FACTORS INFLUENCING PLACE OF DELIVERY AMONG PREGNANT WOMEN IN KISARAWE DISTRICT

By
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A dissertation submitted in partial fulfilment of requirements for the degree of Master of Public Health in the University of Dar es Salaam.

University of Dar es Salaam

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CERTIFICATION

The undersigned certify that he has read and hereby recommend for acceptance by the University of Dar es Salaam a dissertation entitled: *Factors influencing place of delivery among pregnant women in Kisarawe* district, in partial fulfillment of the requirements for the degree of Master of Public Health.

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PROF. LESHABARI, M.T

(SUPERVISOR)

Date. March 21st 2007

DECLARATION

AND

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I, Deogratius Rutatwa Peter, declare that this dissertation is my original work and that it has not been submitted and will not be submitted to any other university for a similar degree award.

Candidate's signature.....

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DEDICATION

This work is dedicated to my wife Anita and our beloved daughter Doreen, my parents in law Mr. and Mrs. Dominic Kagirwa, and the late Mr. Rustamal N Ladha and the late Mr. A Kahwa.

LIST OF TABLES

LIST OF ABBREVIATIONS

ANC	Antenatal Care
DHMT	District Health Management Team
ICPD	International Conference on Population and Development
EDD	Expected Date of Delivery
MCH	Maternal and Child Health
MoH	Ministry of Health
MUCHS	Muhimbili University College of Health Sciences
PMM	Prevention of Maternal Mortality network.
SARA	Support for Analysis and Research in Africa
SMI	Safe Motherhood Initiative
TBAs	Traditional birth attendant(s)
TDHS	Tanzania Demographic and Health Survey
UNICEF	United Nations Children's Fund
WHD	World Health Day
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

Background information

Maternal health has always been a priority area of concern in developing countries. Millions of women do not have access to good quality health service during pregnancy and childbirth especially those who live in the rural areas (AbouZahir, 1997). Each year sixty million deliveries take place with assistance of unskilled birth attendants including family members, untrained traditional birth attendants, and sometimes with none.

Every year about 600,000 women die from complications related to pregnancy especially during or after delivery (WHO, 1998). About 99% of these deaths occur in the developing countries and less than one percent occurs in developed countries (Post, 1997). In developed countries, high quality and accessible health care has made maternal death a rare event and the risk to women's health has been greatly reduced.

Large discrepancies continue to exist in access to maternal health care for pregnant mothers between developed countries and developing countries (WHO, 1997). In developing countries 65% of women make at least one antenatal visit and 53% give birth with a skilled attendant (WHO, 1998). In contrast, in developed countries 97% of women make at least one antenatal visit and 99% deliver with skilled attendant (such as doctors or nurses). In Africa alone 63% of pregnant women make at least

one antenatal visit and about 42% of all pregnant women deliver with skilled birth attendants (WHO, 1997).

The existence of health care facilities does not automatically assure their use and that women use differential antenatal care and delivery services (WHO, 1997). Social, economic and cultural environment, distance to health facilities, health care costs, risk perception of pregnancy and perceived quality of care are some of the factors which influence use of health services (Thaddeus, 1994). Others include multiple demands on women's time and decision-making power (WHO, 1998). In this case, ensuring that women have access to maternal health care, particularly at delivery and in case of complications is very essential to saving their lives.

The Tanzanian situation

In the context of Tanzania, available data show that 97% of all pregnant mothers attend antenatal care (TDHS, 1996). However, like in other developing countries the proportion of women who deliver in health facilities during delivery is lower than those who receive antenatal care (AbouZahr, 1997).

Only 47% of pregnant women deliver in health facilities and 53% deliver at home (TDHS, 1996). In rural Tanzania alone, about 57% of all maternal deliveries take place at home and 40% take place in health facilities while the rest 3% deliver on the way to health facilities. Studies show that in rural districts of Tanzania there is low institutional deliveries, many women deliver at home (Mcleod and Rhode, 1993).

Attempts to improve access to maternal health care through Safe Motherhood initiative in Tanzania have been in place since its inception in1987 (MOH, 1999). This initiative has improved pregnant women's access to antenatal care (MOH, 1999, Corea, 1998). The gap between the use of health facilities for delivery, and home delivery among pregnant women still exists despite the high rate of attendance of antenatal care nation-wide (Urassa, 1995, Corea, 1998). However it is unclear whether existing health facilities can handle all deliveries if all pregnant women decide to use them.

The existing gap has necessitated the need to find out factors that have to be considered into making a significant improvement on pregnant women's access to maternal health services especially during delivery.

STATEMENT OF THE PROBLEM

Although the attendance of pregnant women for antenatal care in the country is very high, a relatively small proportion of them deliver in existing health facilities. A gap between institutional and home deliveries continues to exist across regions and districts in the country. Many women intend to deliver in health facilities but end up delivering at home. Reasons behind the gap between the intention on where to deliver and the actual place of delivery are not well known.

There are many factors that may influence the use or non-use of health facilities for delivery. These factors may include service factors, distance, and lack of transport, costs, social cultural and economic factors such as education, gender, social status, knowledge on pregnancy complications, attitude of health providers and also availability of alternative care.

Available information shows that some pregnant women intend to deliver in a health facility but fail to do so. For example Biego, (1995) showed that more of pregnant women who gave birth at home had intended to deliver in a health facility. Various reasons such as lack of transport, long distance, and rudeness of health workers were cited as barriers for them to use health facilities for delivery care. On the other hand some women do not intend to deliver in a health facility for reasons which are yet to be explored. In both categories there is a need to establish factors that influence pregnant women to have their deliveries at the place where they deliver. Such information will provide an important background for interventions targeting maternal and child health.

OBJECTIVES OF THE STUDY

General objective

This study intended to investigate and describe factors that influence pregnant women's place of delivery during childbirth for the purpose of obtaining the information that will help to improve the utilization of health facilities for delivery care in Kisarawe district.

Specific objectives

The study specifically intended to:

- Determine the proportion of pregnant women in the study area who attended antenatal care during their last pregnancy.
- Determine where pregnant women delivered during their last delivery.
- To explore factors that influenced pregnant women to deliver on the place where they delivered during their last delivery.
- To identify the decision-making process related to delivery care at the household level in the study area.
- To explore the local meanings attributed to childbirth complications that occur during labour.

RATIONALE OF THE STUDY

The need to narrow the gap between health facility delivery and home delivery is of great importance particularly given existing high rates of maternal morbidity and mortality. This study was designed to provide data on reasons behind choices made by pregnant women on where to deliver. The information generated will hopefully be useful not only for improving service delivery and policy in maternal health but would also precipitate important areas for further research.

