CHARACTERISTICS OF WOMEN DELIVERING AT HOME IN SONGEA-RURAL DISTRICT. RUVUMA REGION. TANZANIA.

By

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The undersigned certifies that he has read and hereby recommend for acceptance by the University of Dar-es-salaam a dissertation titled "Characteristic of women delivering at home in Songea-Rural District, Ruvuma region. Tanzania."

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DEDICATION

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ABSTRACT:

A cross-sectional survey of 416 women of childbearing age (15—49years old) was conducted in eight wards of Songea-rural district, from June to August 2001.

The aim of the study was to determine factors associated with home deliveries and recommend ways of intervention so as to reduce the rate of home deliveries.

A simple random sampling technique was used. Interviews were conducted to find out information regarding women's perception of maternity care provided by health workers, traditional birth attendants, traditional healers e.t.c.The questionnaire also elicited women's knowledge of the danger signs during pregnancy and delivery, reasons for non-utilization of health facilities and who determines place of delivery.

Of the 416 subjects interviewed, 398 (95.7%) of the respondents had home deliveries.

The results showed that majority of the interviewees 133 (32.0%) were aged between 26 years and 30 years and 98 (23.6%) of the respondents were aged between 15 –20 years and only 3 (0.7 %) were below 15 years.

The results also showed that 313 (75.2%) of the respondents had attained primary education, 83 (20%) had no formal education. 127 (30.6 %) of the respondents were multiparous having deliveries more than five times.

Factors that were seen to be associated with home deliveries were young age, high parity, single women, husbands and parents as decision makers, poor accessibility to funds, perceived poor quality of maternity services, transport. High costs and distance more than 5 kilometers. Distance and level of education did not have any association with home deliveries.

Low social-economic status of the women has association with home deliveries. 223 (53.6%) of the respondents had financial problems, so could not seek maternity care. The study revealed that 238 (57.3 %) of the respondents felt highly esteemed when they delivered at home, and 96 (23 %) considered home delivery as a normal act.

Results also showed that, husbands 258 (62.0%) had the final decision on the choice of a place of delivery, and 72 (17.8 %) of the respondents, decisions where made by only their In-Laws. Of the 398 who had home deliveries 265 (66.5 %) would prefer to be assisted by a nurse/midwife during delivery.

Although, 397 (95.4 %) of the respondents lived within 5 kilometers from the health units however they had delivered at home. Maternity services provided by health workers were perceived to be poor when compared to those provided by TBA`s. Most of the deliveries are conducted by TBAs.

Accordingly to the findings, it is recommended that, Improve the quality of maternity services in the existing health units, improve the facility structures to provide privacy, look into the possibility of supplying supplies e.g. gloves, syringes, cotton-wool free or at subsidized cost. Improve communication, and interpersonal relationship of health workers with patients, and relevant authorities to look into ways of improving the socio-economic status of the community in Songea Rural District.

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LIST OF ABBREVIATIONS:

PHC _____Primary Health Care

WHO _____World Health Organization

TDHS _____Tanzania Demographic Health Survey

TRCHS _____ Tanzania Reproductive and Child health Survey

TBA`S _____ Traditional Birth Attendants

CHARACTERISTICS OF WOMEN DELIVERING AT HOME IN SONGEA-RURAL DISTRICT. RUVUMA-REGION.

1.0 INTRODUCTION

In many developing countries, including Tanzania, home deliveries remain a problem to be solved. The problem is more common in rural, than urban areas. Major steps are to be considered to solve this situation and provide better services for safe delivery at all levels. All pregnant women are at high risk of complications related to childbirth.

Some pregnant women at increased risk can be identified during the prenatal period and referred to higher health units. However some women referred for delivery in higher health units do not go in time, due to various reasons, which include, unavailability of transport, impassable roads, long distance and the costs. Locally made stretchers are mainly used to carry mothers to nearby health facilities, for delivery. Every woman in Tanzania, who resides in rural areas, should be able to obtain quality maternity care as nearly as possible to their homes.

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Women need support in obtaining access to essential care. Community awareness of the need for women to reach modern health care without delay if complications arise during delivery is particularly critical.

Pregnant women are at high risk of complications during delivery. It is estimated, world wide, that nearly 600,000 women between the ages of 15—59 years die every year as a result of complications arising from pregnancy and childbirth. (WHO, 1999). Complications of pregnancy are found everywhere in the world, but nearly 99 percent of all maternal death is in developing countries. In some developing countries one woman in 12 may die from pregnant related complications compared to 1 in 4,000 in industrialized setting (WHO, 1999).

In Tanzania, the maternal mortality rate in 1996 was estimated to be 529 per 100,000 live birth (TDHS, 1996). Most of the pregnant women do attend antenatal clinics. About 97 % but only a much smaller proportion 47 %, delivers in hospitals. In urban areas women receive antenatal care from a doctor, trained nurses or midwife, while in rural areas they receive antenatal care from health aides and traditional birth attendants (TDHS, 1996).

In rural Songea, most women bear children at too early, an age, before they are physically mature. Either, during their primary school training.

Most of the families in Songea Rural areas live in the farms. Houses are scattered, far from one another. They are long distances between health facility unit and the houses. Specific dates, months and days have to be arranged for outreach clinics. This depends on the season, as during the rains, roads are impassable. Availability of transport becomes a problem.

Good attendance of antenatal clinic is noted with the pregnant mothers in rural Songea. Antenatal care utilization is an important determinant of delivery in health unit.

