the danger to herself. Sharing her experience to me, Pili Kassim (Kitopeni) who had just given birth prior to my first round of interviews told to me:

*You know there is an advantage of attending the ante natal clinic and doing the tests: for example I had problems with my blood, therefore when I was told that I have low blood at the district hospital. They wrote on my card straight away that I should deliver my child at the district*

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*hospital. So when I returned my results at the dispensary they told me point blank that when you start feeling labour pains you should go that the district hospital and that is what I did.*

The findings from my study indicate that apart from antenatal care attendance giving pregnant women assurance of referral to a larger hospital, the women comply with referral advice due to trust they have in their health care providers and in the services provided in a larger hospital. Compliance with referral advice has shown to be associated with perceptions of quality of services, among other things (Maine, 1999; Stark, Akhter, Axis, & Chakraborty, 1994).

Being anaemic was not the only reason that health care personnel referred pregnant women to the district hospital for childbirth. I wanted to know what other conditions would make health care personnel give referral to pregnant women and these included multiparity and caesarean sections. Shani Uledi (Kiromo dispensary) explained to me:

*If it is a woman's first pregnancy, we are not allowed to help her deliver here. We give her all the services like vaccinations but to deliver she will have to go to Bagamoyo, you see? Even those women who have delivered more than four times they are a risk. We just provide them with services like tests and do examinations and everything of the sort, but when the time for delivery arrives we direct her to go to Bagamoyo. We also do not deliver pregnant women who have previous scars, meaning that a woman who has already experienced operation does not deliver in the dispensary.*

### **5.1.5. Previous pregnancy problems/ complications**

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*I am very scared of staying at home without going to clinic because I do not want the same thing to happen to me again. When you attend clinic early, you become safer. Stella Mbwilo (Kerege)*

Stella told me she will never delay to start antenatal care after suffering a miscarriage in 2011. Past experience with previous pregnancies was another factor which encouraged women to attend early visits to antenatal care services. Early attendance at antenatal care permits early detection of problems and hence a chance of getting proper obstetric care (Thomas et al., 1991).

The first interview with Zuhura Hussein (Kitopeni) was around five o'clock in the evening. I found a group of children playing around the house and they told me Zuhura was at her neighbour's house, talking. One child ran and called her for me. She came and she invited me to sit in front of her house made of mud and sticks. The place we sat, akin to a veranda, was elevated with mud to make something like a bench although it was not completely flat. There were also mangoes arranged there which she told me she was selling, and later offered me some to take to my children when I was leaving. Zuhura, who is married and lives with her husband, was shy when we had our conversation. I had to encourage her to talk, despite the fact she understood what I was talking about. Zuhura narrated to me her ordeal with previous miscarriages and what she went through:

*I have had two miscarriages; that is why this time I went to start the clinic early. I had a problem with my previous pregnancies; when the pregnancies were reaching fourth or fifth months, I was miscarrying. The first one was five months and the second one was four months. It was happening so suddenly, I miscarry and then they put me in a car and take me to Bagamoyo to be cleaned.*

I wanted to know if she had started attending the clinic when her miscarriages occurred. Zuhura said to me: *No, there was not even a reason for delay; I just felt it was still early.*

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*I started clinic when this pregnancy was two months old; I was afraid that it was going to happen again so I decided to start early.*

I asked if Zuhura, having two older children before the two miscarriages, had attended ante natal clinic for these children. She said: *The pregnancy for my eldest children I started one when I was three months and the second one when I was four.*

I therefore wanted to know why she did not start early for the subsequent pregnancies when she already had experience of antenatal class with the previous ones. She replied to me [laughing, perhaps feeling unwise]: *there was no any problem, I was just telling myself not yet, I will go tomorrow, I will go tomorrow and that is how it happened.* When I asked her if maybe she had problems with the first two pregnancies (and had thus started attending antenatal clinic early) she said to me firmly: *No.*

### **5.2. Antenatal care needs of pregnant women**

*What I need when I get there is advice on how my pregnancy is doing and secondly if I need any treatment or service, the nurse to be ready to help me properly.* Veronica Chonde (Matumbi)

*...if she has complications, meaning that she is sick she comes to ask: 'why am I feeling this or that way please check me'* Judith Ombeni (Kerege dispensary)

Apart from understanding pregnant women's reasons for antenatal care use, I thought it ideal to hear of women's expectations of antenatal care services. Despite the fact that antenatal care services provided at the dispensaries are known, understanding pregnant women's needs from their own perspectives was crucial to understanding if services were satisfactory and according to women's expectations. Understanding women's

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antenatal needs from their own perspectives may allow opportunities for changes or improvement of antenatal care services.

Pregnant women expressed to me that the ability to monitor their health and the health of their child was a significant reason for attending antenatal care services. As Furaha Ally (Kiromo) told me: *I want to know the development of the baby who is in my womb and my health as well.* Sharing similar views, Bahati Selemani (Kitopeni) told me: *What we want is for them to check our health, how we are doing and the development of the child in the womb.*

Health care personnel held similar views about the reasons pregnant women choose to attend ante natal clinics. The majority of them told me that pregnant women visit the antenatal clinic to get services that will ensure safety of their babies and to monitor their own health. Sophia Taji (Kiromo dispensary) told me: *Majority say they have come to get a clinic card. They just want to know how their children and themselves are doing, that is what they want to know.*

Apart from knowing the state of their health and that of their babies, pregnant women expected good reception and proper services and management from health care personnel at antenatal clinics. Hadija Shukuru (Kiromo) explained to me:

*We need that when a pregnant woman gets to the dispensary, a doctor to receive you well and give you services you need [pauses]... Health services like to check your health like HIV, to examine the child in the womb, if he is active or not...*

*Our main needs are that all the tests to be available and another thing is important service; if you fall sick suddenly you can go there and be helped nicely; they check you so that you know what problem you have.*  
Stella Mbwilo (Kerege)

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I could sense the empathy and compassion of health care personnel Wahida Pandu (Kiromo dispensary) had towards the pregnant women when I asked her about the needs of pregnant women. She said to me: *In this coastal region of ours [thinking] they basically need love and if they get the delivery packs they are contented.* She told me that among the most important things pregnant women value when they attend antenatal care services is to be treated with respect and dignity.

Other needs of pregnant women included things that facilitate delivery and prevent diseases, such as bed nets and delivery packs. Although these things may not always be available from those who provide them, to pregnant women they are as important and as much expected as other services provided to them. Farida Kombo (Kiromo) said to me:

*When we go there we expect to be given nets to prevent us from being bitten with malaria mosquitoes. There are delivery packs that are being given to pregnant women which I have already received, when your pregnancy reaches nine months that is when you are given. I hope this exercise continues because it reduces costs to women.*

Health care personnel also informed me that not only pregnant women seek antenatal care services; mothers with babies and childless women visit antenatal care clinics for services including family planning advice and vaccinations. Judith Ombeni (Kerege dispensary) explained to me what really transpires at antenatal care services:

*Most of the women come and tell you that 'I have come to start clinic, I have come to be examined'. Others ask about family planning, those also come, others come for polio vaccinations... mostly vaccinations and family planning.... There those who come with children breastfeeding them and there are those who are free [neither pregnant nor having babies] come to inquire about family planning. In general young women and mothers can come any day.* Judith Ombeni (Kerege dispensary)

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Judith told me that due to various health care needs of women, antenatal care services provide services for pregnant women, mothers and young women.

Pregnant women also described the convenience of having all the services in one place, rather than having to travel for tests to the district hospital or other hospitals. Furaha Ally (Kiromo) said to me: *...other tests are not done there for example the amount of blood and group we test in Bagamoyo town...* Sharing the same view was Hadija Shukuru (Kiromo) who said to me: *...they test the amount of blood but this is done in the district as they do not have that test there and many more others tests.*

Although women expressed that travelling to the district hospital was inconvenient, it did not deter them from seeking the services required. As Pili Kassim (Kitopeni) told me:

*... of course there are other tests that are not available in our dispensary like that of testing the amount of blood; therefore the nurse will tell you to go to the district or any other hospital to do the test... You have no option than to go because you want your child and you to be safe.*

These findings reveal that women are ready and able to travel further for antenatal care services; even when the services needed are far from where they reside; as long as it is for the good of their health and that of their unborn babies. Similar results are evident in study done in Nepal by Tuladhar, Khanal, Kayastha, Shrestha, and Giri (2009) which showed that despite problems of geographical access, women still utilised ante natal services well.

Paulina Joseph (Kerege) impressed and amazed me by hesitantly saying to me:

*At the dispensary they do not have new machines like 'eksaundi' [ultrasound] to examine. They use normal pregnant tools like that what [thinking]... there is that thing that looks like a spherical object [foetal*

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*stethoscope] I do not know its name, they listen to a child's heartbeat. I think we need advanced machines in dispensaries like eksaundi.*

When I wanted to know where she had heard of or seen such a machine, Paulina assertively told me:

*At big hospital when I was pregnant with my previous child, you could see [pauses]... they show you how the baby moves in the computer [monitor]. It is really good, it assures you that you baby is doing fine.*

Studies in developed where this technology is widely used have shown the importance of ultrasound due to its ability to reassure pregnant mothers of their foetus' well-being (Garcia et al., 2002). The fact that an ultrasound allows early detection of foetal abnormalities also explains its great demand among women (Waldenström et al., 1988; Zechmeister, 2001). However in developing countries like Tanzania, this type of technology is not widely available and therefore most of the rural pregnant women I talked to did not even mention it in relation their health care needs. However, such technology is of significant importance in health care settings and to health care personnel due to its powerful diagnostic capacity. The technology can also bring women a sense of confidence and the assurance of being treated according to the highest standard of quality, as Paulina felt. A study conducted in Ghana by Mensah, Nkyekyer, and Mensah (2014) on the experiences of ultrasound among pregnant women showed that that women considered the ultrasound scan a crucial element of the antenatal care and considered the equipment necessary for continued antenatal attendance. However, because such technology is scarce in developing countries cost effectiveness studies may need to be carried out before introducing routine utilisation of such technology.

Health care personnel informed me that women also ask for their support to inform and encourage their male partners/husbands to attend clinics with them.

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*...They also ask us to do outreach meetings to inform their partners on the importance of attending clinics with them. They therefore ask us saying that since we are the experts, if we tell them very often their partners will be willing to come with them to the clinics. What we do is when their partners come, we educate them on their importance of coming to clinic with their women because in the past only a pregnant woman used to go to clinic herself or with only her child after she delivers. Shani Uledi (Kiromo dispensary)*

Health care personnel told me that they often encourage men to attend antenatal clinics with their women. They explained that men's involvement in antenatal care was important and it proved to be beneficial when both couple attend the services. Studies have shown that women's health is seriously affected because of men's lack of knowledge of the risks of childbirth (Blanc, 2001). Most often husbands /partners do not go to antenatal care clinics but might do so if encouraged; otherwise they wait for their wives to return home and update them, and this is only if they are interested in listening to them. As an effective way to improve maternal health, Gerein et al. (2003) call for more involvement of men in antenatal care and reproductive health.

Needs expressed by women should be taken into consideration, particularly those which all women share. Women's experiences of antenatal care services can be used as a source of information and communication for improvement of such services. Gerein, Mayhew, and Lubben (2003) argue that antenatal care programmes usually target women due to their reproductive role, but their voices are not heard in many social settings in community health decisions, and they are seldom involved in influencing the planning and management of local health services.

### 5.3. Commencement of antenatal care

*According to what the government national policy says, and in order to avoid disturbing her coming very often to the clinic, a woman is supposed to attend clinic four times once she feels she is pregnant. until she comes to deliver she already will have completed her four visits. Shani Uledi (Kiromo dispensary)*

Health care personnel in dispensaries at both Kerege and Kiromo described the usual and expected number of visits of a pregnant woman at antenatal clinic although not all antenatal mothers attended accordingly. As Salama Waziri (Kerege dispensary) told me:

*Normally a woman is supposed to attend four visits during her pregnancy if she has started her clinic early. Because there is that one who starts clinic when her pregnancy has advanced she may not complete all four visits. But normally at our dispensary women usually reach three to four visits because some of them delay to start.*

In agreement was Judith Ombeni (Kerege dispensary) who also said: *Officially, a pregnant woman is supposed to attend clinic for [pauses to think]...four times until she delivers.* WHO and the Tanzanian government recommend a minimum of four antenatal care visits for a woman with a normal pregnancy: one each in the first and second trimesters, and two in the third trimester. (Tanzania Ministry of Health and Social Welfare, 2002; Villar et al., 2001; WHO, 2014a).

I was informed by Sophia Taji (Kiromo dispensary) that despite the normal four visits required to be fulfilled by a pregnant woman, some special scenarios may change the number of visits a pregnant woman needs to have. Sophia explained to me:

*When a woman gets pregnant, she is supposed to attend all four clinic visits, but if a woman has a special case: perhaps she is sick, or we have*

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*tested her and she is positive with HIV, we decide how many times she should come for follow up. You can give her medications every two weeks so as to monitor her health, and then later give her the medications every month. Another woman can come suffering from blood pressure: this one also needs special care. Therefore you make follow up of her. You give her more visits, perhaps every [pauses]... you can give her visits every two weeks, then later every month, so as to see how she is doing. Otherwise if a woman does not have problems it is four times.*

From what I heard from health care personnel, the first antenatal visit and/or a risk condition a pregnant woman has are the determinants of the subsequent number of visits a pregnant woman will be advised to attend. Lincetto et al. (2014) elaborate that the aim of the first antenatal care visit is to identify pregnant women needing the normal four antenatal visits from those needing more visits and special attention.

I wanted to know from health care personnel if pregnant women in the villages usually complete all four visits required during the antenatal care period. Wahida Pandu (Kiromo dispensary) said:

*A pregnant woman is usually supposed to have four visits until she gives birth. They come; they do make effort because as you know these days pregnancy issues are complicated due to this and that. Therefore they come. First of all they have knowledge because we educate them that there is one, two, three. They are also afraid that mmh [sigh signal] why this, it is better I go to start the clinic early, early like two months, very late it is three months, four months she is very late. To say the truth, they respond, they come on time. There are a few of them [pauses]... as you know even with your own children, others can take good care of each other but there is always that one child who will bother you. There are those who disappoint us but they are not many.*

#### 5.4. When do pregnant women seek antenatal care services?

*I have just started my clinic with six month pregnancy. Asked why the delay, she said: I was not around, I was in Rufiji but I live here. I just went there to visit my grandma.*

Mwajuma Rajabu (Matumbi)

Mwajuma confirmed what I had noted: that pregnant women who do not experience problems with their pregnancies seemed to delay using antenatal care services. We have seen that antenatal care is emphasised as an important aspect in the ensuring safety of the child and the pregnant woman because it reduces the chances of morbidity and mortality by early detection of pregnancy problems, prevention and treatment of diseases. When I wanted to know from health care personnel when pregnant women usually seek antenatal care services, Upendo Saburi (Kerege dispensary) told me:

*... there is a problem here, not very often, not all fulfil all the ante natal visits. There are others because of [pauses]... I think I should just say they do not fulfil the visits. There those who delay to start clinic, then there are others who do not follow the calendar. You may find that you have given her a date but she does not come and she did not have any reasonable reason, she can just tell you she had travelled, you see [emphasising]. Another can start clinic when her pregnancy is already seven months. Like today we have examined I thinks two women; they have started clinic today with six month pregnancies. For such women, therefore, whatever you do she cannot have four clinic visits. When she reaches eight months that is the end, her legs will be so tired therefore she can only have one or two visits.*

Similarly, when I asked Sophia Taji (Kiromo dispensary) when pregnant women usually are likely start their antenatal clinic, she said to me: *The majority come at least three times; many delay to start clinic.* A study conducted in Maharashtra India by Griffith and Stephenson (2001) demonstrated that many women seek help only when problems

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become evident; hence they emphasise the importance of providing information on the potential benefits of regular prenatal care since a significant proportion of women consider prenatal care as curative care.

Shani Uledi (Kiromo dispensary) further told me that the delay in starting antenatal clinic has repercussions: *The one who has started clinic early will fulfil all her four visits but that one who comes late cannot complete all the visits, because why? She will have delivered by then.*

Despite the fact that health care personnel expressed their concern on the irregularity of visits among pregnant women, they told me there are ways they try to help women who delay. They told me that some women who do not attend all four required visits are often forced to reschedule antenatal services to ensure they get all the required services. Judith Ombeni (Kerege dispensary) explained to me:

*My experience here is that there are other women who come here only one month pregnant, another can be... I mean it is not stable. When you examine her, therefore you can move her. She can come here one month pregnant, four weeks; another comes: she is twenty weeks, another twenty four weeks. I mean it is not stable to say they come at how pregnant, how many weeks or months. Therefore, it depends on how you examine her. Depending on the four visits, you are supposed to see if she has come with four weeks; therefore you skip her further ahead; at least when she returns she will have some weeks. You give her education that she should not worry that date that we have advanced her but if she gets any problem in between she can always come back. Also with the issue of TT [Tetanus Toxoid- vaccination given during pregnancy to prevent tetanus to the mother and child], because the one who starts you cannot give her TT first dose then make her skip two to three months, you ruin the dose. Therefore we write in her TT card that this will be your date for getting TT and on this card this is the day for your antenatal visit.*

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*Therefore when the day for TT arrives you are supposed to come and get your shot and return but if there is any problem you can come with your card and we can combine both, so it depends.*

Health care personnel told me that women's awareness of the benefits of attending antenatal care services has improved in recent times. Awareness of risks associated with pregnancy was among the major reasons for women attending antenatal clinic. As Upendo Saburi (Kerege dispensary) told me:

*I think what brings women to clinic, first is the fear of birth because she does not know how she is going to deliver her child. She does not know how she will deliver her child, if she will develop complications or not, that is what makes them to come for ante natal clinic.*

Health care personnel mentioned fear as a reason that pushes women to attend antenatal care, a factor highlighted by Thomas et al. (1991) who argue that one of the reasons pregnant women attend antenatal care clinic is to alleviate fear and reduce stress on the mother and the unborn child.

Health care personnel also held that knowledge of the importance of the antenatal clinic to pregnant women has improved a lot over the years in such a way that women know what they want and can express themselves by giving reasons for attending clinics. Salama Waziri (Kerege dispensary) narrated to me:

*So many women are now knowledgeable; a woman knows that 'I am coming to the clinic because I want such and such services for pregnancy'. Many know what types of services they are supposed to get. For example she will come and tell you that: 'I have come for pregnancy services'. You will just examine her womb and say you are done. She will tell you: 'why have you not checked my blood?' you see [emphasising], why I have not been given a shoulder injection?' this means many have*

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*the knowledge that for example when I go to the clinic I expect that I will be tested for HIV, I will get a shoulder injection, I will be given tablet. She will even demand her discount voucher for buying the net, for example. When you are done and you accidentally forget, she will ask you: 'why have not given me discount voucher?' so you see many now know which services they are supposed to get when pregnant. There are only a few, maybe those with first pregnancy, who are not knowledgeable, but after being educated they understand that there is an importance of getting TTT injections, how many you should have and for what period; but those who have had children understand the services they need to get.*

When I wanted to know where pregnant women get this knowledge, Shani Uledi (Kiromo dispensary) said to me:

*You know what? What I would say now is education through newspapers, radio, and televisions helps a lot. Very often, when a pregnant woman comes here, many of them [pauses] others already have knowledge, she can arrive and say: 'I have come to start clinic, I want you to examine my pregnancy so that I know my status' [laughing]. You ask her where she got all this information; she tells you: 'We hear from radios, from announcements, from so and so'.*

Judith Ombeni (Kerege dispensary) also supports the notion that education and media have played a major role in convincing pregnant women to start antenatal care clinic early. She told me that pregnant women in their villages are more informed and therefore most of them start antenatal care clinic early or on time:

*I think education we give them and from the media has helped them. My experience here is that most of the women start their clinic early or on*

*time. There are only a few who attend two visits and deliver, but the majority of them try their best; they come early.*

## **5.5. Conclusion**

Education through antenatal care and various media channels seems to have contributed a lot to women's knowledge of the importance of antenatal care. Pregnant women I interviewed seemed to know the benefits of attending clinics and the risks involved in not attending. Women attending ante natal services at least once during pregnancy demonstrates that pregnant women are aware of or expect some benefits from such a visit. Furthermore, women's non-use of or delay in seeking health care services were not related to ignorance of the benefits of health care services for prenatal, delivery or postnatal services. The findings show that apart from the information women get from the media, antenatal care health care personnel have been working hard to educate women on the advantages of attending the services and informing them of the risks involved if they do not so. The positive responses to early attendance of antenatal care among pregnant women also indicate an increase in women's awareness, knowledge and acceptance of the antenatal care services. Gerein et al. (2003) argue that in order for antenatal care to provide good quality of care during pregnancy it should go further by educating women on the importance of delivering in the health facility or seeking care in case of an emergency. Other studies such as those by Maine (1999) and McDonagh (1996) emphasise the importance of teaching about obstetric emergencies as a crucial component of antenatal care. This study indicates that if pregnant women are given adequate information and education about child delivery, including referrals, they can make the right decision on how and where to deliver, and have the ability to recognise complications and what to do if they occur. Availability of facilities, including equipment, in one health facility needs to be taken into consideration to reduce the burden of women travelling long distances to access services not available at health facilities attended, as well as reducing costs.

## 6. Child delivery at health facilities and its challenges

*I do not know how the government can help us with regard to these things for delivery, because this problem of plastic mattress covers, I do not know... [pauses] cotton wool and other things, is not the problem affecting me alone. You cannot be pregnant preparing twenty fifty or thousand shillings [Tanzanian shillings equivalent to US dollar 11.53 or 17.29] for home use when God blesses you with a child, and again start to prepare - I do not know - cotton wool, I do not what... a thing for one day's use and then it finishes. The government should help us on that.*  
Veronica Chonde (Matumbi)

Critical issues around child delivery at government health facilities, expressed as being of significant importance to pregnant women and women who have just delivered, as well as by health care personnel in Bagamoyo district, are the subject of this chapter. In particular, I have been interested in understanding views and experiences of women in regards to child delivery at health facilities.

A significant body of literature discusses the importance of the safety of mother and child during delivery. This is because child delivery is the time when a mother and her child are at the most risk (Lawn et al., 2009). A clean birthing environment has been recommended as an effective preventative measure against both maternal and neonatal infection (Campbell & Graham, 2006; WHO, 1996b). Hofmeyr et al. (2009) urge recognition of the importance of care during birth and the possibility of saving lives of maternal and newborn by investing in health infrastructure, personnel and implementation research in high risk settings. In Tanzania, dispensaries are first level health clinics that provide primary care and are expected to perform uncomplicated delivery (National Bureau of Statistics of Tanzania and Macro International Inc., 2007). The majority of poor rural women with uncomplicated deliveries rely on these dispensaries, which are the main health facilities found in rural areas. In 1994 the Ministry of Health and Social Welfare introduced waivers and exemptions on health

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services to poor and vulnerable groups in the population in order to ensure equitable access to health care (Maluka, 2013). Pregnant women are among those vulnerable groups that are entitled to receive free maternity services, including delivery care.

This chapter recounts and analyses the perceptions and experiences of women (both pregnant women and women having recently delivered at the time of interviews) about child delivery within government health facilities. In particular I analyse women's views of preparation of items for delivery and delivery packs, access to water supply and electricity, disposal of waste, privacy, conditions at the delivery units, waiting places for families, bringing pregnant women for delivery as well as the issues of staffing and workload.

I also draw on the opinions and experiences of health care personnel in relation to the women's views, unpacking the experiences and challenges they perceive as confronting pregnant women and mothers regarding child delivery at health facilities.

### **6.1. Preparations of items for delivery**

*To say the truth, at the hospital there are things which they tell you are not available. Plastic (mattress protector),...razors, things for tying the umbilical cord..., the things for helping a mother to deliver her child you must buy them, because they tell you there are so many people; therefore things get finished; therefore you have to buy them; therefore I bought those things. Paulina Joseph (Kerege)*

*You are told to buy things for delivery: for example these injections; I do not know, razors... and what, things for motherhood. Therefore I went to the shop and bought them because when you go to the hospital you are told they do not have them. Therefore I went to buy them from the pharmacy to go with them to the hospital. Bahati Selemani (Kitopeni)*

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Child delivery is a health service that pregnant women are entitled to free of charge as stipulated by the government of Tanzania on waiver and exemptions policies (Maluka, 2013). However, women in the study told me they were asked to prepare themselves with items for child delivery at health facilities. They told me that buying delivery items was a necessity if a pregnant woman wanted to use the health services. As part of a free health service for pregnant women, women expected the health facilities to provide items for delivery but that was not the case. Pregnant women felt that most of the items they were buying to prepare themselves for delivery should have been the responsibility of the government because they are told that services are free. Paulina Joseph (Kerege) who said: *I request the government to research more because you find that when a woman gets pregnant it seems like you are buying a baby, too many costs.* Veronica Chonde (Matumbi) added more on the difficulties of preparing oneself for delivery:

*I do not know how the government can help us with regard to these things for delivery, because this problem of plastic mattress covers, I do not know [pauses] cotton wool and other things, is not the problem affecting me alone. You cannot be pregnant preparing twenty fifty thousand shillings for home use when God blesses you with a child, and again start to prepare, I do not know, cotton wool, I do not what... a thing for one day's use and then it finishes. The government should help us on that.*

These women expressed the difficulty of raising money for different circumstances at the same time. Because rural women and/or their partners frequently have unreliable sources of income, they find themselves in economic hardship to raise money for child delivery, child support and household expenditure after delivery. In 1993, the Government of Tanzania introduced a cost-sharing policy for health care services in government health facilities which were previously provided free of charge to community members. With cost sharing, guidelines were developed to waive and exempt poor people and vulnerable groups who could not afford the costs (Mmbuji, Ilomo, & Nswilla, 1996; Newbrander & Sacca, 1996). Among the groups exempted

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were pregnant women and children under five year old, with the policy stating that basic maternal and child health services should be delivered free of charge. When I talked to the women, their request was for the government to abide by its commitment to provide free maternal services, including preventive and curative health services, in all government health facilities in Tanzania. All services and the provision of items for delivery should be readily and constantly available at all times, they argued, as opposed to the current situation which requires pregnant women to prepare themselves for delivery items with their own money. It is important that the government reviews this as it can lead to failure of the poorest women to use health facilities for delivery and to opt for home delivery or go to traditional birth attendants if they do not have the capacity to afford such items. A study by Kyomuhendo (2003) in Uganda found out that some women decline to go to a health facility due to lack of money to pay for the services or lack of suitable clothes to wear. Similarly, a study in Tanzania by Kowalewski, Jahn, and Kimatta (2000) showed that some women in Tanzania do not seek health care services because of poverty which also creates fear of discrimination by health care providers at health facilities.

Most respondents bought the items due to the fear that not bringing them to delivery could lead to inconveniences for themselves because health care personnel cannot help. Hadija Shukuru (Kiromo) explains:

*We buy gloves and razor blades for delivering... those things associated with pregnant women. We are told to come with those things because a nurse cannot buy them for you from her own pocket. You have to go with them so that when you are about to deliver she helps you (sighs)...but these are the things which they are supposed to have them at the dispensary all time.*

Most of the pregnant women I talked with in Kerege, Matumbi, Kiromo and Kitopeni villages told me that they intended to or had delivered their children at their local government dispensaries. Those who could not, due to unavoidable reasons, were

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referred to Bagamoyo hospital and went there accordingly. The women's decision to use health facility delivery was associated with their beliefs that health facility delivery was best and safest for the health of the mother and the baby. Other studies have also shown that increasing health facility delivery rates are influenced by the knowledge of the benefits of attended delivery and assurance of care by a skilled attendant, the availability of equipment and supplies, and the good quality services and care (Kruk, Rockers, Mbaruku, Paczkowski, & Galea, 2010; Mbaruku & Bergstrom 1995; Mpembeni et al., 2007; Otis & Brett, 2008). These studies show that when people are informed, educated and counseled, they become knowledgeable and build confidence in the health system, choosing to have an attended delivery at health facilities. When I talked to the women, they told me that despite the costs involved, they would try as hard as they could to purchase items for delivery in order to deliver at the health facilities because of their belief that health facilities are the best and the safest place for delivery. This illustrates that women's perceptions of the quality of health care services influence their decisions to deliver at health facilities.

Although most pregnant women acknowledged that they did not pay for other expenses at health facilities, they told me they incurred significant expenses buying items needed for delivery, as well as additional costs if they experienced complications and needed to be rushed to a bigger hospital. The items women bought included cotton wool, a plastic mattress protector, bed-sheets, umbilical cord clamps, syringes and medications including oxytocin, an injection given to women to stop bleeding after delivery, which they usually bought from drug dispensing shops. As Latifa Issa (Matumbi) said;

*I bought cotton wool, I bought a syringe and medicine for injection to stop bleeding after delivery, I bought a clamp for a child. Let us say I bought everything needed for delivery.*

When asked if a pregnant woman did not have those items needed for delivery when she arrives at the dispensary, Mwajuma Rajabu (Matumbi) told me of her experience: *They told me to give them money for gloves and clip for tying the umbilical cord. I paid*

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2000 shillings. On the other hand, when I wanted to know from the health care personnel what happens if a pregnant woman does not come with the required things, Salama Waziri (Kerege dispensary) said:

*Not all can afford or get everything required for delivery. Others come here already in labour pain and climbed in bed with nothing. It happens: she comes in the middle of the night crying, already in labour pain, ready to deliver, with nothing. You, as a health care provider, you have to act quickly on what to do. Some other times we do not have anything left but we usually keep emergency gloves. When may keep one or two boxes for emergency for those who come vroom.... she does not have anything. We usually keep some things for our own emergency in cold cramp, so when it happens we help them. If we do not have anything at all that is when we will start calling people with the medical stores near us, 'please wake up and help us, open the store we need oxytocin or what...' This is what happens but it is usually a problem. It is a problem because a person comes in the middle of the night, she does not have anything and does not have money too, what do you do? [Laughs but showing sadness]*

I wanted to know who pays for the items if a dispensary does not have the kits for assisting pregnant women to deliver and at the same time pregnant women do not have money to cover the costs. Salama Waziri (Kerege dispensary) explained: *You have no other option than to find a way out and get money anywhere to go buy those things because it is even for your own benefit. How would you protect yourself from infections? You have to find money for the safety of a mother and yourself.* Sharing the same view about the importance of protecting oneself was Wahida Pandu (Kiromo dispensary) who said:

*It happens but a dispensary as a dispensary or a hospital as a hospital, things for emergency must be available; we keep them and help them. The one who can afford, we attend her with her own thing; the one who cannot afford [pauses]... Can you help to deliver a pregnant woman with*

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*bare hands or leave her to deliver herself? You have to have things for emergency; that is the time to use them.*

Salama Waziri from Kerege dispensary also described circumstances that caused inadequate items for delivery including pregnant women outside their locale coming for services at their dispensary. The practice of women returning to their parental home for delivery is customary in rural areas. Mathole, Lindmark, Majoko, and Ahlberg's (2004) study of a rural area of Zimbabwe showed a similar practice and even indicated that it may also interfere with referrals.

*We educate the majority of the women we serve in our area, so they come here ready prepared. We get problems from those who come from outside our service area; they come here knowing nothing. Most of them are from the city and come to stay here with their relatives, mostly their mothers, waiting to deliver. Now, most of them do not have the things for delivery; it is a problem. You find a woman coming here....sometimes she has never been told to prepare anything for delivery. Even with these delivery packs, those who come from outside do not have them, they even do not know anything about them.*

Apart from the items described above, some women had been told to bring about five pairs of new *kangas*, each which are all used and ruined in the process of delivery. The kanga or khanga is colourful a traditional printed cotton garment popularly worn by women in East Africa including Tanzania. Women often wear two pieces at a time, wrapping one piece around their waist and the other one around the upper body. A piece of kanga is about 1.5m by 1m and often has a border along all four sides known as *pindo* in Swahili and a central part design known as *mji* which is in different in patterns from the borders. A study conducted in Ghana by Cronin, Quansah, and Larson (1993) also showed that pregnant women were asked to bring clean cotton material to be placed on the mattress below them and these were changed whenever they were ruined with blood or fecal matter. Women from this study felt that there were forced to buy such items

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which they felt health facilities needed to provide, but had no option but buy them if they needed services. Faraja Hassan (Matumbi) lamented to me how she again had to incur costs for the items she had already bought and which were used at the dispensary before her referral:

*I bought gloves, a basin as we were told, a bucket, plastics for delivery, a pin for tying the umbilical cord and five pairs of kangas. All things were used, I was not given anything at the dispensary: I bought everything myself.... I got some problems, when I went to Kerege dispensary but it became impossible to deliver so I was taken to Bagamoyo. ..I had to buy other things again the gloves, plastic for delivering because some of the things were already used in Kerege but when I went to Bagamoyo I was asked to add more.*

According to the women I talked to, the total cost of all such items is about Tanzanian shillings 20,000 which is equivalent to US dollars 11.49. This is a significant sum of money to a rural household whose average monthly income is estimated at Tanzanian shillings 32,305/= equivalent to US dollar 18.57. (This figure is according to Hoogeveen & Ruhinduka's (2009) 2007 statistics on the level of poverty in household income and expenditure between years 2001/1 and 2007 in Tanzania. Although women are told to slowly start saving money when they become pregnant, their average monthly incomes are usually not stable due to households depending solely on small-scale farming. Even for those engaging in self-employment unrelated to farming, such petty trade, which is also common in rural households, income becomes unsustainable due to covering other important basic household requirements like food.

I talked to health care personnel to establish if there was any non- governmental organisation that provides any support with delivery items and was informed that there was none. However, the health care personnel told me that the United States Agency for International Development (USAID) and other partners introduced a Pay for Performance (PAP) programme, injecting money directly to account of dispensaries in

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Bagamoyo district for their own direct use. This money is awarded based on evaluation of the performance of a dispensary over a given period of time. Although a dispensary has a mandate to use the money as it sees fit, this money is often not enough to cater for all needs of a health facility. The money is usually used to take care of small problems such as buying items for cleaning a dispensary and its environment.