CHAPTER TWO

LITERATURE REVIEW

Introduction

In the context of the 1994 International conference on Population and Development in Cairo, maternal health was recognized as an important aspect of women's general health (United Nations, 1995). Access to quality health care services during pregnancy and delivery is very crucial in ensuring the survival and wellbeing of pregnant women. However, even with good access to existing maternal health services, these fail to have an effect if pregnant women do not use them. Coverage rates for antenatal care and deliveries in health facilities vary widely and often show a great discrepancy between a high attendance of antenatal care and much lower use of delivery services at the same place (WHO, 1997).

The data on the use of maternal services worldwide shows that during pregnancy the percentage of women who seek antenatal care at least once is 63% in Africa, 65% in Asia and 73% in Latin America and the Caribbean (WHO, 1994). Almost half of the births in developing countries take place without the assistance of skilled birth attendant (such as doctors or mid wives).

In response to this situation the global Safe Motherhood Initiative (SMI) was launched in 1987 with an aim of raising awareness and stimulating national action to improve maternal health (WHO, 1998; MOH, 1999). The strategy put forward by

the SMI was that women with obstetric complications should have access to emergency medical care if maternal deaths were to be substantially reduced.

Models that explain women's barriers to seeking health services have been developed. According to Kutzin (1999), the obstacles that limit use of health services by women are of several types. These include household obstacles such as resource allocation and discrimination of women against financial means to access health services. In this regard many households are not willing to commit resources to female household members for health care. Lack of education, cultural norms, also impede women's access to health care in some societies.

Gender is another dimension which has been used to also explain how social constructed differences among men and women prevent women from utilizing heath services (Kumar, 1998; Pohjomen, 1997). It is shown that the obstacles that women face in accessing maternal health care are largely social, cultural and economic; and these are intertwined with gender inequality reflected in women's lower status in the society.

Delay in deciding to seek care is another important factor that influence pregnant women in accessing maternal health care in time. A "Three delays Model" stipulates that the decision to seek care is the first step that must occur if a woman with pregnancy complication is to receive obstetric care (PMM, 1992). Most studies reviewed by Thaddeus and Maine (1994) show that the decision to seek care is a process that occurs in stages and may be influenced by various factors that can also

influence the cause of action. Factors such as women's economic status, education, autonomy in the family, perceived severity of the complication, distance, and quality of health care could influence women not to seek health care at a health facility.

Recognition of signs and perception of risks

Perceived severity and recognition of signs of pregnancy complication are also very essential in influencing women to seek maternal health care (Kroeger, 1988,Kowalewiski, 1997). The ability of a pregnant woman and her family to recognize life-threatening complications is very essential in seeking care. For example studies from Nigeria and Siera Leone showed that prolonged labour was not recognized as a complication and reason to seek care until two to five days had elapsed (PMM, 1992). Among Bariba tribe of Benin, labor that lasts up to a day is considered as normal and thus is not recognized as dangerous (Sargeant, 1985). Failure to recognize the symptoms and severity of health conditions also were cited as a major reason for delay in seeking care in a study from Zimbabwe (Fawcus et al, 1996).

Findings from a study in Cairo revealed that, women perceive giving birth as a "natural process" that does not require pre natal care (Kane 1986, Hoodfar, 1986). Since modern medicine is typically associated with illness and because pregnancy is not perceived as posing significant health risks to the mother, many women do not seek care from modern health facilities provided. It is therefore important to look at this view in the Tanzanian context if we are to improve maternal health in the country.

The conflict between biomedical and traditional health systems with respect to disease causality influence decision taken during illness. In this light the reference is made to the distinction between popular and professional systems of health care basing on the theory of disease causation whereby perceived causes of illness influence one's choice of health care. This is relevant particularly to pregnancy, where complications might be given different cultural meanings. In Ghana for example, a prolonged period of labour is deemed to be punishment for past infidelity and women are forced to confess their "misdeeds" so that labour may continue without complications (Aloysius, 1999).

Available reports show that women even agreed to have been involved in such affairs even where they had not committed such offences. Consequently, in addition to psychological trauma suffered by the women, this belief delays the seeking for emergence care since the meanings attributed to the problem are not in line with what is expected from modern health care facility (Diallo, 1999).

Findings from one Nigerian study also revealed that cultural meanings were attributed to haemorrhage (Chiwuzie et al, 1995). In this case it was believed that super natural forces caused haemorrhage both in pregnancy and during delivery, which could not therefore be treated in the modern medicine. As a result women continued to seek care from traditional birth attendants and traditional healers even when haemorrhage was present. In this study it was also reported that obstructed

labour was associated with adultery or evil spirits and therefore a pastor is called in for prayer in response to such obstetric emergencies (Chiwuzie et al, 1995).

In Senegal there is a practice of inducing bleeding before or after delivery supposedly to clean the womb of the bad blood (Dia, 1989). In this culture it is believed that a severe bleeding is a good sign because the body is eliminating the bad blood to be replaced by new one. Also in other countries in Africa, among pregnant women a deep cut is made in the interior wall of the vagina, sometimes on the posterior wall. This is known as "Zur Zur"(United nations, 1996). The purpose of this practice is to prepare the woman for an easy delivery. However the consequences can sometimes result in death due to excessive bleeding, shock, infection of the birth canal, and vesicovaginal, or vaginal fistula. Such practices also limit women to access health facilities since they fear and feel ashamed of having their vagina with wound to be seen by nurses when they develop more sufferings and complications.

Social status

Acquisition of social status among women plays an important role in influencing decision to seek care. For example in areas where stoicism is valued, women who suffer pregnancy complication are not reported. If they suffer in silence family members may have difficulty in identifying the problem for instance of a prolonged labor. In this case enduring labor and performing an unassisted delivery is deemed a sign of women's courage and a route to social respect among Benin and Togo

women. This is because of stoicism and bravery, which is culturally, determined (Diallo, 1999, Aloysius, 1996, Sargent, 1985,Maine, 1997).

Societal expectations interfere with the use of health services in emergency conditions (Post, 1997). Delivery at home remains a way for women to achieve status. For example a woman who has to go to a hospital for delivery is thought to have failed in her essential role as a woman and is therefore stigmatized (PPM, 1992). It is also pointed out that women in the lesser-developed countries are culturally socialized to view vaginal delivery as a fulfillment of femininity. It is often considered a failure of womanhood to deliver by Caesarian section. So women will do everything to avoid it. Little is known about similar interpretations from communities in Tanzania.

Acsad,G and Acsad,J (1993) in their analyses on cultural barriers to utilization of health services cited some examples from Africa, Latin America, the Caribbean, and South Asia, showing that in many cultures pain and illness are considered to be a normal part of women's lives and are thus not worthy for medical attention. In South Asia and some parts of Sub Saharan Africa the decision for a woman to seek medical care is not made by the woman herself but her husband, mother in law, village elders or other family or community members. Also there are other cultural restrictions on male health care providers where in many cases women will not seek treatment from these providers because of the belief that they should not be seen by any male other than close relative (Kane, 1986). These factors contribute towards women's access to maternal health care in the society.