The proportion of pregnant women who have care during delivery is lower, than those who attend the clinics. Utilization of health care facilities is a complex phenomenon, which is affected by factors such as availability, distance, cost, quality of care, social structure and health beliefs (Becker et al 1993).

Women access to health care is also influenced by restrictions on mobility and seclusion of women in the household. Cost and distance considerations are also inter-related with gender inequality. Furthermore, gender inequality in access to health care is reflected in women's unwillingness to go to hospital to deliver because it will disrupt household organization. Women have the responsibility of taking care of their home.

In Tanzania, only 47% births occur in a health care facility. Urban birth were much more likely to take place in health facilities than rural births. Trained health personnel during delivery assist only 39% of women. (TDHS, 1996).

In Songea rural district the traditional birth attendants deliver most of the babies. Traditional birth attendants have a role in supporting women during labour, but generally are not trained to deal with complications. However, TBAs can contribute to reducing newborn deaths and disabilities, and play an important role in providing assistance to women during delivery. TBAs can offer pregnant women much-needed moral and emotional support. Many women turn to TBAs because doctors and midwives are not available or cost too much, or because TBAs are neighbors or friends who know local customs and respect women's needs. Recognition of the important role of TBAs as part of the maternity health care system is important.

One role of TBA`s, is advising pregnant women on proper nutrition and hygiene, using preventive practices during delivery, managing certain limited complications, making referrals and acting as an agent of change and role model for other women.

Traditional birth attendants can be provided with cheap and simple delivery kits, which can be distributed to pregnant women for home births and deliveries in the village health facility units. These kits will help to ensure that deliveries are conducted in clean conditions and at least some infection-related deaths could be prevented.

Health workers, TBA`s, traditional healers and other community members should well understand the dangers of home childbirths. With community involvement in decision-making, raised awareness and effective utilization of health facilities will reduce the rate of home deliveries.

1.1 STATEMENT OF THE PROBLEM

Home deliveries are more common in rural Songea District. Modern maternity health facilities are available within a distance of 5—10 kilometers.

Local government, and non-governmental organizations own these health facilities. Antenatal services are provided, almost daily. Antenatal attendance is good, but the proportion of those who give birth in health facilities is low.

Only about 47 percent, of women in Tanzania, deliver in the heath facilities. 53% deliver outside the hospital system being assisted by TBA`s, relatives and some delivery alone (TDHS, 1996). Trained health personnel during deliveries assist only 39% of women (TDHS, 1996). The un-booked cases constitute the main risk group that deliver at home unassisted and contribute the high maternal deaths. Modern trained care providers are available, but women still prefer traditional maternity health care during childbirth. The question that is still unanswered is why these pregnant women prefer traditional maternity health care than, the modern care. Study aims to identify reasons for home childbirth and recommend ways of interventions in order to reduce the rate of home deliveries.

1.2 RATIONALE OF THE STUDY:

Obstetric complications can occur to any pregnant woman.

Antenatal screening does not identify all of the women who will develop complications.

As those complications, cannot be predicted, during the antenatal it is necessary that all deliveries be assisted by skilled attendants who can recognize early danger signs and take action.

Also home deliveries are conducted under unsterile conditions. They are no safe— delivery technique, and this puts women at risk of developing reproductive tract infections and their sequalae.

Even after safe home delivery, postnatal follow-up is important to the mother and this needs skilled attendants too.

Factors associated with home childbirth are to be identified and acted upon.

In Songea rural, home delivery is still a problem. Every pregnant woman needs to be delivered by a skilled attendant in maternity facility units. Findings of this study will give light to reasons associated with this practice of home delivery and recommendations be made for interventions, that will reduce the incidence of home deliveries.

2.0 LITERATURE REVIEW:

Many women in developing countries give birth at home. Sometimes women who choose home as a place of birth for their children are criticized by professionals or relatives and friends, who accuse them of endangering their lives and that of the babies.

There are many reasons that lead women to consider the option of giving birth at home. One is that they themselves regard pregnancy and birth as a normal physiological and family event, rather than a potential medical disaster, which is unfortunately, quite a common attitude amongst obstetricians and hospital staff. (Home birth association of Ireland, 1998).

Some women, never having reason to be in hospital, and not regarding themselves as patients, who are ill, see no need to go there to give birth. For other women they have had natural trouble free births in hospital and wish to have subsequent births at home. Others may have had previous hospital birth and felt unhappy, disappointed or even angry about their birth experiences. Others may have relatives or friends who gave birth at home and who spoke positively about the event. (Home birth association of Ireland, 1998).

For other women they have had natural trouble, no free births in hospital and want a change. It is possible that the unfamiliar setting and the presence of unfamiliar personnel, the limited presence and role of family members. And the restricted

freedom of movement of the laboring women may all create an atmosphere at a hospital birth that undermines self-confidence and encourage passivity on the part of the laboring woman, diminishing her ability to deliver spontaneously (Durand A.M.1992). Also close-relatives are not allowed to be near or encourage them during childbirth.

The factors that influenced their choice of delivery site are accessibility to maternity services, influence of spouse and other relatives, traditional birth attendants or health workers, self-efficacy, previous experience, and the concept of normal versus abnormal pregnancy. (Amooti-Kaguna, B and F.Nuwaha, 2000).

Utilization of health services is a complex phenomenon, which is affected by factors such as availability, distance, cost, and quality of care, social structure and health belief (Becker, et al, 1993).