During my study, some women told me that during antenatal clinic visits they were informed by health care personnel that the government had introduced delivery packs. These delivery packs, which contain everything required for delivery, were to be provided free of charge to pregnant women. However, the women were also informed that the provision of these delivery packs was limited to women who were due to delivering in the months of November and December 2012. Health care personnel confirmed this and stated that sustainability of the delivery packs was uncertain. In most cases women acknowledged having prepared themselves with the required items despite the financial burden because that is what they are told to do when they start their antenatal clinic; they do so to avoid unnecessary disturbances such as denial of services. Women also told me that during antenatal visits they are advised to keep money as a precaution against extra costs including emergency transport to Bagamoyo hospital. Two pregnant women explained to me:

*We have been told to buy things for delivery. We have been told to buy gloves, those plastics for laying in the bed, a basin and a bucket... new ones. When you go to the clinic you are told to prepare yourself with those things... When I went to start clinic that is when we were told to start buying those things and keep them. Faraja Hassan (Matumbi)*

*There are costs involved. We prepare ourselves for transport issues, they tell us to prepare things for delivering for example gloves, clip for the umbilical cord, razors and plastics mattress protector. For example I have been told to prepare those things so I have already bought them. I have used 10,000 shillings; I have got two long plastics for covering the*

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*bed for urine protection [a child's mattress against urine], gloves and the clamp. Furaha Ally (Kiromo)*

Pregnant women's willingness to prepare themselves with the required items for delivery not only shows their adherence to health care personnel's instructions, but also their knowledge and understanding of the importance of attending clinic and delivering a child at a health facility. Most women cannot afford the cost of buying the important materials and equipment required for delivery at rural health facilities. However, due to their knowledge of the importance of delivery at a health facility, they are ready to do anything possible, including borrowing money from other sources, to access the service. In short, pregnant women are pushed beyond their financial limits in order to access and use health care services.

Health care personnel also admitted that preparing a mother for delivery is a challenging task which they have not control over, given the fact that items for delivery are not readily available at their health facilities. As a result they have to inform pregnant women to prepare themselves accordingly. Sophia Taji (Kiromo dispensary) explains:

*Before delivery packs came, we were serving them with what we had. The things we did not have: that is what you tell a mother to bring: go buy, we have run out of them. There are some things you find that they are not adequate, for example gloves, mattress protector, cotton wool... they used to come but you find they bring you a few of them; then they are used and finished, the users are many compared to what is brought.*

Insisting that the problem of delivery items existed even before the delivery packs were introduced Judith Ombeni (Kerege dispensary) said:

*Delivery kits and other things were not available or adequate even before delivery packs. Some other time they are available but there are times*

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*when they are not available at all; they can be unavailable for some time and later we get them. Delivery packs only started in October [2012].*

When I asked Judith what they did in such situations in the past, she said:

*Before that, we were basically giving a pregnant woman education to prepare her for delivery. She should prepare enough clothes as usual for herself and her expected child. We were also telling them to prepare gloves in case it happens to be an emergency: perhaps she get labour pains on the way or at home and delivers. If there are people in the neighbourhood to help her then they will wear the gloves and help her. Okay, unfortunately she delivers and starts bleeding... bleeding heavily; if she prepared herself and there is any nurse or medical assistant in her area, she might help her. We usually tell them to buy that small oxytocin bottle and a syringe, meaning they should prepare everything... a syringe, that medicine which stops bleeding heavily, Oxytocin; there are gloves at least three pairs, and cord clamp for the baby.*

Although health care personnel admitted that the reason for preparing the mothers for delivery was due to the fact that most of the time delivery items are not readily available at their dispensaries, they also insisted that it was important to prepare women, given distance from facilities and other risks factors associated with not making early preparations. Judith Ombeni (Kerege dispensary) explained the reason for preparing women for delivery and gave an example of an ordeal that a pregnant woman experienced due to lack of preparations of delivery things:

*Now we continue to emphasise to the woman in case she lives very far: 'what will happen to her if she develops labour pains and delivers and she does not have a single thing?' It becomes difficult; they take any cloth rope and tie the cord... now infection. Ok, she does not have a razor to cut the cord; she uses grass, I do not know... you see. Therefore, we tell*

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*her to take precautions; if it does not happen, you will come to the hospital, if it does not happen, you thank God. If she comes here with her things and we have ours, we use ours; hers will help another person at home or if she has a relative. But we emphasise to them to prepare themselves because it has happened before. I remember... there was a woman who delivered her twins but nobody wanted to help her with bare hands; every person was 'I am scared, I am scared'. Now you end struggling on your own, your husband is not there, you have just delivered, getting up to do this and that, but if she had those things she would have said 'I have the things; please help me'. Then it becomes easy; therefore, we educate them just in case.*

The perceptions and knowledge of pregnant women about the preparation of items for delivery differed. While some women expressed their concern about preparing items for delivery, there were other women who knowingly or unknowingly regarded the costs incurred as necessary for services provided to them at the health facilities. These women did not mention buying delivery items and exercise books for writing referrals as costs to them but rather saw them as their obligation because incurred cost to them were perceived as costs incurred to the health facilities. Hadija Shukuru (Kiromo) said:

*I have never paid: if it is delivery you do not pay anything, if it is a card it is free. Perhaps they can tell you to buy an exercise book; you will have to buy it because they cannot give you money from their own pocket. The exercise book is for, for example, if you have problems then you have to buy it so that they can write for you to go the big hospital. The exercise book is for keeping your information and you keep it yourself. For example with regards to medicines, for a pregnant woman they write down on a piece of paper; then you go with it to the district. When you go there you do not pay anything; they give you free medicines.*

Sharing the same view was Nuru Salehe (Kitopeni) who said:

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*When I was pregnant we paid. I paid for gloves, I paid for the syringe. All the needs that were required, I paid for them. I did not pay for anything on examination and tests. You pay when you are delivering; before delivery you do not pay for anything. You are examined and tested and given medicines free of charge.*

Latifa Issa (Matumbi) said: *I have not paid for services since I started this clinic but I incur expenses, for example, things for delivering a child. I bought.*

Preparing items for delivery is a challenge that needs an immediate solution if the government wants to ensure continuous utilisation of health care services and hence to reduce maternal mortality. From the findings, there are many costs that women have to incur before, during and after arriving at the health facility. A woman must purchase a number of items for child delivery such as gloves, razors, syringes, cotton wool, a plastic mattress protector, umbilical cord clamps, three to five pairs of kanga and medications including oxytocin. These items cost up to 20,000 Tanzanian shillings [about US dollar 11.49] for uncomplicated deliveries. Similar findings on the costs women incur to buy delivery items have been shown in a study in rural Tanzania by Spangler and Bloom (2010). With an estimated per capita annual income of 1,297,886.40 Tanzanian shillings (The World Bank, 2015) which is about \$ 694.8 dollars as of year 2013, this amount would not suffice needs of a normal family (which very often is composed of parents, their children and members of extended family). The situation of household income is worse in rural areas where more than 80% of poor Tanzanians live. Their most important source of financial income is derived from the sale of food and cash crops from agriculture (National Bureau of Statistics & Ministry of State President's Office Planning and Privatisation of Tanzania, 2009). Worse is the high or sometimes sole dependency on agriculture that may be affected by lack of reliable rain, capital, agricultural produce and the market. In such a situation, not all women, and especially rural women, can afford the costs of these items. For a rural woman who depends solely on farming or on her husband or partner (a poor farmer or casual labourer) for support,

the ancillary costs of delivery are a huge burden. Furthermore, money for delivery items excludes transport costs, and the cost of referral in case of emergency, costs which also prohibit poor families using the health care facilities. A pregnant woman or her family can rarely afford costs which often exceed the financial capacities of the family, and in many cases experience shows that they have to borrow money from other sources.

Buying such items when the government asserts that child delivery is provided free of charge at health facilities makes pregnant women question the reason for paying for such services. This study has shown that the exemption introduced in medical care for vulnerable groups such as pregnant women and children does not cover all areas of service provision. The concerns of women about difficulties and problems they face while preparing for child delivery therefore need to be heard and acted upon so as to ensure continuity of utilisation of health care services. A Delphi study in India by Kennedy (2000) on women's perspectives of midwifery care showed that women felt important and valued by midwives when their needs and concerns were respected. This study demonstrated the importance of listening and respecting voices of women from vulnerable populations in order to expand on knowledge of their specific needs. The study indicated that women can provide insights essential to achieving the best possible health care for women. The issue of preparing items for child delivery was a big problem expressed by pregnant women in my study. While it may be challenging to fulfill the individual needs of women, common problems and needs that seem to be predominant must be given priority and immediate long term solutions found because such challenges hinder women's access to health services.

## **6.2. Inconsistencies in supply of delivery packs**

*There is a problem when going to deliver a child. For example: cotton wool, things for tying the umbilical cord, I do not know, syringes, and that plastic cover for the bed: you find most of the time they do not meet the actual need; they are not there. For example, this year they told us*

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*they brought a few delivery bags; they claim that I do not know forty two bags. Let us just say they have given an offer for the month of November and December, for the one who will deliver her child at that health facility: she will get that service. But after that, in January, that service might not be available because it is finished. Therefore, you find that service is inadequate; therefore, if you go there and the delivery bags are no longer available, you will have to incur the cost to buy them and buying them is very expensive.*

A number of women told me that, during their antenatal clinic visits, they were informed that the government had brought delivery packs that are to be provided free of charge to pregnant women to health facilities. However, pregnant women told me that the issue of these delivery packs was something that was not transparent to them. They told me they did not understand why the government had introduced such an important thing to pregnant women at dispensaries when it seemed inadequate to all women and unsustainable. The women told me that health care personnel informed them at the health facilities that since the delivery packs were few they would only be provided to women who delivered in November and December 2012. The women who were due to deliver around those months were given the packs. They were pleased and thankful that they did not have to incur the expenses for the items the packs contained, as Hadija Shukuru (Kiromo) told me:

*I did not buy anything. I was given everything for delivery at Kiromo, I did not buy anything. We are thankful that now when a mother reaches nine months they give her that bag because the government is self-sufficient. The bag has gloves, razor blades, umbilical cord clamp. Now when you reach nine months, a nurse gives you your bag. You stay to prepare yourself. When you feel you are ready, you carry your bag and go with it to the dispensary.*

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Veronica Chonde (Kerege) also said: *I did not pay for anything. I was given everything, I even have the delivery bag which I now use to go to clinic with.*

However, other women told me they had or would have to buy their own things due to their child delivery not falling on those months. These women felt it was unfair to provide the delivery packs to just a few women and doubted the sustainability of delivery pack provision. Asha Zuberi (Kerege), showing sadness as she explained, she had this to say;

*Currently delivery packs are available but are few; they have been brought this year; those who deliver early are the ones who will get them. We, the last ones, we will have to buy ourselves.*

Even the health care personnel were uncertain; they told me they were not sure of the continuity of receiving the delivery packs from the government. When they were brought to them, staff were not informed if they would continuously receive the packs. Salama Waziri (Kerege dispensary) said:

*...they were brought to us, in October [2012]. That is when we started giving them out; we give them to women who attend clinic in our dispensary...they brought them but they did not tell us they will be bringing them after what period.*

Similar doubts were expressed by Shani Uledi (Kiromo dispensary) who said:

*The situation is better now; perhaps for the first time I can say they have tried to bring delivery packs. When a pregnant woman reaches nine months, we give her that delivery pack which has some things for delivery at labour room. Women are happy about it; now we do not know if it is going to be sustainable or if it will fade away after this first time; we do not as yet. Not even one month has passed since they were brought.*

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When asked about the continuity of receiving the delivery packs, Wahida Pandu (Kiromo dispensary) had this to say:

*A government is a government: they can initiate something and it may not continue. When it runs out that is it, it is over. It is not like a housewife who tells her husband that 'we are only left with flour to suffice us for one week, you see? The man can plan and figure out either to borrow or what, you see? But with the government, you find that a thing is finished all of a sudden vuuup [abrupt expression]: it is no longer available. Like right now, we are thankful we have received delivery packs for pregnant women with everything in it, aaah [pleasant expression]: everything is cool, no problem, but will this continue? We do not know if they will continue supplying them every time.*

Similarly on the question of continuity of receiving the delivery packs Upendo Saburi (Kerege dispensary) sighed and narrated:

*Eeh, we do not know the fate of this issue as we were brought forty eight delivery packs, and us on average we deliver 20 women. Now those forty eight delivery packs... even us the way we use them, we have told the women we do not know when they will be finished. We told them they will be used in November and maybe December and maybe January; we do not know if they will be brought again.*

I wanted to know if they had asked the people concerned when delivery packs were brought to them. Upendo Saburi (Kerege dispensary) said:

*No, a driver brought those delivery packs to us; there was no one who came to tell us what or what. We were hearing that there are delivery packs...but at that time they had not been brought here. In other places*

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*they had already started using them; I think we were late to get them here.*

Health care personnel in both dispensaries told me that even before the introduction of delivery packs in October 2012 at their health facilities, delivery kits and the like were still either not available or inadequate. As a result, they were forced to tell pregnant women to prepare themselves, despite the fact that they know such items are expected at a dispensary. Wahida Pandu (Kiromo dispensary) said: *Before the delivery packs, the government only brought gloves for delivery. Now there are times when we will use those gloves until the last box before getting other boxes...when they run out, the women were going to the shops and buying them and we attended them.* Salama Waziri (Kerege dispensary) explains further:

*Before delivery packs were introduced the situation was very bad because there were some few things that we were getting but others we did not get; therefore, sometimes were forced to tell pregnant women to bring them. We could have gloves although were not enough; therefore, even when a pregnant woman did not come with anything we could use such things. However, there are times when things run out and you stay for even a month without sterile gloves. We are therefore forced even to tell a pregnant woman 'get these things yourself because it is for your own use'. Even oxytocin, that medicine for injecting for women: you tell them to buy them because you can stay for a long time without getting them at all. You therefore tell pregnant women that the government supplies them but there are not enough.*

When asked why the supply given to them is not adequate she had this to say:

*You know we depend on MSD (Medical Stores Department) to supply us, and MSD distribution is after every three months. Now, you can receive things that do not reach three months because of the number of people*

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*you get. We therefore have no other option but to tell women to prepare things for themselves. We educate them that these are important things for them and are for their own use.*

Medical Stores Department is the Tanzania government department that was established for the procurement, storage and distribution of medical supplies and to provide for other matters connected or incidental to the establishment and management of the department (Medical Stores Department, 1993). Salama Waziri (Kerege dispensary) expressed her doubt on the sustainability of the delivery packs and the implications of this to pregnant women. She said:

*We are thankful for the delivery packs; if they continue to provide us with these packs it will be helpful, especially for those women who are unable to afford anything. However, as you know, the government things start well and then later they stop. When they stop coming and women are already used to getting the things, they no longer buy and prepare themselves anymore because they know when they come to the health facility they will be given a delivery pack; it creates a big problem. Now we go back to where we started: 'go buy cotton wool, go buy gloves, go buy cord clamp'. You see, it becomes a problem, but if we have adequate supply I think services will be good.*

The introduction of delivery packs for pregnant women by the government is a commendable effort towards ensuring that women get the required services at dispensaries free of charge. However, most of the pregnant women were and are still required to prepare delivery items for themselves. The certainty and sustainability of free delivery packs was not clear to either pregnant women or the health care personnel. The government may have good intentions in introducing such packages, but if the issues around provision are not made transparent and the government cannot assure its sustainability, it creates mistrust among women who utilise the services. Health care personnel are also left with unanswered questions which can lead to bad relations

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between them and their clients. Bergstrom (2001) indicates that one of the barriers to good quality of maternity care is a lack of material and efficient logistics such as basic supplies and equipment like gloves, cotton pads, cloth and sheets. He argues that the lack of essential equipment continually affects staff attitudes, which in turn affect their interaction with patients seeking care.

In my first interview with Nuru (Kitopeni) she was very upset about lack of provision of delivery packs. She told me that she had not received a delivery pack from the dispensary when she went to the antenatal clinic, despite being eligible given her delivery due date. I encouraged her to ask the health care personnel when she went back to the antenatal clinic. In our second interview, Nuru was in a happy mood. She invited me to sit outside on the side of her house. We had our conversation at around eleven o'clock and fifty minutes in the morning. Apart from telling me that she had a new baby boy, she was so excited to tell me that she finally was given the delivery pack after asking about it in her subsequent clinic visit. Given the inadequacy of supplies, Nuru's situation indicated that sometimes health care personnel were not giving the packs to all pregnant women who qualified, probably assuming that women would still buy them if not provided and therefore the staff retain them for emergency. Therefore if a woman did not ask about the pack, she did not get it.

Provision of essential items such as delivery packs to some pregnant women and not others without providing adequate explanation of the reasons why can lead to poor relationships between women and health care personnel as well as creating negativity in women about using health care services. Dieleman, Cuong, Anh, and Martineau (2003) insist that health workers get feedback from women because it can assist in determining if services are valued; feedback may also motivate health care providers to work harder, even if it may not be adequate substitute for professional appreciation. Further, Wong, Li, Burris, and Xiang's (1995) studies in China recommend that conscious efforts be made to reach out to women in order to find out their concerns and opinions on health care and incorporate them into policy-making.

### 6.3. Poor water supplies

*When you are attending a pregnant woman for example in labour, you use a lot of water. Now, at the moment, the tap we depend on is over down there, far from here [shows me]. You therefore have to go there with a bucket to fetch water and bring it here. It is a problem; perhaps even a relative has to go fetch water to bring it here. We ourselves when we want water for cleaning utensils to wash our hands we have to go fetch water from there and bring it here. Salama Waziri (Kerege dispensary).*

Water is essential in everyday life. It is particularly a prerequisite for a pregnant woman and health care providers when delivery of a child is concerned. The issue of water supply was raised in dispensaries at both Kerege and Kiromo, but in different ways. At Kerege dispensary, health care personnel told me that water supply is a persistent problem that needs immediate solution. They raised the issue of water as a major hindering factor in service provision. They told me that at the source of water for the dispensary is a significant distance away from the dispensary. This distance is an inconvenience to the health workers and to the relatives of pregnant women. They all have to fetch water from the tap and bring it to the delivery room and other places where it is needed for provision of services.

I discovered that the tap Salama Waziri (Kerege dispensary) was referring to was located near the household of the health care personnel. I therefore asked Salama if the households had their own water taps. She said: *the same tap is used for both patients and health care personnel households, so you see it is not good all.*

Some pregnant women even told me that they had been advised by health care personnel to bring bucket and basin when they went to dispensary for delivery. When asked what these items were for, pregnant women at Kerege dispensary told me that they were

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needed by the relatives escorting them to fetch water for use in the delivery room and to wash clothes while waiting to deliver.

Health care personnel at Kerege dispensary suggested that water be connected inside the dispensary for effective execution of their duties. As Salama Waziri (Kerege dispensary) said:

*If possible, we request the government bring and make available a water service inside the dispensary, as opposed to only having one tap which is down there, making it hard for us to provide services.*

On the other hand, pregnant women at Kiromo told me that the situation had improved at Kiromo dispensary compared to the past. Zuwena Hemed (Kiromo) explained:

*In the past they were using tap water and it was disturbing because was not available most of the time; therefore they improved the availability of water by building a well to eradicate the problem. In the past you could open the tap and there would be no water and you need water for use during pregnancy or delivery, but now water is available all the time.*

Hadija Shukuru (Kiromo) narrates more:

*Nowadays, water availability is not a problem. You know as a pregnant woman when you go to deliver water is needed. Even in normal circumstances, water is needed in a toilet. You cannot go to the toilet and come out without cleaning yourself or washing your hands. In the past there was no water in the toilet, although taps were there.*

Ensuring water is accessible and available constantly within the health facility buildings, such as delivery room, is vital if infection and contamination are to be avoided, not only among pregnant women but also to patients and those who attend them. A study

conducted in India by Mehta, Mavalankar, Ramani, Sharma, and Hussein (2011) showed that availability of running water in one of the important aspects to assess control of infection in delivery rooms.

#### **6.4. Intermittent electricity supplies**

*Right now, we are thankful at our dispensary. We did not have electricity in the past, but this year electricity has been installed recently. In the past we used to deliver with no adequate light. Habiba Juma (Kerege).*

Sharing the same view was Zuwena Said (Kiromo) who said:

*To say the truth, right now things have improved because in the past there was no electricity such that pregnant women were told to come with seeing gadgets but now they have put electricity; therefore there are no disturbances.*

*The village has helped us to bring the electricity we are using now because in the past we were using hurricane lamps while the electricity was passing right there on the road. We therefore thank the village government for connecting us; at least now we are working in the light. When they connected the electricity, we wrote a letter to our employer that the work has been done by the village government. The employer therefore said that they would take the responsibility of what? To pay the electricity bills; therefore until now electricity is being paid by the Director of Bagamoyo Municipality.*

There is no doubt that electricity at the health facilities is vital and plays various roles in execution of duties. Activities requiring electricity range from operating machines like

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Hemocue for testing haemoglobin, storing vaccines, sterilising equipment, to use in the night for attending patients, and child delivery, to mention but a few.

Electricity during delivery came out as an issue of great concern, particularly in cases where delivery had to be conducted in the night. Both pregnant women and health care personnel described the comparative ease electricity had brought to delivery. In both dispensaries some women had experienced deliveries conducted when electricity supply was unreliable but informed me that the situation had now improved. Sharing the same points of view were health care personnel. Salama Waziri (Kerege dispensary) explains, giving an example:

*We are thankful because the dispensary did not have electricity and it was a big problem. When a pregnant woman came for delivery we used to use hurricane lamps you see? And the time when I moved here it was really, really dark. You wake: it is dark; you come from there [showing me her house] up to here. Sometimes using a light from a phone you help a woman to deliver. For example, a pregnant woman arrives on a motorbike calling 'nurse'; immediately she delivers there. You have come out of the house. When do you get the time to light the hurricane lamp? You find yourself using a torch, you give it to a relative to hold for you and you take care of the woman.*

Salama explained the risks involved when there was/is no electricity:

*There are risks involved with lack of electricity because here, in our places, there are so many snakes; you just pray to be safe when you come out. Sometimes someone calls you outside but you do not see who is calling you and where he is because of the dark. However, you come out and pray to God that he will be a good person...you give them service they need and go back home.*

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Narrating a similar experience at Kiromo dispensary was Sophia Taji (Kiromo) who said:

*The most important thing that has been done by the village community is to get the dispensary connected with electricity because it used to be a problem in the past when it was dark. When a mother came with a hurricane lamp you sometimes find that you do not have kerosene; you have no money. Therefore you tell her to go buy kerosene to put in the lamp, or we used to use torches, which was not good. Therefore the village made effort to connect electricity from Tanesco, so now aah [expressing contentment] it helps and the electricity is paid by the municipal.*

Tanesco stands for Tanzania Electrical Supply Company. It is the sole producer of electricity in the country. However the introduction of electricity in both dispensaries has come with its shortfalls. Wahida Pandu (Kiromo dispensary) said to me:

*Problems in many villages' dispensaries are similar. Sometimes electricity goes off due to running out of LUKU and it is the district itself that buys electricity for us and then gives us numbers to put into the LUKU machine. For example up until now the district has not yet brought us electricity therefore we are forced to send vaccinations to another dispensary, this costs us bus fare.*

LUKU is a Swahili abbreviation of *Lipa Umeme Kadri Unavyotumia* meaning *Pay for electricity as you use it*. LUKU is pre- paid electricity supplied by the Tanzania Electrical Supply Company, the main producer of electricity in Tanzania. LUKU is in the form of units that a person buys from the Tanzania Electrical Supply Company's LUKU stations. Users are given either a card to insert or a receipt with numbers to log into a LUKU machine of the Tanzania Electrical Supply Company installed in different places (homes, offices, industries and health facilities) in order to access electricity.

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When all the units are used, the electricity automatically disconnects until a new LUKU card is bought. For health care facilities that use electricity from the Tanzania Electrical Supply Company such as Kerege dispensary, this means that they have to wait and rely on receiving LUKU from the government provided in form of units to connect to power. If the LUKU is not received in time, assisting pregnant women to deliver their babies during the night becomes difficult and the storage of materials such as vaccines becomes impossible. As a result of such disturbances and inconveniences, health care personnel find themselves forced to use their own money to pay for electricity during delivery and/or incur unnecessary expenses, travel time and inconvenience taking vaccinations for storage at other dispensaries as described in chapter four.

After the interviews, I went to check the meter of Kiromo dispensary which confirmed that electricity was disconnected due to lack of payment. That day, the health care personnel had followed the vaccines from another government dispensary in Zinga village in order to vaccinate children. They had sent the vaccines to Zinga dispensary for storage due to lack of electricity in Kiromo dispensary. The health care personnel told me that when they were done with vaccinations, they would have to return them to the dispensary if electricity was not reconnected by the end of the day. Hearing this made me consider that they had been there since morning, serving women and other patients, and possibly the previous night, yet were still required to send back the vaccinations at their own cost, simply due to lack of electricity. Unreliable electricity supply calls for a review of how government can help its health institutions like dispensaries to find workable solutions that will allow health care personnel to work comfortably and efficiently.

In Kerege dispensary, health care personnel told me they had not received LUKU from the government since they connected electricity through their own initiatives. Expressing disappointment, Salama Waziri (Kerege dispensary) said to me:

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*Imagine: up until now we have not received LUKU since we connected electricity in our dispensary with the help of our village government, community, councilor and a member of parliament.*

I wanted to know where they obtained money for electricity if the government had not done/is not doing so. Salama said: *Right now we struggle: we use little money we get now and then to buy LUKU. We can sometimes buy ten thousand shillings worth of LUKU depending on what we have; we buy ourselves.*

Health care personnel in Kiromo also told me about the delays in receiving electricity supply from the government. Shani Uledi (Kiromo) said:

*Eeh [expressing to agree] but not at the right time, electricity can run out and you end up waiting for sooo [emphasising] long. Like right now, we do not have electricity; they have not paid for us, you see enh?*

Similarly, Sophia Taji (Kiromo dispensary) had this to say:

*On paying, that is where the problem; for example, now LUKU has finished since... [pauses to think first], it is a month now. Now we are buying LUKU ourselves using our own money. In fact, right now I have come from asking somebody to go buy... When you log in your request there the process takes too long. They can sometimes tell you that the share has not come out yet: wait, long process. Therefore, until you get it you find you already incur costs.*

I wanted to know if staff are refunded when they pay for electricity using their own funds. Sophia said: *They do not, you just put. They tell you that you will use your own brain so that you do not miss electricity. It is a long time since we last had electricity. As you can see, I just want to go the district to make a follow up.* Sophia told me that they

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usually use their own funds to go to Bagamoyo to make follow ups of electricity supply. Wahida Pandu's (Kiromo dispensary) also complained about delays:

*Electricity cut off does not happen regularly and also is a normal thing. But when LUKU runs out and you do not know when it will be bought, do you not see the problem? That is when you find a doctor taking one thousand shillings or ten thousand shillings and buying it; does she not have children to feed? Or sometimes someone gives out five thousand to buy LUKU so that electricity continues to be on: five thousand shilling electricity, ten thousand shillings (pauses)... or the way the fridge uses power, what do you expect? The medicines cannot be in a good state because of that. LUKU does not come on time, does not come on time at all.*

I wanted to know if they are provided with funding to pay for electricity or receive a pre-paid electricity supply card (LUKU) for use. Wahida said:

*Not money, we are not given money; they buy LUKU themselves and bring us the number to put on the LUKU machine. We have never been given money, even one day's worth. They can bring us 200 unit or 300 units of LUKU: it is not stable; it changes depending on what they have.*

I had noticed that both the dispensary and the health care personnel houses had electricity and so wanted to know if buildings share the same electricity supply or if each had its own. Salama Waziri (Kerege dispensary) said:

*We share the same LUKU; therefore, some other time we are forced to pay ourselves and so share with dispensary. We use our own money (two thousand, three thousand, five thousand) at least to put the light on; what else can we do? The government tells it does not have money to bring to the dispensary. Therefore as we get, for example, money from P for P*

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*[Pay for Performance] programme. That 25%, we sometimes use some of that money on electricity, but the Municipal has not given us anything, ... our problems in Tanzania. Imagine if we did not make effort to ensure we get electricity in this dispensary: that means there would not be electricity here.*

The sharing of electricity supply between dispensaries and the households of the health care personnel indicates a further dilemma health care personnel face. So many questions can be asked about the issue of electricity. Are health care personnel taken for granted because lack of electricity at the dispensaries means lack of electricity within their households? Are they forced to pay for the electricity because they need it for their household as well? One would wonder what the situation would be if each had their own electricity supply. Would the health care personnel be ready to use their own money to pay for electricity for the dispensary in order to provide the services as they do now? Who is to blame?

Health care personnel also told me that the lack of electricity at dispensaries was a problem they encounter when they want to deliver pregnant women, particularly those who delay or arrive when it is already night time. In both dispensaries, staff said that in the absence of electricity, they are often forced to use their own money to pay for it to provide services to women. Salama Waziri (Kerege dispensary) gives an example of incidents that have occurred when a woman is already at the dispensary and in labour and electricity runs out:

*Sometimes a pregnant woman is in labour in the night and all of sudden electricity runs out; you have to look for money from M-Pesa in your phone and buy LUKU quickly so that the power returns and you able to help the woman.*

M-Pesa (M for mobile, Pesa is Swahili for money) is a branchless banking service which was launched in 2008 by Vodacom, one of the largest mobile network operators

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in Tanzania. The service enables users to complete basic banking transactions without visiting a bank branch. It is a money transfer and micro- financing service that enables people who have access to a mobile phone but do not have or have only limited access to a bank account, to send to and/or receive money from other people, pay bills, purchase LUKU electricity from Tanesco or a flight ticket, as well as to purchase top-up airtime for the phone. A person registers for the service at an authorised agent which can be a small mobile phone store or retailer anywhere in a city or a village and then deposits cash in exchange for electronic money. All transactions are completed securely by entering a PIN number, and both parties: the sender and the recipient receive an SMS confirming the amount that has been transferred. M-Pesa service is used widely for financial transactions and has shown to be very effective in Tanzania, especially in places where there is little or no immediate access to infrastructure such as reliable transport or after hours when offices for certain services are closed. Vodacom reported five million subscribers of M- Pesa as of May 2013 across the country, breaking the record it had projected (TeleGeography, 2003). M-Pesa is one way that health personnel deal with critical situations at health facilities when women come to deliver. This places health care personnel under pressure to incur expenses that are not their responsibility but which, given their ethical responsibilities, they cannot ignore. They have no option but to do the needful in order to save lives of women.

From talking with women and health care personnel, it was clear that health care personnel, particularly those living within the dispensaries, provide services out-of-hours including late at night, necessitating availability of electricity. Rural women still depend on utilising health services within their locale during the night because of its convenience. In realisation of the importance of having electricity, both communities of Kerege and Kiromo went to great lengths to organise themselves and connect the power at the dispensaries. However, it is a disappointment that the government has not been able to provide such services to many rural health facilities: if the community has done its part, and is contributing to the health services, the government should at least provide electricity supply at an appropriate time so as to facilitate the health services. Thaddeus and Maine (1994) argue that although a lack of equipment and supplies affect health

facilities in most regions of the developing world, the very issue of limited resources it is often perpetuated by poor management and organisation of available resources. Further, re-channeling the funds to the district without discussion with the dispensary health committees (the majority of its members are community members who used to collect, manage and be accountable for Community Health Funds (CHF) under supervision of dispensary health committees) could be interpreted as undermining the credibility and ability of dispensary health committees to perform their duties as well of the district to delegate responsibilities at lower levels. The feeling of exclusion from the health care system, commonly experienced by marginalised groups, deprives the system of an important voice in improving access and fair financing and is an indicator of inequity (Loewenson, 2000; Mackintosh, 2001). The government could re-channel funds back to the dispensaries which could assist them in solving pertinent issues like electricity supplies and therefore reduce delays and unnecessary inconveniences to those providing and receiving the services.

### **6.5. Toilets and bathroom facilities**

*The toilet used is very far from labour ward and it is the only one that is being used by staff and all patients, including pregnant women. You know, the first dispensary that was built is the one which is used as a house for health care personnel and that was its toilet. When we got the TASAF project, they built us buildings but did not build a toilet for the dispensary. So we continued to use the previous house as a delivery room but when the number of health care personnel increased they had to move in that house; meanwhile there was no toilet built....The community then built us a toilet last year, but it was not stable because when the rain came it broke and until now they have not built another one. Salama Waziri (Kerege dispensary).*

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TASAF stands for Tanzania Social Action Fund. It is a government funding facility that provides a mechanism to allow local and village governments to respond to community demands for interventions that will contribute to the attainment of specific Millennium Development Goals. It contributes to achieving the goals of alleviating Tanzania poverty. (TASAF, 2014).

Health care personnel in both dispensaries elicited grave concerns for women regarding the location, usage and conditions of the toilets and bathroom facilities, as well as lack of running water supply within the facilities and other building such as the delivery units. Health care personnel in both dispensaries told me that the toilet and bath/shower were located far from the delivery rooms. The location of toilets and bath/shower far from the delivery rooms brought inconvenience and disturbance to pregnant women and resulted in women not using those facilities. At Kerege dispensary, the toilet facilities were located very far from the labour room building and near health care personnel's homes and therefore due to the distance, pregnant women and mothers used bedpans and relatives had to dispose of the waste putting themselves at risk of infection. Upendo Saburi (Kerege dispensary) said: *At the moment, we do not have a toilet nearby; therefore, pregnant women use bed pans and then their relatives go to dispose the waste outside.* Furthermore, all pregnant women, patients and health care personnel depended on the same facilities. Health care personnel informed me of the difficulties pregnant women face when they wanted to use the toilet or bathroom. Health care personnel at Kerege dispensary also told me that the available toilet and bath facilities had not been upgraded since the facility was made into a dispensary. Though the toilet facilities at Kiromo dispensary did not have flushing mechanism, they were more modern and spacious compared to the one at Kerege dispensary as figure 6.1 below depicts.