Distance and transportation

Distance alone, to the health facility is reported to be not a significant barrier to access health facilities particularly during labour. It is shaped by other factors such as the cost and quality of care (Thaddeus and Maine, 1994), perceived severity of illness and the reputation of the health facility (Stock, 1983), condition of the road and weather (MoH, 1999). Distance is also considered in relation to availability and means of transport and geographical accessibility of the health facility (Post, 1997).

Availability and cost of health care

Women's ability to access health services depends largely on a range of factors beyond mere availability of health services (Thaddeus and Maine1994). Such factors include financial costs of receiving care that include transportation costs, physician and facility fees (if they exist), the cost of medication and other supplies.

Decision making process

Making decision is a very crucial determining factor in seeking health care. Deciding where and when to seek health care is a process that is determined by several factors. Knowing and defining a health problem and having knowledge of alternatives implies the defining of preferences and making the best possible choice of health care (Leger, 1994).

With regard to decisions if and when to seek care in pregnancy and childbirth, Thaddeus and Maine (1994), identified the following components; distance from the health facility, financial and opportunity cost, previous experiences with health care systems, characteristics of illness such as recognition of danger signs, perceived severity and aetiology of illness.

By whom decisions on seeking maternal care are made depends on the social cultural environment of a person (Patel, 1998). In other places for instance in Burkina Faso and Namibia, the family has the power and responsibility to decide in all therapeutic matters (Nougtara, 1989,Zeeb, 1995). In countries with large Moslems population the husband has an outstanding authority to make decision (Campbell, 1995,Kazmi, 1995) while in other places like in Namibia decision is made by the mother in law (Zeeb, 1995).

Traditional birth attendants also sometimes influence women' decisions to seek maternal health care. In Nigeria it was found that women were being deliberately discouraged from seeking higher levels of care by the TBAs, while in other areas women's organizations strongly influence pregnant women's health care seeking behaviour by even charging their members a levy if delivery occurred at home or if delivered without the supervision of a trained TBA (Okafor, 1991).

Women's position in the household

Women's status and autonomy in the household may also influence the decision to seek care. For example in West Africa, in some communities no one will take a woman to the hospital without permission from her husband (PMM, 1997). In countries like Nigeria, Ethiopia Tunisia, India and Korea studies show that women do not decide on their own to seek health care. Instead decisions are made by a spouse or senior member of the family (Stock, 1983;Kloos, 1987;Dia, 1989). Others include mother in –law, family or community relatives, village leaders and even village elders.

Giving birth at parents' home

In some areas of Tanzania there is a tendency for expecting mothers to deliver at their parents in law or other relatives. An unpublished study on maternal depression done in Tanzania (Leshabari and Kaaya, 1997) revealed that expecting mothers from urban areas sometimes go to rural villages that are miles away for delivery. Reasons and meanings behind this practice were not explored in the mentioned study. There was therefore a need to know the meaning of this practice in relation to maternal health and delivery care in particular.

Reputation of the Facility

People may not seek medical help from a health facility at all if they believe the service to be of poor quality (Thaddeus and Maine, 1994,Okafor, 1994). The manner in which the prospective patient expects to be treated by health providers at the health facility is an important dimension of the patient's assessment of the quality of

care. If the facility has a reputation of having uncaring and humiliating staff, and unfriendly services in which case the prospective patient may withdraw from seeking care unless the seriousness of her condition necessitates overcoming all barriers. Therefore women's access to maternal health care services particularly during delivery requires a special attention that requires an understanding of the scenarios which influence the behaviour of pregnant women in seeking care for delivery.

CHAPTER THREE

METHODOLOGY

Study design

This was a cross section descriptive study carried in four randomly selected villages in Kisarwe district. The study was carried among women with underfives children. Both qualitative and quantitative methods were used to collect data. Household survey using structured interviews was used to collect quantitative information and in-depth interview guide was used to collect qualitative information from women who participated in the in-depth interviews. All interviews were conducted at the residence of the respondents.

The study area

Kisarawe is one of the six administrative districts in the Coast region. The district is bounded by Mkuranga district to the east, Morogoro district to the south and Dar es salaam City to the North and Rufiji to the South (UNICEF, 2000). The whole area covers 3,555 square kilometres and has an estimated population of 100,000 people (Lwihula, 1997). The average growth rate of population is 2.1%. The total number of households is 19, 853 and the average household size is 5 to 6 people.

The district is made up of four administrative divisions, namely Sungwi, Mzenga Cholesamvula and Maneromango. These are further subdivided in to fifteen wards, with a total of 72 villages and 216 hamlets. Kisarawe is characterised by heterogeneous ethnic groups whose indigenous people are Wazaramo,

Wandengereko and Wamatumbi. The majority (86%) of the inhabitants are Wazaramo followed by Wandengereko 11% (Lwihula, 1997).

A Large proportion of inhabitants (90%) are peasants dependent on agriculture. Crops that are grown include Cashewnuts as the main cash crop. Coconut is another cash and food crop. Others are cassavas (often cash crop), Rice, Maize, Millet and Legumes are grown on a small scale. A variety of tropical fruits including Pineapple, papaws, Mangoes, Citrus fruits and Jackfruits are also grown in the district. Petty trading on various food items to and from Dar es salaam is common among the youth. Cattle rearing and lumbering are also done on a small scale. Mining of Kaolin is also done on a small scale as well.

The district is served by one district hospital located in Kisarawe township. There are two rural public health centres located in Maneromango and Mzenga wards, and 17 dispensaries, two of them being operated by government institutions, 2 owned by religious organizations and one owned by private institution and the remaining 12 are owned by the local government. Parallel to the formal health sector is the presence of a wide range of traditional healers including TBAs (MoH, 1999).

The target population

The target population of this study was all women who had undefives children in Kisarawe district during the study period.

The study sample

A sample of this study involved women who had underfives children obtained from four villages in four wards that were randomly selected from eleven wards in the district. These four wards were Masaki, Maneromango, Chole and Mzenga.

Sample size estimation

The sample size for the survey was estimated by using the following formula:

N=Z*Z. (P (1-P)/D*D, where

N= the desired sample size

Z = percentage of the standard normal distribution corresponding to 95% confidence level (For 95% confidence level Z =1.96)

P= expected proportion of institutional delivery in the district that was estimated at 25%.

D = Maximum likely error between means which was set (0.05).

Using the above formula the estimated sample size for this study was 300 women who had children of underfives years of age. A total of 335 mothers were involved in the study. The other 35 mothers were added in order to avoid non-respondents and dropouts during the interviews. These were estimated at 10% of the total sample.

Sampling technique

Multistage sampling was used in identifying villages where the study was conducted. A sampling frame consisting of all 11 wards in the district was made from which four wards were selected randomly. From each selected ward, one village was randomly selected. From each village a sampling frame of households was made. From each selected household one woman who had a child with less than five years of age was eligible for the study.

In depth interviews were conducted with nine women who were selected from among women who participated in the household survey. The criterion for selection was that, all women who had experienced any of the childbirth complications during their last delivery were eligible for in-depth interviews. These were screened from information obtained when the household survey questionnaire was being administered.