There are certain major associated factors that influence home childbirths. These factors may include: - Service factors; Socio-economic factors; and Socio-cultural factors. (See figure 1.)

SERVICE FACTORS

The Tanzania government emphasizes equity in the distribution of health services and views access to services as a basic human right. The government provides more than 60 percent of health services. Other key players in health care include non-governmental organizations (about 35%) and private for profit organizations and individuals (about 5%). With an extensive network of health facilities in the country, at the national level

there are four consultant hospitals, and two special hospitals one of which is the university teaching hospital. Most regions have a regional hospital and there are a total of 195 hospitals in the country. There are 302 health centers and about 3,500 dispensaries. At the village level, village health posts have been established with at least two village health workers (TRCHS, 1999 and National PHC Supervision guideline, 1999).

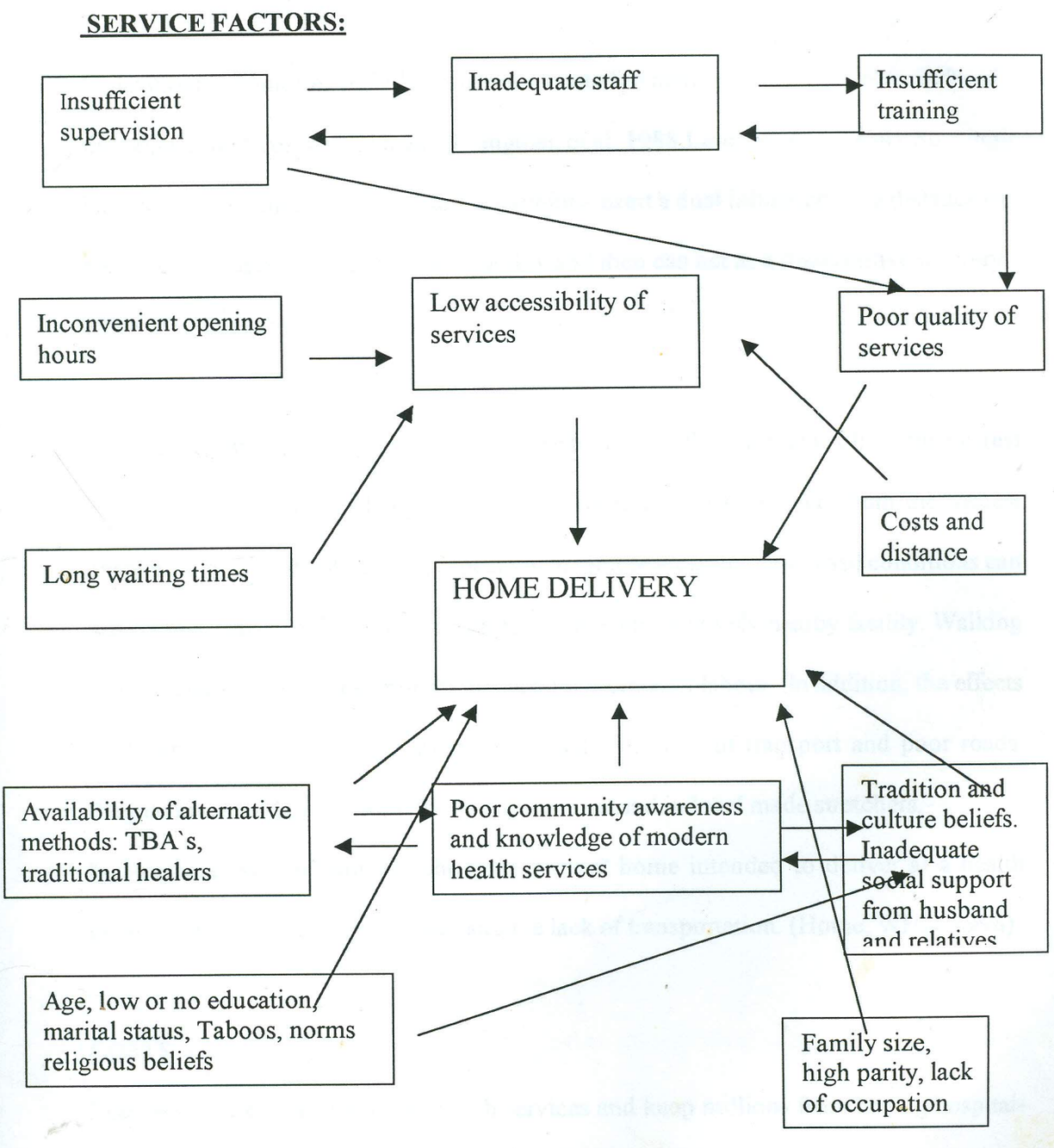
Although health facility units are found in all parts of the country, they are still inaccessible. The services are provided in old, ruined buildings, with very limited space. Little or no care is taken to up-date them. There environmental surrounding doesn't offer privacy and enough shelter for women. The level of privacy of the health units is not good. Most of the equipments in health units are worn-out, some are beyond repair. Essential equipments and other supplies are irregularly obtained and the supply is always not enough compared to the amount needed.

They are long waiting time and inconvenient opening hours. This is an important factor of not using or seeking health services. Time spent getting to, waiting for and receiving health services is time lost to other more productive activities, such as farming, fetching water and wood for fuel, herding, trading, cooking and so on. As women carry out a large majority of these tasks, the value of their times and computing demands made on it are important to consider (Thaddeus, et al.1994).