**Figure 6.1: Kerege dispensary toilet (pit latrine) also used as a bathroom (Barongo, 2012).**

A pit latrine is a type of dry toilet where a big hole is dug on the ground and the top is covered with a floor built from wood or cement. An open hole is left for use and the toilet often emits odours all the time due to human excrement being exposed. On the other hand, the modern Asian toilet, also known as a squat toilet, consists of a hole in the ground covered with cement floor with an open porcelain toilet bowl on top or on the same level with the floor for use. The toilet may have a tank for flushing in place or may not have a toilet flushing system and, instead, a bucket of water may be placed on the side for flushing down the human excrement after use. To use both types of toilets, a person needs to be in a squatting position, rather than sitting, and to place one foot on each side of the toilet.

Pregnant women need clean toilet and bathroom facilities to use for their own safety while at the health facilities. The toilets, particularly the one in Kerege dispensary was in

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a very bad condition and smelled. Further, it was used as a toilet and bathroom. As Salama Waziri (Kerege dispensary) stated:

*To tell the truth, the condition of our toilet is saddening. It is a pit latrine; therefore, the bad smell does not go away no matter how hard you try to clean it. Many people depend on this dispensary: now with this kind of toilet (pauses)... we should have at least a modern toilet.*

Health care personnel at Kiromo dispensary described the issue of toilets as challenging in terms of the problem of maintaining cleanliness due to the lack of a fence. Wahida Pandu (Kiromo dispensary) said:

*The surroundings we have here are not pleasant [showing sadness]. As you can see, a person can pass anywhere he wants; he can cut across anywhere: you find that people have done what? Dirtied the toilets because we do not have a fence. Even a person who is not supposed to use, uses the toilets...*

Clean toilets and bathrooms are essential in health facilities due to the high risk of infection and contamination. Due to their vulnerability and high risk of infection, pregnant women need clean toilet and bathroom facilities that are easily accessible and within delivery units. There is a need for better health facilities that consider easy accessibility to the usage of vital amenities such as toilets and bathroom facilities, and water supply to decrease the likelihood of infections to patients and those who take care of them.

### **6.6. Disposal of the afterbirth and other dispensary waste**

*We do not have a place to dispose waste; the place we depend on disposing things from labour unit and serving patients is broken. Right*

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*now we burn some of the waste outside because the hole where used to dispose waste was built inside and so we cannot burn the waste. If you burn you will pollute the whole area because it does not have a vent. As health care personnel, this is a big challenge to us. Upendo Saburi (Kerege dispensary).*

Safe disposal of waste coming from health facilities is an important concern. There are different types of waste at health facilities ranging from the garbage to things used on patients' wounds and the afterbirth. All these forms of waste are potentially infectious and therefore ensuring that they are well disposed of is vital.

Health care personnel at both dispensaries informed me of the lack of a proper place for disposing of waste after the delivery process. They particularly expressed great concern about the disposal of the afterbirth than that of other waste. Their issue was that is not easy to just throw the afterbirth (such as placental and blood matter) in the hole used for other waste and to leave it unattended. As a result, they are forced to dig a deep hole every time a pregnant woman delivers a child in order to bury the waste. As Wahida Pandu (Kiromo dispensary) explains:

*You have to dig a hole every time and you have to go very deep. There are dogs and cats here they can dig waste up. It has to be one hole every time and you dig it deep down and bury the placenta.*

Shani Uledi (Kiromo dispensary) elaborated:

*That is the biggest problem we have here. To tell the truth, we do not have an incinerator or a special area where we can say we dispose of the placentas. What is done is, we only dig hole, deep we bury them: that is the system we use. You see that toilet there? [showing me], on the other side, that is the place we usually bury those things. We have a hoe, special for that job...*

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When I asked Sophia Taji (Kiromo dispensary) who disposes of the placentas and other blood matter, she said:

*It is often their relatives who do that job: they dig a hole, you supervise, they bury. You cannot say that you will take money and pay somebody to do that; the situation has become difficult.*

Wahida Pandu (Kiromo dispensary) said even though staff are often compelled to tell the relatives of pregnant women to bury the placentas, sometimes staff do it themselves if a pregnant woman did not come with anybody to help. She said: *Other times you find you are all by yourself with a mother, but that job you will have to do. You cannot leave the placenta unattended.* On the same note, Shani Uledi (Kiromo dispensary) also said: *We sometimes dig the holes ourselves. It is a big problem, we risk ourselves, my sister. For other regular waste, the dumping hole is outside there near the toilet.*

The health care personnel request the government to provide dispensaries with incinerators to burn waste to enable them to carry on their duties effectively. Wahida Pandu (Kiromo dispensary) said:

*We request to be assisted with building an incinerator for disposing of placentas. Currently we dig just holes and we do not use a particular place. We just dig around the same area and bury them; it is not good...To tell the truth, the important things are incinerator... those things - no way out [expressing sadness].*

In my observation of both dispensaries I encountered the disposal of waste near the health care buildings. At Kerege dispensary, the hole for disposal of other waste was immediately behind the delivery building and the place was not clean. At Kiromo dispensary, the place for disposal of other waste was a little bit further from the service delivery building, but the state of the pit was the same. I also found that used oxytocin

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bottles were thrown next to the health facility bath and toilet building used by pregnant women, other patients, and health care personnel. This is the same place, I was told, that placentas are buried. Furthermore, this was the area where people have established a way to pass by while heading to their destinations. Below are figures 6.2, 6.3 and 6.4 showing the state of the waste disposal places.



**Figure 6.2: Kerege dispensary waste disposal place (Barongo, 2012).**



**Figure 6.3: Kiromo dispensary waste disposal place (Barongo, 2012).**



**Figure 6.4: Kiromo dispensary disposal area for placentas (Barongo, 2012).**

Figure 6.4 above shows Oxytocin bottles thrown next to the Kiromo dispensary bath and toilet building. This is the same area where placentas are disposed. To the left is an unfenced area which people also use as a thoroughfare. Further ahead is where a waste disposal place for the dispensary is located.

Safe disposal of waste from health facilities is an important concern that needs attention because, if managed ineffectively, it can compromise the quality of health care and pose significant public, occupational and environmental health risks (Cole, 2000; Diaz, Savage, & Eggerth, 2005; Mbongwe, Mmereki, & Magashula, 2008). The World Health Organization defines waste that is generated from health care facilities as health-care waste, and this definition includes *all the waste from health-care establishments, research facilities, and laboratories* (WHO, 1999, p.2). While this study indicated how placentas were disposed of, observation of other disposal of waste did not go unnoticed. Most waste was disposed of on the ground in open dumping sites and pits, which were not in a secure fenced area to prevent scavenging. Further, my findings revealed that both health care personnel and the public, in this case women's relatives, handle the wastes (placentas) and therefore were at risk of infection. Lack of fences in both health facilities exacerbates the possibility of infections spreading to dispensary communities and communities living near or around the dispensaries due to use of open dump sites. Given the hazards posed by waste to health care personnel, patients, communities and the environment, there is an urgent need for change of method in the management of waste if possible infections and contamination is to be avoided. Although in most economically developing countries, resources are inadequate to manage these wastes, The World Health Organization (WHO, 2004b) recommends incineration as a feasible temporary solution, especially for developing countries where alternatives for waste disposal such as autoclave, shredder or microwave are limited.

Furthermore, disposal of placentas and any other materials containing blood emanating from a woman during delivery need to be treated with dignity. Culturally, these things

are supposed to be hidden, properly disposed of and not seen in public to maintain the dignity of women and communities. The disposal of such waste is still done in the unfenced open grounds of health facilities with the high possibility of being such scavenged by animals. The problem of improper waste disposal in rural health facilities is huge and the lack of incinerators makes the situation worse. It is essential for the government to make it a priority for all health facilities to have proper working incinerators in order to prevent infection and contamination within the facilities and the communities around them, as well as protect the dignity of women.

### **6.7. Lack of privacy**

*We suffer a lot, we sweat a lot. As you help a pregnant woman she also sweats even more because she is in labour pain and you must close the window curtains for privacy. As you can see, the road is just right there. Motorbikes pass all the time, and people, but you have to tolerate it: what else can you do? Even if you try comfort her there are other times she feels pain, she shouts, and people outside hear the noise: what do we do?[pauses]. To tell the truth, there is no privacy. Even inside the unit; the delivery place and postnatal unit are very close. Imagine this woman has already finished delivering: she is resting but still she hears the other struggling, or there is another one who has arrived waiting for her turn to reach eh (sighs for support), it is not good...*

Privacy is an important aspect of health care visits and even more important during child delivery. Health care personnel in both dispensaries told me of the lack of privacy within the delivery room and from people passing by which made their work more difficult, especially when they have a pregnant woman in labour. At Kerege dispensary there was a road passing very close to the dispensary and a foot passage created next to the delivery room building. At Kiromo dispensary, people passed through the dispensary

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grounds, near the labour unit, due to the lack of fence to prohibit them. Wahida Pandu (Kiromo dispensary) said:

*The surroundings we have here are not pleasant [showing sadness]. As you can see, a person can pass anywhere he wants, he can cut across anywhere... Other times you are there helping a woman to deliver, just because a person sees the area is open, he passes nearby and hears everything.*

While at Kerege dispensary there were not fencing at all, at Kiromo fencing poles were present but lacked fencing wires. Below are figures 6.5 and 6.6 showing the real state of the dispensaries.



**Figure 6.5: Delivery unit at Kerege dispensary (Barongo, 2012).**

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Figure 6.5 above is the delivery room building of Kerege dispensary. On the left of this photo, there is a foot passage next to the building created by passersby, which directly enters into the Kerege dispensary's boundary. A little bit further to the left of this photo, there is a busy public road. The movements and sounds of transport and people can be heard and seen from the inside the delivery room building.



**Figure 6.6: Thoroughfare through Kiromo dispensary, adjacent to delivery room (Barongo, 2012).**

Figure 6.6 above shows a foot passage between the two poles created by people, which directly enters into the Kiromo dispensary's boundary and passes next to the delivery room building.

Privacy is an important aspect in quality of care because it creates and promotes trust and ensures a good relationship between patient and provider. Pregnant women, like any other patients, needs privacy during health care visits and, even more importantly, during child delivery. A study conducted in India by Bhattacharyya, Srivastava, and

Avan (2013) indicated that among the things pregnant women value most at health facilities during delivery are respectful treatment, privacy, and emotional support. Health care personnel in Kerege dispensary spoke about of the lack of privacy among women within the delivery room. The distance between the delivery room and mothers who have just delivered was minimal, contributing to women's discomfort. Finerman (1983) argues that modern medical facilities have values which often conflict with the values of potential users. The lack of privacy in a hospital setting is one of the issues which contributes to women's dissatisfaction with maternity services compared with the home (Auerbach 1982; Wedderburn & Moore, 1990). Similarly, Zanconato, Msolomba, Guarenti, and Franchi (2006) also point out that the clinic setting does not always provide privacy for the individual woman and may prevent her in disclosing vital information to the nurse resulting in a compromise to the quality of care she would have otherwise received. Building fences around health facilities is vital infrastructure that the government should consider investing in because it will not only ensure the privacy, comfort and sense of respect of women but also maintain the security and safety of the health facilities.

### **6.8. Conditions at the labour unit**

At Kerege dispensary, health care personnel expressed their concern about the uncondusive, unpleasant and risky conditions present in the labour unit. The issues were the lack of enough space for mothers within the delivery unit, safety to the mothers and the health care personnel themselves, as well as problem of maintaining cleanliness in the unit. Upendo Saburi (Kerege dispensary) said:

*Some other times we receive three to four pregnant women [pauses]... we go into so much trouble: you keep moving them from here to there; it is difficult and creates a lot of disturbance to them.*

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Judith Ombeni at Kerege dispensary narrates a scary incident staff encountered due to the poor conditions of the delivery room:

*That room needs renovation very quickly because there was a day when we were cleaning the room and all of a sudden we saw a snake on the ceiling. We saw a tail moving as the head had already got inside the labour room. We had to call the husband of one of the health care personnel who hit it with a big stick, squeezed it and it fell down and he killed it. Now, imagine a mother who has just delivered is inside there with a baby and does not understand a thing and you are busy somewhere else attending to other duties. Or you are in a middle of helping a pregnant woman to deliver: what do you do? In short the room needs renovation.*

On the problem keeping areas of the unit clean, Judith further said:

*In the delivery room itself the place where we put thing for delivery we have to cover all the time. There is sand coming from the roof which can damage medicines...Sometime I get so bored: you will dust and clean the place but after five minutes the dirt comes down again. That is the way it is; we just tolerate the situation.*

Child delivery is a sensitive process and therefore conditions at delivery units need to be clean, pleasant and risk-free. It is important that comfort, cleanliness and safety are reflected in the labour rooms so as to avoid any accidents, infections and contamination (Mehta et al., 2011). A study conducted in India by Bhattacharyya et al. (2013) indicated that women who went for delivery at health care facilities considered the cleanliness of the place of delivery, of themselves and of their new born babies, was of great importance to them. Pregnant women are often psychologically and emotionally vulnerable when they are in labour or about to deliver and for some days after delivery, a vulnerability shared by their newborn babies (Gibbins & Thomson, 2001; Larkin,

Begley, & Devane, 2009; Sawyer et al., 2011); therefore, they need to be supported in a clean, comfortable and risk-free environment. Studies conducted in Bangladesh, Kenya and Malawi identified poor quality of maternity care services as one of the factors that contributes to low utilisation of maternity services. (Hodgkin, 1996; Kabir, 2007; Seljeskog, Sundby, & Chimango, 2006; Wanjira, Mwangi, Mathenge, Mbugua, & Ng'ang'a, 2011). Proper actions therefore need to be taken to alleviate the problems in buildings and conditions that pose a threat to women so as to ensure their safety and continuity of utilisation of the maternity services they attend for delivery.

### **6.9. Lack of waiting areas**

*There is no sitting area for waiting. Imagine when it is raining, what happens? Sometimes two to three women come for delivery and are escorted by their relative in the night: where do they sit in the middle of the night? And their relatives must escort them. You are therefore forced to bring them to sit at OPD (Out-Patient Department) area. Now the distance from here to there... even inside the delivery unit, the room is so tiny, you can even suffocate. As you can see the way windows are, how do you breathe? And the curtains need to be closed when a pregnant woman is delivering. Salama Waziri (Kerege dispensary)*

Taking a pregnant woman to deliver does not guarantee immediate delivery on arrival. It may take some minutes or hours before a mother delivers, and therefore it is important that those who escort a pregnant woman are placed in a comfortable and safe area while waiting for her to deliver.

From what the health care personnel told me and from my own observation, relatives of the pregnant women waited outside the facilities for their pregnant women to deliver. Sometimes with delays, relatives at Kerege dispensary are forced to wait near the delivery room so that in case of emergency, for instance a health care personnel needing

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water for their pregnant women can immediately respond to them. Due to the location of the delivery room, which is isolated from other facilities, health care personnel told me that relatives at Kerege dispensary have to wait under the trees in the middle of the night and have even encountered snakes while waiting, imposing danger to them.

Provision of a waiting area for family members who escort a pregnant woman is crucial for their own comfort and safety since she may take minutes or hours to deliver, and will also need some hours for follow up before she is discharged. Findings show that despite coming to escort their relatives for child delivery, relatives are depended on by staff to assist in miscellaneous tasks such as fetching water, and disposing of waste, including urine and placentas. These relatives were even at risk of getting bitten by snakes during the night due to the lack of and/or low light available in the surrounding areas. Anand, Kaushal, and Gupta (2012) and Gadallah, Zaki, Rady, Anwer, and Sallam (2003) indicate that majority of studies done on satisfaction with health care services usually only focus on views from patients/clients receiving the services. Research on the views of relatives and/or companions who escort pregnant women could be equally significant because studies have shown that proper amenities increase patient satisfaction levels and willingness to use the facility for subsequent health care needs (Brown, Franco, Rafeh, & Hatzell, 1993; Ovretveit, 1992). A determined political will to change the conditions of health services for pregnant women by improving such things as water supply, and toilet and bathroom facilities within the health care service buildings, along with providing convenient and comfortable waiting areas can assure not only safety of relatives but also of pregnant women and health care personnel.

### **6.10. Staff shortages and excessive workload**

*Understaffing is a major challenge we have here, and it contributes to a failure to work efficiently. For example, you have seen me in the morning: I came from labour unit, I am here now, I have not finished what I am supposed to do; meanwhile there are others waiting for me.*

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*Even at the labour unit, I do only what I can, not systematically at all [moans]. I cannot perform in a proper manner because time is not on my side; therefore I will be attending things which are more important and then go to another place to do other things... The challenge we have is understaffing: we are very few, we move here and there; women get angry. We ask for an addition of two personnel, or at least one. Judith Ombeni (Kerege dispensary).*

Child delivery is one of the major duties performed by health care personnel at the dispensary. There are several other duties such as attending to patients, conducting antenatal and children's clinics, and report writing, to mention but a few. It is therefore important that the number of health care personnel is adequate enough to ensure the effective execution of their duties.

In both dispensaries of Kerege and Kiromo, health care personnel lamented the burden of their workload. Wahida Pandu (Kiromo) said: *The number of employee is very small, while the workload is big.* Salama Waziri (Kerege dispensary) narrates a normal scenario of their day-to-day work, revealing the challenges they face due to the volume of workload and the low number of staff at the dispensary:

*At present we are four health care providers but to tell the truth, we are not enough due to the burden of work. Delivering fifteen pregnant women or more at a dispensary level is hard work. Now imagine getting forty pregnant women per month: they are many; therefore, work piles up. And with four it is not like you are all present the whole time; like now, one is on annual leave, the other one is on training [pauses]... you find that there is a lot of work to do. For example now I am supposed to finalise a report, at the same time attend patients- it is hard. At other times you can even miss doing some things for pregnant mothers; for example she has come to antenatal clinic and because of workload around you, you end up attending to some things and leave others. You can either forget or*

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*perhaps you can just say aah [expression] I will write her a bed net voucher another time she comes: 'Go mama, I will write a bed net voucher some other time' only because you are burdened by workload.*

Health care in both dispensaries of Kerege and Kiromo call for an increase number of personnel so as to work efficiently, as opposed to the current situation where they are burdened by the workload. Salama Waziri (Kerege dispensary) said:

*If they increase at least a little number of employees, maybe the work efficiency can improve. We are trying our best but it is not enough, we get tired, we do no sleep: there is a lot of work; that is how it now.*

Supporting that is Shani Uledi (Kiromo dispensary) who said: *The number of employees should be increased at least one or two; it would help.*

Studies have shown that understaffing and excessive workload among health care personnel can contribute to the poor service quality (Shahidzadeh- Mahani, Azin, Omidvari, & Baradaran, 2008; Shelton, 2001). Health care personnel find themselves in a difficult situation during execution of their normal working routines and duties. They experience a heavier workload due to understaffing which very often sees one health care personnel carrying out all activities. It is a known fact that universal skilled birth attendance is challenged by personnel shortages among other things ((Koblinsky et al., 2006; Lee et al., 2009; Prata, Sreenivas, Vahidnia, & Potts, 2009). In my study I found that health care personnel were working under pressure due to staff shortages while trying to fulfill all their tasks; this sometimes made them prioritise to accomplish urgent tasks at a particular time. When health care personnel are burdened by workload, it might reduce their efficiency in other areas and create dissatisfaction among their clients. Bergstrom (2001) explains that among barriers to good quality maternity care is staff being poorly supervised, underpaid, overworked, or not receiving training or refresher courses to upgrade skills, which in turn results in substandard care. The fact that health care personnel I talked to were working overtime and often late hours of the

night without being paid overtime indicates their love and dedication to saving the lives of women and children. However, heavy workload coupled with lack of motivation among health care personnel who constantly work overtime may lead to dissatisfaction and discouragement to remain at work, especially in rural areas. It is therefore important to ensure that the number of health care personnel allocated in a health facility can adequately manage the allocated tasks if maximum execution of their duties is to be expected.

### **6.11. Lack of control of the Community Health Fund (CHF)**

Given the various problems addressed by the health care personnel such as delays in electricity supply and lack of equipment, I wanted to know if staff have any set funds for supporting emergencies. Salama Waziri (Kerege dispensary) had this to say:

*We have Community Health Fund (CHF) which the community contributes to money for treatment. We collect those funds. In the past [pauses]... when we started, those funds were collected and sent to District Medical Office (DMO) account. Later, we were told all health facilities should have their own accounts so that the funds go to those accounts. That way it was easy take care of urgent needs because you just sit with the dispensary health committee and order this and that; when approved, you go and take out the money and buy the stuff you need. We therefore started putting money in our account; then, last year things changed again. We were told the money should be sent to the DMO account again. It has now become difficult; it was much better when the funds were in dispensary's account because signatories were committee members in the village including the in-charge of the dispensary who was the secretary... At the district you just take the letter and inform them that we sat as a committee and we want this and that, and they approve. To tell the truth, this process was very helpful and quick. But nowadays if*

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*things run out at the dispensary we do not have cash in hand to say that we can go to a shop and buy something...*

The Community Health Fund (CHF) is a voluntary prepayment scheme of health care, which was introduced in Tanzania by the Ministry of Health to target the rural population and the informal sector to enable them to affordably access government health care services (Mtei & Mulligan, 2007). The scheme, which has been in operation since 2001, allows a household to join by contributing between Tanzanian shillings 5,000 to 30,000 per year (equivalent to US dollars 2.87 and 17.24 respectively) (Ifakara Health Institute, 2012).

Health care personnel told me that in the past the funds collected for Community Health Funds were saved into a dispensary account, and that the dispensary, with approval from the Village Health Committee, could use the funds to solve pertinent problems facing the dispensary. However, the health care personnel told me that the system had changed and that now; all funds collected at the level of dispensary were sent to the district which has the mandate to allocate funds to the dispensaries according to their decisions. Health care personnel informed me of the inconveniences and costs brought by the system change. They maintained that the previous system worked well, with maximum accountability. Salama Waziri (Kerege dispensary) told me:

*Sending Community Health Funds to the District Medical Officer's account has brought a lot of disturbance to our performance because at times you do not get everything that you need. In the past, we could easily and quickly solve problems such as buying electricity.*

Sophia Taji (Kiromo dispensary) told me:

*In the beginning they said we would keep Community Health Funds in the dispensary account where Pay for Performance money is also kept.*

*Therefore, if we had any problem we could access, withdraw and use [funds] accordingly. However, after a short period the system changed. It came to a point where the situation at the dispensary was very difficult; at times we could not even afford costs of maintaining the dispensary grounds, such as slashing grass.*

The health care personnel told me that the Pay for Performance system was introduced by the USAID and other partners to assist dispensaries in Bagamoyo district to have their own money, injecting money directly to their accounts. The money is paid based on an evaluation of the dispensary's performance over a given period of time. The dispensaries have the mandate to use money according to their needs but funds are not adequate to cater for the costs of running and maintaining the health facilities. The health care personnel told me that without Pay for Performance money, however, the situation at the dispensaries would be worse than it is currently.

Hearing the perspectives of health care personnel on their struggle to ensure that pregnant women and other patients receive services, made me acknowledge their role and their commitment to these communities. To solve problems like the ones raised by health care personnel, a study conducted in Tanzania by Mubyazi, Magnussen, Byskov, and Bloch (2013) recommends prioritisation of adequate budgets, disbursement of funds, and supply of essential materials at an appropriate time by the central government and local government council authorities at district levels.

## **6.12. Conclusion**

Observations and findings from this chapter have shown that the concerns and opinions around child delivery of pregnant women and health care personnel are important and should be recognised and used as to improve maternal health care services and health care services in general. As discussed, there are challenges around the utilisation of health care services during child delivery at health facilities that need to attention and

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solutions. Government policies on the provision of health care services have their shortcomings because not all that is advocated is in place. It is therefore important for the government to ensure that introduced policies are fully implemented to ensure satisfactory use of the services. Furthermore, introducing projects without transparency on their sustainability creates confusion and a sense of despair among pregnant women. Health care personnel who also have an obligation to inform women on what is going on with the services they provide are left with unanswered questions which in turn can affect health care utilisation among women. It is also vital to understand the needs of pregnant women and, where possible, use that information to design strategies that increase the utilisation of health services in rural areas. Better conditions of the maternal health care services including proper buildings, reliable toilet and bathroom facilities, privacy provision, safe disposal of waste, reliable water supply and electricity are a necessity for a pregnant woman and those who serve them to ensure that the services provided are satisfactory and of good standard and quality. This chapter has shown that perceived quality of health care services by pregnant women and health care personnel is essential in revealing and explaining the difficulties encountered in the use of maternal health services and therefore can be used as a gateway for the improvement of such services.

Based on the finding of this study, Community Health Fund (CHF) seemed to have worked efficiently when health facilities along with their communities were operating them, as opposed to the current situation. CHF can therefore be used as one way to tackle and improve the difficult situation faced by the health facilities, provided that all funds are being accounted for and reported at the district level. The government may be facing difficulties in financing the district and higher levels, but if health facility problems can be solved easily and faster at the grassroots/ community level, using their own funds, it could decrease the burden encountered by the district to fund all government health facilities under their management. The issue of understaffing and workload at government health facilities also needs keen attention. In order for the health care personnel to work efficiently and provide quality services, their number should be adequate so as to avoid overburdening them, which often results in complaints

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from the users of the service. Adequate staffing will in turn ensure proper organisation of their activities and routines, which will eventually contribute to the good quality and high performance of health services. As with any qualitative research, this study had a limited sample of respondents and therefore does not represent all rural communities in Tanzania. However, important issues have been raised around health care services provided in government health facilities that can be further researched to improve use of the services.

## **7. Perceptions and experiences of Human Immunodeficiency Virus (HIV) testing**

*When you get there for example [pauses] when you start clinic the first thing is to test for HIV. You get tested and told to wait, if your results are good they tell they are good and give you another date. And if your results are bad they also tell you but it is confidential, they tell you to go get your treatment in Bagamoyo. Habiba Juma (Kerege)*

In this chapter, I discuss the issues around the HIV testing discussed by pregnant women in Kerege, Matumbi, Kiromo and Kitopeni villages in Bagamoyo district. Different understandings were established from the interviews with pregnant women, as well as health care personnel and male partners of pregnant women. The practice of HIV testing in the country is commonly known as voluntary counselling and HIV testing (VCT). However, in this chapter when addressing the testing process, I use the term *HIV testing* without the modifier *voluntary counselling* due to the variation of opinions that arose during conversations I had with women regarding the test, although the questions of voluntarism and counselling will be included in the discussion.

I have been interested in understanding the ways in which pregnant women understand HIV testing in relation to their health and that of their babies. Closely linked with this is the nature of their understanding of importance of such a test during pregnancy, and during and/or after delivery.

Substantial literature emphasises the need for and importance of HIV testing among pregnant women in both developed and developing countries. While some past literature indicates that this was recognised as an issue twenty years ago (Allen et al., 1992, 1993), it has continued to be an issue and to present difficulties for pregnant women, health care personnel and governments (The Global Fund to fight AIDS, Tuberculosis and Malaria, 2010; United Nations Programme on HIV/AIDS (UNAIDS)/WHO, 2004;

WHO 2005b; WHO, 2003a; WHO, 2010c). This is due to the fact that infection with the Human Immunodeficiency Virus (HIV) and Acquired Immuno Deficiency Syndrome (AIDS) continue to be the primary cause of morbidity and mortality among women and children worldwide (The Global Fund to fight AIDS, Tuberculosis and Malaria, 2010). In 2008 WHO estimated that over 430,000 children were newly infected with HIV worldwide, of whom over 90% acquired the virus from their mothers (WHO, 2010d). In low- and middle-income countries, the Report on the Global AIDS Epidemic (UNAIDS, 2013) shows that the annual number of newly infected children dropped by 35% from 2009 with 260,000 (230,000 – 320,000) cases in 2012. The expanded access to services to prevent mother-to-child transmission is attributed with the prevention of more than 670,000 children from acquiring HIV between 2009 and 2012 (UNAIDS, 2013). The Global Plan towards the elimination of new infections among children by 2015 and keeping their mothers alive (UNAIDS 2011) recommends acceleration of efforts to end vertical transmission and safeguard maternal health. The efforts to reduce the number of new HIV infections among children by 90% are based on several major components: preventing new HIV infections among women of reproductive age, helping women living with HIV to avoid unintended pregnancies; ensuring that pregnant women have access to HIV testing and counselling; and that those who test positive have access to antiretroviral medicines to prevent transmission during pregnancy, delivery or breastfeeding and providing HIV care, treatment and support for women, children living with HIV and their families (UNAIDS, 2011).

International institutions like the World Health Organization (WHO) (2010d) and the Global Fund to fight for AIDS, Tuberculosis and Malaria (2010), recognise prevention of HIV infection among women, prevention of unintended pregnancies among HIV positive women, prevention of babies from being infected with HIV and the provision of appropriate treatment, care and support to HIV positive mothers, their children and families as are of significant importance. The World Health Organization's (WHO) 3x5 Plan to Fight HIV/AIDS, which intended to reach three million people living with HIV on antiretroviral therapy by the end of 2005, advocates antenatal testing as one of the main access points for antiretroviral programmes (WHO, 2003b). HIV counselling and

testing of pregnant women attending antenatal care is used as an entry point to prevention of mother to child transmission (Desgrées-du-loû et al., 2009). As in many developing countries, Tanzania has adopted HIV counselling and testing practices in its antenatal care clinics at health facilities (United Republic of Tanzania, 2008b, 2013b).

This chapter provides and analyses the knowledge of women in both antenatal and postnatal state at the time of interviews about HIV testing. I explore their perceptions and experiences of the tests. In particular I discussed with these women a number of difficult issues around partner testing, confidentiality and privacy, prevention of mother-to-child transmission of HIV (PMTCT), refusal and/or delay in testing, as well as testing and receiving other services during their contact with antenatal care clinics or health facilities.

In relation to women's knowledge, the opinions and experiences of health care personnel about the experiences and challenges they perceive as confronting pregnant women and mothers regarding HIV testing when they visit health care services are discussed. In addition, the views and opinions of men regarding the issue of HIV testing are relevant to women's perception and therefore form an integral part of this discussion.

### **7.1. Processes for HIV testing in pregnant women at health facilities**

*When you go there they take your blood. After they have taken your blood 'that big test', they test it and if they find you have been infected they tell you the truth so that you continue to protect your child who is in your womb. And if they find you are uninfected they continue to give you advice so that you continue to protect yourself. Paulina Joseph (Kerege)*

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This is what Paulina told me when I asked her about processes of HIV testing of pregnant women at health facilities but I also wanted to know from Paulina if women were adequately prepared before being tested. She told me:

*No, when you go there they give you seminar; they tell those who have not done the HIV test they have to test. It is not like you get there and they take the test. But the day you go there they must take your blood.*

Similarly Asha Zuberi (Kerege) told me: *When you arrive they tell you that it is the day for taking HIV test. They educate you, test you and then give you your results.* The same view was also shared by Habiba (Kerege) who said: *First, they educate you until you are satisfied. They ask you if you are satisfied and then they do the test.*

HIV testing has been integrated with antenatal care as a routine test in most of the rural government health facilities in Tanzania and is mainly used as a conduit for PMTCT services (Isangula, 2012; Nkuoh, Meyer, & Nshom, 2013). When women therefore go to register for antenatal care during early stages of pregnancy, they are expected to take the HIV test as part and parcel of other antenatal care services.

I talked to health care personnel in Kerege and Kiromo dispensaries to understand HIV testing processes at their facilities.

*We test majority of them on their first visit. When they come we give them health education. We put them in groups because when they come they are many. We avoid the trouble of educating them one by one because it takes time. In short, if they are many we give the health education in groups. We therefore talk to them about HIV, we do pre-counselling with all the women together. After that then we introduce them to HIV testing process which is done in a room, each person alone. If a pregnant woman has come with her husband, they will enter the room and take the test*

*together. After they will wait for a while, then we call them one by one to come take their results...* Salama Waziri (Kerege Dispensary)

Similar to my study findings, Nkuoh et al., (2013) report that HIV counselling in groups of either women or groups of couples is commonly practiced in many rural health facilities. However, counselling couples in groups may not allow couples to be free to ask questions and make the intended decision, due to stigma attached to HIV/AIDS, fear of embarrassment, or just a mere lack of confidence. The decision to put women or couples in groups for HIV education was mainly to save time and avoid having so many sessions per day of HIV education in order to serve more clients, as well as due to having a few number of health care personnel who often have to multitask. While it may be argued that time at health facilities is limited, this may deny couples privacy and present a barrier to freedom of expression. They may need to have a one-to-one discussion with health care providers to ask questions, bring their concerns out, and hence make the right decision.

The problem with HIV counselling at the health facilities was that it was part and parcel of the health education provided to pregnant women, and therefore there was not enough time for women to have a long one-to-one discussion with health care personnel. Due to having many women waiting to take the test, health care personnel did health education/ pre- counselling of women together. Soon after health education/ pre counselling was provided, the process of HIV testing in a private room followed. After health education, it was assumed that all women who entered the room had agreed and were ready to take the test.

I wanted to know the kind of information, advice and services that clinic staff provide in relation to issues of HIV testing, privacy and/ or confidentiality, partner testing, PMTCT and provision of other services.