Recruitment, training and supervising research assistants

Two research assistants were recruited and trained to assist in data collection. These research assistants were responsible for conducting structured interviews with women who had underfives children in the study area.

Two days were scheduled for training the research assistants. The purpose for this training was to familiarize them with the study and equip them with necessary skills for data collection. This was done by using role-plays and field tests. The pre testing of research instruments was done in Kisarawe. The findings from the pre-test

showed that women were able to estimate distance by counting hours to be spent to reach the nearest health facility by specific means of transport (mainly on foot or by car). They could not estimate distance by using standard measures such as Kilometres and Miles. Questions were changed and hours were used to estimate the distance that was used to reach the nearest health facility by type of means of transport.

To observe and maintain the quality of data that was collected, the investigator supervised the research assistants very closely in the process of fieldwork. Each research assistant was given a code number that was used throughout the study and was written in all questionnaires to help in monitoring the quality and performance of work for each person. Later the data was recoded and entered in the computer for analysis.

Data collection methods

The data for this study were obtained from using both qualitative and quantitative methods where structured and in-depth interviews were employed.

Structured interviews

A total of 335 structured interviews with mothers of underfives children were conducted. Major themes of Structured interviews were information on demographic characteristics of the mothers who participated in the study, use of antenatal services, use of maternal delivery services, types of delivery attendants, decision making process for seeking delivery care during childbirth, and local meanings of pregnancy

related complications during childbirth. Also structured interviews were used to screen eligible women who had underfives children and had experienced any of the childbirth complications during their last delivery for in-depth interviews. Each interview on average took 30 minutes.

When an eligible woman for in depth interview was identified the investigator was informed and she was referred to the investigator who was responsible for this component of the study. For consistency purposes every day in the evening after data collection the principal investigator checked all filled in questionnaires on that day and discussed with other interviewers about problems they faced during the interview sessions.

In-depth interviews

In addition to structured interviews, in-depth interviews were also conducted for the purpose of gathering qualitative information in order to complement quantitative data from structured interviews. These in depth interviews were organised with women of underfives children who had experienced at least one childbirth complication during her last delivery, and these women were screened from among those women who participated in the household structured interviews.

The primary purpose of using in-depth interviews was to obtain information on pregnant women's reasons for intending and giving birth at a particular place of delivery, barriers in using the intended place of delivery, and local perceptions on the complications of pregnancy that occur during childbirth. The instrument was also

used to generate information on the description of the household decision-making process on matters related to childbirth and other childbirth related problems. Social and cultural issues influencing decision to seek care for a pregnant woman were also explored through this method.

The interviews took place at the home of each mother or at any other place of her convenience but within the area of her residence. Note taking and tape recording was done in the field and a summary of expanded field notes was done immediately after each interview so as to control the quality of data. Before starting the interview each respondent was informed about the use of the tape recorder and the consent was obtained. Later the investigator himself transcribed the interviews.

Data analysis and presentation

Quantitative data

Data collected from the structured interviews were first given codes for variables that were going to be analysed and were given serial numbers before entered in the computer for data processing. The EPI-INFO version 6.0 was used for data entry, to process and analyse the data. All data from the structured questionnaire were entered in the computer for analyses and the results obtained are presented in the next section.

Qualitative data

Data from In-depth interviews were analysed manually. Summary made from the field notes and audiotapes transcriptions were used in the process of analysing and interpreting the data. Major findings from in-depth interviews are presented in the next chapter as well.

Ethical considerations

Before going to the field the research clearance was obtained from the College's ethical committee. District officials including the District Medical Officer, selected wards, villages and hamlet leaders were informed about the purpose of the study in order to obtain permission to conduct the study in their area. In the field, verbal consent from study participants was sought before starting each interview. Participants were left free to withdraw from the study at any time should they had felt to do so. All women who participated in this study had their last born alive.

Confidentiality was highly observed by not disclosing or exposing any information about the respondent. During the fieldwork all filled in questionnaires were strictly kept in the locker and watched over by the investigator alone. After the data analysis was completed all data sets were destroyed.

Limitations of the study

In many African cultures, including Tanzania, sharing information related to pregnancy or childbirth with an outsider especially among women is always difficult. It is believed that if one dares to expose such information would therefore face

punishment or suffer ill consequences. This may affect the quality of data. However a good rapport was established between the interviewers and respondents to create a sense of trust between each other to ensure that the required information was obtained. Also the in-depth interviews conducted were very useful especially in gathering cultural sensitive information. This gave an opportunity to do more probing. The study design was also subject to recall bias. To minimize this bias the information collected was strictly referring to the last delivery of the women selected.

CHAPTER FOUR

RESULTS

Findings from structured interviews

Characteristics of the study sample

This study involved a total of 335 women who had underfives children from the study area whose mean age was 28.3 years with a standard deviation of ±7.8 years. The majority (84%) were Wazaramo by tribe, and were predominantly Muslims. Although over two thirds of the women interviewed had primary education, illiteracy rate was fairly high. Every four out of five women were peasants. And about two thirds of all women were married. Detailed demographic characteristics are summarised in table 1.

Antenatal attendance

Antenatal care is one of the major components of maternal health services in health facilities in the country, and attendance rates are usually fairly high. Findings from this study show that the attendance for antenatal care was 99.7% with an average number of six visits per pregnancy (the data based on the last pregnancy of the mothers interviewed). Only one woman did not attend. Even though in the study area pregnant women are recommended to start attending antenatal care during the first three months of pregnancy, findings (in appendix 2) show that the majority start late (from 4 months and above).

Table 1 Demographic characteristics of the study sample.

	Number	Percentage
Age		
14 –24	124	37.0
25 –34	140	41.8
35+	71	21.2
Total	**335**	**100.0**
Religion		
Muslim	320	95.5
Roman catholic	5	1.5
Protestants	8	2.4
Others	2	0.6
Total	**335**	**100.0**
Marital status		
Married	200	59.7
Cohabiting	74	22.1
Single	31	9.3
Others	30	9.0
Total	**335**	**100.0**
Education status		
Non formal education	129	38.5
Formal education	206	61.5
Total	**335**	**100.0**
Occupation		
Peasants	282	84.2
Small business	48	14.3
Civil servants	5	1.2
Total	**335**	**100.0**
Parity		
1	81	24.2
2	69	20.6
3 – 4	89	26.6
5+	96	28.7
Total	**335**	**100.0**
Family size		
2 – 6	206	62.4
7 – 10	105	31.3
11 –22	21	6.3
Total	**335**	**100.0**

Utilization of delivery services

Respondents in this study either delivered at home or in one of the health facilities. Trained and non-trained traditional birth attendants were facilitating home based delivery care while in the health facility based care, deliveries took place with the assistance of trained birth attendants.