Poor supervision of health workers is another contributing factor of unsatisfactory services. Lack of supervision of staff was an additional avoidable factor in Zimbabwe (Fawcus et al.1996). The study reported that relatively junior staff that failed to diagnose or recognize the severity of the complications often shouldered the responsibility for managing emergency complications. This was further compounded by limited supervision of the junior medical staff. Supervisors should however be aware it is neither desirable nor possible to supervise each and everything during each visit (National PHC supervision guidelines.1999).

Essential drugs should be constantly available. Services be placed within a passage acceptable to women and their families. Quality of health care services be improved, available affordable, and accessible as near as possible to their homes.

Figure 1. Diagram showing factors associated with home deliveries.



SOCIO-ECONOMIC FACTORS:

In developing countries most hospitals are located in towns, while about 60%-90% of the population lives in rural areas (Leingmei, et al, 1988,Lennox, et al, 1984). So people have to walk a long distance. Distance therefore, exert a dual influence-long distance can be an actual obstacle to reach health facility and then can act as a disincentive to every effort of trying seek care.

In most rural areas, one in three women lives more than five kilometers from the nearest health facility and 80% of rural women live more than 5 kilometers from the nearest hospital. The scarcity of vehicle, especially in remote areas and poor road conditions can make it extremely difficult for women to reach every relatively nearby facility. Walking is the primary mode of transportation, even for women in labour. In addition, the effects of distance become stronger when combined with lack of transport and poor roads. Pregnant women have to walk for hours or are carried in local made stretchers.
In Tanzania, 84% of women who gave birth at home intended to deliver at a health facility, but did not due to distance and the lack of transportation. (Home, WHD, 1998).

COSTS: -

Fees reduce women's maternal health services and keep millions from having hospital-based deliveries, or from seeking care even when complications arise. User charges for health services have been introduced or raised in a number of developing countries, for

example in Ghana, Niger, Nigeria and Zaire. Studies in these countries have shown a decline in use of health services. (Greese, A.1990). This can be a serious danger for very poor people. Hence, rural women often do not go to health facility units where they may not be treated with respect, often tipping the balance against their survival. Even when formal fees are low or non-existent, there may be informal or under the table fees, or other costs that pose significant barriers to women's use of services. These may include costs of transportation, drugs and other foods or lodging for the women or family members who help care for her in the hospital (WHO, 1998).

Costs and distance considerations are also inter-related with gender inequality. Furthermore, gender inequality in access to health care is reflected in women's unwillingness to go to hospital to deliver because it will disrupt household organization, there may be none to take care of older children or their husband (Okojie, 1994).
Cost and distance often go hand in hand as considerations in the decision making process as longer distances require higher transportation costs. The shift from free to fee-based services makes women to seek alternative traditional medical care, as they cannot afford to pay for the services.

Many parts of the developing countries, women do not travel alone to a health facility. Other adults and children who cannot be left at home alone because caretakers are not available accompany them. All these additional people increase the cost of transport. Low social and economic status of girls and women is a fundamental determinant of

home childbirth in many developing countries. Low status limits the access of girls and women to education and good nutrition as well as to the economic resources needed to pay for health care or family planning services. The low social status of women in developing countries limit their access to economic resources and basic education and thus their ability to make decision related to their health and nutrition (WHO, 1999).

Worlds populations growth and socio-economic trends and poverty, has inter—relation with home childbirths. Population growth is a result rather than the cause of poverty. The high rates among the poor can be understood as defense response against structures of power that fail to provide sources of security beyond the family, that is land, food, jobs and the means to prevent pregnancy. Many poor families view children as a source of power and perceive their children's labour as necessary to augment family income.

Illiterate women tend to marry earlier, to have many children with short intervals between them. Studies from many developing countries show that number of children a woman bears decline with increased education. In Colombia and the Sudan, women with 7 years of schooling are likely to have only half the number of children that their uneducated sisters have (World fertility survey.1991).

Poverty, poor education and multiparity increase the risk of home delivery (Bolam, 1999).

40% of women in Tanzania have never been to school. The proportion with no education increases with age. For, example, the proportion of women who have never attended any formal schooling increases from 17% in age group 20—24 to 88% among those age 65 and older. Thirty percent of women have completed primary school, with just under 5% having attended some secondary school (TRCHS, 1999). Education attainments are higher in urban areas than in rural areas.

Poverty in developing countries is featured by foreign debts (Greenwood, 1987), which strains it's already dilapidated economy, thereby aggravating social inequity, and vicious cycle of poverty and starvation, both by decreasing the availability of government support for health and education.

Economic status affects the use of health services. In a study conducted in Addis Ababa, Ethiopia economic income, house ownership and occupation measured the status. The lowest level rates of prenatal attendance and highest level of home delivery were found among women from the lowest economic status groups (Kwast et al, 1984). Survey done by Tanzania Demographic Health Survey (TDHS), on employment and occupation of women in Tanzania, on whether they were working for pay, selling things, or working on a family farm or in a family business. Forty eight percent reported being self employed, with 39 percent working on a family farm, 17% engaged in the food processing business, and a small proportion selling wild products or engaged in crafts or skilled work.

Fifteen percent of women combine agriculture with other economic activities of their own. Another 15% of women were working for others and 7% were working in agriculture jobs. Most of the younger women were unemployed or had unspecified business (TDHS, 1996).