Wahida Pandu (Kiromo Dispensary) told me:

*When a pregnant woman comes to our clinic, we first of all inform her that she should come with her husband, or her lover, or her partner, because others are not married. Once she is here with her partner we give them education together as a couple. If there are three or four couples we put them together and give them the general education including HIV...*

When I asked Judith Ombeni (Kerege Dispensary) about the process for HIV testing of pregnant women at health facilities, she told me:

*When women arrive in the morning, we educate them that these days the national policy requires that every pregnant woman should test for HIV. We give them health education in general; educate them about HIV, issues of testing, PMTCT and services available. After counselling we introduce them to HIV testing.*

Health care personnel told me that counselling was an important aspect to ensure that women agree to take HIV testing. Narrating how they introduce the topic of HIV testing to pregnant women at health facilities, Sophia Taji (Kiromo dispensary) told me:

*Very often women come for antenatal care services on their own and a few with their partners... For those who do not come with their partners, we advise them to come back with their partners. We then tell them that although they have come for pregnancy services, there is also an issue of testing for HIV which will help them to know their status. We therefore counsel them by telling them the benefits of knowing their status. We tell them knowing their status will also help the mother if infected not to pass the infection to the unborn child. We continue to counsel them until they agree to take the test.*

Shani Uledi (Kiromo Dispensary) told me that counselling was as important as advice and proper management to both HIV-infected and uninfected women. She said to me:

*When a mother comes with her partner or without her partner, we sit with her and do counselling first. After counselling... [pauses] as you know, you talk to a person until she reaches a point of agreeing to taking the test or not, but for you, you already have done your part. If she agrees that she is ready to take the test, we take a blood sample and do the tests. If we find that the blood does not have infection at that time, we tell her to return after three months for her to take the second test and also give her precautions of what to do. She should not involve herself in unsafe sex so that when she comes to the second test she gets good results. Now if it happens that the results are positive and the blood already has infection, we give that woman a referral straight forward so that she goes to the specific centre for people living with HIV infection. At the same time we start giving the pregnant woman medications to prevent infection of the unborn child.*

Although counselling pregnant women and/or their spouses is used as a way to convince couples to take the HIV test while emphasising the benefits of taking the test, it may be argued that women may still adhere to it because they are told to do so by the health care personnel. Health care personnel seemed to have influence over pregnant women, who often believed whatever health care personnel was telling them was right. This may be attributed to the trust in or fear pregnant women may have of health care personnel as professionals and, therefore, if women are told that taking the HIV test is the government policy, they will not object. Obermeyer, Verhulst, and Asmar (2014) argue that consent among clients is usually influenced by their dependence on providers for health care services, power difference between patients and health care professionals, and fear that they may put their care at risk if they refuse.

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I wanted to know men's experience with their partners of the HIV testing process. I therefore had focus group discussions with men with pregnant wives or partners and those who have had history of having pregnant wives or partners in the prior two years. From their comments, it seemed that most of men do not accompany their wives to antenatal services. I wanted to know from men if they knew any process for HIV testing, they gave me interesting and very short answers. Baraka Mtemvu told me: *We are usually told to go tested before we get married but it does not happen here.* On the other hand, Zuberi Tamba (Kitopeni) told me: *When a pregnant woman goes there she is asked to come with her husband. Some of us go but others refuse to go.* What shocked me is when Amiri Daudi (Kerege) told me: *There is no such service, I had already gone there with my wife but we did not see that services until I went to take the test in Mwananyamala.* Amiri insisted that there were no such services at the dispensary, despite his fellow group members in the discussion telling him what he was saying was not correct.

The attitude of men towards HIV testing may be explained by the process of antenatal services in the past. Very often and for many years, antenatal care had been using a *woman only* approach to cater for the health and needs of women. The fact that antenatal care services focused mainly on women may have contributed to men's perceptions that these services are meant for only women (Nkuoh et al., 2013). Furthermore, the fact that HIV testing is integrated with antenatal care in most rural government health facilities perpetuates such perceptions. It therefore takes an effort to convince men to visit antenatal services for HIV testing when they were not used to doing that in the past. A study conducted in Cameroon by Nkuoh et al. (2013) found that male participation in antenatal care was not supported by many in the community and that the participation was often centered on an individual belief.

## **7.2. Voluntary/ mandatory HIV testing for pregnant women**

*Testing for HIV is voluntary but for a pregnant woman even if it is voluntary you will take the test. For a pregnant [woman it] is not voluntary, it is a must. Hadija Shukuru (Kiromo)*

I talked to the women in the villages about whether they regarded HIV testing as voluntary or mandatory for pregnant women and realised that the issue of testing of HIV produced a range of experiences and differing views that clearly showed a degree of confusion. There were those who told me that HIV testing for pregnant women was mandatory and those who told me that it was voluntary. Women told me that their understanding of HIV testing being voluntary or mandatory came from what health care personnel told them at the health facilities when they went for antenatal services. The understandings of perception of HIV testing differed from one woman to another and more importantly came from what they were being told by the health care personnel.

Those who said that HIV testing was mandatory and voluntary for other women said they were told by health care personnel that once a woman is pregnant, she has no option but to take test in order to save the unborn baby from HIV infection. Zuwená Hemed (Kiromo) had this to say to me:

*I think if you are already pregnant they are supposed to know your health status especially with this AIDS disease. It is a must to do the test. It becomes voluntary when you just go there; you are not pregnant and they tell you 'why don't you get tested for HIV?', and you can tell them 'I don't want to get tested.' That is when it becomes voluntary. But if you are already pregnant it is a must to get tested to know your status: if you are safe or have already got the virus.*

Paulina told me: *Testing for HIV for a pregnant woman is not voluntary at all, it is not voluntary*, while Veronica Chonde (Matumbi) said to me: *There is a difference when you*

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*are pregnant; very often when you get there and you are pregnant they must get you tested.* The same views were shared by Pili Kassim (Kitopeni) who told me: *Testing for HIV is a must, when you are a pregnant woman, it is a must.*

The fact that HIV testing in many rural government health facilities has been made part and parcel of provision of antenatal care services creates the expectation that pregnant women will take the HIV test without objecting. Similar to my study, studies conducted in Kenya, Malawi, Tanzania, Uganda and Zambia have indicated that there is a likely perception that routine testing for HIV as mandatory, and that people who seemed to have consented to take the test actually experienced a degree of coercion (Angotti, Dionne, & Gaydosh, 2011; Larsson et al., 2012; Njeru, Blystad, Shayo, Nyamongo, & Fylkesnes, 2011).

Bahati Selemani (Kitopeni) elaborated, telling me:

*You have to take the test; it is the first thing they tell you to come with your husband... If you do not go with your husband you will be told to go bring him to get tested... Testing for HIV is not voluntary anymore, it is now a must.*

This study demonstrated that women believe that they have an obligation to take the HIV test because they are pregnant. Very often the pressure put on women by health care personnel to take the test is based on the pretext of saving the lives of unborn babies from HIV infection; this makes women consent to take the test, even though they are unwilling. Branson et al. (2006) elaborate on the benefits of screening for HIV early in pregnancy: it enables women infected by HIV and their children to access appropriate and timely interventions including antiretroviral medications, planned cesarean section and alternatives to breastfeeding. While the benefits of HIV testing are obvious, the question is whether women are allowed to refuse testing. Women told me that HIV testing for pregnant women is not optional, which indicates the pressure and tension that women experience during antenatal care service. Studies conducted in Botswana, Kenya,

Malawi and South Africa have demonstrated that despite people consenting to take the HIV test, more than 50 percent of clients are coerced to take HIV tests (Abdool Karim, Abdool Karim, Coovadia, & Susser, 1998; Angotti et al., 2011; Ujiji et al., 2011; Weiser et al., 2006). If a pregnant woman is not informed that she can decline to take the HIV test, it is justifiable to say that legally and ethically her rights are being violated even if knowing the HIV status of a mother potentially protects the unborn child from HIV infection. The Tanzania HIV and AIDS Prevention and Control Act (United Republic of Tanzania, 2008b) prohibits mandatory testing for HIV. Part IV of the Act on Testing and Counselling; Section 15:5 p. 12 states that: *Every pregnant woman and the man responsible for the pregnancy or spouse and every person attending a health facility shall be counselled and offered voluntary HIV testing.* However, the same Act; (Section 15:8(b) p.12) allows medical practitioners to carry out HIV test in respect of a person without the consent of the person when they *reasonably believe that such test is clinically necessary or desirable in interest of that person.* Arguably, this implies that medical practitioners in Tanzania are authorised to conduct HIV tests on a pregnant woman if they reasonably believe that it is for the benefit of a mother and unborn child. Furthermore, the fact that HIV testing has been integrated with antenatal care services (Isangula, 2012) makes the HIV test appear to be one of the obligatory tests a pregnant woman is expected to undertake.

Women told me that despite the fact HIV testing was said to be voluntary, information about HIV testing is relayed in a manner that is mandatory, especially to pregnant women in health facilities. Latifa Issa (Matumbi) told me:

*The day you go there, you are told to take the test. First they give you information, then you go to do the test. They tell you that Tanzania rules say that a pregnant woman must get tested.*

Women perceived that HIV testing for pregnant women was mandatory because the health care personnel told them that it is a government requirement. It is a known fact that HIV can be transmitted from an HIV-infected mother to her child during pregnancy,

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labour, delivery or breastfeeding (UNAIDS, 1998; WHO, 2014c). Although the intention behind HIV screening is good, still women seem to be left without freedom of choice, signifying legally and ethically the denial of their human rights. The debate is: whose rights should be protected, a mother's or a child's? Is it permissible to allow a child to be born with HIV infection when an opportunity to protect the child from acquiring the HIV infection is possible?

McMillion (1998) emphasises the need to protect the rights of both mothers and children and states that there is no need to put women under pressure in order to win their trust and cooperation to take the HIV test. Previous studies arguing against mandatory testing have indicated that women will voluntarily consent to take the HIV test if provided with appropriate counselling and information, including the option to be tested (American Journal of Public Health, 1996).

Talking through her experience, Zuwena Hemed (Kiromo) told me:

*The way they tell us, testing seems to be a must, even testing your partner because when I had my two other children in the previous years it was not that way. But with this pregnancy it was a must. I got tested first and then my partner took the test later because he did not accompany me when I had my test due to living far away.*

In recent years, voluntary counselling and testing of couples has been promoted in antenatal clinics in order to increase the rate of men testing for HIV, increase the uptake of HIV interventions and reduce negative outcomes related to the disclosure of HIV status (Barker, Ricardo, & Nascimento, 2007; Grinstead, Gregorich, Choi, & Coates, 2001; Maman, Mbwapo, Hogan, Kilonzo, & Sweat, 2001; Painter, 2001; Pool, Nyanzi, & Whitworth, 2001; Semrau et al., 2005). Studies from developing countries have shown that couple counselling is linked with changes of behaviour including an increase in condom use (Allen et al., 2003; Merson et al., 2000; The Voluntary HIV-1 Counselling and Testing Efficacy Study Group, 2000). Counselling and testing couples

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has also demonstrated to have benefits such as providing clear and accurate information about HIV, and couples learning their HIV status together and receiving interventions accordingly (John Hopkins Center for Communication Programs, 2010; Farquhar et al., 2004). However, as indicated in my study, there is still a challenge in getting men to go to antenatal care clinics for HIV testing with their partner. Studies conducted in Kenya, Tanzania and Zimbabwe indicate that still very few male partners are being tested even in countries that have integrated couple counselling and testing of HIV in their antenatal care (Becker, Mlay, Schwandt, & Lyamuya, 2010; Farquhar et al., 2004; Katz et al., 2009; Theuring, 2009; Tsara, Zvinavashe, Kasu, & Gundani, 2011).

In most cases, women are still the most vulnerable and targeted group of people, often obliged to take the test even when their husbands do not agree to go for HIV testing. The vulnerability of women is due to the fact that they are the ones who carry babies in their womb and those babies are the ones targeted for HIV prevention through PMTCT. As a result of their reproductive role, women are subjected to being the first hand bearers of the news of the HIV status if they take the test on their own (Farquhar et al., 2004).

The women who said HIV testing was voluntary told me this was due to the fact that health care personnel counsel a pregnant woman before she takes the test. In this group, there were women who told me HIV testing was voluntary but health care personnel use convincing powers and sometimes a degree of coercion to make sure a pregnant woman agrees to take the test; others told me it was purely voluntary. Counselling was the major means that women perceived health care personnel use in order to convince women to take the test. I wanted to know what would happen if a pregnant woman refuses to take the test. Zuwena Hemed (Kiromo) told me: *They will counsel you but if you refuse they will let you go.* A view also shared by Veronica Chonde (Matumbi) said to me:

*If you refuse, they will continue to counsel you; they will explain to you, they will give you seminar, advice. But if you still refuse they will let you go because you are an adult: they cannot tie you with a rope. But the testing is a must.*

Stella Mbwilo (Kerege) also told me:

*The health care personnel will not agree. They do not agree for you to say that you do not want to test for HIV. They usually give us education. If you go there like us pregnant women, when we get there during clinic, before examining us they start first to educate us. For those who have not tested, they even talk about blood.*

When I asked about whether the antenatal women are educated every time they go to the clinic, Stella said:

*Because you can go this month (pauses) for example if I go this month, when I go to start clinic I will find a class educating about it. If I go there next month I will find others who have come to start clinic; therefore the class has to be there, they teach the same thing.*

The women's view that counselling never ends until a woman agrees to take the test is also shared by health care personnel, and indicates that it is not possible to avoid the test. This again raises the question of whether HIV testing is voluntary or mandatory. Furthermore, it raises the question of whether the decision of women not to take the HIV test is really heard and respected. The Tanzania HIV and AIDS Control Act (United Republic of Tanzania, 2008b), Part IV on Testing and Counselling Section 15 prohibits compulsory HIV testing for various groups of people. Section 15:5 states: *Every pregnant woman and the man responsible for the pregnancy or spouse and every person attending a health care facility shall be counselled and offered voluntary HIV testing*, but Section 15:8(b) empowers medical practitioners to carry out HIV test to a person if they believe is clinically necessary in interest of that person. The latter section may explain why health care personnel insist that women take the test during antenatal care and persist in performing the test during labour, as health care personnel told me. Counselling, or *education* as it was referred to by women and health care personnel, is a

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very important aspect of HIV testing. However, continued or persistent counselling may be confused with coercion if women are pressured to take the test whenever they attend antenatal clinic, even when they decline the test. Although HIV testing is described as voluntary, women are not left with freedom of choice but instead are pushed until they do the test and this may indicate that their decision to decline the test is not respected.

However there were also women who told me that HIV testing was purely voluntary and those who did not want to take the test do not do so even until they deliver their babies. Asha Zuberi (Kerege) told me this:

*It is a voluntary act. On the testing day, those who want to get tested stay and take the test and they continue to get their results; those who leave are not forced to do so. [pauses]. The one who wants to get tested takes the test, and the one who does not want, leaves... Even when she refuses they do not force her. And until she delivers she does not get tested and she does not know her status.*

Also holding the view that HIV testing is voluntary was Mwajuma Rajabu (Matumbi) who told me:

*Usually when you go there they advise you to get tested. They call and counsel you; those who want to do the test do it. If you tell them you do not want to do the test, they let you go.*

These two women who had never refused to take the HIV test told me what they thought happens if a pregnant woman refuses to take the test.

Faraja Hassan (Matumbi) told me, by contrast, that although HIV testing was voluntary it was beneficial to one who takes it. She said:

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*When you go there you are told 'here there is a test for you to know your health status' enh [searching for my support], but you are not told it is a must, no. However, you yourself, within your heart you feel it is better you know your health status, so many agree to do the test.*

When I talked to health care personnel they told me that they told me that HIV testing for pregnant women was voluntary because women are counselled before they agree to take the test. Health care personnel told me that HIV testing was voluntary but it was important that pregnant women and/or their partners take the test. They said HIV testing is voluntary because they do not force people to take the test but rather convince them to take the test for their own good and benefit. Salama Waziri (Kerege dispensary) said to me:

*Testing is voluntary, but due to the importance of the testing which you explain during the health education, you find that a person will see the importance of taking the test. Sometimes it happens a person may tell you that I am not ready to take the test today. But because the education we provide is continuous, you let her go, and when she comes again another time you meet with her and continue to educate her until one day she agrees to take the test. However, it is still voluntary; you do not need to force a person to take the test.*

The health care personnel's views on HIV testing for pregnant women being voluntary were based on the fact that they do not force women to take the test but rather educate them on why they should take the test. They told me that seeing the benefits of taking the test as opposed to disadvantages eventually makes most of women agree to test. Shani Uledi (Kiromo Dispensary) said to me:

*To tell you the truth, I have not seen a section saying it is a must, it is still voluntary. However, with the education we are giving them, a person assesses the advantages and disadvantages of testing; a person out of her*

*own will voluntarily ask herself why she should not get tested so that she can get services which are beneficial to her. They understand. I have never seen a woman who refuses to take the test. Once you educate her immensely, she voluntarily agrees.*

The fact that women had different views on whether HIV testing for pregnant women is voluntary or mandatory shows that the message women are getting from health care personnel is not clearly understood or consistent and as such, it creates confusion among women. There were even inconsistencies among health care personnel themselves on whether HIV testing for pregnant women was voluntary or mandatory. There were those who told me that HIV testing for pregnant women is voluntary and others who told me that the test was mandatory but justified as a measure preventing unborn babies from infection through PMTCT programme. Upendo Saburi (Kerege Dispensary) told me:

*The policy requires that all pregnant women should test for HIV, but we are still told it is voluntary, not a thing to force. Therefore when we receive a pregnant woman, we educate her that she is required to test for HIV to know her health status and tell her the benefits of knowing her status. Because women need the child, they do not have any other option that to agree to test for HIV.*

As the contradictory views above illustrate, many pregnant women take the HIV test due to pressure they get from health care personnel at health facilities. Some studies have shown that pregnant women are disproportionately targeted for HIV testing because such women have more contact with health care facilities (Csete, Schleifer, & Cohen, 2004; Gruskin, Ahmed, & Ferguson, 2008). The problem of targeting pregnant women at health facilities may result in HIV/AIDS being perceived as a problem mainly affecting women. This is due to the fact that PMTCT programmes mainly focus on pregnant women at health facilities.

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Health care personnel told me that although HIV testing is said to be voluntary, it is indirectly mandatory because health care personnel are advised or required by the government to encourage and ensure that women take the test in order to protect the unborn child. Sophia Taji (Kiromo dispensary) told me:

*Testing is no longer voluntary because if she does not take the test during clinic visits, she will take the test in labour ward. If she does not take the test during labour, she will take the test after she has delivered because we want to help the child.*

In addition, Wahida Pandu (Kiromo Dispensary) told me that inclusion of pregnant women's partners in the HIV testing process makes it mandatory. She said to me:

*Nowadays I think it is not voluntary because you are told you must come with your partner. Now once you say that, do you think it is a voluntary thing? And then once you educate them that if you want a child who is not infected and the fact that they know that once they have tested and found out that they are infected they get support from the government, they agree. There are medications that a mother can use until the day she delivers because a child gets infected during delivery. Now for the wish of getting a child who is not infected, a mother voluntarily agrees to take the test.*

Although men told me that pregnant women are usually advised to go to the dispensaries with their partners, HIV testing is still voluntary. Majid Enzi (Matumbi) told me:

*Although a pregnant woman is usually told to come with her husband, I still regard testing as voluntary because even if she goes on her own, she will still get all services she needs.*

### **7.3. Partner's HIV testing**

*When you arrive there they tell you that you not going to get any services until you get tested for HIV. You are supposed to go there with your husband, you get tested first and then the rest follows. That is the day when you come to start you clinic for the first time. Furaha Ally (Kiromo)*

*When you become pregnant you are supposed or advised to go to the clinic with your husband. There they give you a lesson and after educating you, you are both tested for HIV to know your status. Farida Kombo (Kiromo)*

HIV testing for husbands/partners was also an issue of great concern among women, health care personnel and even men. Women and health care personnel told me that persuading men to go for HIV testing at health facilities was a big challenge. Health care personnel told me the best they could do is to tell women to convince their husbands/partners to come for the test. Given the attitudinal behaviours of men, it may be very difficult for women to convince their male partners to test if they do not agree to go. A study carried out in Cameroon by Nkuoh et al. (2013) found that men felt that they had the right to know the HIV status of their female partners but their female partners did not have right to know their status. Refusal of men to disclose their HIV status may be attributed by men's perceptions of masculinity whereby HIV infection amongst men is seen as a sign of weakness and insufficiency (Wyrod, 2011). Furthermore, due to the stigma attached to HIV/AIDS epidemic (Mahajan et al., 2008) men may also be reluctant to accompany their female partners for fear of being found HIV positive. Men may prefer to know the result of their female partners first so that if their female partners are infected they can blame their women.

Women attending Kerege dispensary told me that although they were always advised to come to the HIV test with their partners, it was not a requirement to bring husbands/partners who refused to accompany them. When I asked Habiba Juma

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(Kerege) if it was a requirement for her partner to go with her to the dispensary for HIV testing, she told me: *We are advised about it but and we have not been forced. They just tell us that 'if you have a partner tell him to come get tested as well'.*

Men also told that when women attend antenatal care clinic on their own, they are usually told to inform their partners to accompany them for HIV testing. Jumanne Kwasi (Kerege) told me: *If she goes there [dispensary] she is told to tell her husband to come take the test. However, some men go but others do not go.*

When I asked health care personnel in Kerege if it was a must for a pregnant woman to come with her husband to take the test, Judith Ombeni told me:

*We usually tell the women that it is good to come with your partner because there are things that they need to share together, they need to know them. However, they tell us that sometimes their partners refuse. When they tell them that the nurse or a doctor has advised them to come together for the counselling and testing they do not understand. We advise them every time they come to come with their partner on the next visit.*

Similarly, Upendo Saburi (Kerege Dispensary) said to me:

*The partners... that is a big issue, we are still struggling. To tell the truth... [pauses to think] men's involvement in women and... mother and child services is a challenge to us. The problem is they do not come. If they were coming maybe we could get them to take the test, but the problem is they do not come. We have started and are continuing to do sensitisation, but only very few men come with their partners.*

Women indicated that persuading men to accompany them for HIV testing was difficult because many men do not even accompany their female partners to other antenatal

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services. Apart from promoting awareness of health issues through outreach programmes in communities and leaving a man to make a decision based on individual beliefs, it is frequently difficult to get a man to attend antenatal care with his female partner. Health care personnel's strategy or reliance on women persuading their male partners fails to because very often men regard antenatal care as specifically for women (Nkuoh et al., 2013). The biological role of carrying pregnancy contributes to the notion that antenatal care is a woman's issue. Studies in South Africa, Uganda and Nigeria still demonstrate that although the involvement of male partners in antenatal care is acceptable, their participation in labour and birth is still limited (Homsy et al., 2006; Iliyasu, Abubakar, Galadanci, & Aliyu, 2010; Mullick, Kunene, & Wanjiru, 2005; Oboro, Oyeniran, Akinola & Isawumi, 2011). Convincing men to attend antenatal care and taking a HIV test with their female partners remains a challenge, but other strategies could be explored in order to increase the rate of HIV testing.

Community outreach programmes may be the most convenient means of reaching men in order to sensitise and promote awareness of the importance of participation in maternal health care. A study conducted in South Africa has even indicated that if antiretroviral treatment services are available, a written invitation to a male partner to attend voluntary HIV couple counselling and testing after community sensitisation increases the number of male partners attending antenatal care and HIV testing (Mohlala, Boily, & Gregson, 2011). Since health care personnel often seem to have influence over their clients (Obermeyer et al., 2014), this method could also be explored in rural Tanzania. Furthermore, continuous education and counselling may contribute to changing negative attitudes and behavior among men and in improving communication between two couples within a household.

At Kiromo dispensary, the process for HIV testing was different from at the Kerege dispensary. Women told me that when a pregnant woman begins clinic she is required to come with her husband/partner for HIV testing. As Bahati Selemani (Kitopeni) told me:

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*When you start clinic, you go there with your husband because if you do not go there with him, they will tell you that 'We are not going to examine you until you come with your husband' ...*

Similarly, Hadija Shukuru (Kiromo) told me:

*When you arrive there they start to explain to you the process: 'here we are testing for HIV so please come with your partner'. But if you are with your partner they straight away inform you and then you enter into a room where they counsel you; then they do the test.*

Zuhura Husein (Kitopeni) and Zuwena Hemed (Kiromo) also told me that health care personnel often emphasise women to bring their male partners or husbands to the clinic to take the HIV test.

Pili Kassim (Kitopeni) told me that it is a known fact that pregnant women are required to go for HIV testing with their partners. She elaborated:

*All people know that when you go there for the first time to start clinic you have to be accompanied by your husband. When you therefore leave home to go start the clinic, you know that you will have to be accompanied with your partner to take the HIV test. Even during children clinic these days they inform us that now the procedures for testing for HIV require a pregnant woman to come with her husband. For a person who does not know, she will be told to return there next Thursday with her partner. The health worker cannot even write anything for you before you do the test. Sometimes, she can only just give you the clinic card without doing any examinations until next week when you come with your partner.*

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When I asked Zuwena (Kiromo) if a pregnant woman would be given the services if she went to start antenatal clinic without her partner, she told me:

*When you go there alone they will still tell you to come with your partner. The first trip they will not get you tested until you go back and tell your partner to come.*

Women had told me that male partners/husbands could refuse to go and take the test. I wanted to know what would happen if a husband refuses to take the test at the health facility and the wife wants to be tested. Zuwena told me:

*If your partner refuses then the nurse will get you tested because you need that service, and then you are told to go back home and continue convincing your partner to come for the test. They cannot leave you, they will get you tested.*

Farida Kombo (Kiromo) told me the same, but said:

*They will test her for HIV but while blasting her because even if she takes the test and her husband does not while he has the virus it will be a loss for her. I am thankful that my husband and I went together and both got tested.*

Women told me that health care personnel are often considerate and allow a pregnant woman to take the test if her male partner is absent. Bahati Selemani (Kitopeni) told me:

*... If you do not go with your husband you will be told to go bring him to take the test. Maybe if you say that you are pregnant and the man is not present then they can allow you to take the test.*

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Zuhura Husein (Kitopeni) told me she was allowed to take the test because her husband was not around; she said:

*...If he [husband/partner] is not around and you explain to them well, they will allow you to take the test. They test you for HIV before examining your pregnancy. When I went there I was on my own. I explained to the nurse that my husband was not around, he had travelled to Tanga, and they accepted me for the test.*

Similarly Pili Kassim (Kitopeni) told me:

*Unfortunately for me, my husband had travelled to Morogoro. When I went there for the first time, they did not attend me; they refused to give clinic services and told me to return on Thursday; antenatal clinics are on Thursdays. The following week when I went there and I explained again to the nurse that my husband was not back yet. After pleading with them so much and because I was also late to start the clinic, they agreed me to take the test without him. They tested me for syphilis and HIV and fortunately the results were good. They then told me to tell my husband to come for testing when he returns.*

Men also told me that women are not refused services if they do not go with their partners. Musa Haji (Kitopeni) told me: *If a woman does not go with her partner, they will still provide her with services including testing her for HIV.*

It was heartening to realise that pregnant women could still access antenatal services including HIV test if male partners refuse to go for the test. At the same time it was distressing to realise through HIV testing, women endure a difficult process in order to access clinic services. Being the first recipients of antenatal care, pregnant women automatically have to carry the burden of disclosing their results to their male partners (Farquhar et al., 2004) or convincing their male partners to go for the testing. In such

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circumstances, it is important that sensitisation at rural communities through outreach programmes be used to raise awareness about HIV. The fact that women are often blamed for HIV infection of their male partners makes them susceptible to dangers if men are not informed and knowledgeable.

Similarly, health care personnel told me that pregnant women are never refused the services because they understand the difficulties of getting men to take the test. As Judith Ombeni (Kerege dispensary) told me:

*That is the biggest challenge we have, it is very difficult, very few women come with their partners. What do you do? We test the women because it becomes difficult to get their partners.*

Sharing the same views was Wahida Pandu (Kiromo Dispensary) who told me:

*We give her other ANC services; we cannot leave her pregnancy to grow without giving her other services; she will get the services as needed. When the husband refuses to come, as you know the way other men are; they do not agree, therefore we will give that woman all the required services including HIV test.*

Health care personnel told me that they understand and take into consideration the various circumstances and problems pregnant women face in attempting to bring their partners to take an HIV test with them. Clinic staff therefore find themselves with no other option than to accept and provide services to women attending services alone. Shani Uledi (Kiromo Dispensary) told me:

*A woman can come and tell us that she has not seen her partner since he gave her the pregnancy or, she got pregnant when she attended 'ngoma' [traditional dancing ceremony], and when the ngoma ended she has not seen him since. Another woman can tell us that her partner was a mason;*

*he disappeared after finishing building a house. Another may tell us that her partner is in prison. Another may even tell us that her partner does not want her anymore, where can she find him, or her partner has refused to come for testing; he does not want to hear such thing. What do you do with such woman? No other way; we help her, we give the services she needs.*

Wahida Pandu (Kiromo Dispensary) told me:

*...When she comes we educate her, sometimes we can even send her back home today because here we usually do not test a pregnant woman without her partner. If she tells us that her partner is in Arusha or Mwanza, we give her all the services required but we tell her to bring him once he is back, even if it is not a clinic day, and she will bring him.*

Shani Uledi (Kiromo Dispensary) also asserted that a woman will not be refused services. However, she attributed the men's refusal to come for HIV test to be due to sometimes the way women relay message to their partners.

*We can ask a mother [pregnant woman] the reason for her to come alone, and she can tell you that she did not know that she is supposed to come with her partner. We therefore tell her that because she did not know that she was supposed to come with her partner, we ask her to inform her partner that he also deserves to get the same services she is getting. She will agree if we do not send her back home; we give her the services as we normally do. When she goes and tells her partner, if he feels it is important he will accompany her and they will take the test together... For the one who refuses to come we continue to insist. We educate the woman more on how to go and talk to him wisely. We may tell her to go persuade him that we just need to talk to him. You know sometimes we may give women information and they may relay it differently. Or when*

*they talk to their partners they do not talk to them nicely. Do you think they will agree to come? [asking me to support her point]. Imagine getting home and telling the partner 'you have been told to go take the HIV'. Do you think a man will agree? That is how the women do it. So we educate them on how to relay the message to their partners appropriately.*

Women told me male partners had a tendency of negligence around the issue of the HIV test. I wanted to know from Zuhura Husein (Kitopeni) if her husband has gone to take the test since he came back. She told me: *No, since he came back he has not gone to take the test. I do not know why though I have already told him to do so.*

From the interviews I had with women, it seemed to me this male negligence does not only end once a woman has taken the test but extends up to when she delivers and may be contributed to by both men and women. I asked Pili Kassim (Kitopeni) if her husband went to take the test when he returned from his journey; she told me: *No, I had already delivered.* Failure to go take the test may be due to the fact that once the women have taken the test or delivered their babies, the urge to go for the test lessens and testing seems irrelevant. No one continues insisting or is bothered to follow up to ensure that the men still take the test. As a result, the HIV status of men may not be known and this puts a woman at the potential risk of HIV infection.

I wanted to hear about pregnant women's experience at home when they asked their partners/husbands to go take the test as advised. Stella Mbwilo (Kerege) looked at me and laughed loudly, and then said to me: *Aah, on testing our partners usually there is a little of disagreement, there is a battle.* Even Bahati Selemani (Kitopeni), who told me that her husband attended the first antenatal clinic where both took the first HIV test, had her doubts if he would accept to accompany her to the subsequent two HIV tests. She told me:

*I do not know, you know with men, even when I told him to go with me that first time, it was so difficult for him to accept but eventually he did. Now I do not know with the second trip if he will agree to go or not. Even the third time I am not sure of what will happen.*

When I asked about their opinions on couples taking the HIV test, men told me that women are likely to be divorced by their partners if they take an HIV test and tell them that they are infected. Sadiki Masudi (Kiromo) told me: *If the mother is not safe [HIV positive] and informs her husband, as soon as she informs the husband she gets divorced.* Similarly, Amiri Siwatu (Kiromo) told me that women suffer the consequences of telling their partners their HIV positive status. He said to me:

*They can first separate, and then divorce; two divorces [referring to number of divorces given to Muslim wives] and later divorced completely. When the husband divorces his wife he feels he has removed shame.*

In their HIV testing and counselling protocols, Centers for Disease Control and Prevention (2001) and UNAIDS (1997) emphasise disclosure of HIV status to sexual partners as an important goal toward prevention of HIV. Despite the likely problems women may face due to disclosure of their HIV positive status to their partners, it is believed that disclosure provides several important benefits to the infected person and to the general public. A South African study has shown that disclosure of HIV results to sexual partners is associated with anxiety reduction and increases social support among many women (Matthews, Kuhn, Fransman, Hussey, & Dikweni, 1999). Other studies conducted in Rwanda, Haiti and Burkina Faso have shown that disclosure of HIV status to sexual partners result in a change of risky behaviours among couples (Allen et al., 1992, 1993; Johnson Jr., Deschamps, Pape, & Hafner, 1996; Nebié et al., 2001), and enables couples to make informed reproductive health choices that may ultimately lower the number of unplanned pregnancies among HIV positive women (Allen et al., 1993). Further, disclosure of HIV status increases the awareness of HIV risk to partners who

have not taken the test, which may result in greater acceptance of voluntary HIV testing and counselling and promulgating safer behaviours (Allen et al., 1992, 1993; Barker et al., 2007; Johnson Jr. et al., 1996; Nebié et al., 2001).

Health care personnel told me that couple counselling and testing are ways of minimising the negative outcomes that women experience when disclosing their HIV positive status to their partners. They maintain that insisting that pregnant women bring their partners to take an HIV test not only establishes the couple's serostatus and hence provides them with appropriate treatment but also reduces conflict. This perspective is supported by de Bruyn and Paxton (2005) who advocate for couple counselling and testing at antenatal care services to reduce the levels of discrimination that women who take the test alone encounter and to assist in screening for sexually transmitted infections, promote mother's nutritional status and prevent the spread of infection. Studies from African countries have shown women are unable to take preventive measures and to obtain the necessary support to undertake PMTCT strategies if their partners are not involved in HIV counselling and testing (Antelman et al., 2001; Cartoux, Msellati, et al., 1998; de Paoli, Manongi, & Klepp, 2002). I asked Sophia Taji (Kiromo Dispensary) who decided that a pregnant woman must come for testing with her partner, she said to me:

*I think this is a government call because the plan is when a pregnant woman comes to clinic; she should come with her partner for involvement. You find that once a woman knows she is infected it is very difficult for her to go tell her partner at home or, if she tells him she maybe chased out of the house. But if they take the test together and get the results together it is easy to accept and agree on what to do next enh.*

Expertise and experience in counselling could also be factors that cause people to accept HIV testing. Health care personnel in Kiromo dispensary told me that HIV testing for couples is now an acceptable trend among couples. Wahida Pandu (Kiromo dispensary) told me:

*For me I have never experienced people who do not want to take the test once they are here, no [refusing], I have never experienced it. And I am the one who gives that education; maybe when I am not around, but if I am present, that is my job. They all agree to take the test after counselling.*

#### **7.4. Privacy and confidentiality in HIV testing procedures**

*There is a special place for taking the test and giving you the results. After taking the test, they tell you to wait for the results. They also give results one by one; each person is given her results at her own time.*

Habiba Juma (Kerege)

Privacy is an important aspect of HIV testing procedures. Most of the women I talked to were pleased with the way the HIV testing procedures were conducted at health facilities. The fact that testing and result giving was done in privacy gave them comfort and a sense of assurance and security that their results will be unknown to outsiders. As Paulina Joseph (Kerege) said: *They test you when you are alone, you and the doctor only. Even during getting your results it will be only you and the doctor.*

Consent, confidentiality and counselling are central to the whole process of HIV testing. These three elements, commonly referred to as the three C's of HIV testing, are the foundations for protecting individuals from potentially adverse effects associated with knowing one's HIV status, such as discrimination and stigma (UNAIDS/WHO, 2004).