Intended place of delivery

In this study an attempt was made to find out where each of the respondents intended to deliver in their last pregnancy. Findings summarized in table 2 showed that seven out of every eight pregnant women intended to deliver either in a dispensary, health centre, or a hospital and the rest intended to deliver at home. More than half of those who intended to deliver in a health facility believed that it was safer to deliver in a health facility. On the other hand, lack of transport and long distance to the nearest heath facility were major reasons given by more than half of those who intended to deliver at home.

The actual place of last delivery

Information on the actual place of delivery was collected with reference to the last delivery of the respondents. More than half of the respondents delivered at home (Table 2).

Table 2: A summary of percentage distribution of respondents regarding their intended and actual places of their last delivery

Intended place of delivery	Actual place of delivery					
	Home		Health Facility		Total	
	N	%	N	%	N	%
Home	37	90.2	4	9.8	41	100.0
Health Facility	138	46.9	156	53.0	294	100.0
Total	**175**	**52.2**	**160**	**47.8**	**335**	**100**

For mothers who delivered at home (even though initially they intended to deliver in a health facility) the majority mentioned that sudden/brief labour, and lack of transport during labour were the major reasons for them to have delivered at home contrary to their prior intention. The responses given were largely mutually exclusive. Reasons for why labour signs should appear suddenly for such a big proportion of mothers were not explored.

Table 3:Percentage distribution of reported reasons by women who delivered at home contrary to their prior intention

Reasons	Actual place of delivery	
	Home	
	N=138	%
Sudden labour (mainly in the night)	83	60.1
Distance; too far from health facility	4	2.9
Lack of transport during labour	61	44.2
Availability of TBAs	5	3.6
Fear of pregnancy complications	1	0.7
Did not experience any pregnancy complication	6	4.3
Adult/old age with many pregnancies	2	1.4
First pregnancy	3	2.2
Others	8	5.8

Relationship between the actual place of delivery and selected demographic characteristics

When the actual place of delivery was examined in relation to selected demographic characteristics of the respondents, it was observed that the tendency to deliver at home increased with increasing number of children of the respondent. However the association between age and the actual place of delivery was not statistically significant (Chi square =3.05 df = 2,P=0.2).

Table 4 Percentage distributions between place of last delivery and selected demographic characteristics

Parity	Actual place of delivery					
	Home		Health facility		Total	
	N	%	N	%	N	%
1	31	38.3	50	61.7	81	100
2	33	48.5	35	51.4	68	100
3-4	51	56.7	39	43.3	90	100
5+	60	62.5	36	37.5	96	100
Total	**175**	**52.2**	**160**	**47.8**	**335**	**100**
Age						
14-24	59	47.6	65	52.4	124	100
25-34	73	52.1	67	47.9	140	100
35+	43	60.6	28	39.4	71	100
Total	**175**	**52.2**	**160**	**47.8**	**335**	**100**
Literacy level						
Illiterate	71	55.0	58	45.0	129	100
Literate	104	50.5	10.2	49.5	206	100
Total	**175**	**52.2**	**160**	**47.8**	**335**	**100**
Marital status						
Married	109	54.5	91	45.5	200	100
Cohabiting	43	58.2	31	41.9	74	100
Single	12	38.7	19	61.2	31	100
Others	11	36.7	19	63.3	30	100
Total	**175**	**52.2**	**160**	**47.8**	**335**	**100**

Transport from the community to health facilities

Reaching a health facility especially during labour requires transport. Lack of transport in the study area contributes significantly to the problem of delivering at home. For those who delivered in health facilities, more than one third used bicycles, and almost one quarter had to walk to the nearest health facility. A few others especially those who were referred to hospitals, used public transport such as buses, lorries, and Pick-Ups.

Although the association between the time estimated and actual place of delivery was not statistically significant (Chi square=3.94,df2, P=0.1) the tendency to deliver at home increased with increasing time to a nearest health facility as summarised in table5. As the walking time to the health facility increased the proportion of women who delivered at home also increased.

Table 5: Relationship between walking time to a nearest health facility and the place where delivery took place

Estimated time in hours	Actual place of delivery					
	Home		Health facility		Total	
	N	%	N	%	N	%
< 1hour	79	49.1	82	50.9	161	100
1 – 3hours	87	54.0	74	46.0	161	100
Over 3 hours	8	80.0	2	20.0	10	100
Total	**174**	**52.4**	**158**	**47.6**	**332**	**100**

Assistance during delivery

Although the World Health Organisation recommends that delivery should be performed by qualified birth attendants, half of the women in the study area were assisted by unqualified birth attendants (including TBAs, parents and other close relatives) during their last delivery. Others (3%) delivered without any assistance as summarised in table6.

Table 6: Distribution of birth attendants by place of last delivery

Birth attendants	Place of delivery				Total	
	Home		Health facility			
	N	%	N	%	N	%
Qualified health worker	8	4.9	154	95.1	162	100
Trained TBAs	61	96.8	2	3.2	63	100
Untrained TBAs	71	94.7	4	5.3	75	100
Relatives	7	100.0	0	0.0	7	100
No assistance	9	100.0	0	0	9	100
Respondents' mothers	19	100.0	0	0	19	100
Total	**175**	**52.2**	**160**	**47.8**	**335**	**100**

Decision on where delivery should take place

The distribution of women regarding who decided on where delivery took place is summarised in table 6. The decision on where to deliver was in the most cases made by the women themselves followed by their husbands. Less than 6% indicated they got advise from health care workers. Among those who delivered at home, half made the decision on their own and less than 26% of those who delivered in a health facility had made such a decision on their own. It appears that the role of the husband is relatively important among those who delivered in health facilities. Interestingly only13% of those who delivered in health facility did so after been advised by the health workers and about 5% were advised by the TBAs.

Table 7: Percentage distribution of the person who decided where to deliver by place of delivery

WHO DECIDED	*Actual place of delivery*					
	Home		Health facility		Total	
	N	%	N	%	N	%
Husband	32	18.3	42	26.2	74	22.1
Herself	86	49.1	41	25.6	127	37.9
Mother*	23	13.1	32	20.0	55	16.4
Father*	6	3.4	3	1.9	9	2.7
Wife&husband	10	5.7	15	9.4	25	7.5
Doctor/nurse	0	0.0	21	13.1	21	6.3
TBAs	8	4.6	3	1.9	11	3.3
In-laws	3	1.7	1	0.6	4	1.2
Others	7	4.0	2	1.3	9	2.7
Total	**175**	**100.**	**160**	**100**	**335**	**100**

***Parents of the respondents**

Local meanings attributed to pregnancy and childbirth complications

The social construction of meanings associated with pregnancies and related complications to a large extent influenced decisions on what to do when problems are suspected. To explore more information on this aspect an attempt was made to find how prolonged labour was being locally interpreted in the study area.

Although prolonged labour is one of the most dangerous complications that pregnant women face during delivery, none of the respondents attributed prolonged labour to biomedical causes (see table 8). The majority believed prolonged labour was caused by witchcraft, jealousy, bad wishers, or evil eyes. Sex with men other than the one

who is responsible for the pregnancy and violation of cultural norms were also perceived to be among causes of prolonged labour.