SOCIO-CULTURAL

Different cultures understand, organize and manage birth in their own way (Jordan, 1993). Anthropologists insist that the social aspect of birth can never be separated from its physiological aspect, for they physical events of childbirth are always taking place within a shared understanding of the best way, the right way, indeed the way to bring a child into the world (Jordan, 1993).

Pregnancy and childbirth are normal events. Although acknowledged as potentially risky, pregnancy and childbirth are considered natural, normal work for women. So many women consider childbearing as their only means of gaining status. Women often believe, that having many children is the main channel to improve their status. Even in some society where women are financially independent, they deliver pride and prestige chiefly from their roles as mothers. Societal expectation interferes with the use of health services in emergency conditions. Delivery at home remains one way for women to achieve status. For example, a women who has to go to a hospital for delivery is thought to have failed in her essential role as a women and is stigmatized.



In Benin, women of the Bariba tribe are expected to be stoic during labor and delivery and the woman who manages to deliver without calling for assistance is especially esteemed (Sargent, 1985).

In such situation, a woman's efforts to gain esteem and raise her status have direct implication for home childbirth.

Women's low status influences their health in many ways; for instance reduced access to education and information. They are often poorly informed about their health. Women's lower status in the family, where decisions regarding mobility and expenditures for their health care are in the hands of men, it is not easy for them to seek health care. Also it is recognized that health care providers treat women in an inferior way. Interactions with service providers: many women describe providers in the formal health care system as unkind, rude, brusque, unsympathetic and uncaring. Where health workers are perceived to be hostile and unfriendly, many women rely instead on traditional birth attendants and traditional healers for antenatal, delivery and postnatal care.

In Tanzania, a study found that 21% of women delivered at home because of the rudeness of health staff even though they thought delivering in a health facility was safer.

In Sudan, a study found that many women were ashamed of being poorly dressed in front of health worker (who were generally of a higher socio—economical class), and were also afraid the health workers would react negatively to their illiteracy. These

feeling deterred many from using formal maternal health services. Birth practices within a particular culture or sub-culture group within a larger one, are influenced by the way of living and thinking of the people who share that culture or sub-culture. Although some common elements may be found these practices, as a rule, vary considerably among societies (WHO, 1978).

Formal health services can conflict with cultural norms surrounding childbirth, including preferences for privacy, modesty and female attendants. Among the Saraguro Indians in Ecuador, hospital-based deliveries are perceived to violate privacy, many health providers are men, which is unacceptable culturally, and birth position preferred by providers are not those preferred by women in labour. As a result, affordable and accessible maternal health services are under-utilized (Leslie et al, 1989).

Women have very little or no control over the use of modern services. They have no say on matters pertaining to their health. For instance, traditionally in the community men normally decide for them the place for delivery, in his absence she has to wait for him to make a decision (Urassa, 1997).

Access to health care services is not a simple concept. It implies not only that the facilities exist, but that people have the information they need to use them properly, that the facilities can be reached by the people who need them, that the cost of care is reasonable, that the supplies and equipment are adequate and that services are provided

in a manner acceptable to the patients and their families. This invokes the whole concept of availability, accessibility and affordability (Thaddeus, S.and Maine, D.1990).

Women access to health care is also influenced by restriction on mobility and seclusion of women in the household. Utilization of the modern health services increases with increasing level of education. Education affects individual by introducing them to a new modern culture, that increasing level of education increase knowledge and awareness and that education increases access to information. Also increases self-confidence.

Many women giving birth in rural areas use the services of traditional birth attendants because primary care clinics are inaccessible. TBA`s are people (usually) women who have some experience in midwifery, and often also have skills in traditional healing. However they may simply be a neighbour or even a family member who usually acts as the midwife, during births in the area. (Update Issue No.38, Nov.1998).

TBA`s also called the traditional midwife, is defined by World Health Organization (WHO) as a "Person usually a women- who assists the mother at childbirth and who initially acquired her skills delivering babies by herself or by working with other TBAs. Traditional medical practitioners and birth attendants are found in most societies. They are often part of the local community culture and tradition and continue to have high social standing in many places, exerting considerable influence on local health practices.

With the support of the formal health system, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community.

Some communities may select them as community health workers. It is therefore well worthwhile exploring the possibilities of engaging them in primary health care and of training them accordingly (WHO, 1978).

This concept of traditional medical practitioner who can be found in most societies and is part of the social community, culture and tradition, came to prominence as part of the WHO emphasis on PHC.

It emphasizes the importance of obtaining information on TBA`s practices, in each local situation, when planning and conducting training programmes. It then goes on to sketch food prohibitions, ceremonies, and beliefs, about prenatal and postnatal care.

TBA`s could be a big asset in decreasing high rate of obstetric complications in developing countries. To be effective they need to be trained and respected by their medical colleagues. Training programmes should include:-increased safety in the TBA`s practice, such as cleanliness especially washing of the hands and clean or sterile cord-cutting procedure. Non-interference during labour. Include care of mothers before, during and after delivery, and also the identification and referral of mothers at risk. Doing away with traditional harmful practice and leaving alone or supporting those that contribute to psychosocial support. (Asghar, 1999).