The women told me that counselling was either done individually, in a couple, or in a group of people. However, all women reported that testing and result provision were done privately to individuals or couples. Zuwena Hemed (Kiromo) told me:

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*.... When you go there with him [husband], they counsel you first and then take blood from both of you. They counsel you and your husband alone; only two people go into a room. They do the test and give you the results when you are together.*

On receiving results Nuru Salehe (Kitopeni) told me:

*When you arrive, they first call you for counselling... After that you wait to take the test. After taking the test they call you one by one to get your results.*

Confidentiality was also taken into consideration during the process of HIV testing. As Bahati Selemani (Kitopeni) told me:

*... When I went there with my husband, he was the first one to take the test. They took his blood [sample] and put it aside and then took my blood and put it aside. My husband was given number one and I was number two. They called us with those numbers to get our results.*

In general women told me that privacy and confidentiality were fully taken into consideration by health care personnel. Women told me that they were pleased with the way health care personnel conducted the HIV testing and handled their results. This was important to women because it helps them reveal their HIV positive status only to family and other community members who they personally wish to know. Further, despite the fact that Tanzania policy on HIV/AIDS (Tanzania Ministry of Health and Social Welfare, 2007) allows health care personnel within law to disclose to a partner's status without the infected individual's consent if an HIV- positive person declines to disclose his/her status to the sexual partner, none of the women complained of having experienced such a situation. A study conducted in Tanzania emphasises the importance of confidentiality for HIV infected women: because of the stigma associated with HIV/AIDS, women face difficulties in finding effective and suitable coping mechanisms

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within their families and communities (de Paoli, Manongi, & Klepp, 2004). Studies in Nigeria (Reis et al., 2005) and Botswana (Weiser et al., 2006) found that health care workers sometimes breach confidentiality by giving out information about HIV patients to other parties without their consent. This is a challenge that has to be taken into consideration in settings where women are vulnerable to negative reactions from their partners, family members and communities.

Health care personnel stated that usually numbers are used instead of people's names for identification so as to ensure confidentiality. As Salama Waziri (Kerege Dispensary) told me: .... *Very often we use numbers to identify them because it is not allowed to use names.... we are not allowed to use names or call them by name.*

Saving time and attending to more people were major factors considered during HIV testing, as long as privacy and confidentiality were observed. Health care personnel told me that HIV education and counselling is usually done in groups due to the volume of clients per visit in relation to the number of number of health care personnel to attend them. They said that they are forced to conduct group education and counselling but considered privacy and confidentiality during HIV testing and result provision. Judith Ombeni (Kerege dispensary) told me:

*If women come with their partners they will listen to health education together with other women, but during testing a woman who has come with her partner will take the test with him.*

Shani Uledi (Kiromo Dispensary) told me:

*According to the rules, it is supposed to involve two people, a woman with her partner because the issues are private. However, when people are many we have no other option than giving the education or counselling in groups, you see eh? But very often we give education to the couple. When it comes to taking specimen for testing, we do it*

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*privately with the person or the couple and results are also given in private, not in groups as we do in education. We do not test and give results in groups because it will deny a person's or a couple's privacy to talk if they have anything to say or ask afterwards.*

Sharing the same view was Wahida Pandu (Kiromo Dispensary) who told me:

*... We give them education together as a couple. If there are three or four couples we put them together and give them the general education including HIV. However, during HIV testing only one couple by itself at a time is attended. You cannot test them for HIV and give them their results while they are all together, aha [indicating refusal].*

Tanzania's HIV/AIDS policy states that pre-test counselling should be given individually; nowhere does the policy indicate counselling be offered in groups (Tanzania Ministry of Health and Social Welfare, 2007). The problem I saw with the group pre-counselling approach is the likely lack of time and freedom for a pregnant woman and/or with her partner to ask important questions before deciding to take or not to take the HIV test. Various studies have shown that health facilities in many parts of Sub-Saharan Africa do not offer privacy due to overcrowding and lack separate places for counselling (Gruskin et al., 2008; Obermeyer & Osborn, 2007; Turan, Bukusi, Cohen, Sande, & Miller, 2008). Although group counselling may be a convenient option at many health facilities due to overcrowding and shortages of staff, it may contribute to the fear and insecurity of those counselled in a group of people who may or may not be known to them. Not all people can speak out their minds/opinions during group sessions, especially on a sensitive topic like HIV. WHO/UNAIDS (2007, p.30) elaborates in its section on ensuring and enabling environments for HIV testing:

Positive outcomes are most likely when HIV testing and counselling is confidential and is accompanied by counselling and informed consent, staff are adequately trained, the person undergoing the test is offered or

referred to appropriate follow-up services and an adequate policy and legal framework is in place to prevent discrimination.

### **7.5. HIV testing and Prevention from Mother to Child Transmission (PMTCT)**

*If you do not get tested it is your own loss because if you do not get tested you will not know your health status. If you agree to get tested even if you are found to have the disease you will save the life of your baby from getting infected.* Farida Kombo (Kiromo)

The World Health Organization describes mother to child transmission as the transmission of HIV from an HIV-positive mother to her child during pregnancy, labour, delivery or breastfeeding (WHO, 2014c). The goals of PMTCT are mainly to protect the child from HIV before, during and soon after child delivery, and to protect the health of a mother including providing antiretroviral prophylaxis and treatment to those affected (United Republic of Tanzania, 2013). When I talked to women they told me that they regarded HIV testing as important to them because it is beneficial to the HIV positive mothers and the babies they were carrying. I asked Stella Mbwilo (Kerege) if women respond well to HIV testing, and she told me point blank: *They do, they test very well.*

On a positive note, Asha Zuberi told me ... *it is good to know your status early so that you get protection.* From the views I heard from the women, the education and counselling women receive about HIV testing and its potential benefits seem to have the positive effect of encouraging them to take the test.

Women also told me that the medications are available to those who are infected, which should be an incentive for people to take the test; as Bahati Selemani (Kitopeni) told me: *...If you have the disease you will start taking medications. HIV medications are available now.*

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Women told me that they viewed HIV testing as important especially for pregnant women. They told me that once a mother knows her HIV status and the status of her baby it becomes easy to know how to take care of both herself and her child. As Stella Mbwilo (Kerege) told me:

*Testing for HIV is now like a must, although others say it is not a must; but it is a must because you know your status, and you will also know how your child will live, and therefore it is good for us.*

Due to the risk of HIV infection to the child women told me that health personnel will often enforce HIV testing to pregnant women, even if the women want to refuse the test. Zuhura Husein (Kitopeni) told me: *At the moment it is a must, a pregnant woman has to take the test because the baby inside the womb can get infected; they will not let you go.* This point was also shared by Nuru Salehe (Kitopeni) who told me: *The way I see it there, it is a must for a pregnant woman to take the test because they want to save the child, for it to be born without the infection.*

HIV testing in relation of PMTCT demonstrated the positive attitudes and knowledge women have about HIV infection. The perceived benefits of taking the HIV test include protection of a child from HIV infection through PMTCT programmes and assurance of treatment and support; these perceptions of benefits have increased acceptance of the HIV test. A study conducted in the countries of Burkina Faso, Kenya, Malawi and Uganda by Obermeyer et al. (2014) demonstrated that women who tested for HIV acknowledged the importance of taking the test. Similar to what I found from my study, this study suggests that the improvement of HIV services compared to the past may have attributed to high level of consent and compliance among clients to take the test.

Health care personnel also told me counselling women on the reasons and benefits of taking the HIV test has increased levels of client consent. They told me that nowadays, more pregnant women take the HIV test than before because they are aware of the

benefits of testing for themselves and their unborn children. Sophia Taji (Kiromo dispensary) told me:

*...because counselling is an ongoing process, we continue to talk to a mother all the time until she understands. Very often when we talk to the mother and tell her that one of the benefits for testing is to prevent her child from infection if she herself is infected, she agrees, so most of the women agree to take the test.*

Similarly, Salama Waziri (Kerege dispensary) told me:

*We tell the mother the benefits of knowing if she is infected: that it will prevent her child from getting the infection. Once we give her the benefits of testing, she will easily agree.*

Health care personnel told me that counselling about PMTCT was an important aspect addressed during antenatal clinic services and during delivery. I wanted to know what information is given to women, especially to infected mothers, as part of the PMTCT programme. Salama Waziri (Kerege dispensary) told me:

*The counselling we give to a pregnant woman or an infected mother is different from the one we give as normal HIV counselling. We usually educate all pregnant women about breastfeeding, feeding of the child and danger signs of an infected mother which can lead to a child becoming infected as well; we give all this information to them. We educate all women on feeding options but we spend more time with the HIV positive mother to explain more about the options available for her to choose. We explain to her all the options available which are breastfeeding only without giving a child anything else, or the other option is, not to breastfeed the child at all but instead give the child alternative milk. However, sometimes we have to evaluate a mother's condition: can she*

*afford the costs? For example, she can opt not to breastfeed and instead give her child alternative milk, but when we look at her condition, her income, we see that she cannot not afford. We therefore talk to her and see if she can afford the costs of providing her child with alternative milk. We try to get information from her about her family, if she has people to support her and their economic status. This is because she can tell us that she will not breastfeed but when she gets home she starts breastfeeding and therefore put her child at risk of being infected. We therefore sit with her and discuss if she really can afford the costs of the milk and then give her advice. This is how we go about educating mothers on breastfeeding and feeding the child.*

Breastfeeding, because of its relation to PMTCT, was an important issue that I wanted to explore with health care personnel. HIV infection may be transmitted to a child through breastfeeding (WHO, 2008). Health care personnel told me that they counsel HIV infected mothers on feeding options; I wanted to know their opinions on breastfeeding in relation to government's advocacy that every mother should breastfeed her child for six months. I asked Salama Waziri (Kerege dispensary) about her views on HIV infected mothers and breastfeeding and she told me:

*I think it is a good thing and it helps because when you say all mothers should breastfeed for six months it means it does not matter if a mother is infected or not. This means if you talk differently you are stigmatising the other mothers, you see? So it helps to reduce stigmatisation. In the past you used to know a mother who is infected does not breastfeed, therefore even in the family when they saw a woman has delivered today and is not breastfeeding, immediately they put a question mark - this woman has a problem. But now that all mothers are told to breastfeed, it helps reduce the stigmatisation at communities because of not knowing if a woman is infected or not. Right now, even the duration of breastfeeding has been increased to one year. In the past an infected mother was breastfeeding*

*for six months, but now because of medication a child is breastfed up to one year. The child continues to take medication: nevirapine syrup for children until he/she stops breastfeeding. And then, when the child stops being breastfed, he/she has one week of taking the medication and that is when he/she stops. For the mother who is already infected, we now tell her that she can breastfeed for a year. In the past mothers were afraid, after six months a mother could call you on the phone, 'my child is now six months: should I stop breastfeeding him/her?' Somehow it was making them feel sad, but now that it has been decided that a child can continue to be breastfed for one year, they feel happy and happy for their children too. The fact that a child can continue to be breastfed for one year while eating food and taking the medications while the mother is also on medications, makes her feel the same as uninfected mother.*

The World Health Organization (WHO) recommends breastfeeding because it provides the best food for the healthy growth and development of infants as well as longer-term health benefits for the mother (WHO, 2015). Tanzania, like any other developing country, adopted exclusive breastfeeding as a 2001 WHO infant feeding recommendation. Exclusive breastfeeding is defined as: *the practice of only giving an infant breast-milk for the first 6 months of life (no other food or water)* (WHO/UNICEF, 2014, p.1). The fact that mothers in Tanzania are/were advised to feed their children of less than six months with only breast milk made it easy for women with HIV infection. Prior to having alternative HIV preventions and medications, HIV infected mothers were advised not to breastfeed in order to protect children from acquiring HIV infection, although it was often difficult to convince women not to breastfeed. A study done in Tanzania by de Paoli et al. (2002) demonstrated that it was difficult for women to decide not to breastfeed in settings where breastfeeding is the custom due to possibility of being suspected to be HIV positive. From my study, health care personnel told me that the fact that HIV positive women can now breastfeed their babies while taking medication without fear of possibly infecting their children or of people suspecting their HIV

positive status is a huge relief, and an important step towards prevention and elimination of stigma and discrimination.

Apart from PMTCT, antiretroviral therapy is crucial for HIV infected mothers' health and ability to feed and support their babies. I wanted to know from health care personnel what services they offer to the HIV infected mothers. Upendo Saburi (Kerege dispensary) told me:

*...After testing we provide preventive services for the infected mother. We still we do not have the unit to give medications to the mother who has low CD4 [Cluster of Differentiation 4] counts. We therefore give out preventive medications to the mother and to the baby born. Issues to do with CD4 and the like such as starting medications are still done in Bagamoyo.*

Shani Uledi (Kiromo Dispensary) explained in detail on what, where and when preventive services are offered to HIV infected mothers.

*... When a woman is four weeks pregnant we start what? We start giving her medications, fourteenth week, eighteenth week of pregnancy we are supposed to start giving her medications which are prophylaxis called AZT [Azidothymidine] or Zidovudine. The mother will use these medications depending on the amount of blood she has. If she has low blood she is not allowed to use the medications, but if her blood is normal she is allowed to use them. She will use those medications until the day she delivers. After delivery when we allow her to go home, it depends if during her pregnancy she took the medications for the whole acceptable period. If she took them for less than the acceptable period, we give her medications to use for another week at home. We also give the newborn medicine called Nevirapine. This is also prophylaxis for children given during the 72 hours; that is the process. At that time we also send the*

*mother to CTC [HIV/AIDS Care and Treatment Centre] if it is found out that she has low CD4 counts for further management.*

I wanted to know what happens to a pregnant HIV infected woman with anaemia who needs to use the medications to prevent infecting her unborn child. Shani told me:

*That woman now needs to see the doctor for advice. We only advise her on things to use to increase her blood, or special medications that increase blood. Those infected have follow-up visits; we cannot just leave her when her blood is low and not give her medications. And very often we do not get the anaemic ones that cannot use medications, very rarely. We also give them more ferrous and folic acid tablets to help increase their blood.*

## **7.6. Women's refusal and/or delay in HIV testing**

*Yes, she does not do the test and may never return or can go to another dispensary. However, where she goes I do not know if she will get the services without doing the test. Faraja Hassan (Matumbi)*

When I talked to the women, they told me that refusal and delay in HIV testing was also common among women and also their partners. Studies have shown that refusal to be tested is common among pregnant women, even when HIV counselling and testing are available and offered to them (Basset, 2001). The women told me that despite the fact that HIV testing was said to be voluntary, HIV testing is presented as mandatory for pregnant women which could prevent some pregnant women from accessing health services. When I asked Bahati Selemani (Kiromo) if fear of mandatory HIV testing could be a reason for pregnant women's non-utilisation of health services, she told me:

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*Very possible because there is no way now you can avoid taking the test. You are told you will not be given a clinic card until you take the test for them to know your health status.*

Similarly Zuhura Husein (Kitopeni) said to me:

*It is possible for others, but what will you do if you are pregnant? You have to go and take the test. If you are told you have the disease you will have to accept the situation and even accept to start the dose.*

Women told me that fear of taking the HIV test and finding out that one is infected was the reason behind refusal and/or delay in attending antenatal clinic among women. When I asked Faraja Hassan (Matumbi) what she thought were the reasons for women's refusal to take the test, she told me: *I think it is the fear to find out that they are infected.*

Similarly, when I asked Furaha Ally (Kiromo) if she thought HIV testing could be a reason for pregnant women's non-utilisation of health services, she told me: *Yes, other people are scared because they know once they get there they will be told to take the test. I was not scared: I went there and got tested.*

Pregnant women's fear of discovering that they are infected could be the reason for not attending antenatal clinic because they may not be ready to handle positive results when confronted with the provider-initiated models of testing in their health care facility (Gallegly et al., 2008)

The men I interviewed concurred with this observation. Safari Aziz (Kitopeni) told me:

*When pregnant women see that their partners have refused to go take the test, they get worried to also take the test because they become scared that they might have been infected.*

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Various studies have shown that fear of negative impacts such as stigma, discrimination, abandonment and violence are among the reasons for women refusing to take the HIV test (Campbell & Benhardt, 2003; Fernandez et al., 2000; Jones, 2004; Peltzer, Mosala, Shisana, Ngueko, & Mngqundaniso, 2007). Although both men and women may be HIV positive, very often the HIV status of women is more likely to be detected first because women take the HIV test when they are pregnant even if their partners refuse to be tested.

The women told me that the refusal to take the HIV test due to fear often results in women delivering outside health facilities or going to health facilities only when it is time to deliver or when they develop complications. Pili Kassim (Kitopeni) told me: *Many do go for the test but I hear there are others who do not go for testing until they start labour pains and health workers become very mad at them.* Women also related that some women will go to health facilities after they deliver to enroll their children with clinic. When I asked Mwajuma Rajabu (Matumbi) if fear could be a reason for pregnant women's non-utilisation of health services, she said to me:

*Enh [agrees] there are those who refuse to start clinic because of fear to be tested. After she delivers that is when she goes to start clinic for her child. Or she may deliver at home and then go to get treatment at the dispensary, or when she fails to deliver at home that is when they [relatives] take her to the dispensary.*

When I wanted to know where pregnant women deliver their children if they refuse to take the test, Asha Zuberi (Kerege) told me: *Some deliver at home, others return to the same clinic when it is time to deliver or if they develop complications.*

I also wanted to know who assist those women who choose to deliver elsewhere other than the clinic. Asha told me: *There are people one by one in our community, they have not been educated but they know how to deliver a child.*

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From the women's points of view, traditional birth attendants seemed to be a last resort when the situation at the health facilities were viewed as inconvenient or threatening to them. Just as a lack of transport, the time of day and geographical location are factors that contribute to women delivering their children at home, HIV testing is also factor. If women fear that by attending antenatal clinic they will have no option but to take the HIV test, they may hesitate to utilise the antenatal care due to fear of finding out that they are infected. Furthermore, finding out that they are infected and having to disclose their HIV positive results to their male partners may have repercussions at home and within the community (Gielen et al., 2000; Maman et al. 2002; Maman, Mbwambo, Hogan, Kilonzo, Sweat, & Weiss, 2001; Maman & Medley 2004; Medley et al., 2004; Mucheto et al., 2011; Pool et al., 2001; Shah & Shah, 2000; Simbayi et al., 2007; Visser, 2008; WHO & UNAIDS, 2007).

Protecting women from the adverse consequences of an HIV positive result is an element of international human rights. The Office for the High Commissioner for Human Rights (2011) advocates protecting individuals from human rights abuses, whether civil, political, economic, social and cultural. Just like many other policies, Tanzania's policy on HIV/AIDS (Tanzania Ministry of Health and Social Welfare, 2007) does not address gender-based risks or the potential consequences of HIV testing a woman could experience during pregnancy or delivery. Such issues need to be taken addressed and measures taken to ensure that women do not experience negative consequences associated with HIV testing during pregnancy or delivery.

Hearing all this information from pregnant women, I wanted to know from health care personnel what happens if a pregnant woman refuses to take the HIV test until she comes to deliver her baby. Salama Waziri (Kerege dispensary) told me:

*HIV testing is not only done at the ANC [antenatal care], this service is provided even in labour ward, and therefore we will continue to educate her in the ward. If a pregnant woman did not take the test at the ANC, we do the test when she comes to labour ward because the testing does not*

*end at ANC. We have to tell her though, we do not just perform the test on her. We tell her that she did not take the HIV test, and she will admit that she has not taken the test. We then ask her what she thinks of taking the test now to know her status. You find that many women who are already in labour pain agree easily; only very few will refuse. However, we tell them we are taking the test, we do not just take their blood without telling them. When we find out that she has been infected, we give her the required services. There are also those who come puuh [abrupt], and deliver outside because sometimes others come already in labour and deliver under a tree and you find out they had not taken the test. We therefore have to counsel them and advise them to take the test. We counsel and test them after they have already delivered and also give them all other services.*

Although health care personnel said that women are counselled before taking the HIV test, it is very difficult to know how much counselling is given to a pregnant woman already in labour and how much she can understand and consent to in that condition. It is possible that during labour a woman may not be able to give full informed consent and she may not be able to decline the test in her condition. Gruskin et al. (2008) and Rennie and Behets (2006) argue that that power inequities between health care personnel as trained professionals who assume the role of authority in issues related to health and patients can prevent patient's ability to decline HIV testing. Measures are therefore needed to ensure that a woman understands the consequences of an HIV positive result for both her child and herself before and after testing. Postnatal care provides an opportunity where mothers can be counselled and come to fully understand and accept their HIV status.

I asked Salama Waziri (Kerege dispensary) the reason for a woman to take the test on having delivered her child, she told me: *The reason for her taking the test is to prevent transmission of HIV infection from mother to her child.*

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Health care personnel said that despite some women refusing to take the test, staff use persuasion to make them accept, explaining the reasons for and benefits of taking the test. Eventually, most women consent. As Upendo Saburi told me:

*We tell them about the benefits of testing and that the government has advised that but still a woman can agree or refuse to take the test. However, we still insist that she takes the test. We want her to take the test because we want to prevent her from infecting her unborn child and we explain to her the stages for preventing her child from infection are during pregnancy, during delivery and during breastfeeding. I think majority of women agree to take the test because they will deliver uninfected children.*

In Tanzania, the health care personnel's emphasis for pregnant women to test for HIV could be explained by the fact that they are required to use every opportunity to test the women and therefore will continue to encourage women to take the test every time the women visit the health facility (United Republic of Tanzania 2013). However, Avert (2012) raises important ethical concerns such as whether a laboring woman can be adequately counselled and give informed consent as well as to whether she will be able to cope with a new HIV result. Although HIV testing could be beneficial to the unborn child, the potential risks to women associated with one being found HIV positive need to be taken into consideration. Studies in low income countries have shown that HIV is regarded as an exceptional disease due to the potential social risks women could experience after taking the test (Bennett 2007; Csete et al. 2004; DeCock, 1998; Gruskin et al., 2008; Rennie & Behets, 2006). King, Maman, Wyckoff, Pierce, and Groves (2013) argue that most policies do not consider the social risks to women diagnosed with HIV and do not address how to protect women's rights and welfare which could be adversely affected by HIV testing during pregnancy or delivery.

Zuwena Hemed (Kiromo) had a different outlook when I asked her if HIV testing could be a reason for pregnant women's non-utilisation of health services. She told me:

*It depends on a person's view and her common sense because if you go everywhere now that service is available. Therefore if she refuses to go to our dispensary she will go to the district. At the district she will be told the same thing. What I do not know is, if other people also get tested, but for us pregnant women, to tell the truth, it is a must to get tested.*

Other women also told me ignorance was another factor in women's refusal and/or delay in taking the HIV test and therefore a reason for pregnant women's non-utilisation of health services. Hadija Shukuru (Kiromo) told me:

*HIV testing is a normal thing. If you see people refusing to do the test it is because they are ignorant. How can you stay without testing or decide not to go for health services just because they tell you to do the test? What if you fall sick? Will you not go there and do all the tests that are required? Those who refuse, I see them as just ignorant.*

Similarly Paulina Joseph (Kerege), said to me:

*You know, they usually look at your clinic card first. That means if you are infected they would have filled that information in. Now if you do not do the test, how are those doctors going to help you? It helps to take the test. They also look at how to protect themselves so that they do not get the infection.*

Despite the fact some women told me that refusal and/or delay in HIV testing still prevails in their communities, other women told me HIV testing is more acceptable among them since they became aware of its benefits. As Veronica Chonde (Matumbi) puts it:

*For me... [pauses], let us say for the periods that I have been going for services at our dispensary, I have never heard of any complaint from a person saying 'aah testing this or that'. I think people are knowledgeable these days. A person knows what she is doing, she cannot just say 'that nurse or that doctor is telling me this issue so that she can know my secret' ahah [disagreeing]. People know that the testing is for their own benefit. Frankly speaking, I have never heard a person complaining.*

This perspective was shared by Salama Waziri (Kerege dispensary) who told me: *At the moment there are only a few who do not want to take the test; most of them do agree to take the test.*

Several studies in African countries such as Abidjan, Bobo- Dioulasso Ivory Coast and Burkina Faso have shown that pregnant women generally accept HIV counselling and testing (Cartoux, Meda, et al., 1998; Cartoux, Msellati et al., 1998). The interviews I conducted with women and men show that acceptance of HIV counselling and testing among pregnant women is contributed not only by their awareness of the benefits of taking the test, but also by the assurance of early and appropriate intervention and treatment opportunities, and care and support of their unborn children and themselves. A study by Kiarie, Nduati, Koigi, Musia, and John (2000) cautions that testing is less likely in settings where stigma is attached to HIV infection. This study describes the reasons given by the women I interviewed for wider acceptance of HIV counselling and testing.

### **7.7. HIV testing and receiving other services**

*Enh [agreeing] they will give you other services but every time you go there they will continue to counsel you and ask you what you think about the issue of testing of HIV. They keep on asking you 'what do you think about testing and why are you refusing?' Veronica Chonde (Matumbi)*

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When I visited the dispensaries I realised that HIV testing was part and parcel of other services for pregnant women. I therefore wanted to know what happens when a woman refuses to get tested for HIV but needed other services for pregnancy. I asked Faraja Hassan (Matumbi), she laughed and told me: *They will accept and give her other services if she refuses but it will be to her own disadvantage not knowing her health status.* Asha Zuberi (Kerege) also told me: *They will give her other services: she gets other services as usual.* Latifa Issa (Matumbi) concurred: *If you refuse they will not do anything, it is your decision, they will just perform other tests on you.* Men also told me that women's refusal to take the HIV test does not deny her other services. As Ramadhani Bora (Matumbi) told me: *If she does not want to take the test, they will still provide her with other services.*

Despite the fact that other women told me that women are not denied services for refusing to take the HIV test, they were unsure if those who refuse to take the test are left without taking the test until they deliver. Mwajuma Rajabu (Matumbi) said: *Enh [agrees] they do give them other services, but I do not know if they leave them until they deliver their babies.*

Some women told me that no one is denied health services during pregnancy but an untested woman will be counseled on the benefit of testing every time she attends clinic. However, other women I talked to informed me that a pregnant woman can be refused services if she refuses to take the HIV test. Hadija Shukuru (Kiromo) told me:

*If you do not agree to take the test, they will not examine your pregnancy there. They might not examine your pregnancy because you are supposed to take the HIV test.*

I wanted to know how health staff know whether a pregnant woman has already taken the test or not. Paulina Joseph (Kerege) told me: *You know, they usually look at your clinic card first. That means if you have already taken the test, they would have filled out that information on the card.* Veronica Chonde (Matumbi) also told me:

*They know because they write that information in your card. Now when you give them your card for other ANC issues they take a look at it and see that you have not done the test and therefore they will tell you to get tested first before getting other services.*

Hadija's and Veronica's views indicate that despite the fact that some women may not wish to take the HIV test, health care personnel at the health facilities may not allow them to refuse but rather insist that they undergo the test in order to receive other services. Pool et al. (2001) argue that many women feel the pressure to test so as to receive services. Similar findings were found in a study found in Tanzania which showed that pregnant women seemed to be forced to undertake HIV counselling and testing (de Paoli et al., 2002).

Hadija further told me the consequences for women with non-compliant partners: *If you do not go with him they will not examine your pregnancy until you bring your partner to take the HIV test.* Farida Kombo (Kiromo) told me the same: *They do not accept until you both go there together; it is a must to go there with your husband otherwise they refuse to examine your pregnancy.* With a similar view was Furaha Ally (Kiromo) who said to me: *I think you will not get any services.*

When I asked Hadija if she has ever seen a pregnant woman being refused other services, she told me that that is what she believed was happening because HIV testing for pregnant women is a must. Farida, on the other hand, told me although HIV testing is a must, staff would test the woman for HIV and provide her with other services while complaining at her inability to convince her partner to come for testing.

## **7.8. Conclusion**

The study demonstrates that women get different individual experiences at health facilities which lead them to perceive HIV testing as mandatory or voluntary. The perceptions of women are shaped mostly on what healthcare personnel inform them during their antenatal care visits. From the two health facilities of the study, health workers from one facility informed me that HIV testing was voluntary, while the staff from the other facility told me it was mandatory. The different view about HIV testing among health care personnel from the two health facilities was based on the interpretation held by the health care personnel of that particular health facility which corroborates with the views of women I interviewed based on the facility they attend.

This study demonstrates that Human Immunodeficiency Virus (HIV) testing gives people a crucial opportunity to know their status and take advantage of preventative measures and treatment interventions. We have seen how women share their perceptions and experiences on HIV counselling and testing. Similar to other studies, this study has shown that pregnant women are the most targeted group in communities for HIV testing because they visit health facilities for antenatal care and delivery services. The intention of HIV testing is good since its aim is protect unborn children from infection as well as providing prevention and treatment to women themselves.

This study indicated that if a pregnant woman refuses to take the HIV test until she comes to deliver her baby at a health facility, she will be required to take the test while in labour ward to prevent transmission of HIV infection to her child. This is due to the fact that health care personnel are directed by the government to use every opportunity to encourage the women to take the HIV test every time they visit health facilities. Although counselling was said to be provided, the degree of understanding and consent of a woman who is in labour is questionable. The situation raises concerns of whether a pregnant woman can exercise her right of choice to HIV testing, cope with new HIV positive results if found infected, or be ready to face negative outcomes that come with being HIV positive in a community.

Policies on HIV testing need to address protection of women's human rights and welfare so that they are not adversely affected by their decision not to take the HIV test. Despite the fact that couple counselling is encouraged, there are still challenges in getting the male partners to test. Further, due to the stigma attached to HIV infection, especially in developing countries, HIV positive women often face extreme difficulty if they choose to disclose their status to their partners, family, friends and community. HIV counselling and testing remains vital because early knowledge of HIV status may enable women to make appropriate decisions about their own health and that of their unborn child including treatment, labour and delivery care, infant feeding and social support. The study has also shown that health care personnel and partners of pregnant women play significant roles in the acceptance of HIV counselling and testing; therefore, if these two groups are involved in the process of counselling and testing, the feeling of coercion to take the test or the perceptions that it is a mandatory test may be mitigated.

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*I like implants because once they are put in you; you do not get worried about getting pregnant until when they are taken out. They are good; you can plan to have children when you want. Even after I deliver this child I am going to use them again.* Latifa Issa (Matumbi)

This chapter explores the critical issues around family planning among pregnant women and women who have just delivered in Kerege, Matumbi, Kiromo and Kitopeni in Bagamoyo district. In particular, I draw upon issues which were addressed as of significant importance from interviews with pregnant women and health care personnel. Significantly, I have been interested in understanding the extent to which family planning is utilised by women. I explore the opinions and experiences of women regarding availability and utilisation of family planning within and outside health facilities.

Promotion of family planning and use of contraceptives are among strategies used by the international community to reduce the maternal mortality and to reach Millennium Development Goals (Campbell & Graham, 2006; Nour, 2008; United Nations Millennium Development Goals, 2000b). The Millennium Development goals are targets that were set during the Millennium Summit held at the United Nations in New York in 2000 by world leaders from UN member states to address and eradicate extreme poverty. The eight goals endorsed include: eradication of extreme poverty and hunger; achieving universal primary education; promoting gender equality and empowering women; reducing child mortality; improving maternal health; combating HIV/AIDS, malaria and other diseases; ensuring environmental sustainability; and lastly developing a global partnership for development (United Nations Millennium Development Goals, 2000a).

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Substantial literature shows that family planning has benefits not only for women but also for men and the community as a whole. In poorer countries, family planning gives women the power to plan their families through delaying, spacing and limiting the number of children that they have (Carr, Gates, Mitchell, & Shah, 2012). Additional literature indicates that family planning is considered to have social benefits, economic and health gains (Disease Control Priorities Project, 2007). These include saving the lives of infants (Graham et al., 2006; Singh, Darroch, Ashford, & Vlassoff, 2009), improving maternal health (Singh, Wulf, Hussain, Bankole, & Sedgh, 2009), prolonging education (Lloyd & Mensch, 2008), empowering women (Barnett & Stein, 1998; Kristof & WuDunn, 2009) preventing Human Immunodeficiency Virus (Wilcher, Cates Jr., & Gregson, 2009), producing affluence (Barnett & Stein, 1998), and protecting the environment (Speidel, Weiss, Ethelston, & Gilbert, 2007).

This chapter therefore recounts and analyses the knowledge of women, both pregnant and women having recently delivered at the time of interviews, about family planning within and outside health facilities. I explore their perceptions and experiences with family planning. In particular I discuss insights of women about family planning, the types of family planning available to them, and the problems, benefits and challenges they encounter in using family planning methods.

As an essential counterpoint, I also draw opinions and experiences of health care personnel regarding the experiences and challenges they perceive as confronting pregnant women and mothers in relation to family planning.