Table 8: Perceived causes of prolonged labour

Causes of prolonged labour	Frequency N=335	%
1. Has been bewitched	269	80.3
2. Has had sex with other partners out of wedlock	69	20.6
3. Has been cursed / is in conflict with her parents/ in-laws	11	3.3
4. Time for the baby to come out is not yet	60	18.0
5. The baby is not well positioned in the womb	42	12.5
6. Has violated the norms/values	85	25.4
7. Fearful/worries	5	1.5
8. Others	58	17.3
9. Don't know	26	7.8

Perceived signs of problems of pregnancy

Bleeding during pregnancy was perceived by a relatively large proportion of women to be a sign of a potential problem during pregnancy. Other symptoms, which were mentioned, are summarised in table9.

Table 9: Percentage distribution of perceived problems during pregnancy

Problem during pregnancy	Frequency N=335	%
1.Loss of blood and "water in the body" during pregnancy	122.	36.4
2. Bleeding (menstruation) and vaginal discharges in pregnancy	134	40.0
3. Disappearance of movement of the baby in the womb	42	12.5
4. Convulsions before or after delivery	4	1.2
5. Fast heart beats and swelling of legs	136	40.6
6. Stomach, back, and waist pains	72	21.5
7. Others	64	19.1
8. Don't know	52	15.5

FINDINGS FROM IN-DEPTH INTERVIEWS

There were nine women who were selected for in-depth interviews. Among those who were selected, 5 women suffered from prolonged labour, 2 suffered from severe bleeding during delivery and the rest had retained placenta and breech pregnancy complications. The following information was obtained from the in-depth interviews.

Women's preferred place of delivery

All women who participated in the in-depth interviews mentioned that the majority of pregnant women in the study area intend to give birth in a hospital (health facility) but during childbirth most of them deliver at home. Lack of expertise and fear of potential problems of pregnancy are among the reasons for avoiding to deliver at home. Health facilities were perceived to be safe particularly where pregnancy complications were anticipated. For instance it was said that,

"...Women fear that pregnancy complications may occur when giving delivery at home..."

"... Many women say that it is more safe to deliver in a hospital because at the hospital there are, more skilled and competent personnel and sufficient delivery equipment"

"...At the hospital there is quick and timely assistance whenever you get complications..."

Reasons for home deliveries

Lack of pregnancy complications in their previous pregnancies, sudden labour, long distance to a health facility, and lack of transport were cited as major reasons for delivering at home. The following are expressions given by some of the women in this study,

" *...It depends on one's previous experience; if one has had 2 or 3 safe deliveries at home in the past she does not see the reason to deliver in a hospital...*"

"*...always it is because of sudden labour and also it is distant(too far)to reach the health facility.*

"*...Transport becomes the major constraint when labour is at peak ("uchungu unapokaza"), it is very difficult to walk because the dispensary (health facility) is too far from here...*"

Lack of good clothing for pregnant women at the time of going to the health facility for delivery also deter them to use health facilities during childbirth. For instance it was said that;

"*...There are others who feel ashamed because they do not have good clothes to wear, as you can see most of us are poor, clothing is a problem, so women find it better to deliver at home to avoid being laughed at, or being embarrassed by the nurses.*"

Other reasons include the belief on stoicism, by thinking that tolerance and sustaining labour pains was a heroic and bravery thing. It was said,

"...It is a pride to give birth at home because if you go to hospital for delivery others will say 'She is weak and fearful. But for the one who give birth at home is really a really brave woman"

Unnecessary delays in deciding to refer a pregnant woman with a problem to the nearest health facility, sometimes account for why some of them deliver at home. In case of prolonged labour, parents and TBAs tend to delay to refer pregnant women in labour to the nearest health facility due to a belief that she committed adultery during her pregnancy and therefore has to confess so as to be able to deliver without suffering more pains. Some of the women confirmed it by saying…

"...This belief is very common, sometimes TBAs say, you must mention all men that you had sex with...others do mention them up to three, five, or even more men"

"...yes we are told that we must mention all men (apart form your partner) that we had sex with so as to be able to give safe delivery; even when you were in the health facility if they (parents) see the nurse is not around they will tell you to mention them(even by not mentioning them loudly).

Cost sharing

According to the government policy, maternal health services both during pregnancy, delivery and post delivery period should be free of charge. However in the study area women were paying for delivery services even at dispensary and health centre level. These costs were considered to be expensive, unaffordable and unrealistic. Health care providers were demanding a lot of money from pregnant women and some were refused services if they failed to pay. One woman said,

"...Yes charges are there, you have to pay. But others have no ability to pay that is why others are refraining from going to hospital for delivery. Look, while you have to pay shs 3000/= you need also to buy other delivery equipment, it is money, gloves it is money, water to induce labour, is money, and you can't pay all this."

Charges for delivery services varied from one health facility to another. The minimum amount to be paid for delivery services was said to be Tsh 3000/= and the amount was higher when several people were involved in the process of delivery. However the women who were interviewed did not know why such money had to be paid. The majority of the informants were even ignorant of existing cost sharing policies for pregnant women.

Costs incurred in home deliveries were not considered as expensive. They were considered as a form of of appreciation for the service rendered. Women were of the opinion that paying for delivery services at health facilities was more expensive than home based delivery care. For instance during the conversation in the in-depth interviews mothers revealed that:

"...We don't pay them (TBAs), actually we just give them an appreciation or just a soap (sabuni) or...anything...we normally give them some money...it depends ... it is between 3,000/= and 2,000/=, sometimes 4000/= or even more..."

"...the TBA can assist the pregnant mother to deliver but do not demand anything, But if you have money you can still give her any thing (especially money) later..."

"..for the untrained TBAs normally they volunteer in assisting deliveries

'...a nurse /doctor can tell you to bring him /her 'something' because he /she is in need of soap, so you find yourself being obliged to offer anything like,1500/=,2000/= or sometimes 3000/= but normally we pay 3000/=..."

Decision making on where to deliver

Decision-making was found to be a complex process especially when it comes at dealing with pregnancy including childbirth related matters. Mothers who were interviewed described the process by saying that,

"...the procedure is that... when a wife starts experiencing labour, should explain/tell the situation (about her labour) to her husband, the husband then must talk to/tell his mother or his mother in law so that a decision can be made on where the "mother in labour" should go for delivery, or the TBA will be called to assist"

This showed that a decision about the place where the pregnant woman delivers is made through a certain consultative process in which apart from the husband and his wife, the process also involves other individuals from outside the members of the household including pregnant women's mothers, mothers in law, TBAs and sometimes close relatives.