In many developing countries, Traditional birth attendant is an important liaison between the community and the formal health care system. Developing culturally

appropriate home birth aids help TBA`s to make births safer. For example, PATH (Program for appropriate technology in health) has worked with groups in Bangladesh and Nepal to develop an inexpensive, single—use delivery kit that pregnant women can purchase in their communities. The kit contains pictorial instructions and the following new clean materials: a plastic delivery sheet, a razor blade, cord ties, and a bar of soap. Based on extensive qualitative research and pre—testing, the kits now are being locally produced and marketed in many regions and are contributing to clean, safer home births (Outlook vol.16, special issue.1998).

Home deliveries meet the emotional needs of family. Several family members and friends are commonly in attendance are encouraged to take an active role in the birth during home deliveries. The laboring woman is encouraged to stay off her back and remain physically mobile through labor and delivery. They are also encouraged to eat and drink during labor in the belief that this allays maternal exhaustion and the need for operative delivery (Durand A.M.1992).

TBA`s continue to attract a large clientele because they live within and are easily accepted as part of the culture and tradition of their local communities. Such TBA`s are familiar to their clients and easily accessible at anytime of the day or night, do not insist on payment before delivery, and are prepared to accept payment in kind anytime after the delivery. Even when and where modern, trained care providers are available, many women prefer traditional care at delivery for economic and social-cultural reasons (Itiana, 1997).

3.0 OBJECTIVES:

3.1: BROAD OBJECTIVE.

To describe the characteristics of women delivering at home in Songea-rural as an entry point for developing interventions.

3.2: SPECIFIC OBJECTIVES.

1. To determine women's perception of maternal care services provide by health workers.
2. To determine women's perception of maternal care services provided by others (TBA`s, Traditional healers etc.).
3. To determine women's knowledge of the danger signs during pregnancy and delivery.
4. To identify factors for non-utilization of health facilities.
5. To identify who determines place of delivery.

4.1.0. METHODOLOGY

4.1.1. STUDY DESIGN

A cross sectional study was conducted in Songea—rural district from 16th June to 30th August, 2001.The study focused on home deliveries and the associated factors, among women of reproductive age (15—49 years).

4.1.2. Description of the study area

Songea –rural is one of the four districts in Ruvuma region, which is located in the southern part of Tanzania. The size of Songea district is 33,925 square kilometers. (Figure 2.). Songea-rural district is sparsely populated with only 377,381 inhabitants. The Ruvuma River in the south constitutes the border with the Republic of Mozambique. In the East Songea district borders with Tunduru district, in the West with Mbinga district and in the North with Ulanga and Njombe districts.

The district is composed of seven (7) divisions: -Ruvuma, Madaba, Hanga, Undendeule, Mkongo, Muhukuru and Sasawala division. These divisions are sub-divided in twenty-six (26) wards with in total one hundred and twenty eight (128) registered villages.

The climate is cold especially in June to July. The daytime temperature ranges from 20°c to 25°c,while during the night the temperature is between 15°c and17°c. Songea has only one rain season (long rain) in the period of November to May. Rainfall usually increases with altitude, hence the lowland is relatively drier compared to the highlands. The soil is generally fertile and productive for both cash and food crops, which include tobacco, cashwenuts, coffee, maize, beans and rice.