### **8.1. Availability and utilisation of family planning services**

The first time I went to visit Furaha Ally (Kiromo), she was asleep in a mud house. The house had two entrances, one into a room in which Furaha and her family lived and another into a room in which an older couple lived. The two families shared the cooking area. Furaha was married and living with her husband. When I knocked she opened the

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door and we greeted each other and she told me to wait. She went inside and came out with a stool which she offered me to sit while she sat down on an upturned bucket. We started our conversation around two o'clock in the afternoon. Furaha understood what I was asking and was very free and cooperative in our talk. I did not need to encourage her to talk but rather probed for more. When I asked if there were any family planning methods provided at their dispensary, she said: *Family planning service is available. They give out contraceptives pills, implants, injections.*

Mwajuma Rajabu (Matumbi), who told me that she was using a family planning method which she got from their dispensary before her current pregnancy, said that apart from pills and injections, there were other services which were brought to them from outside their clinic. She told me: *... there are health personnel who come from Bagamoyo who bring implants and IUD [Intrauterine Device].*

Similarly Bahati Selemani (Kitopeni) told me:

*The service is available at our dispensary and myself, I have used injection. There are also other services like pills. However for implants you have to go to Bagamoyo. The services available there mostly are pills and injection.*

Health care personnel told me that provision of family planning methods goes hand in hand with giving women advice regarding contraceptives. When I asked Sophia Taji (Kiromo dispensary) what family planning services they provide to women, she told me:

*We usually provide pills, injection, condoms and injection. We educate mothers on about the advantages of using contraceptives and advise them to report back in case they experience any discomfort after using them.*

Studies from Africa and Asia indicate that the availability and quality of family planning services in developing countries are essential factors in the increased use of

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contraceptive and the reduction of fertility (Leete & Alam, 1999; Sambo, 2004). The provision of education about contraceptives is therefore crucial to family planning; counselling is imparting clients with the correct information in order for them to make informed choice about their contraceptive method (Center for Communication Programs, 1989; Huezo & Diaz, 1993). A study conducted in Kenya by Kim, Kols, and Mucheke (1998) suggests that informed choice is an important component in family planning. In many developing countries, unsafe abortion continues to be a major cause of maternal morbidity and mortality, and therefore continued and consistent use of family planning is viewed as an effective the way of preventing unplanned and unwanted pregnancies and reducing the occurrence of unsafe abortion (Smith, Ashford, Gribble, & Clifton 2009).

With some family planning methods being readily available at the dispensaries, I wanted to know from health care personnel when they usually advise women to use them. Apart from serving those who normally come to seek for family planning when they are not pregnant, health care personnel told me that there is a period allocated which they advise mothers who have just had their babies to return to health facilities for family planning. Shani Uledi (Kiromo Dispensary) told me:

*We usually advise mothers that forty days after delivery they should come and get family planning services. At the family planning they choose which family planning they want.*

Similarly, Wahida Pandu (Kiromo dispensary) told me: *We educate them about family planning and advise them that they should return forty days after their delivery for family planning services.* The advice given by health care personnel to mothers on when to return to health care facilities for family planning services after delivery was a good indication that there is consistency of advice across health care personnel.

Salama Waziri (Kerege dispensary) told me:

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*Very often we advise them to come for family planning services after forty days of delivery. And there are also some cases whereby we also look at the condition of a woman and advise her to use family planning services to avoid getting pregnant or to have a period of rest.*

Salama gave me an example of an unfortunate incidence that occurred at their dispensary whereby a young woman lost her baby due to her delay in going to the hospital as she was advised. Salama told me that the unfortunate loss of a baby was caused by the young woman's family not heeding to the advice given to them. Salama told me that due to lack of transport during the night at the dispensary the girl lost her baby. Given the girl's condition and her young age therefore, Salama advised her to use family planning to avoid conceiving for a while Salama said:

*Fortunately the girl healed after attending her in our dispensary for some time. We then therefore advised her to use family planning in order for her to rest, so she came and got implants.*

Effective family planning is emphasised because of its protection of women from unplanned pregnancies, disabilities and prevention of maternal and child mortality (Singh, Darroch et al., 2009). However, the story of this young woman demonstrates not only how the use of family planning can be recommended by health care personnel given certain conditions, but the situational problems related to access and utilisation of health care services in rural areas.

### **8.2. Family planning method preferences**

When I talked to women, most of them told me that they had either used or preferred to use family planning methods which were easy and convenient. As Bahati Selemani (Kitopeni) also told me:

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*I prefer to use injection for family planning. Even before this pregnancy I was using injection because once you get a shot you forget for a while; it is not like pills you can sometime forget to take them and it becomes a problem.*

Mwajuma Rajabu (Matumbi) also told me she used a contraceptive injection before her current pregnancy: *I usually use injection because it is easy to use; when you get a shot you rest for a while without worrying that you will get pregnant.*

From the conversations, most of the women told me that they preferred injections and implants methods of family planning. The injection, or ‘injectable hormonal contraception’ is a liquid that contains the hormone progestogen given as an injection into the muscle of a woman’s arm or buttocks, stays in her body and keeps working to stop her getting pregnant for three months at a time (Family Planning NSW 2009). Implant or ‘contraceptive implant’ is a little plastic rod or a set of rods also containing hormones that are inserted underneath the skin on the inside of the upper arm whereby hormones are released into woman’s body over a period of time and prevents her from becoming pregnant (Family Planning NSW (2009).

The use of family planning methods directly administered at health facilities such as injections and implants seemed to be very convenient to the women in two ways. First, they are convenient because they reduce the risk of unintended pregnancies posed by contraceptive pills which they could simply forget to take. Secondly, using these family planning methods prevent domestic violence because women can use them without their husbands’ knowledge in situations where male partners may want their women to conceive without taking into consideration the needs and health of women.

When we talked about the reason for preference of one method of family planning over another, Farida Kombo told me:

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*You know with injection it is easy to avoid getting pregnant until when you want to have another baby without your husband knowing. If you use pills your husband will find out and then fights may start. Tell me, how will you hide them from him in the house? [As if asking me].*

This statement indicates that some men in rural communities still hold negative attitudes towards their wives or female partners using family planning methods. It also suggests the importance of involving men in family planning programmes in order for women to be free to use the family planning openly. A study conducted in Tanzania by Marchant et al. (2004) has shown that due to the fact that men have a strong influence over reproduction decision, some women are using family planning methods in secrecy. That family planning services in many African countries are integrated into maternal and child health clinics (Bawah, 2002) as is the case in Tanzania, makes it easier for women to access contraception without their partners' knowledge and/or approval if they may wish.

When I talked to women, they told me that if there is no good communication and understanding between women and their male partners and particularly with regards to desire for, number and spacing of children, the use of family planning methods such as injection the become the only solution in order to avoid domestic violence from their male partners. Faraja Hassan (Matumbi) told me:

*Sometimes you have to use contraceptives in secrecy; otherwise you might find yourself giving birth every year. And now that there are methods that you can use without your husband knowing; if you see your husband is not understanding you use in secrecy. If he asks you why you are not getting pregnant you tell him you also wonder why. Then when you think the time is right, you stop using them and get pregnant. You know... sometimes you need to rest and let the other child grow.*

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The use of contraceptives by women in relationship with violent spouses is challenging (United Nations, 1979; United Nations Committee on the Elimination of Discrimination Against Women, 2004). Sexual and domestic violence has been shown to impair the ability of women to negotiate with their partner on the use of contraceptives (Diop-Sidibe et al., 2006; United Nations Committee on Economic, Social and Cultural Rights, 2005; United Nations Committee on the Elimination of Discrimination Against Women, 1999; United Nations Human Rights Committee, 2000). As a result at a place using contraceptives without her husband or partner's knowledge, as practised by Faraja, becomes the only safe solution. Access and use of family planning services in Tanzania is made easier by the health facilities because contraceptives are part and parcel of services rendered and therefore present the best means of women accessing contraception them without domestic conflict. It is therefore important, especially in rural communities that low level of health facilities like dispensaries, have adequate and diverse contraceptives to meet women's needs.

There are studies that have shown a relationship between domestic violence and the use of family planning methods among women (Diop-Sidibe, Campbell, & Becker, 2006; Kaye 2006; Stephenson, Beke, & Tshibangu, 2008). While a study conducted in Egypt by Diop-Sidibe et al. (2006) revealed that women were less likely to use family planning methods when they experienced domestic violence, a study conducted in South Africa by Stephenson et al. (2008) found that in areas where many women reported to have experienced physical abuse from their spouses, women were more likely to use a contraceptive. What we learn from my study in relation to the study by Stephenson et al. (2008) is that when women are knowledgeable about the benefits of family planning but experience conflicts or domestic violence from their partners, they may find convenient ways to use the family planning methods.

Past studies conducted in Tanzania by Mturi and Hinde (1995), in Indonesia by Schoemaker (2005) and evidence from developing countries (Bankole & Singh, 1998) indicate that social-cultural and attitudinal factors affect contraceptive use due to the high economic value attached to children and large families. The high value attached to

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children and large families, particularly in Sub-Saharan Africa, has traditionally been attributed to parents viewing children as future investment for financial security (Caldwell, 1983), and source of labour in agricultural activities (Acsadi & Johnson-Acsadi, 1990; Mturi & Hinde, 1995) and domestic chores (Mturi & Hinde, 1995). In addition, children are expected to take care of their parents in old age (Mturi & Hinde, 1995) and having many children is perceived as boosting prestige and status to parents in the community (Isiugo-Abanihe, 1994). Studies have also indicated that the desire for large families is mostly attributed to families being poor, less educated and having higher child mortality resulting in higher fertility (Bongaarts, 2011).

If there is lack of communication or understanding between two couples, it often becomes difficult for a woman to control her fertility. As a result, in rural areas of Tanzania you may find a woman like Farida who told me that the use of injection to space births or limit the number of children is important and a safer method of family planning which avoided conflicts and violence with a male spouse. Barnett (1999) points out that women who use contraceptives secretly are afraid of spousal violence if they are found out. In Tanzania, family planning services are integrated into other reproductive health services; therefore it is easy for women to access contraceptives without their partner's knowledge. The experiences of women I talked to indicate that women use family planning methods because they know that the methods allow them an opportunity to recover and plan for the future, their children and the family as a whole. Despite this, women still face challenges in using family planning methods, even if contraception is available free of charge, due to socio-economic and cultural factors that favour men and disempower women. It has been substantiated that while improving availability, accessibility and knowledge of family planning services is crucial, these strategies by themselves may not guarantee the use of family planning methods (Crissman, Adanu, & Harlow, 2012; Haider & Sharma, 2013). A study conducted in Eastern Democratic Republic of Congo by Mathe, Kasonia, and Maliro (2011) found that despite the fact that the knowledge of contraceptives was 82%, the prevalence of contraceptives was only 7%. In order to find workable solutions to assist women to

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freely use family planning it is therefore important that the reasons for women not using or secretly using of family planning methods are fully explored.

In many developing countries men are still regarded as the main decision makers in most issues related to the economic, household and social wellbeing of the family (Matsuoka, Aiga, Rasmey, Rathavy & Okitsu, 2010; Tanner & Vlassof 1998; Timyan, Brechi, Measham, & Ongunleye, 1993) including decisions about fertility and contraceptive use (Bankole & Singh 1998; Bawah, Akweongo, Simmons, & Phillips, 1999; Ezeh, 1993; Lasee & Becker, 1997; Mathe et al., 2011; Mosha, Ruben & Kakoko, 2013). In Sub-Saharan countries the use of contraceptives is influenced more by husbands than wives and the level of use is higher when only the husband does not want more children (Bankole & Singh, 1998; Dodoo, 1998). Studies conducted in Africa and Asia have demonstrated that partner support is an important determinant of contraceptive use (Avogo & Agadjanian, 2008; Bankole & Singh, 1998; Dodoo, 1998; Link, 2011; Nagase, Kunii, Wakai, & Khaleel, 2003; Razzaque, 1999). Misconceptions and opposition by men on contraceptive use have been attributed to the exclusion of men in family planning programmes (Bankole & Singh, 1998). Some studies have indicated that men believe that family planning allows their partners to easily engage into adulterous sexual relationships (Bankole, 1994; Mwageni, Ankomah, & Powell, 1998). Further studies conducted in Zimbabwe (Mbizvo & Adamchak, 1991) Sudan (Mustafa & Mumford, 1984) and Tanzania (Mwageni et al., 1998) demonstrated that even when men are positive about their partners using contraceptive, they still want to be the one making decisions as to whether and when their partners can use contraceptives.

Given the socio-economic and cultural status of men and women within households in many developing countries including Tanzania, the provision of family planning education to men, especially the benefits of family planning, need to become a priority. As highlighted earlier, there is evidence to suggest that family planning has social, economic and health benefits such as improvement of maternal health; saving lives of infants; prolonging education; empowering women; prevention of diseases such as Human Immunodeficiency Virus; production and accumulation of wealth, and

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environmental protection. Although, the National Policy Guidelines and Standards for Family Planning Services Delivery and Training in Tanzania indicates its commitment to both genders in the provision of equitable health services including the right to access to family planning, information, education and services (United Republic of Tanzania, 1994), implementation seems to be slow or non-existent in these aspects. As per the guidelines, on HIV testing, couples in Tanzania are encouraged to accompany each other to HIV counselling and testing during women's antenatal clinic visits however encouragement of men to attend family planning education is non-existent. Integration of men into family planning programmes seems advisable since often a woman-only approach is used and therefore men find themselves excluded. Giving as an example of how the AIDS pandemic influenced the attitudes and behaviours of men towards women's health, Wegner, Landry, Wilkinson, and Tzani (1998) argue that programmes that only involve one partner in education, testing and treatment may not be effective in protecting the health of a couple and therefore recommends male involvement in family planning services. A study conducted in Kenya by Wilkinson (1997) and in the United States by Grady, Tanfer, Billy, and Lincoln- Hanson (1996), revealed that men are more likely to support their partners in decisions regarding family planning and use of contraceptive if they are educated about reproductive health matters. With such evidence, more in-depth research into identifying the determinants of use and non-use of family planning at the household and community levels needs to be conducted.

### **8.3. Decision making on utilisation of family planning methods**

While other women told me that they use family planning secretly due to fear that their husbands/partners may react negatively, others told me that they share their intentions to use family planning with their husband and partners. Pili Kassim (Kitopeni) had this to say:

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*Me and my husband we talk, there is no problem at all [laughing]. He understands that we cannot have many children: what are we going to feed them with? [Asking] life is hard.*

A study conducted in Tanzania by Mwangeni (1998) demonstrated that the economic burden of raising large families contributes to families opting to use family planning methods. Zuhura Hussein (Kitopeni) also had no difficulties in using family planning; she said me: *Oh that is no problem, we talk and agree upon. It is good to plan how many children you want, and this life nowadays.* Corroborating what Pili and Zuhura told me, a substantial literature from several developing countries shows that contraceptive use is positively associated with communication between spouses and the perceived support of contraceptives among spouses and community (Bankole & Singh, 1998; Bawah, 2002; Gipson & Hindin 2007; Kadir, Fikree, Khan, & Sajan, 2003; Mahmood & Ringheim, 1996; Nyabblade & Menken, 1993).

A study in Sudan showed that disapproval of husband is one of the influential determinants against the use of family planning (Ali, Rayis, Mamoun, & Adam, 2011). The disapproval of partner or family members who expect women to bear children due to socio-cultural factors also prevent the use family planning methods, especially in younger women (Abdul-Rahman, Marrone, & Johansson, 2011; Nalwadda, Mirembe, Byamugisha, & Faxelid, 2010). Mutual decision making about family planning seems vital for the couple if they wish to have a better life.

### **8.4. Reasons for utilisation of family planning methods**

*I used to have implants because I did not want to get pregnant without expecting, I took them out when I got this man and wanted to have a baby with him. However, I stayed for one year and that is when I got this pregnancy. Latifa (Matumbi)*

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Just as Latifa explained to me, women use family planning methods for different reasons. Farida Kombo (Kiromo) told me: *Before this pregnancy I was using contraceptives because I did not want to get pregnant without planning.* Apart from unplanned pregnancy, Pili Kassim (Kitopeni) who had a two-week-old baby when I went to talk to her for the first time had other reasons for using contraceptives, she told me:

*I was using injection before getting this baby. I had planned with my husband to stay for three years before getting pregnant again. And it has helped me because I was able to rest and open my small business.*

Studies conducted in Matlab, Bangladesh have shown that family planning not only plays a major role in improving the health of mothers and children but also empowers women to engage more in economic production (Joshi & Schultz, 2007; Razzaque et al., 2005) which further contributes to reduction of maternal and child mortality (Cleland, Conde-Agudelo, Peterson, Ross, & Tsui, 2012). The fact that women are able to plan for and space their children allows them to have good and healthy lives, ensures the good health of their children, and gives them an opportunity to engage in economic activities that can generate income to support themselves and their families.

Health care personnel told me women's needs for family planning differ and so family planning services cater for women of different age groups and type. As Judith Ombeni (Kerege dispensary) told me:

*Apart from health education in general and examinations for pregnant women, we also provide family planning services for different groups of women. We get different types of women who enquire about family planning services. There are those who come with children they are breastfeeding and there are those who are just free, they are neither pregnant nor have children. They all come to ask about family planning.*

*In general, young women and mothers come for the services and can come any day for such services.*

### **8.5. Challenges in family planning**

Although family planning methods were readily available for women at both health facilities of Kerege and Kiromo, there were some challenges that came along with it. Some women told me they had experienced problems with the methods of family planning administered to them. Habiba Juma (Kerege) told that she had implants for three years and when she took them out she fell pregnant with her last child. When I asked her the reasons for taking the implants out, she told me: *I took them out because they were disturbing me but I also wanted to have a baby.*

Habiba (Kerege) who had lost her baby in 2006, told me of a difficult pregnancy which the doctors could not explain. After the loss of her baby they advised her to use family planning in order to delay pregnancy. However, she told me that the contraceptive they gave her brought problems. She had this to say:

*After returning home, the nurse here in Kerege dispensary advised me that because I had a difficult pregnancy, I should use family planning methods so that I can rest for a while. I therefore went and was given an injection. I had only one injection. To tell the truth, that injection also gave me a lot of problems. I bled heavily for three months. I therefore returned to the dispensary. There was a nurse there, unfortunately she has died, who gave me a small tablet, she told me to take it so that the menstruation will stop [I asked her the name of the tablet, but she did not know]. I took that tablet in the afternoon but when it reached night the stomach started to hurt me very badly. I had to be carried to the hospital. When I got to the dispensary, my relatives were told to take me straight to Bagamoyo. They took me to Bagamoyo and I was admitted. That tablet*

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*made me that way. When we got to Bagamoyo they gave me a bed, gave me other medicines and I was given two drips. After I got better, the doctor told me to go check my stomach if it is not clean so that he can clean it. The doctor checked me but told me the stomach does not have any problems. I was therefore told to return home and not to use any contraceptives until after I get another pregnancy. I never got any problems with my other pregnancies, and with this one I am doing well.*

Side effects and failure of contraceptive methods have been shown to make women discontinue family planning methods even while they still need them or want to prevent unwanted pregnancy (Bradley & Schwandt, 2009). Habiba told me the administration of an injectable contraception was suggested by the health care personnel but it is not clear if she was counselled and offered other methods of family planning to make an informed choice. Health care personnel told me they instruct the women to return to the health facilities if they experience any side effects associated family planning methods. Bruce (1990) emphasises the importance of providing clients with information on all available family planning methods including the benefits, side effects and complications of each method because willingness to use contraception is determined by knowledge of the contraceptive.

A further challenge experienced by women was that their preferred method of contraception was not always readily available to them. Paulina Joseph (Kerege) told me:

*To tell the truth, family planning is available at our dispensary but not all contraceptives. If you want to have implants or IUD you have to go to Bagamoyo hospital; otherwise you have to wait until they announce to you that there are people coming to our clinic on certain dates for those types of contraceptives, so be ready.*

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The health care personnel also indicated that there was a limited choice of contraceptives available. Wahida Pandu (Kiromo dispensary) told me: *When they come they choose which type of contraceptive they prefer. However, the services here are limited, so we have only pills, injection and condoms.* Women told me that unavailability of other methods of family planning methods was a challenge to them. Certain methods are preferred because of their ease of use, few adverse effects and the need to keep contraceptive use from their spouses. Women's needs and preferences are influenced by both individual and medical factors (Abdel-Tawab & RamaRao, 2010; Bruce, 1990). Factors such as relationship with a male partner, family members, friends, as well as characteristics, discomfort, and the side effects of contraceptives all contribute to the discontinuation of family planning use (Abdel-Tawab & RamaRao, 2010). A study conducted by Desai and Tarozzi (2011) in Ethiopia showed that family planning methods were determined by the preference for some methods of family planning over others, particular for injectable contraception, which that programme did not provide. The need to use contraception may be evident to women but the lack of the desired method (one which may be kept secret from spouses, for instance) may deny women the right to control their fertility. A lack of women's preferred methods of family planning may lead to non-use of contraception and thus efforts to find solutions to such unmet needs of women are required.

The International Conference on Population and Development (United Nations, 1994) was held in Cairo, in 1994 and the United Republic of Tanzania (1994) also produced the National Policy Guidelines and Standards for Family Planning Services Delivery and Training. Among its commitments, the guidelines affirmed to provide any woman or man with the family planning method of her or his choice and to ensure the availability and accessibility of a wide range of family planning methods to give the user wider choice. However, as this study revealed, the policy is not implemented at a grass-roots level. The Tanzanian government must take serious measures to ensure the availability of family planning methods that suit its users, as the guidelines assert. In a recent comparative study of family planning services in both public and private health facilities in Tanzania, Kakoko, Ketting, Kamazima, and Ruben (2012) recommend provision of a

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variety of methods not only in government health facilities but also private facilities, in recognition of the fact that the contraceptive needs of a woman may change during her reproductive years.

Health care personnel indicated to me that there are ways to ensure that women get the types of contraceptives that are not readily available. When I asked Salama Waziri (Kerege dispensary) what they offer women for family planning, she told me:

*We give out family planning services and we have different types of family planning which we provide here. The ones we provide are pills, injections and condoms. We also have implants but so many times we do not keep them here at the dispensary. However, we have an outreach programme for mothers ... from outside to give services at our dispensary. And very often those who help us are the people from PSI and Marie Stopes. They are the ones who provide this service. They usually pass and bring us a timetable saying that they will come on certain dates to provide the service. Sensitisation therefore takes place all the time: when the women come we sensitise them. When the service providers come they therefore find the people are already here waiting for them and do that exercise of putting implants and IUDs. And I am very thankful that many women have now accepted these methods. For example if we announce today that providers of implants are coming, many women come and the providers provide the service to women but do not finish all of them. Women accept implants and IUDs very well. They are the methods that have been understood. In the past women were afraid of getting implants or IUDs. Women used to refuse to get implants, but now they enquire about them. Even now there is a woman who came and asked me if the implants have already been brought. Once we put on the announcement here at our dispensary, for one day those providers can put those contraceptives to forty women or more. We therefore are*

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*thankful that the sensitisation is good; women accept the family planning methods.*

I wanted one of the health care personnel to explain more about the announcement I saw on the noticeboard of one of the dispensary regarding *loop*: a contraceptive. Sophia Taji (Kiromo) had this to say:

*Regarding loop, there is one organisation called PSI [Population Services International] which usually comes and informs us that they will come to our dispensary at a certain date. Therefore we get mothers ready for the service on the date they come to put implants and loop on the women.*

Despite the availability of family planning methods in their dispensaries, health care personnel told me that sometimes contraceptives run out and delay in receiving another stock can affect their provision of services. Judith Ombeni (Kerege dispensary) told me:

*...However, we had run out of contraceptives; injections and pills for quite some time. It is only recently that we have received pills and injections, only these two methods. Right now very few come for the service, one by one. I think it is because they do not know that we have already received the supply.*

The right to contraceptive information and services among women and adolescents is one the major issues addressed by the Center for Reproductive Rights of the United Nations Population Fund (UNFPA, 2010). Ensuring that women have access to contraceptives in order to decide on the number of children they want and to space them accordingly is among issues that are strongly advocated. Given this fact, the lack of contraceptives at dispensary level and/or other lower health facilities in rural areas when women need them, denies them their right to exercise choice in fertility and reproduction. The inability of women to control their fertility arguably has economic and

social consequences because it may hinder women from acquiring the skills to increase their income and deny them resources to invest in the health and education of their children, thus perpetuating poverty (Canning & Schultz, 2012). It is therefore crucial that the government ensures a regular and consistent supply of contraceptives, are distributed in timely manner at lower level of health facilities, so that women can have access to them.

## **8.6. Conclusion**

Findings from this study clearly indicate that the majority of women are willing to seek family planning services if they are readily available to them. However, the family planning services currently provided are inadequate and do not always supply women's preferred methods. Nonetheless, this lack of choice does not seem to hinder women using the methods of contraception that are available. It is possible that the unavailability of other methods of family planning be due to financial capacity of the government or lack of expertise in administering such methods by health care personnel. However, it is worth the government making a full commitment to executing the national programmes that it introduces. This includes ensuring that all family planning methods are available to women in rural communities. Currently, women in rural areas who wish to use an implant or IUD must wait for outreach clinics on designated dates or follow the services to hospitals. This may result in unnecessary cost to women and delays in using family planning methods, issues that would be avoided if services were readily available at the designated health facilities. Since the use of contraception empowers women to control their fertility and reproduction, protects them from sexual transmitted infections and diseases and thus reduces maternal and child mortality, the need to ensure consistent availability of different methods of family planning at dispensary level in the rural communities is essential.

A range of family planning options at the village level will give women power to choose methods they feel are suitable and the least problematic. Choice in contraception also

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gives women the power to control their fertility while avoiding potential conflict and violence from their husbands or partners. This is particularly important when women have no power over their fertility and may not be able to use certain methods for fear of discovery.

In addition, the involvement of men in family planning programmes is crucial because even when women are educated and interested in family planning methods they may not be able to use due to disapproval from their male partners. Education and involvement of men in family planning programmes and other reproductive health issues may broaden men's view, change their negative attitudes towards family planning, and eventually encourage them to support their partners in decisions regarding family planning and use of contraceptive. As indicated earlier, family planning has social, economic and health benefits such as improving of maternal health; saving lives of infants; prolonging education; empowering women; prevention of infections such as HIV; wealth production and accumulation; and environmental protection. The provision of education to men on the benefits of family planning can therefore result in male acceptance of and use of family planning within the household. The involvement of men in family planning, along with women, may reduce fear of conflict and violence from spouses. The knowledge and acceptance of family planning among men may provide women freer access to contraceptives and hence reduce maternal and child mortality. Designing strategies and implementing interventions oriented to increasing information, knowledge and communication between spouses as well as promoting awareness and dialogues within the communities on the importance of family planning could ultimately ensure an uptake of use of family planning.

The need for more in-depth research into the socio-economic and cultural determinants of utilisation and non- utilisation of family planning at the household and community levels, including research on socio- economic benefits to men and women in reducing pregnancies, women and child mortality rates, is evident. This in turn will inform family planning programmes on how their programmes can succeed.

## **9. Conclusion and recommendations**

Under-utilisation of the healthcare services by pregnant women in Tanzania, despite the fact that maternal and child health is free, has been well documented. Health services for mothers and children include antenatal, delivery and post natal care; family planning; curative and preventive services for anaemia and malaria, including discount vouchers for insecticide treated nets, which are provided free of charge to pregnant women. Although free and low-cost services and products enable women, particularly those from low-income households, to access such services, there are also significant challenges for women and their families in utilising services. Barriers to access and utilisation of services are understood to some extent, although detailed local qualitative studies have not previously identified individual or community perceptions of the underlying reasons for these barriers. Nor have the mechanisms to create an enabling environment for access and utilisation of the antenatal and maternal health services among pregnant women living in rural districts been explored.

Access to health care is an important aspect of the human right to health. According to The World Health Organization and the Office of the United Nations High Commissioner for Human Rights (WHO & OHCHR), the right to health requires the governments to generate conditions in which everyone can be as healthy as possible (WHO/ OHCHR, 2007). In health care, the right to health is guided by the four elements of, availability, accessibility, acceptability and quality (WHO/ OHCHR, 2007). WHO/ OHCHR (2007) define these elements: availability means functioning public health and health care facilities, goods and services, as well as programmes in sufficient quantity. Accessibility means health facilities, goods and services accessible to everyone, within the jurisdiction of the State party. In addition, accessibility includes four overlapping dimensions: non-discrimination, physical accessibility, economical accessibility (affordability), and information accessibility. Acceptability means all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, as well as sensitive to gender and life-cycle requirements. Finally, quality means health

facilities, goods and services must be scientifically and medically appropriate and of good quality. When all the elements above are taken into account, access to health care can be realised.

This study, conducted in villages of Kerege, Matumbi, Kiromo and Kitopeni in Bagamoyo district in Tanzania, was an in-depth qualitative research study. It has provided important insights into many factors that affect pregnant women's access to and utilisation of health services. The main findings of the study on access and utilisation of health care by pregnant women are discussed and recommendations provided under the main themes of transport, child delivery, antenatal care, Human Immunodeficiency Virus (HIV) testing, and family planning.

### **9.1. Transport and its issues**

From my study findings, issues of unavailability and unreliability of transport, combined with distance, location, time of day, and costs were the major important factors in explaining non-use of maternal health care. This study demonstrates the problem of transport as a major obstacle to access and utilisation of health care services within the rural communities of Bagamoyo. The problem of transport consists of the long distances and transport costs to health facilities, particularly during referral to Bagamoyo Hospital. Pregnant women who live far from health facilities and those who are unable to walk on their own or without assistance are the most affected. The forms of transport available, particularly during the night, are also hindering factors. Women are often forced to board lorries or motorbikes to go to health facilities thus using modes of transport which are not safe and are very uncomfortable for pregnant women. For a pregnant woman to use a motorbike is difficult and risky; particularly when she is in labour. Boarding a motorbike or a lorry may put a woman in danger of losing her life or that of her child. Furthermore, as the study indicates, frequently pregnant women are not accepted as passengers by a hired motorbike riders. Although denying her motorbike access prevents

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her from danger, it does not solve her problem of needing to reach a health facility in time for immediate antenatal care.

Distance and isolation from homes to the nearest health facilities in the village is another problem. Some areas become unreachable during the rainy season because the roads become impassable. I escaped drowning in a temporary pond that developed in the road when I was going to visit and interview one of my respondents. The incident showed me the trouble a pregnant woman and/or her relatives could experience while travelling to the clinic for child delivery or due to any complications that come along with pregnancy.

The problem of distance is made worse with the unavailability of transport. Insufficient transport means delays to reach health facilities on time especially when a pregnant woman in labour needs to be rushed to the health facility during the night. Even when women are willing to utilise health facilities for delivery, they are prevented from accessing services due to inappropriate modes of transport. Because of distance, isolation and lack of transport, women may resort to using a traditional birth attendant or any person who is known to have experience of childbirth within their neighbourhood. This in turn may put a woman at risk of infection and contaminations due to a lack of proper sterilised equipment for delivery. There is also a risk that if a woman delivers safely she may decide not to go for follow-up consultations unless she develops threatening complications. Traditional birth attendants still play an important role in reproductive and maternal health in rural communities of Tanzania. Although traditional birth attendants still assist women to deliver children in difficult circumstances, their recognition by the government is limited to providing counselling on maternal and neonatal health and initiating timely referral. Furthermore, despite the fact that traditional birth attendants are recognised by the government as potentially important resources, especially in remote communities and those who cannot access transport facilities, most traditional birth attendants lack training to improve their skills and competencies. In addition they lack hygienic and safe equipment and places to assist women to deliver babies.

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Travel costs are a further prohibitive factor, as due to low earnings, many rural community members cannot afford the transport fares. While women may wish to go to the health facilities, not all families can afford the costs of transport. There is also an issue of unexpected referral due to emergency and complications that may require a woman to be sent to the major hospital. Often, as the study indicates, ambulances are not readily available when requested from the major hospital. This means a pregnant woman and her family members need to incur extra costs to hire transport, most often private transport. These extra costs are often the woman or family's personal responsibility; her family will also have to escort her to the major hospital and such costs are not refunded. The study also shows that even in circumstances where the costs of transport are affordable, securing private transport, especially during the night, is a major problem. The women request the government to provide stationed reliable transport at the level of a dispensary to guarantee timely referral of pregnant women.

This study demonstrates that women are knowledgeable about the importance of delivering their children at health facilities with the assistance of well-trained health personnel. Promotion of health education through outreach programmes, media and clinics in health facilities has contributed to the increased awareness on the importance of accessing better health services. However, due to infrastructure issues, such as poor transport systems and road network, coupled with distance and costs involved, women fail to utilise health care services.

Lack of equipment for testing at rural health facilities is another problem which contributes to women incurring unnecessary costs when they must travel from health facilities within their community to take a test to a distant health facility. Tests are important to monitor the health status of a pregnant woman in order to take appropriate measures if required. As was indicated in this study, often women were referred to the government hospital at Bagamoyo which is about 26 kilometres from Kerege dispensary and 8 kilometres from Kiromo dispensary.

At the rural health facilities, women are increasingly being encouraged to save some money before they deliver, including money for emergency transport. However, given the socio economic circumstances of rural families, which rely on small scale farming, it is often hard for a poor family to save and keep money until delivery while there are other dire needs to take care of in the household.

## **9.2. Antenatal care services**

Antenatal care is important and beneficial because it prepares pregnant women for safe delivery. This study has demonstrated positive responses to early attendance of antenatal care among pregnant women. It has also shown there is a wide awareness, knowledge and acceptance among pregnant women of antenatal care services in rural Tanzania. Antenatal care and media in rural communities play an important role of communicating the importance of the attending antenatal care.

It was obvious that most of the women in the study attended antenatal care services due to its perceived importance and benefits to their health and that of their unborn babies. There were many reasons for pregnant women attending antenatal care ranging from monitoring their health and the growth of the child, prevention and treatment of various diseases and conditions, and preparations for child delivery. Knowing their health status assured women of the safety of themselves and their unborn babies. The testing, prevention and treatment of malaria, anaemia, urinary tract infections, sexually transmitted infections and diseases, immunisation and monitoring of weight, blood pressure, blood level and blood type further reassured women. The provision of a discount voucher for insecticide-treated bed nets and free delivery packs were also incentives for the use of antenatal care.

Further reasons for attending antenatal clinics included information and advice about the prevention and treatment of various conditions and diseases, nutrition, and advice on where to deliver. Those who attend antenatal clinic are assured of referral to a larger

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hospital in case of complications with a registered clinic card. Those automatically referred to hospital are first-time mothers, those who have had more than four pregnancies, and women with scars from previous caesarean sections.