Means of transport and related problems

Apart from walking and using bicycles as means of transport for taking a pregnant woman in labour to a health facility, locally made beds were also used. In this case neighbours especially adult men were mobilised to carry the pregnant woman to the nearest health facility. This mode of transport was perceived to be shameful since it denied them their privacy and lowered their reputation among fellow women. Consequently pregnant women would resist to be carried to a health facility this way unless their condition worsen beyond their own control.

Women's perception of health providers

Result of this study show that health care providers are perceived to be arrogant towards pregnant women particularly when they were in labour. They said,

" *...unlike TBAs who attend pregnant women with care, polite language and love some nurses use abusive language, are rude and very uncaring towards pregnant mothers at the dispensary.*

It was also mentioned that health providers were not observing privacy of the pregnant women during labour. They were sometimes mixed with other female patients who were neither pregnant nor in labour, and during childbirth the procedure was being performed before them.

Reasons for why pregnant women give birth at their parents' homes

It was said that women with first pregnancies, are supposed to go to their parents' homes at the moment when the pregnancy is about six, seven, or eight months. In the study area this was a tradition. It was found that the Wazaramo have several levels of initiations, one being during pregnancy. However it was not known how many of the mothers interviewed had delivered at their parents' homes regarding this initiation in particular.

This period of staying at parents' home traditionally has an important role. Apart from doing several rituals, this time is meant for the pregnant woman to learn all norms, customs, taboos, dos and don'ts of what pregnancy is all about. Therefore a pregnant woman must stay at her parents' home and deliver there so that she can be assessed on how she will manage to take care of herself in the next pregnancies. In this case delivery at home without any complication creates a high chance that future pregnancies would also be delivered at home.

Local interpretation of prolonged labour

Local meanings and perceived causes of prolonged labour interfere decisions on what action should be taken at the household level. Witchcraft, infidelity, superstitions, disobedience to parents or parents in law and violation of traditional taboos were perceived to be causes of prolonged labour in the study area. Other local experts are called to attend the woman with such a problem at home. This process delays going to existing health facilities for assistance and contributes toward home deliveries and associated problems.

Based on the information of these findings, it was shown that antenatal attendance by pregnant women is fairly high but only a relatively smaller proportion deliver in existing health care facilities. Nearly 88% intended to deliver in a health facility but only 48% actually did so. Generally as the number of children born by the mother increased the tendency to delivery at home also increased. Several reasons were given for delivering at home. These include sudden labour and lack of transport. The women or the husband or both were quite instrumental in the decision on where to go for delivery.

Data from in-depth interviews revealed that pregnancy and childbirth is a process, which is influenced by cultural beliefs, which to a large extent account for delays in getting attention from existing health services. The lay referral system when problems are suspected during pregnancy also contributes towards delays in seeking assistance from the health facility. Apart from the husband, mothers, neighbours are among the network of people involved in arriving at a decision on what steps should be taken during pregnancy complications. Generally women perceived health care workers to be rude and demand money for services, which are supposed to be free under existing health policies.

CHAPTER FIVE

DISCUSSION

The main concern of this study was the existing gap between the institutional and home deliveries among pregnant mothers in Kisarawe district. The study findings have shown that pregnant women in the study area have better access to antenatal care than during delivery care. A large proportion of pregnant women intend to deliver in the health facilities but end up in delivering at home. This brings the discussion to focus on the following issues.

Antenatal attendance

Antenatal attendance rate, which was recorded in the study area, was very high as compared to the national antenatal attendance coverage of 96% (TDHS, 1996). The similar antenatal attendance coverage was recorded in Mtwara (Kowalewiski, 1996). Those who attended antenatal care in Kisarawe did so at least six times. The findings suggest that many women make more than recommended visits. The world health organisation recommends that a pregnant mother should at least make one visit for antenatal care (WHO, 1999). However it is not quite clear whether women are informed about the importance of the expected date of delivery. In any case existing health facilities cannot cope with the volume of deliveries if each pregnant woman was to deliver in the nearest health facilities.

Intended versus actual place of delivery

Intended place of delivery was considered as the priority choice of the pregnant women where they had preferred to give birth on the day of delivery. And the actual place of delivery was considered as the place where delivery actually took place on that particular day /time of delivery.

The study showed that the majority of the women interviewed intended to deliver in health facilities. However, during the time of actual delivery more than half of the mothers interviewed delivered at home. Four out of five of those who delivered at home had earlier intended to deliver in the health facilities. This study share the same findings with other studies in Tanzania (Biego, 1995) where it was found that 84% of pregnant women who wanted to deliver in health facilities delivered at home and Ssembatya and Lule (1999) in their study in Malawi where it was found that a large majority of pregnant women (90%) wanted to deliver in health facility but only 25% did so.

Both qualitative and quantitative data showed that sudden labour (especially at night) and lack of transport to the health facility outweighed all the prior intentions of delivering at existing health facilities. However these factors raise a serious concern on the fact that it is always expected that every pregnant woman who attends antenatal care is informed about her expected date of delivery (EDD) and therefore delivering at home was not expected. Reasons such as non-compliance with advise from health care workers, poor memory about the expected date of delivery, might account for reasons behind delivering at home.

Lule and Ssembatya, (1999) in Malawi showed that 53% of women who delivered at home did not recognise earlier the labour signs. By the time the labour came out it was too late for them to seek assistance for delivery at a health facility. In both cases the findings do not show whether these mothers were unaware of their expected date of delivery. It is assumed that if they had known about their expected delivery date, and live far from the health facilities attempts would have been made to come nearer or to the health facility and the proportion for home deliveries would have been substantially reduced. Similar studies by Kane (1986) and Hoodfar, (1986) revealed that labour experience in pregnancy is just perceived as a natural process that does not pose a significant health risk to a pregnant woman. In Nigeria, labour experience would need medical attention if it persists for two to five days (Chiwuzie, 1999).

The Tanzania demographic health survey (TDHS, 1996) shows that young age, history of pregnancy, and higher level of education are positively associated with the use of delivery services. However, from results of this study showed that only history of pregnancy had a positive association between the actual place of delivery and number of pregnancies of the woman. In this case women with more than one child deliver at home if previous pregnancies had no complications and existing social support does not reinforce delivering in existing modern health facilities. This suggests a need to educate women and the community in general in order to attenuate barriers to seeking care in health facilities.

Distance to the health facility

This study indicated that distance did not positively influence pregnant women's intended place of delivery. This agrees with Thaddeus and Maine (1994) where they pointed out that distance alone cannot influence pregnant women on where to deliver. Part of the problem in this study could be poor reliability in estimating time from home to the nearest health facility. The topography of the study are a might have also contributed to this problem. Distance is always shaped by other factors including, costs of transport and delivery service, severity of the disease, perceived cause of the disease and even quality of care and geographical accessibility (Maine, 1994).

However to minimize such problems pregnant women could be advised to stay closer to the nearest health facilities around their expected day of delivery or communities could be mobilized to arrange for quick transport means whenever health related emergencies occur.