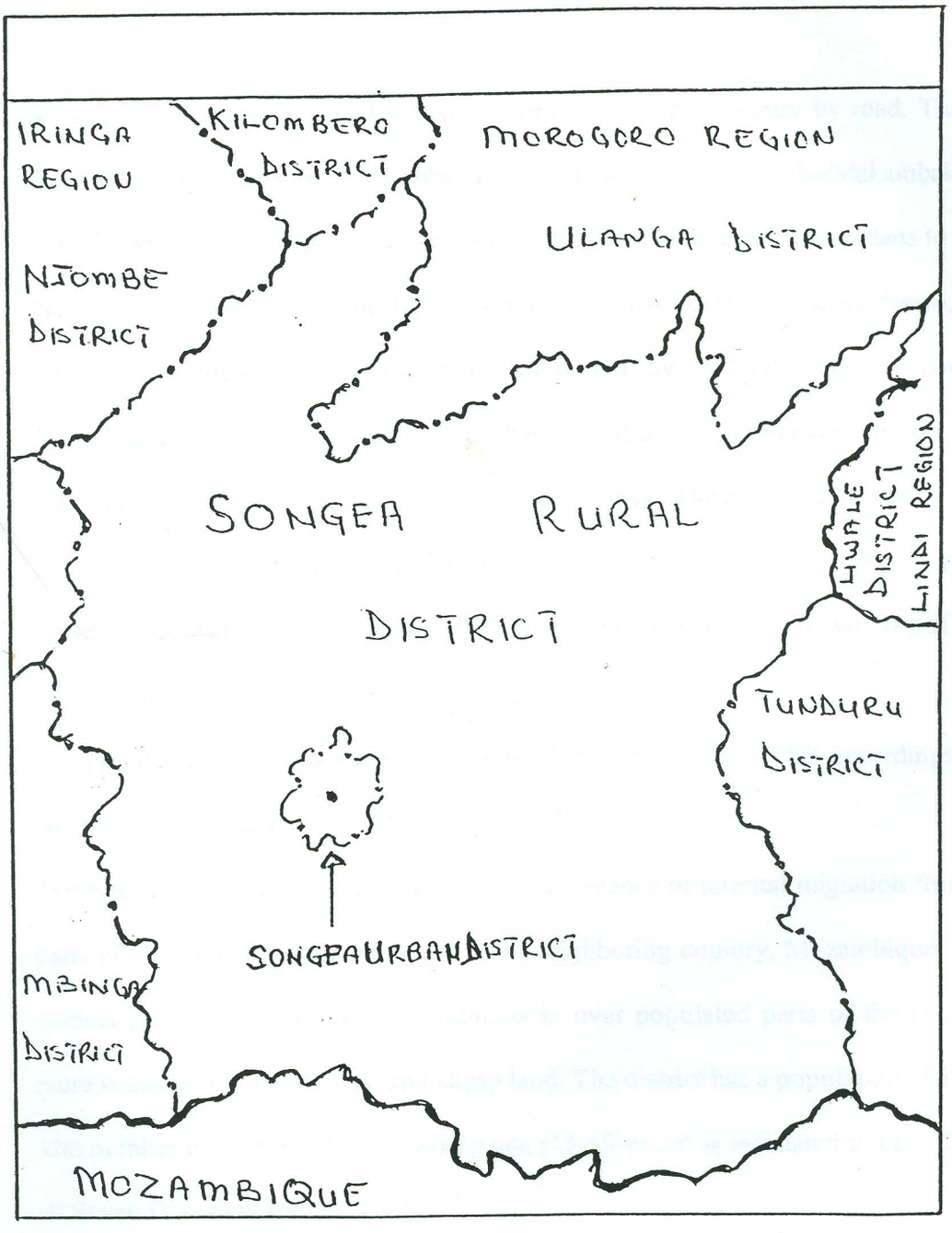


FIGURE 2: Map of Songea Rural District with its boundaries

Songea is accessible from other districts and parts of the country by road. There are three main roads: to Mbinga/Mbamba-Bay, to Tunduru and to Njombe/Makambako. The Njombe/Makambako road is the only one with tarmac. There are future plans to tarmac the road from Mtwara on the Coast through to Mbamba-Bay on Lake Nyasa, under Mtwara Development Corridor to be supported by SADDC member countries. Travelling in Songea district is difficult because of poor road network. In general the roads (village roads in particular) are in bad shapes. They are gravel roads without proper construction, drainage and maintenance. The muddy soils, steep slopes and intensive seasonal rainfall are factors that complicate securing the accessibility of remote villages during rain season.

The population growth rate is 3.4%, which is higher than that of 2.8% accordingly to the National Census Report of 1988.

The population of the district is growing fast, because of internal migration from other parts of the country and immigration from neighboring country, Mozambique. Songea attracts people from farming communities in over populated parts of the country, as there is abundant uncultivated and cheap land. The district has a population of 377,381. The number of women of childbearing age (15-49 years) is estimated to be 182,861 in all Seven Divisions and 26 Wards.

Ethnic composition of the district population comprises of Ngoni, Ndendeule, Yao, Bena, Pangwa, Matengo and Nindi

Agriculture is the main occupation for all ethnic groups. Industrial development is virtually notexisting.A few industrial activities includes tiles production at Peramiho Mission, paper printing, carpentry and small-scale sugar production. Other non-farming economic activities include fishing, charcoal making, timber harvesting, pottery, blacksmiths mining and beekeeping.

The Songea-Rural District has one (1) Hospital, which is Peramiho Mission Hospital, Seven (7) health centers and 64 dispensaries. (Figure3).

4.1.3. Target Population

The target population of the study was women of childbearing age (15—49 years) who had home deliveries, in the past five years.

4.1.4. Study population

This consisted of a sample of 416 respondent women from Songea-Rural District from eligible target population. This sample consisted of women who had delivered at home, with or without living child.

All women who had home deliveries were included, regardless of the outcomes of their pregnancies that might have been stillbirths, livebirth or prematurity. They were studied to be able to know reasons for not seeking maternal health care in the health facilities.