Past traumatic experiences with pregnancy also contributes to women preferring antenatal care which facilitates early detection of problems and appropriate obstetric care. Women expected to receive good reception, and quality services in one place, and to be heard and provided with clear explanations when they presented with unusual or troubling conditions.

The expected number of antenatal visits for a woman with a normal pregnancy is four, as recommended by the World Health Organization and the government of Tanzania. The study indicates that in special cases a pregnant woman is given more than four visits. Conditions and risks necessitating more than four visits include high blood pressure and HIV detected during antenatal testing. Although most of the women make all four visits, some do not, due to delay in starting clinic; others never attend clinic until delivery day. In cases of a delayed start to antenatal clinic visits, health care personnel try to schedule closer visits.

Education and awareness of the benefits of attending antenatal care and fear of the risks associated with pregnancy and complications have contributed to the high frequency of ante antenatal visits among pregnant women. Their understanding of about the benefits of attending antenatal care stems from the education provided by health care personnel, outreach meetings and media such newspapers, radio, and television.

In many rural areas, women are the targeted group of antenatal care services, and therefore their voices are a useful source of information and communication about how to improve such services and could valuably influence planning and management of local health services. Women attribute men's more frequent involvement in antenatal care clinic visits to outreach meetings which emphasise the importance of men supporting their spouses by attending clinic visits.

### **9.3. Child delivery at health facilities and its challenges**

Child delivery is a sensitive issue discussed at length with pregnant women. As with antenatal care child delivery, delivery is supposed to be provided free of charge to pregnant women. However, as the study indicates, many issues surrounding delivery arose as of major concern to women and staff at the health facilities. The issue of the preparation of relatively costly items for delivery was very distressing for pregnant women. Women argued that items for delivery should be the responsibility of the government and not theirs since such items, including medicines, are part and parcel of health care delivery that is supposed to be provided to them free of charge.

Women's desire to deliver at health care facilities often pushes them to find any means to secure funds, such as borrowing money, to buy the items because they know that delivery at health facilities by skilled health care personnel is the safest. Although women showed that they will prepare themselves with the required items for delivery, most of them often cannot afford the cost. However, showing up at the clinic for delivery without the necessary items presents the possibility of being denied services and therefore women are compelled to pay for such items. There was also a possibility of incurring expenses for delivery items twice if a woman, having used her delivery items at the dispensary, developed post-partum complications and needed to be referred to a hospital.

Health care personnel usually keep emergency kits to assist women who come to deliver with nothing due to the prohibitive cost or not being aware of the system of buying the delivery kits. Although emergency kits are important in protecting mothers, children and health care personnel from infections, they were insufficient and there was no any non-governmental organisation or special funds to provide such items for the dispensaries.

Despite the fact that women are encouraged early on in their pregnancies to start saving money for emergency transport and delivery kits, most rural households depend solely on small scale farming; their incomes are always unstable and expected to cover

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household costs. The government's introduction of a free delivery pack, which contains everything required for delivery was a relief to pregnant women. However, the limited number of delivery packs provided to dispensaries created misunderstanding among women and health care personnel as not all women were entitled to get them. That some women received delivery packs while others did not caused confusion and anger among some women. Free delivery packs were not regarded by either dispensary staff or pregnant as sustainable. The lack of adequate delivery packs and health facility kits is not a recent problem. The study showed that even before their introduction, a lack of items such as sterile gloves, syringes, medication such as oxytocin was common, and therefore the practice of encouraging women to buy their own items has been in place for quite some time.

Furthermore, given the transportation difficulties that pregnant women in remote rural areas experience, buying their own items for delivery becomes a necessity rather than an option. Pregnant women are encouraged by clinic staff to equip themselves for their own protection from infection and for that of those who assist them during emergency delivery in the community before they report to health facilities.

The lack of running water connected within the dispensary was a major issue that upset women and health care personnel due to the inconveniences and disturbances during delivery it caused. Although running water was available within the dispensary compounds, the distance to the water source and the fact that a pregnant woman, her relative or health care personnel were compelled to fetch and carry water from outside the service buildings was frustrating.

In addition, the location of basic amenities such as toilets and bath/shower facilities away from the building where health services and delivery rooms are located created discomfort, and was an inconvenience to the pregnant women and their families. The distance of amenities from the delivery rooms meant unreliable hygiene in the handling of clothing and the disposal of waste from pregnant women and mothers by their relatives. There was also a problem of maintaining the cleanliness of the amenities

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particularly due to the lack of a perimeter fence at the health facilities which makes them accessible for use by passersby who leave them dirty.

Availability of electricity is also important at night in rural health facilities, becoming an important necessity due to lack of other health services like hospitals that usually operate during the night. Electricity is vital for providing light to attend pregnant women who may give birth in the night and other patients who come during the night in emergency situations. Compared to the past when women were asked to come with their own source of light such as hurricane lamps due to lack of electricity, the situation has improved. However, there are still times when health care personnel are forced to use torches to assist pregnant women to deliver. The study shows women still get services from the health care personnel during the night and therefore, the lack of electricity is a challenge to the health care personnel who are there to assist the women. Although the working hours at dispensary are limited during the day, health care personnel still operate in the night. It is always very difficult for the health care personnel to deny people services which are within their capabilities to provide, particularly during emergencies such as assisting a woman to deliver a child. The lack of electricity in dispensaries also poses a risk during the night due to the unsafe environmental conditions outside and within the building of health facilities.

Electricity also emerged as an issue of great concern due to its importance to the dispensaries' operations, which are dependent on fridges to store vaccinations, Hemocue for testing haemoglobin, and sterilising equipment. Delay in receiving electricity and gas to operate fridges at dispensaries also means that health care personnel have to travel to other rural health facilities to collect and return the vaccinations. Travel means time and money spent by health care personnel that is never refunded by the government.

The sharing of the same LUKU between dispensaries and households of the health care personnel within the compound was another dilemma to health care personnel because it left them in a state of suspense about who was to bear the cost of electricity. Again, the returning Community Health Funds to the dispensary level would assist in solving

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pertinent problems such as electricity which make the management of dispensaries even harder.

Management of waste was also another challenging problem at the dispensaries. Dispensaries did not have appropriate and secure places, such as incinerators, to be used for waste disposal and instead some waste was thrown inappropriately near dispensary buildings such as toilet facilities or delivery units; otherwise holes had to be dug in the ground to bury the waste. Waste included placentas and other waste of delivery. For placentas, a new hole had to be dug on the ground every time a woman delivered; often the activity was done by the woman's relatives. Such haphazard activity threatens the possibility of infection or contamination of households if not managed well. Furthermore, since there are no fences around the health facilities, waste become accessible to scavenging of any sorts which could lead to infection and contamination.

The lack of privacy in and around delivery was problematic in many ways. The quasi-public disposal of placentas, which culturally should be handled in secrecy, fails to respect and protect the dignity of women. Lack of privacy during delivery was also a concern, caused by a lack of perimeter fencing at dispensaries which allowed passersby to hear sounds coming from the delivery rooms. There was also lack of privacy within delivery rooms due to lack of space, which denied individual pregnant woman the comfort of waiting her turn to deliver or resting after delivering. Poor conditions of the health facilities, particularly in delivery units, made it difficult to maintain cleanliness, provide safety, and manage more pregnant women at a time due to lack of space.

The lack of safe and sheltered waiting areas for family members who escort a pregnant woman was also a concern to rural women who come to deliver with relatives to escort them. These relatives have demonstrated themselves to be reliable in assisting health care personnel in the miscellaneous tasks related to care of pregnant women such as fetching water and disposing of afterbirth waste. However, long waiting hours and environmental risks such as attack from snakes, particularly during the night, were a major concern for health facilities.

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Understaffing and workload on the part of health care personnel was a major concern: apart from assisting women with child delivery, staff must attend other patients, antenatal and child clinics, prepare reports and the like. It is often difficult for health care personnel to perform all tasks, particularly if they are few in numbers and are under the pressure of attending to pregnant women who want to deliver. When health care personnel find themselves burdened by workload their efficiency is reduced and causes them to perform the most pressing activities while delaying less essential tasks. As a result of this, health care personnel find themselves being blamed by patients who attend dispensaries seeking health care services.

The Community Health Funds being managed by the district was an issue that health care personnel suggested reviewing to allow staff full and immediate access to money used for supplies and electricity. The community members contribute to the Community Health Fund. In the opinion of health care personnel, these funds could be used to quickly solve problems arising in their dispensaries as opposed to the current situation where the funds are under the management of the district. This causes unnecessary delays because every time a problem must be addressed via a request which, due to bureaucracy, takes time to be responded to. The fact that the health facilities have to collect the Community Health Funds from community members and send them to the district, and then the district plan for or allocate the use of funds for material on behalf of health facilities is viewed as unnecessary bureaucracy and causing unnecessary delays. Previously, lower health facilities used to collect, manage and be accountable for Community Health Funds under the supervision of dispensary health committees. In the opinion of the health care personnel, this system enabled the dispensaries to solve pertinent problems quickly and effectively. Currently, the government is responsible for providing the health facilities with medical supplies, facilities, equipment, and services such as electricity. The government also receives and manages the Community Health Funds from lower health facilities, and then caters for any needed request from the lower health facilities.

#### **9.4. Perceptions and experiences in Human Immunodeficiency Virus testing**

Human Immunodeficiency Virus (HIV) testing is integrated with antenatal care in most rural government health facilities. Pregnant women are expected to take an HIV test as part of the antenatal services. The study indicated that the process of HIV testing in both dispensaries usually starts with counselling with a woman or a couple, or groups of women or couples, depending on the number of clients on the day. The counselling includes information about testing, prevention of mother-to-child HIV transmission (PMTCT) and the services available, followed by testing and provision of test results in a setting that maintains privacy and confidentiality. HIV testing is repeated three months after an initial test for those found uninfected to ensure that they are safe, and advice on how to take precautions to avoid infection is provided.

Counselling is important in encouraging woman or couples to take the test because it emphasises that testing for and treatment of HIV protects the unborn child from infections. Women or couples were often put in groups during HIV pre counselling sessions due the ratio of staff to clients. Although counselling was done in a group of women or couples, testing and provision of results was done in privacy, using numbers for identification in assurance of confidentiality. However, providing HIV counselling in groups has its own limitation. Not all people are comfortable to share or ask questions in groups and therefore the likelihood of not getting adequate information to make an informed decision is high. The group sessions on sensitive issues like HIV make people reluctant to talk openly.

The issue of whether HIV testing is voluntary or mandatory for pregnant women elicited different experiences and opinions. There was a degree of confusion due to the way health care personnel relayed messages about HIV testing. Some regarded HIV testing as mandatory based on what they were told by health care personnel who asserted that HIV testing for a pregnant woman is a must and a government policy requirement. The

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argument given for HIV testing was that it could potentially save the unborn baby from HIV infection, and this argument was persuasive to pregnant women.

Those who viewed HIV testing as voluntary based this on the fact that a pregnant woman is counselled prior to agreeing to take the test. Taking the HIV test after counselling indicates that one has agreed voluntarily to take the test, even when convincing powers are used. While those who viewed that HIV testing as voluntary indicated that a pregnant woman who refuses to take the test will be let go, those who said it was mandatory claimed that a woman who refuses to take the test may be denied other services. Similar inconsistencies of opinion existed among health care personnel. While some said the test was mandatory because the government requires that all pregnant women should take the HIV test, others emphasised that it was voluntary because pregnant women were not coerced but rather convinced to take the test.

HIV testing of a male partner is encouraged and emphasised at clinics, although getting men to go to health facilities to take the test proves to be a challenge. Although pregnant women were delegated with the responsibility of bringing partners for the test, men only infrequently agree to accompany their female partners. Male respondents also indicated that men in the rural communities were unaware of HIV testing for male partners in dispensaries, and also pointed out that men refuse to accompany their female partners or wives to antenatal clinics for HIV testing. Due to their reproductive role, pregnant women were the ones targeted for testing and are often relied upon by health care personnel to convince their male partners to go for the test.

Although pressure was exerted by health care personnel by postponing provision of services to the women until they brought their partners for testing, women were still allowed to take the test alone, particularly if their male partners refused to acknowledge paternity, disappeared, refused to turn up or had travelled. Women were asked to bring absent or travelling spouses for the test when they returned, although not all men went. Additionally, follow up of male partners by health care personnel falls off or becomes non-existent after delivery unless the mother is HIV positive and continues to take the

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child to clinic. The absence of follow-up could result in new or multiple infections to women who engage in sexual relationships without knowing the HIV status of a male partner.

The resistance of male partners to accompanying their female partners for HIV testing is common and often attributed to the stigma, shame and discrimination of HIV positive serostatus prevailing in many rural areas. When women go for testing, find out that they are infected and decide to disclose their status to their male partners, they are often subjected to verbal and physical abuse, abandonment or expulsion from homes, separation or divorce and loss of economic support. Very often women are blamed for infidelity by their male partners, family members and communities, even when they may not be responsible. The potential risks of disclosing their HIV positive status may make women unwilling to share results with their partners or anyone else in their circle; this potentially put them at risk of new infections or of failing to access proper treatment, care and support where available.

Couple HIV counselling and testing is seen as the best solution to minimise the negative outcomes that women experience due to disclosure of HIV positive status to their male partners. The fact that couples go through the process of counselling and testing together decreases the tensions and fears that both spouses might have and they are therefore more likely to accept their status and be ready to receive treatment. Prevention of Mother to Child HIV Transmission (PMTCT), a programme that aims at protecting unborn babies from HIV infection, was regarded positively by women, despite the pressures brought to bear on women to do the HIV test. The advice on how to take care of the HIV positive mother and child including feeding options for the child, and preventative treatments before and after delivery were incentives for taking the test.

Refusal and delay in testing was also said to be common among pregnant women. Very often women's refusal and delay to take the test was associated with fear of being tested, finding out that one is infected, being blamed and accused of infidelity by partners, family members or community, and suffering stigma, physical and verbal abuse,

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abandonment and discrimination. Ignorance was also identified as a reason for refusal or delay to taking the HIV test in the sense that some women lack information about the importance and benefits of testing and therefore miss the opportunity for prevention, treatment or support.

Women are the most targeted group due to their reproductive role. The fact that women know that antenatal care is synonymous with the HIV test may inhibit some women from utilising antenatal care due to fear of discovering and having to disclose that they are infected. It was indicated that women who refuse or delay testing may opt for other places to deliver their children such as to traditional birth attendants or community members with previous experience of delivering children, and will only go to the health facilities if they develop complications or when they want their children to access clinic services. There was also an indication that if a pregnant woman refuses to take the HIV test until she comes to deliver her baby at a health facility, she will still be required to take the test while in the labour ward to prevent transmission of HIV infection from mother to her child. Although counselling was said to be provided, the degree of understanding and consent of a woman who is in labour could be questioned.

Refusal to take the HIV test did not prohibit a woman from receiving other services but counselling continued to be given to a woman at each antenatal clinic until delivery. Despite all the factors for refusal or delay, acceptance of HIV counselling and testing has increased due to increased awareness and knowledge of the importance and benefits of testing, and to assurance of early and appropriate preventive and treatment opportunities, and care and support of the unborn children and mothers.

HIV testing is crucial because it gives people opportunity to know their status and take advantage of prevention and treatment interventions. However, HIV is still a sensitive issue and in many communities there is stigma attached to seropositive status. Often HIV testing is emphasised as protecting unborn babies from HIV infection while the welfare of women in communities is neglected.

Counselling and testing for HIV will remain an important aspect in preventing and curbing the spread the AIDS. There is no doubt that HIV testing does protect unborn children from getting the infection as enabling the treatment of infected women themselves. Furthermore, early knowledge of HIV status is beneficial in enabling women to make appropriate decisions about treatment, labour and delivery care, infant feeding and social support.

### **9.5. Utilisation of family planning**

Family planning is a health service in great demand in rural areas by women. Family planning prevents unplanned pregnancies, disabilities, and contributes to reduction of maternal and child mortality. Women use family planning methods to avoid unplanned and unwanted pregnancies, to delay pregnancies or space children so as to be able to rest and regain normal health, to ensure the good health and growth of their children, and/or engage in economic production to support their families.

Women indicated their knowledge of family planning and available family planning methods and services in their dispensaries. The most common family planning methods used were contraceptive pills, injections and condoms. However, although these are the methods which are easily available and accessible, supplies sometimes run out and remain unavailable for a while which affects provision of such services until the next government. The periodic lack of family planning methods commonly used among women in rural areas was a source of complaints. Inability to control their fertility and reproduction, impacts on women's economic and social spheres of life. Other methods such as Intrauterine Device (IUD) and implants were only accessible through special outreach programmes for mothers at dispensaries on special designated dates, or at district hospitals like Bagamoyo where women would have to travel in order to get them. The seasonal availability of such family planning had an impact on women who had problems using other methods, meaning that they incurred costs being supplied at the hospital.

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Family planning services went hand in hand with the provision of advice on the benefits and side effects of each method in order for women to make informed choice. Services cater for women who are not pregnant, have young children or have never had children. Pregnant women who had just delivered often are advised to return to the health facilities after forty days in order to get advice and select a family planning. Furthermore, in cases where a woman is considered at risk if she becomes pregnant, health care personnel take initiative to advise the woman to use family planning methods.

Preference of method is often influenced by ease and convenience of use, the absence of adverse effects, and need to maintain disclosure from the male partners. Family planning methods such as injections and implants were preferred to other methods. Injections were preferred because one did not need to remember to take one's pill or to disclose that one was using contraception to a partner. The major reasons for women using injections and implants were to avoid conflict with their male partners who may want their female partners to conceive frequently or to continue to have children regardless of the health and needs of the women.

Women will be ready to use family planning methods if they are aware of the benefits. If the man is dominant within the household, secrecy in using family planning methods becomes the safest solution. Since family planning services are integrated into maternal and child health clinics, it becomes easy for women to access contraception without getting into conflicts with their spouses. However, family planning becomes difficult if low level health facilities like dispensaries in rural areas lack diverse or adequate methods and if the women are economically dependant on their male partners. On the other hand, if there is openness in communication among spouses and a woman is listened to and heard by her male partner in other household issues, including family planning, it becomes easy for a woman to share information with her male partner and get support to use family planning methods openly. The negativity of men towards family planning was held to be contributed to by their exclusion from family planning

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programmes where, just as with antenatal care programmes, a woman- only approach is mostly used. Economic hardship has nonetheless influenced change of attitudes of men towards utilisation of family planning. Those who understand the economic burden of raising large families usually accept their female partners' use of family planning.

There are other challenges in the use of family planning methods. These were related to side effects or failure of methods. Women complained of discomfort, heavy bleeding and stomach pains, which sometimes forced women to discontinue using family planning even when they did not wish to do so. An inadequate variety of methods at dispensaries and intermittent availability of other methods at special outreach programmes forced women to forgo using family planning or to use methods which were not of their preference.

The study has shown that family planning services influence women to access and utilise health care services. Most women are willing to use family planning services if they are readily available to them because use of family planning methods gives them power to control their fertility and reproduction, protects them from sexually transmitted infections and diseases and hence reducing maternal and child mortality. However, as this study shows, there is still an insufficient variety and availability of planning methods for women to allow wide choice. In addition, health care personnel in rural health care facilities do not administer some methods and therefore women seeking them are forced to wait until the dates of outreach clinics or follow services to other health facilities. The lack of the full spectrum of family planning options may therefore either create worry and tension among women who need to control their fertility. Any delay or lack of family planning services puts women in danger of failing to control their fertility and reproduction, with the possibility of acquiring sexual transmitted infections and diseases thus increasing maternal and child mortality.

## **9.6. Recommendations**

The study demonstrated that women understand the importance of seeking care support from health care facilities, but issues related to access to health are the major hindrances to utilisation of the services among pregnant women. The government therefore needs to take appropriate measures, such as reviewing the rural and health care system and infrastructure support, in order to develop feasible plans and policies to cater for communities' needs while ensuring efficient execution of work by the health care personnel. Prioritisation of adequate budgets in health care system and infrastructure could be an important step towards improvement of health care provision and access to care among women in rural communities.

The government could invest on rural infrastructure such as transport systems and road network to increase women's use of health care services. Dispensaries are the immediate and closest health facilities, particularly in rural communities, making them very reliable source of health care to women and children. Government could also explore provision of stationed transport particularly ambulance at lower level of health care facilities such as dispensaries in order to reduce the risks of infant and maternal mortality.

The government need to ensure the availability of all necessary equipment and essential supplies at dispensary levels to enable women to receive the services within their local communities and reduce the unnecessary travel and costs for women to seek for services from health facilities outside their locale. Upgrading some dispensaries gradually to health centre status in order to provide more services for pregnant women in rural communities also need to be explored so as to minimise inefficiencies,

The government's introduction of schemes such as delivery packs for pregnant women should have transparency in order to avoid confusion and minimise misunderstanding among intended recipients and health care personnel. The government could allocate funds for mass production of delivery packs and consider distribution of the delivery packs at household levels through outreach programmes. The more women are reached

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with the packs especially in rural and remote area may also ensure safe delivery at home during unavoidable circumstances.

The government should invest on appropriate infrastructure for maternal health care services to a satisfactory and good standard quality. This can be done through prioritisation of adequate funds in proper buildings, reliable water supply and electricity, toilet and bathroom facilities, safe and appropriate disposal of waste, provision of privacy and waiting areas. The problem of poor water supply at the health facilities could be solved by connecting the health facilities to the water supply and distributing water to all building in the health facilities. With the problem of interrupted electricity supply, the government could consider possible innovations for example investing on solar electricity for lighting.

Furthermore, poor toilet and bathroom facilities could be solved by building ventilated improved pit latrines and modern toilet and bathroom facilities, as well as separating dispensary's ablution facilities from those of health care personnel. Poor disposal of dispensary waste could be solved by building incinerators, proper waste disposal facilities and dispensary fences. The problem of lack of privacy could be solved by building separate and independent rooms specific for pregnant women waiting to deliver, those in labour and post-delivery, and also building of fences to prohibit people from trespassing the facilities. Building of waiting areas for relatives and families of pregnant women who accompany pregnant women is also important.

The problem of understaffing and excessive workload could be solved by increasing in number of skilled health care personnel to ensure proper organisation of activities and routines, contributing to good quality and performance of health services. Furthermore, the government needs to consider provision of overtime payments and rewarding incentives to health care personnel for the extra effort, commitment and time they put into their work so that they can continue to execute their services efficiently.

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The government needs to delegate responsibility for managing finances to lower levels of health facilities particularly those funds emanating from the community such as Community Health Fund in order to improve efficiency in provision of health care services. As long as there is transparency and accountability by health committees and financial reports are sent back to the local council authorities at district levels, returning control of the Community Health Fund to dispensaries would assist health care personnel to solve pertinent problems and work efficiently.

Male partners need to be an important targeted group for counselling and testing for HIV in order to tackle the problem of HIV/AIDS in Tanzania. Despite the fact that couple counselling is encouraged, not all male partners visit antenatal care clinics with their female partners. Programmes to fully integrate men in reproductive health issues and services such as antenatal care need to be established in order to increase men participation in counselling and testing for HIV. Community outreach programmes targeting men through sensitisation and promotion of awareness on the importance of participation in maternal health care with their female partners could be used to reach the men.

This study mentioned that fear of stigma and domestic violence are among factors that may lead to some women choose not to disclose their status to their partners, family, friends and community if they are HIV infected. Further research to explore the welfare of women in communities after disclosing their HIV positive status need be conducted to understand the extent of the problem in order to find ways of addressing protection of women's human rights and welfare so that they are not adversely affected by their decision to take the HIV test and share their results.

The government needs to ensure provision of regular supplies of family planning methods to cater for women's needs at all times, and provision of more choices of different methods of family planning. A range of family planning options will give women power to choose methods that they deem suitable and best for their bodies and circumstances to control fertility. Furthermore, the government should invest in

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providing training to health care personnel on administering family planning methods so that all family planning methods that do not need hospital medical procedure could be readily available to women at dispensaries in rural communities.

Family planning education should target men and integrate them in programme implementation in order to raise their awareness and increase their acceptance of their female partners using contraceptives. Men's knowledge and acceptance of family planning will give women the freedom to access and use contraceptives openly, leading to a reduction in maternal and child mortality rates. Literature suggests that the support of a partner is an important contributing factor in using family planning methods. Designing strategies and implementing interventions that are couple-oriented and focus on increasing information, knowledge and communication, as well as promoting awareness and discussions with the communities on the importance of family planning could ultimately therefore ensure increased acceptability and use of family planning.

### **9.7. Conclusion**

As with any qualitative research, this study had a limited sample of respondents and therefore cannot represent all rural communities in Tanzania but may portray a picture of what is happening in rural areas with similar characteristics. Different from large surveys, this was a small-scale study which aimed at listening to voices through eliciting individual perceptions and experiences. It employed a naturalistic ethnographic approach which involves intensive listening to the stories and experiences of participants without trying to control or influence, coupled with observation.

The study has provided a deep understanding of problems of access to and utilisation of health care services by pregnant women in rural Tanzania. This study has also indicated that in Tanzania: rural areas in a district being located near an urbanised area and having easy access to a big city, a point of contact with a variety of opportunities and access to reproductive health services does not guarantee easy access and utilisation of health care services by women. There is similarity of challenges related to health care service in

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terms of access and utilisation of healthcare services with rural communities in remote areas. This study has also demonstrated that there are opportunities to increase access and utilisation of health care services among pregnant women and to reduce maternal deaths in Tanzania if the voices of women are heard and heeded. Being the main users of health care services, women have raised significant issues and recommended important actions which if taken on board could contribute significantly to the improvement of access and utilisation of the health care services. The outcomes of this study inform the existing knowledge in both scholarly and applied fields, promote more culturally-sensitive empirical research on access to care, and assist in the enhancement and development of better and/or novel access to health care services.

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**Appendices**

## **Appendix A: Interview guides- English and Swahili versions**

### **Access to Health Care Services among Pregnant Women in Rural Communities: In-depth Case Studies from Bagamoyo District in Tanzania**

In-depth interview guide for pregnant women and women with pregnancy history not exceeding 24 months from when the study is conducted and who are not under 18 years old of age.

#### **Context:**

Age of a woman  
Occupation  
Education  
Marital status  
Occupation of husband/ partners  
Average income per month  
Distance to the nearest health facility  
Availability of transport  
Sources of health care in the community

#### **General Knowledge and Perception**

1. What are health services available for pregnant women in health facilities in this community? *Probe for antenatal, childbirth, postnatal, preventive and curative health services sought and received including HIV testing*
2. Do all pregnant women in this community use the health services available? If *Yes/ No* give reasons. *Probe for other alternative means available and sought*
3. What are the needs of pregnant women in this community at health facilities? Please list and explain.
4. Do health services provided cater for the actual needs of pregnant women? If *Yes/ No* give reasons
5. What are processes for HIV testing to pregnant women at health facilities? *Probe to find out if it is voluntary done and if it could be one of reasons for pregnant women's non utilisation of health services.*
6. Do you pregnant women in this community face similar problems like other nearby communities? If *Yes/ No*, give reasons.
7. What has been done in this health facility and in the community to help pregnant women to easily access and utilise available health services? *Probe for available mechanisms in the village to assist pregnant women and if they have been helpful.* If *Yes/ No* give reasons.
8. What can be done to improve the access and utilisation of these services among pregnant women living in rural communities?

#### **Personal Experience**

9. Is this your first time you are pregnant/were pregnant?
10. Do/did you ever attend the health care services during pregnancy? If *Yes/ No*, give reasons
11. Where is/was your child expected to be born/ born? *Probe if the place of delivery is/ was her choice? If Yes/ No give reasons.*
12. Did you deliver your child safely? If *Yes/ No* give reasons

## Appendices

13. At anytime when you attend/attended health facilities during your pregnancy have/did you pay for any services? *Probe for which type of services and reasons why*
14. Is/ was there anytime when you are/ were not able to afford the costs when you are/ were in the health facility and need/needed the services? If *Yes probe for what happens/happened*
15. Apart from health services costs (if available/ or not), do/did you incur any other expenses during your pregnancy in order to access and utilise the services? If *Yes*, how much? Are/ were you able to afford the costs? If *Yes/No*, give reasons

**Ufikiaji wa Huduma za Afya kwa Wanawake Wajawazito Vijijini: Utafiti wa Kina katika Wilaya ya Bagamoyo, Tanzania**

Mwongozo wa mahojiano ya kina kwa ajili ya wanawake wajawazito na wanawake wenye historia ya kuwa na ujauzito isiyozidi miezi 24 toka utafiti huu uanze na ambao wana miaka isiyo chini ya 18.

**Taarifa:**

Umri wa mwanamke  
Shughuli aifanyayo  
Elimu  
Ndoa  
Shughuli ya mume/mwenza  
Wastani wa mapato kwa mwezi  
Umbali wa huduma ya afya iliyo karibu  
Usafir uliopo  
Huduma za afya zinazopatikana kijijini

**Ufahamu wa Jumla na Mtazamo**

1. Ni huduma gani za afya zinapatikana katika vituo vya afya kwa ajili ya akinamama wajawazito katika kijiji hiki? *Dodosa kuhusu huduma za kabla, wakati na baada ya kujifungua, kinga na tiba zinazohitajika na kutolewa ikiwa ni pamoja na kupima maambukizi ya UKIMWI.*
2. Je wanawake wote wajawazito katika kijiji hiki wanatumia huduma za afya zinazopatikana hapa? Kama *Ndio/ Hapana* toa sababu. *Dodosa njia nyingine zinazopatikana na kutumiwa.*
3. Je ni nini mahitaji ya wanawake wajawazito katika vituo vya afya hapa kijijini. Tafadhali orodhesha na elezea
4. Je huduma za afya zitolewazo zinakidhi mahitaji ya wanawake wajawazito? Kama *Ndio/ Hapana* toa sababu.
5. Taratibu za upimaji maambukizi ya UKIMWI kwa wanawake wajawazito zikoje katika vituo vya afya? *Dodosa kufahamu kama upimaji unafanywa kwa hiari na kama unaweza kuwa moja ya sababu za wanawake wajawazito kutotumia huduma za afya.*
6. Je wanawake wajawazito hapa kijijini mnapata matatizo yanayofanana na vijiji vingine? Kama *Ndio/ Hapana* toa sababu.
7. Kitu gani kimeshafanyika katika kituo cha afya na katika jamii hii kusaidia wanawake wajawazito kuweza kufikia na kutumia huduma za afya zipatikanazo? *Dodosa kufahamu kama kuna mbinu kijijini za kusaidia wanawake wajawazito na kama zimekuwa za msaada kwao. Kama Ndio/ Hapana toa sababu.*
8. What can be done to improve the access and utilisation of these services among pregnant women living in rural communities?  
Kitu gani kinaweza kufanyika kuboresha ufikiaji na utumiaji wa huduma hizi kwa wanawake wajawazito wanaoishi vijijini?

**Uzoefu Binafsi**

9. Je hii ni mara yako ya kwanza kuwa/kuwahi kuwa mjamzito?
10. Je unaenda/ulienda kupata huduma za afya wakati wa ujauzito? Kama *Ndio/ Hapana* toa sababu.
11. Unategemea kujifungua/ Ulijifungua wapi mtoto wako? *Dodosa kufahamu kama mahali pa kujifungua ni/ ilikuwa ni uchaguzi wake. Kama Ndio/ Hapana toa sababu.*
12. Je ulijifungua mtoto salama? Kama *Ndio/ Hapana* toa sababu.

## Appendices

13. Je katika kipindi chochote ulichohudhuria kituo cha afya ukiwa mjamzito, uliwahi kulipia huduma yoyote? *Dodosa kufahamu ni huduma gani na sababu za kulipia.*
14. Je kuna wakati wowote ambao unashindwa/ulishindwa kumudu gharama wakati unapokuwa/ ulipokuwa katika kituo cha afya na ukawa unahitaji/ulihitaji huduma? *Kama Ndio, dodosa nini kinatokea/kilitokea?*
15. Zaidi ya gharama za huduma za afya (kama zipo/au hakuna), je unaingia/uliingia gharama nyingine zozote wakati wa ujauzito wako ili kufikia na kutumia huduma hizo? *Kama Ndiyo, kiasi gani? Je unaweza/uliweza kumudu gharama hizo? Kama Ndiyo/Hapana, toa sababu*

## Appendices

### **Access to Health Care Services among Pregnant Women in Rural Communities: In-depth Case Studies from Bagamoyo District in Tanzania**

In-depth interview guide for health workers who work at government health facilities of the selected rural communities.

#### **Context:**

Occupation

Education

Years working in the health facility

#### **General Knowledge and Perception**

1. What are health services available for pregnant women in this health facility? *Probe for antenatal, childbirth, postnatal, preventive and curative health services sought and received including HIV testing*
2. Do all pregnant women in this community use the health services available? If *Yes/ No* give reasons. *Probe for other alternative means available and sought*
3. How often do pregnant women in this community use the health services available in this community? *Probe for number and regularity of service utilisation.*
4. What are the needs of pregnant women in community e at health facilities? Please list and explain.
5. Do health services provided cater for the actual needs of pregnant women? If *Yes/ No* give reasons
6. When pregnant women attend health facilities, do they pay for services? If *Yes/No*, *Probe for which type of services and reasons why?*
7. Are pregnant women able to afford the costs for health services? If *Yes/No*, give reasons
8. What happens if pregnant women are not able to afford the costs, and are already in the health facilities and need the services?
9. What are processes for HIV testing to pregnant women at health facilities? *Probe to find out if it is voluntary done and if it could be one of reasons for pregnant women's non utilisation of health services?*
10. Do pregnant women in this community face similar problems like other nearby communities? If *Yes/ No*, give reasons.
11. What has been done in this health facility and in the community to help pregnant women to easily access and utilise available health services? *Probe for available mechanisms in the village to assist pregnant women and if they have been helpful.* If *Yes/ No* give reasons.
12. What can be done to improve the access and utilisation of these services among pregnant women living in rural communities?

**Ufikiaji wa Huduma za Afya kwa Wanawake Wajawazito Vijijini: Utafiti wa Kina katika Wilaya ya Bagamoyo, Tanzania**

Mwongozo wa mahojiano ya kina kwa ajili ya wahudumu wa afya wanaofanya kazi katika vituo vya afya vya serikali vilivyopo katika vijiji vinavyofanyiwa utafiti huu.