Problems of transportation

Lack of transport during labour emerged as a major factor inhibiting pregnant women to reach health facilities for delivery care. Data from the quantitative information revealed that most women in this study needed two hours walking to the nearest health facility. For a pregnant woman who is in labour this is a long walking distance particularly during pregnancy emergencies. Biego (1995) showed that 84% of pregnant women delivered at home due to distance and lack of transport problems.

Kowalewiski (1996) found that transport problems ranked second for non-compliance of referral advice among pregnant mothers in Mtwara.

Apart from walking, bicycles were the only alternative transport n available during emergencies requiring patients to be taken to health facilities. There were no emergency transport in the community and even existing health facilities do not have means of getting women with problems from home to the nearest health facility. The topography of the area is another stumbling block to this means of transport. A large part of Kisarawe district area is hilly in most of the parts, and is almost impassable during rainy seasons (MoH, 1999).

Costs of delivery services

It was revealed from the study that delivery costs is another important aspect that may influence the place where actually pregnant mothers do give birth. These costs may include transport charges, delivery materials, user fee charges, and sometimes accommodation and food costs which may deter women to deliver in health facilities.

Existing the government policy requires people to pay for health services (cost sharing) except for a few exempted groups including maternal health services. Findings in this study show that both women who delivered at home and those who delivered in health facilities paid for services. Paying for services was however perceived differently by the women. While demands for payment made by the health care workers were considered rather high and undesirable, similar payment paid to the TBAs or others who assist during delivery at home was considered normal since

the money paid was considered an appreciation. Reasons for these differences were not explored. However they may arise due to attitudes of these women toward health care workers. They were generally perceived to be rude and unfriendly when delivering services. Similar findings (Corea, 1998) show that 66.2% of home deliveries were not cost free, the majority voluntarily paid to 'thank the assistance.'

Women in this study were unhappy with the mode of paying for health services and they were not sure of the amount that was required to be paid. Lack of transparency in the way services were charged created mistrust between pregnant women and healthcare workers.

Customs and traditions

Customs and traditions play a great role in the process of seeking health care especially in the rural population. Local interpretations and recognition of signs of problems during pregnancy and childbirth to a large extent interfere both decision making and health seeking behaviour. Prolonged labour for example was attributed to socially constructed local models including witchcraft superstitions and infidelity. Such perceptions led to consultations of traditional healers and other local experts conversant with such maternal problems. Use of such alternative models of health care delayed such women from consulting heath care facilities in time.

Other studies (Sargeant, 1985,Margreth1995, Aloysius, 1999) have shown that prolonged labour is a problem that usually does not require medical attention. Women are inclined to confess of their past misdeeds, or infidelity or parents have to look for a traditional healer to save the life of the pregnant woman. This scenario suggests that seeking care from medical health facilities becomes less important and hence results into pregnant women giving birth at home.

In deciding about childbirth, Patel (1999) said that childbirth is not a purely personal domain. It is not a private affair concerning the woman and /or the husband, as is the case in the western cultures. It is a household and family matter, which is handled by a cobweb of social support from the local community. In making decision about pregnancy, pregnant women are highly respected in the family due to the social recognition and value that is attached to pregnancy. Pregnancy becomes a family matter and members of the extended family including parents of both spouses. All matters concerning delivery (childbirth) must be known to the elder members of the family.

However this study found that despite the fact that other family members were involved in the process of seeking health care for a pregnant woman, in situations of normal delivery women decided where to go to deliver. This is contrary to (Stock, 1983, Kloos, 1987, Dia, 1989) where decisions are made by a spouse or a same member of the family. This finding is also contrary to the report that husband has an outstanding authority to make decision on where his wife should go for delivery (Campbell, 1995,Kazmi, 1995).

Reputation of health facility

Privacy and confidentiality make pregnant women feel more comfortable when seeking services from health facilities. Data from this study show that there are problems with privacy and confidentiality. There were cases in which women in labour were being attended in the presence of other patients. This problem might have contributed towards the habit of delivering at home particularly in cases where there were no obvious signs of problems of pregnancy. In this case health workers contribute towards problem of delivering at home and also the negative attitudes towards health facilities designed for maternal and child health services.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

CONCLUSIONS

The gap between institutional and home delivery still exists in Kisarawe district. Almost every pregnant woman in Kisarawe has access to antenatal care. However less than half of pregnant women deliver in existing dispensaries or other health facilities. Apart from negative attitudes which pregnant women have towards health care workers, lack of essential facilities including drugs and other diagnostic facilities make one wonder whether the existing facilities have the capacity to cope with the volume of deliveries if each pregnant women would go for such services in the village dispensaries.

Given the topographical situation of the study area, transportation will continue to be an obstacle for getting pregnant women to dispensaries or hospitals when need for referral arises. There was also a problem of sudden labour, which was one of the major reasons for delivering at home. The meaning behind this concept was not explored during this study. However it is quite possible that poor communication about the expected date of delivery by health workers coupled with lack of reminders and reinforcement to pregnant women lead to poor memory of the date of delivery over time.

Women did not perceive the introduction of user fee in the health facilities as the deterring factor for them to use such health services. However lack of transparency on charges made even where a need for contribution for gloves and delivery kits is necessary, makes women ignore obvious shortages in the dispensaries and blame the health care workers for corruption instead. There is need to make cost sharing policy clear and community should be involved in deciding what to do where services cannot be delivered due to shortage of drugs, diagnostic facilities, and equipments in the village health facilities.

RECOMMENDATIONS

General recommendations

The findings generally show that pregnancy and childbirth matters in the study area are culturally sensitive and hence the need to effectively support, encourage and train more TBAs in the study area. Health interventions intending to improve the use of health facilities for delivery care should consider the influence of culture on women's health. There is need to re-examine the need for pregnant women to deliver in health facilities especially given the ability of existing facilities to cope with the potential load.

Specific recommendations

There is a need for always keeping pregnant women informed about the early signs of labour and the expected date of delivery. Communities and pregnant women should be educated on pregnancy related problems so that if possible waiting homes can be built near existing health facilities to minimize emergencies during labour or during home deliveries.

There is a need for transparency on the user fee charges and payment of delivery services. Pregnant women should well be informed about services that are to be paid for and the mode of payment. Similarly, communities should be mobilized to deal with shortages of basic drugs and equipment required during delivery so that health workers can work without demanding money for would be mothers due to lack of basic facilities during the delivery process.

Interpersonal communication between healthcare workers and expecting mothers should be improved in order to reduce or eliminate negative attitudes towards health care workers by pregnant women.

In dealing with problem of transport especially in emergencies there is a need to involve the community in finding possible means of transport within the community itself and the government would assist by giving support to the community initiatives. It is suggested that in seeking short-term solution the community should be involved in designing means of transport that is accepted and affordable during emergency health problems.

There is a need for more studies on what goes on in health care facilities particularly elements which affect expected quality of care during pregnancy and delivery. Views from health workers on factors which affect provision of quality health services which significantly contribute to towards interventions aiming at reducing maternal morbidity and mortality in Tanzania.

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