**Taarifa:**

Kazi

Elimu

Miaka ya kutoa huduma katika kituo cha afya

**Ufahamu wa Jumla na Mtazamo**

1. Ni huduma gani za afya zinapatikana katika kituo hiki cha afya kwa ajili ya akinamama wajawazito? *Dodosa kuhusu huduma za kabla, wakati na baada ya kujifungua, kinga na tiba zinazohitajika na kutolewa ikiwa ni pamoja na kupima maambukizi ya UKIMWI.*
2. Je wanawake wote wajawazito katika kijiji hiki wanatumia huduma za afya zinazopatikana hapa? Kama *Ndio/ Hapana* toa sababu. *Dodosa njia nyingine zinazopatikana na kutumiwa.*
3. Je ni kwa kiasi gani wanawake wajawazito katika jamii hii wanatumia huduma za afya zinazopatikana hapa? *Dodosa kufahamu kawaida na ni mara ngapi mwanamke mjamzito huweza kutumia huduma?*
4. Je ni nini mahitaji ya wanawake wajawazito katika vituo vya afya hapa kijijini. Tafadhali orodhesha na elezea
5. Je huduma za afya zitolewazo zinakidhi mahitaji ya wanawake wajawazito? Kama *Ndio/ Hapana* toa sababu.
6. Je wanawake wajawazito wanapokwenda kwenye kituo cha afya wanalipia huduma zozote? *Dodosa kufahamu ni huduma gani na sababu za kulipia*
7. Je wanawake wajawazito wanaweza kumudu gharama za huduma za afya? Kama *Ndiyo/ Hapana*, toa sababu
8. Je ni nini kinatokea iwapo wanawake wajawazito wanashindwa kumudu gharama, na tayari wanakuwa wapo katika kituo cha afya na wanahitaji huduma?
9. Taratibu za upimaji maambukizi ya UKIMWI kwa wanawake wajawazito zikoje katika vituo vya afya? *Dodosa kufahamu kama upimaji unafanywa kwa hiari na kama unaweza kuwa moja ya sababu za wanawake wajawazito kutotumia huduma za afya*
10. Je wanawake wajawazito hapa kijijini mnapata matatizo yanayofanana na vijiji vingine? Kama *Ndio/ Hapana* toa sababu.
11. Kitu gani kimeshafanyika katika kituo cha afya na katika jamii hii kusaidia wanawake wajawazito kuweza kufikia na kutumia huduma za afya zipatikanazo? *Dodosa kufahamu kama kuna mbinu kijijini za kusaidia wanawake wajawazito na kama zimekuwa za msaada kwao. Kama Ndio/ Hapana toa sababu.*
12. Kitu gani kinaweza kufanyika kuboresha ufikiaji na utumiaji wa huduma hizi kwa wanawake wajawazito wanaoishi vijijini?

**Access to Health Care Services among Pregnant Women in Rural Communities: In-depth Case Studies from Bagamoyo District in Tanzania**

Focus group discussion with husbands/ male partners with pregnant women or have had history of having pregnant women for the last 24 months

**Introduction:**

This study aims at getting a deep understanding of factors that influence access and utilisation of reproductive health services among pregnant women in rural districts. Particularly we would like to know how access to and utilisation of maternal, preventive and curative services among pregnant women living in rural communities in Bagamoyo district in Tanzania are both constrained and enabled.

1. What are the common health problems of pregnant women in your community?
2. Do you consider access and utilisation of health services among pregnant women as a major health problem in this community?
3. What are health services available for pregnant women in health facilities in this community? *Probe for antenatal, childbirth, postnatal, preventive and curative health services sought and received including HIV testing*
4. Do all pregnant women in this community use the health services available? If *Yes/ No* give reasons. *Probe for other alternative means available and sought*
5. What are the needs of pregnant women in this community at health facilities? Please list and explain.
6. Do health services provided cater for the actual needs of pregnant women? If *Yes/ No* give reasons
7. What are processes for HIV testing in pregnant women at health facilities? *Probe to find out if it is voluntary done and if it could be one of reasons for pregnant women's non utilisation of health services?*
8. When pregnant women attend health facilities, do they pay for services? If *Yes/No*, *Probe for which type of services and reasons why*
9. What happens if pregnant women are not able to afford the costs, and are already in the health facilities and need the services?
10. Apart from health services costs (if available/ or not), do pregnant women incur any other expenses during their pregnancy in order to access and utilise the services? If *Yes*, like how much? Are they able to afford the costs? If *Yes/No*, give reasons
11. Do pregnant women in this community face similar problems like other nearby communities? If *Yes/ No*, give reasons.
12. What has been done in this health facility and in the community to help pregnant women to easily access and utilise available health services? (*Probe for available mechanisms in the village to assist pregnant women and if they have been helpful*). If *Yes/ No* give reasons.
13. What can be done to improve the access and utilisation of these services among pregnant women living in rural communities?

**Ufikiaji wa Huduma za Afya kwa Wanawake Wajawazito Vijijini: Utafiti wa Kina katika Wilaya ya Bagamoyo, Tanzania**

Mwongozo wa majadiliano ya kikundi na waume/ wenza wa kiume wenye wanawake wajawazito au wenye historia ya kuwa na wanawake wajawazito kwa kipindi cha miezi isiyozidi 24 toka utafiti huu uanze

**Utangulizi:**

Dhumuni la utafiti huu ni kupata uelewa wa sababu zinazopelekea ufikiaji na utumiaji wa huduma za afya ya uzazi kwa wanawake wajawazito vijijini. Hususan, tungependa kufahamu jinsi ufikiaji na utumiaji wa huduma za uzazi, kinga na matibabu kwa akina mama wajawazito wanaoishi vijijini wilayani Bagamoyo Tanzania unakwamishwa au kuwezesha

1. Je ni matatizo gani makubwa ya kiafya yanayowapata wanawake wajawazito katika jamii yenu?
2. Je mnafikiri ufikiaji na utumiaji wa huduma za afya kwa akinamama wajawazito ni tatizo kubwa sana katika jamii yenu?
3. Ni huduma gani za afya zinapatikana katika vituo vya afya kwa ajili ya akinamama wajawazito katika kijiji hiki? *Dodosa kuhusu huduma za kabla, wakati na baada ya kujifungua, kinga na tiba zinazohitajika na kutolewa ikiwa ni pamoja na kupima maambukizi ya UKIMWI.*
4. Je wanawake wote wajawazito katika kijiji hiki wanatumia huduma za afya zinazopatikana hapa? Kama *Ndio/ Hapana* toa sababu. *Dodosa njia nyingine zinazopatikana na kutumiwa*
5. Je ni nini mahitaji ya wanawake wajawazito katika vituo vya afya hapa kijijini. Tafadhali orodhesha na elezea
6. Je huduma za afya zitolewazo zinakidhi mahitaji ya wanawake wajawazito? Kama *Ndio/ Hapana* toa sababu.
7. Taratibu za upimaji maambukizi ya UKIMWI kwa wanawake wajawazito zikoje katika vituo vya afya? *Dodosa kufahamu kama upimaji unafanywa kwa hiari na kama unaweza kuwa moja ya sababu za wanawake wajawazito kutotumia huduma za afya.*
8. Je wanawake wajawazito wanapokwenda kwenye kituo cha afya wanalipia huduma zozote? *Dodosa kufahamu ni huduma gani na sababu za kulipia.*
9. Je ni nini kinatokea iwapo wanawake wajawazito wanashindwa kumudu gharama, na tayari wanakuwa wapo katika kituo cha afya na wanahitaji huduma?
10. Zaidi ya gharama za huduma za afya (kama zipo/au hakuna), je wanawake wajawazito huwa wanaingia gharama nyingine zozote wakati wa ujauzito wao ili kufikia na kutumia huduma hizo? Kama *Ndiyo*, kama kiasi gani? Je wanaweza kumudu gharama hizo? Kama *Ndiyo/ Hapana*, toa sababu
11. Je wanawake wajawazito hapa kijijini mnapata matatizo yanayofanana na vijiji vingine? Kama *Ndio/ Hapana* toa sababu.
12. Kitu gani kimeshafanyika katika kituo cha afya na katika jamii hii kusaidia wanawake wajawazito kuweza kufikia na kutumia huduma za afya zipatikanazo? *Dodosa kufahamu kama kuna mbinu kijijini za kusaidia wanawake wajawazito na kama zimekuwa za msaada kwao. Kama Ndio/ Hapana toa sababu.*
13. Kitu gani kinaweza kufanyika kuboresha ufikiaji na utumiaji wa huduma hizi kwa wanawake wajawazito wanaoishi vijijini?

## Appendix B: Participant information sheet- English and Swahili versions

	
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<b>Participant Information Sheet</b>	
STUDY TITLE:	Access to Health Care Services among Pregnant Women in Rural Communities: In-depth Case Studies from Bagamoyo District in Tanzania
My name is Vivien Barongo and I am a student at Curtin University in Perth, Western Australia.	
You are invited to participate in the above research study which is being conducted by Associate Professor Joan Wardrop (Supervisor) Dr. Anne Marie Hilsdon (Supervisor) and me, all of the Department of Social Sciences at the Curtin University. This study is for the purpose of research and will be submitted by me in partial fulfilment of the requirements for the degree of Doctor of Philosophy at Curtin University. All data collected will be limited to this use or other research-related usage as authorised by Curtin University	
The aim of this study is to get a deep understanding of factors that influence access and utilization of reproductive health services among pregnant women in rural districts. Particularly we would like to know how access to and utilization of maternal, preventive and curative services among pregnant women living in rural communities in Bagamoyo district in Tanzania are both constrained and enabled.	
We would request you to voluntarily participate in an interview/focus group discussion that may last approximately an hour, so that we can get more detailed insights into many factors that affect pregnant women's access and utilization of such services. With your permission, the interview/focus group discussion would be tape recorded unless otherwise requested by participant, so that we can ensure that we make an accurate record of what you say and you can verify the information once the tapes have been transcribed. There may be additional follow up interviews unless otherwise requested by participant.	
We assure you that all information you provide including the signed informed consent form will be kept confidential in the secure possession of the researcher at Curtin University and will be destroyed after five years. We shall protect your anonymity and the confidentiality of your responses to the fullest possible extent. Your contact details will be kept in a separate password protected computer file from any data that you provide. In the final thesis and any publications arising from the research, you will be referred to by a pseudonym and any references to personal information that might allow someone to guess your identity will be removed.	
Your participation in the study contribute both to scholarly understandings of issues around access to health care for rural women in developing countries, and to processes of transformation in policy and practices in developing countries through revisions, enhancement and the	
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## Appendices

development of new forms of access to health care services, more comprehensively designed empirical research on access to care, and practical models to assist policy makers design programs that better meet the needs of individuals and communities. There are no risks associated with participating in the study.

Once the thesis arising from this research has been completed, a summary of the research findings will be available to you upon request at the Department of Social Sciences.

Please be advised that your participation in this study is completely voluntary. Should you wish to withdraw at any stage, or to withdraw any unprocessed data you have provided, you are free to do so without explanation or any repercussion.

If you would like to participate, please indicate that you have read and/or understood this information by signing the accompanying consent form provided, with a duplicate copy for you to keep. We shall then start, or arrange a mutually convenient time for you to participate in an interview/focus group discussion.

Should you require any further information or have concerns, please do not hesitate to contact either of the researchers; Associate Professor Wardrop +61 8 9266 7688, Dr. Hilsdon +61 8 9266 3349 and Ms. Barongo +61 426856511.

This study has been approved by the Curtin University Human Research Ethics Committee with approval number HR 24/2012. Should you wish to make a complaint on ethical grounds you are welcome to contact Secretary to the Human Research Ethics Committee (phone 9266 2784 or [hrec@curtin.edu.au](mailto:hrec@curtin.edu.au) or in writing C/- Office of Research and Development, Curtin University of Technology, GPO Box U1987,mPerth WA 6845)



**Karatasi ya Maelezo ya Mshiriki Utafiti**

JINA LA UTAFITI: Ufikiaji wa Huduma za Afya kwa Wanawake Wajawazito Vijijini:  
Utafiti wa Kina katika Wilaya ya Bagamoyo, Tanzania

Jina langu naitwa Vivien Barongo, na ni mwanafunzi katika Chuo Kikuu cha Curtin, Perth, Australia Magharibi

Unakaribishwa kushiriki katika utafiti ambao unafanywa na Profesa Mshiriki Joan Wardrop(Msimamizi), Daktari Anne- Marie Hilsdon (Msimamizi) na mimi, wote wa Idara ya Sayansi za Jamii katika Chuo Kikuu cha Curtin. Uchunguzi huu ni kwa ajili ya utafiti tu utakabidhiwa na mimi kama sehemu ya mahitaji ya kukamilisha digrii ya uzamivu katika Chuo Kikuu cha Curtin. Makusanyo ya taarifa zote zitakazotolewa ni kwa ajili ya utafiti huu na mwingine unaohusiana kama utakavyokuwa umeruhusiwa na Chuo Kikuu cha Curtin

Dhumuni la utafiti huu ni kupata uelewa wa sababu zinazopelekea ufikiaji na utumiaji wa huduma za afya ya uzazi kwa wanawake wajawazito vijijini. Hususan, tungependa kufahamu jinsi ufikiaji na utumiaji wa huduma za uzazi, kinga na matibabu kwa akina mama wajawazito wanaoishi vijijini wilayani Bagamoyo Tanzania unakwamishwa au kuwezesha.

Tunakuomba ushiriki wako wa hiari katika mahojiano/ majadiliano ya kikundi ambayo yanaweza kuchukua kiasi cha saa nzima, ili tuweze kupata taarifa za kina zaidi kuhusu sababu zinazoathiri wanawake wajawazito katika ufikiaji na utumiaji wa huduma hizi. Kwa ruhusa yako, mahojiano/ majadiliano ya kikundi yatarekodiwa kabla utakubali, ili tuweze kuhakikisha kuwa tunapata kumbukumbu sahihi ya ulichozungumzia na ukaweza kuhakiki taarifa hiyo tukishaifanyia kazi.

Tunakuhakikishia kwamba taarifa zote utakazotoa hapa ikiwa ni pamoja na fomu ya kukubali ushiriki utakayoivekea sahihi zitatumizwa kwa usiri katika mikono ya mtafiti katika Chuo Kikuu cha Curtin na zitaharibiwa baada ya miaka mitano kupita. Tutazuia wewe kufahamika na majibu yako yatatumizwa katika usiri wa hali ya juu. Taarifa za mawasiliano yako zitatumizwa kwenye kompyuta na kuwekwa kizuizi cha mtu kuzifikia. Katika andiko la mwisho la utafiti huu au machapisho yoyote yatakayotokana na utafiti huu jina lako halitatumika badala yake litatumika jina la kutunga, na viashirio vyovyote vitavyoweza kufanya mtu ahisi kuwa ni wewe unayezungumziwa vitaondolewa.

Ushiriki wako katika utafiti huu utasaidia uelewa wa mambo mbalimbali yanayohusiana na ufikiaji wa huduma za afya kwa wanawake vijijini katika nchi zinazoendelea na pia katika kubadili sera na uendeshaji wa huduma hizo katika nchi hizi kwa kupitia, kurekebisha na kutunga njia mpya za ufikiaji wa huduma za afya, na zaidi kuelewa jinsi ya kufanya utafiti katika nyanja

## Appendices

hii na kusaidia wana sera kutunga miradi ambayo inakidhi mahitaji ya mtu na wananchi. Hakuna athari katika ushiriki wa utafiti huu.

Andiko litokanalo na utafiti huu litakapokamilika, taarifa fupi ya matokeo ya utafiti huu itapatikana kwako kwa kufanya maombi katika Idara ya Sayansi za Jamii.

Tafadhali fahamu kuwa ushiriki katika utafiti huu ni wa hiari. Kama utapenda kujitua wakati wowote, au kutoa taarifa zozote utakazokuwa umetoa, una uhuru wa kufanya hivyo bila kutoa maelezo yoyote au kupata athari yoyote.

Kama ungependa kushiriki, tafadhali onyesha kuwa umesoma na/au kuelewa taarifa hii kwa kutia sahihi fomu ya kukubali ushiriki iliyoambatanishwa yenye kivuli kwa ajili ya kumbukumbu yako. Tutaanza au kupanga muda ambao ni muafaka kwako kwa ajili ya ushiriki katika mahojiano/ majadiliano ya kikundi.

Kama utakuwa unahitaji taarifa yoyote zaidi au una hoja, usisite kuwasiliana na mtafiti yoyote kati ya; Profesa Mshiriki Wardrop +61 8 9266 7688, Daktari Hilsdon +61 8 9266 3349 na Bi. Barongo +61 426856511.

Utafiti huu umekubaliwa kufanyika na Chuo Kikuu cha Curtin, Kamati ya Maadili ya Tafiti zinazohusu Wanadamu kwa namba HR 24/2012. Kama utapenda kutoa malalamiko kuhusiana na maadili, unakaribishwa kuwasiliana na Katibu wa Kamati ya Maadili ya Tafiti zinazohusu Wanadamu (simu 9266 2784 au barua pepe [hrec@curtin.edu.au](mailto:hrec@curtin.edu.au) au kwa kuandika C/- Office of Research and Development, Curtin University of Technology, GPO Box U1987,mPerth WA 6845)

## Appendix C: Participant consent form- English and Swahili versions

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Department of Social Sciences School of Social Sciences and Asian Languages Faculty of Humanities	
<b>Informed Consent Form for Study Participants</b>	
STUDY TITLE:	Access to Health Care Services among Pregnant Women in Rural Communities: In-depth Case Studies from Bagamoyo District in Tanzania
Name of participant:	_____
Name of researcher:	_____
<b>Participant's Understanding</b>	
<ul style="list-style-type: none"><li>• I agree to participate in this study of which the details have been explained and provided to me in an information sheet to keep.</li><li>• I understand the study is for the purpose of research and that will be submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy at Curtin University</li><li>• I understand that my participation is voluntary.</li><li>• I understand that all data collected will be limited to this use or other research- related usage as authorised by Curtin University</li><li>• I am aware that all records of the information I provide will be kept confidential in the secure possession of the researcher.</li><li>• I understand that my participation will involve an interview/ focus group discussion/ observation and I agree that the researcher may use the results as described in the information sheet.</li><li>• I have been informed that with my consent the interview will be audio-taped and I understand that audio-tapes will be stored at Curtin University and will be destroyed after five years;</li><li>• I understand the benefit of my participation in the study and that there are no risks associated with participating in the study.</li><li>• I understand that I will not be identified by name in the final thesis or any publications arising from the research;</li><li>• I have been informed that a summary of the research findings will be available to me upon request.</li><li>• I acknowledge that the contact information of the researcher and her supervisors have been made available to me along with a duplicate copy of this consent form</li><li>• I understand that after I sign and return this consent form it will be retained by the researcher.</li><li>• I understand that I may withdraw from the study at any time without explanation or any repercussion and to withdraw any unprocessed data I have provided.</li></ul>	
I consent to this interview/ focus group discussion being audio-taped	<input type="checkbox"/> yes <input type="checkbox"/> no (please tick)
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Appendices

I wish to receive a copy of the summary study report on research findings  yes  no  
(please tick)

By signing below, I acknowledge that I have read and/ or understood the above information.

Participant signature: \_\_\_\_\_ Date: \_\_\_\_\_



Idara ya Sayansi za Jamii  
Shule ya Sayansi za Jamii na Lugha za Asia  
Kitivo cha Sanaa

**Fomu ya Kukubali Ushiriki kwa ajili ya Washiriki wa Utafiti**

JINA LA UTAFITI: Ufikiaji wa Huduma za Afya kwa Wanawake Wajawazito Vijijini:  
Utafiti wa Kina katika Wilaya ya Bagamoyo, Tanzania

Jina la mshiriki: \_\_\_\_\_

Jina la mtafiti: \_\_\_\_\_

**Uelewa wa mshiriki**

- Nakubali kushiriki katika utafiti huu ambao taarifa zake kamili nimeelezwa na kupewa katika karatasi ya maelezo kwa ajili ya kumbukumbu yangu.
- Naelewa kuwa uchunguzi huu ni kwa ajili ya utafiti huu na kwamba utakabidhiwa kama sehemu ya mahitaji ya kukamilisha digrii ya uzamivu katika Chuo Kikuu cha Curtin
- Naelewa kuwa ushiriki wangu ni wa hiari.
- Naelewa kuwa makusanyo ya taarifa zote nitakazozitoa ni kwa ajili ya utafiti huu na mwingine unaohusiana kama utakavyokuwa umeruhusiwa na Chuo Kikuu cha Curtin
- Ninafahamu kuwa taarifa zote nitakazotoa zitatumizwa kwa usiri katika mikono ya mtafiti.
- Naelewa ushiriki wangu utahusu mahojiano/ majadiliano ya kikundi/utazamaji na nakubali mtafiti atumie matokeo yangu kama ilivyoelezwa kwenye karatasi ya maelezo.
- Nimetaarifiwa kwamba kwa ruhusa yangu, mahojiano yatarekodiwa na naelewa kuwa kanda zake zitatumizwa katika Chuo Kikuu cha Curtin na zitaharibiwa baada ya miaka mitano kupita.
- Naelewa faida ya ushiriki wangu katika utafiti huu na kwamba hakuna athari zinazohusiana na kushiriki katika utafiti huu.
- Naelewa kwamba jina langu halitatumika katika andiko la mwisho la utafiti huu au machapisho yoyote yatakayotokana na utafiti huu.
- Nimefahamisha kuwa taarifa fupi ya matokeo ya utafiti itapatikana kama nitaiomba.
- Nakubali kuwa nimepewa taarifa za mawasiliano ya mtafiti na wasimamizi wake pamoja na kopi ya fomu ya kukubali ushiriki katika utafiti
- Naelewa kuwa baada ya kutia sahihi na kurudisha fomu ya kukubali ushiriki katika utafiti, mtafiti ataitunza.
- Naelewa kuwa naweza kujitoa katika utafiti wakati wowote bila kutoa maelezo au kupata athari yoyote na kutoa taarifa zozote nitakazokuwa nimetoa.

Nakubali kushiriki na mahojiano/majadiliano ya kikundi kurekodiwa  ndiyo  hapana  
(weka alama)

Ningependa kupata taarifa fupi ya matokeo ya utafiti huu  ndiyo  hapana  
(weak alama)

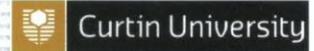
Kwa kutia sahihi, nakubali kuwa nimesoma na/au kuelewa taarifa iliyotolewa hapo juu.

Appendices



Sahihi ya mshiriki: \_\_\_\_\_ Tarehe: \_\_\_\_\_

## Appendix D: Letter of introduction



**School of Social Sciences &  
Asian Languages**

GPO Box U1987  
Perth Western Australia 6845

**Telephone** +61 8 9266 4997  
**Facsimile** +61 8 9266 3166  
**Email** B.Pokrant@curtin.edu.au  
**Web** www.curtin.edu.au

29 May 2012

To whom it may concern,

**Re: Letter of Introduction**

The bearer of this letter, Ms Vivien Barongo, is a doctoral student with the School of Social Sciences and Asian Languages at Curtin University. During her time in Tanzania, she will be engaged in field work for her PhD dissertation entitled: Access to Health Care Services among Pregnant Women in Rural Communities: In-depth Case Studies from Bagamoyo District in Tanzania.

I would appreciate it if you could assist Ms Barongo with her research. If you have any questions about the student and her research, please let me know. You can also contact her supervisor, Associate Professor Joan Wardrop at [J.Wardrop@curtin.edu.au](mailto:J.Wardrop@curtin.edu.au)

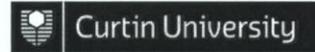
Many thanks for your assistance.

Yours faithfully,

A handwritten signature in black ink, appearing to read "B. Pokrant".

Professor Bob Pokrant  
Head of School  
Social Sciences and Asian Languages

## Appendix E: Ethics clearance letters



### Memorandum

<b>To</b>	Associate Professor Joan Wardrop, Department of Social Sciences
<b>From</b>	Professor Stephan Millett, Chair, Human Research Ethics Committee
<b>Subject</b>	Protocol Approval HR 24/2012
<b>Date</b>	4 April 2012
<b>Copy</b>	Ms Vivien Kokutangilila Barongo, Department of Social Sciences Dr Anne-Marie Hillsdon, Department of Social Sciences

Office of Research and Development  
Human Research Ethics Committee

**TELEPHONE** 9266 2784  
**FACSIMILE** 9266 3793  
**EMAIL** hrec@curtin.edu.au

Thank you for your application (4238) submitted to the Human Research Ethics Committee (HREC) for the project titled "*Access to health care services among pregnant women in rural communities: in-depth case studies from Bagamoyo District in Tanzania*". Your application has been reviewed by the HREC and is **approved**.

- You have ethics clearance to undertake the research as stated in your proposal.
- The approval number for your project is **HR 24/2012**. Please quote this number in any future correspondence.
- Approval of this project is for a period of twelve months **03-04-2012** to **03-04-2013**. To renew this approval a completed Form B (attached) must be submitted before the expiry date **03-04-2013**.
- Your project is the following special conditions: NIL

#### Applicants should note the following:

It is the policy of the HREC to conduct random audits on a percentage of approved projects. These audits may be conducted at any time after the project starts. In cases where the HREC considers that there may be a risk of adverse events, or where participants may be especially vulnerable, the HREC may request the chief investigator to provide an outcomes report, including information on follow-up of participants.

The attached **FORM B** should be completed and returned to the Secretary, HREC, C/- Office of Research & Development:

When the project has finished, or

- If at any time during the twelve months changes/amendments occur, or
- If a serious or unexpected adverse event occurs, or
- 14 days prior to the expiry date if renewal is required.
- An application for renewal may be made with a Form B three years running, after which a new application form (Form A), providing comprehensive details, must be submitted.

Yours sincerely,

SM  
Professor Stephan Millett  
Chair Human Research Ethics Committee

THE UNITED REPUBLIC OF  
TANZANIA



National Institute for Medical Research  
P.O. Box 9653  
Dar es Salaam  
Tel: 255 22 2121400/390  
Fax: 255 22 2121380/2121360  
E-mail: [headquarters@nimr.or.tz](mailto:headquarters@nimr.or.tz)  
NIMR/HQ/R.8a/Vol. IX/1398

Ministry of Health and Social Welfare  
P.O. Box 9083  
Dar es Salaam  
Tel: 255 22 2120262-7  
Fax: 255 22 2110986

02 October, 2012

Vivien K Barongo  
PhD Student Curtin University, Australia  
National Institute for Medical Research, NIMR Headquarters  
P O Box 9653, Dar es Salaam

**CLEARANCE CERTIFICATE FOR CONDUCTING  
MEDICAL RESEARCH IN TANZANIA**

This is to certify that the research entitled: Access to Health Care Services Among Pregnant Women in Rural Communities: In-depth Case Studies from Bagamoyo District, Coast Region, Tanzania (Barongo V K *et al*), has been granted ethical clearance to be conducted in Tanzania.

The Principal Investigator of the study must ensure that the following conditions are fulfilled:

1. Progress report is submitted to the Ministry of Health and the National Institute for Medical Research, Regional and District Medical Officers after every six months.
2. Permission to publish the results is obtained from National Institute for Medical Research.
3. Copies of final publications are made available to the Ministry of Health & Social Welfare and the National Institute for Medical Research.
4. Any researcher, who contravenes or fails to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine. NIMR Act No. 23 of 1979, PART III Section 10(2).
5. Approval is for one year: 02<sup>nd</sup> October, 2012 to 01<sup>st</sup> October, 2013.

Name: Dr Mwelecele N Malecela

Name: Dr Donan Mmbando

Signature

Signature

CHAIRPERSON  
MEDICAL RESEARCH  
COORDINATING COMMITTEE

ACTING CHIEF MEDICAL OFFICER  
MINISTRY OF HEALTH, SOCIAL  
WELFARE

CC: RMO  
DMO

## Appendix F: Permission letters to conduct research

### HALMASHAURI YA WILAYA YA BAGAMOYO

Tel. 023 2440008  
Fax: 023 2440338

Ofisi ya Mganga Mkuu,  
S. L.P. 29,  
BAGAMOYO.



Kumb. HWB/I.20/42/VOL IX/86

16/11/2012

Mtendaji Kijiji

KEREGE

BAGAMOYO

**YAH: KUMTAMBULISHA KWENU BI. VIVIEN K. BARONGO MTAFTI KUTOKA TAASISI YA TAIFA YA UTAFTI WA MAGONJWA YA BINADAMU (NIMR)**

Husika na kichwa cha habari hapo juu

Bi Vivien K. Barongo ni mfanyakazi katika Taasisi ya Taifa ya Utafiti wa Magonjwa ya Binadamu (National Institute for Medical Research- NIMR). Kwa sasa anachukua masomo ya Udaktari kutoka katika Chuo Kikuu cha Curtin kilichopo nchini Australia.

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Kwa kuwa mtafiti huyo atapenda kukutana na akina mama wajawazito katika maeneo yetu, tunaomba apewe ushirikiano wa kutosha ili kufanikisha utafiti huo. Ikumbukwe kuwa amepewa ruhusa kufanya utafiti wake kuanzia tarehe 02 Oktoba 2012 mpaka tarehe 01 Oktoba 2013

Nawasilisha

A handwritten signature in black ink, appearing to read 'Bonaventure Sagamila'.

Bonaventure Sagamila

Kny Mganga Mkuu (W)

BAGAMOYO

**KNY: MGANGA MKUU (W)**  
S.L.P. 29  
BAGAMOYO

Nakala: Mtendaji Kata

BAGAMOYO

**HALMASHAURI YA WILAYA YA BAGAMOYO**

Tel. 023 2440008

Fax: 023 2440338

Ofisi ya Mganga Mkuu,

S. L.P. 29,

**BAGAMOYO.**



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16/11/2012

Mtendaji Kijiji  
MATUMBEI  
BAGAMOYO

**YAH: KUMTAMBULISHA KWENU BI. VIVIEN K. BARONGO MTAFIGI KUTOKA TAASISI YA TAIFA  
YA UTAFIGI WA MAGONJWA YA BINADAMU (NIMR)**

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Nawasilisha

  
Bonaventure Sagamilwa

Kny Mganga Mkuu (W)

**BAGAMOYO**

**KNY. MGANGA MKUU (W)  
S.L.P. 29  
BAGAMOYO**

Nakala: Mtendaji Kata  
BAGAMOYO

HALMASHAURI YA WILAYA YA BAGAMOYO

Tel. 023 2440008

Fax: 023 2440338

Ofisi ya Mganga Mkuu,

S. L.P. 29,

BAGAMOYO.



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16/11/2012

Mganga Mfawidhi  
KEREGE DISPENSARY  
BAGAMOYO

**YAH: KUMTAMBULISHA KWENU BI. VIVIEN K. BARONGO MTAFIGI KUTOKA TAASISI YA TAIFA  
YA UTAFIGI WA MAGONJWA YA BINADAMU (NIMR)**

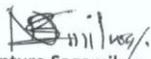
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Nawasilisha

  
Bonaventure Sagamilwa

Kny Mganga Mkuu (W)

BAGAMOYO

Nakala: Mtendaji Kata

BAGAMOYO

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**S.L.P. 29**  
**BAGAMOYO**

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Ofisi ya Mganga Mkuu,  
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Mtendaji Kijiji  
KIROMO  
BAGAMOYO

**YAH: KUMTAMBULISHA KWENU BI. VIVIEN K. BARONGO MTAFIGI KUTOKA TAASISI YA TAIFA YA UTAFIGI WA MAGONJWA YA BINADAMU (NIMR)**

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Nakala: Mtendaji Kata  
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S.L.P. 29  
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Tel. 023 2440008  
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Ofisi ya Mganga Mkuu,  
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Mtendaji Kijiji  
KITOPENI  
BAGAMOYO

**YAH: KUMTAMBULISHA KWENU BI. VIVIEN K. BARONGO MTAFIGI KUTOKA TAASISI YA TAIFA YA UTAFIGI WA MAGONJWA YA BINADAMU (NIMR)**

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Nawasilisha

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Bonaventure Sagamilwa

Kny Mganga Mkuu (W)

BAGAMOYO

**KNY: MGANGA MKUU (W)  
S.L.P. 29  
BAGAMOYO**

Nakala: Mtendaji Kata  
BAGAMOYO

HALMASHAURI YA WILAYA YA BAGAMOYO

Tel. 023 2440008

Fax: 023 2440338

Ofisi ya Mganga Mkuu,

S. L.P. 29,

BAGAMOYO.



Kumb. HWB/1.20/42/VOL IX/86

16/11/2012

Mganga Mfawidhi

*KIROMO DISPENSARY*

**BAGAMOYO**

**YAH: KUMTAMBULISHA KWENU BI. VIVIEN K. BARONGO MTAFIGI KUTOKA TAASISI YA TAIFA YA UTAFIGI WA MAGONJWA YA BINADAMU (NIMR)**

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Nawasilisha

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Bonaventure Sagamiliwa

Kny Mganga Mkuu (W)

**BAGAMOYO**

**KNY: MGANGA MKUU (W)**

**S.L.P. 29  
BAGAMOYO**

Nakala: Mtendaji Kata

**BAGAMOYO**

### Appendix G: Timeline

The study and writing began September 2011, and the completed thesis submitted in June 2015.

<b>Months and Years</b>	<b>Activity</b>	<b>Duration</b>
September 2011 – March 2012	Background reading Development of research proposal Completion and submission of; - Candidacy proposal - Application for human ethics research- Curtin University	6 months
April 2012- November 2012	Application for national ethical approval in Tanzania- NIMR Preparation for fieldwork Actual fieldwork in Tanzania - Conducting interviews with pregnant women and others relevant to the research - Conducting further interviews - Data analysis and preliminary writing - Conducting further interviews	9 months
December 2012- December 2014	Data analysis Writing first draft of thesis Correction and revision of the thesis Further revision, editing and compilation of the thesis Submission of the first draft of the thesis	24 months
February- June 2015	Final revision, editing and compilation Submission of the final thesis	5 months