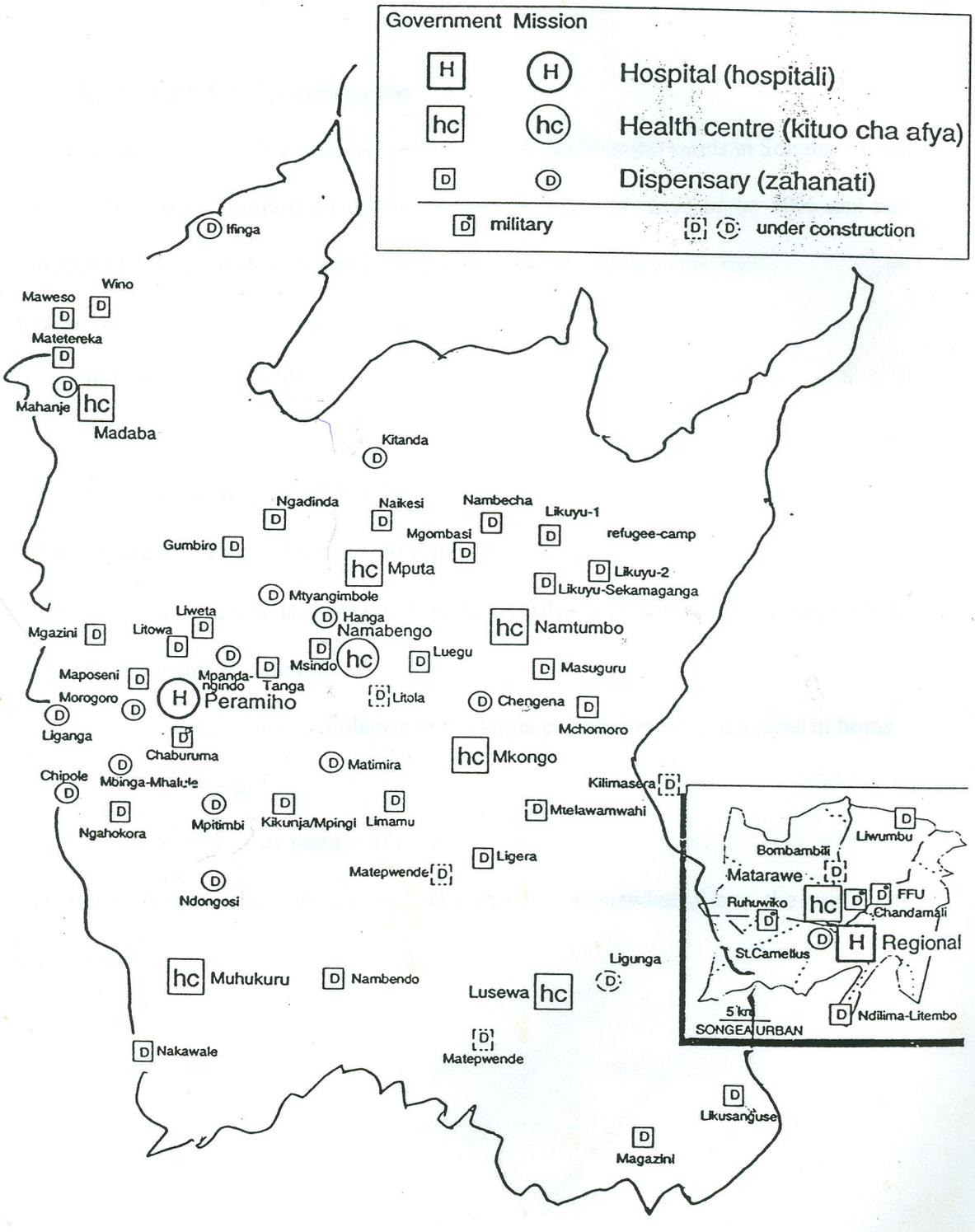


Figure 3: Map shows health units in the district

4.1.5. Sample Size Determination

The study involved women who had childbirth at home from the wards in Songea—rural district. The study proportion of the population was estimated to be 50% and the maximum likely error expected to be 5%. Therefore, the sample size was:

$N=z^2pg/d^2$

$$n=\frac{(1.96)^2 \times 50 \times (100-50)}{25}$$

n= no. Of participants =384 =400

Where n= estimated total sample size

z= the standard normal deviate, usually set at 1.96 which corresponds to 95% confidence interval.

p= estimated population in the target population who delivered at home

q= 1—p

d= tolerable margin of error.

The actual sample size attained was 416,which is somewhat above the minimum required sample size.

4.1.6. Sampling technique

The study was carried in five divisions, out of the seven divisions of Songea rural district. Two divisions were excluded because of the distance and impassable roads. The selected divisions were Ruvuma, Madaba, Hanga, Undendeule and Mkongo.From these division eight administrative wards were selected by simple random methods. Lottery system was used. Working together with division and ward administrative leaders, eight wards were selected by lottery system. The wards selected were Maposeni, Wino, Kitanda, Msindo, Namabengo, Namtumbo, Mgombasi and Ligera.

It was planned that, from the eight wards, to have eight villages with an estimation of 100 households. In each village it was expected to have 50 women of childbearing age, that is 50 deliveries from each village for the past 5 years. That is, 50 x8 =400 women of reproductive age (15-49 years) as a sample size.

During the study, this was difficult, as they were no people in the houses, some were in the farms cultivating, and others had traveled to nearby villages to sell their products. Most villages had ceremonies that made people move from one village to another.

For this reason, the number of study villages had to increase from eight to sixteen, within the same eight wards. The villages where interviews were conducted are Litowa, Mgazini, Wino, Lilondo, Madaba, Shule ya Tanga, Namabengo, Kitanda, Mgombasi, Chengena, Likuyusekamaganga, Nambecha, Mtelamwahi, Matepwende, Limamu and Nakawale.

The social-cultural and agricultural activities, made it difficult to get women of childbearing age at their houses. Women were interviewed in places found at that

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particularly time of the day in that village, that is, whether at the dispensary, market place or ceremony area.

Many women were interviewed, so as to get the required sample size. Some areas more women were interviewed to compensate areas with fewer women of childbearing age. Woman was first asked if she had delivered in the last 5 years. If yes these women were included and if it was no, these were excluded from the study.

The interview was conducted to each respondent at her own convenient place of her choice so as to increase confidentiality.

4.1.7. Recruitment and training of research assistants

Two responsible, committed female health workers from Songea rural district were recruited to carry out the fieldwork. Their qualifications were nursing officers. All of them had training and long experience on maternal health care services. They had worked on several maternal mortality and child health research. In additional, the research assistants were fluent in the vernacular languages spoken by the studied population (Kingoni, Kindendeule and Kimatengo).

A one-day seminar was conducted in Songea town, at which instructions were given on the study approach in general and on some specific responsibilities. The Kiswahili

translated questionnaire was used. All the interviewers participated in pre-testing the questionnaire.

4.1.8. Pre-testing of the tools

Before starting the full scale-study, a pre-test was carried out to test the study procedures and instruments. The pre-testing was conducted at Songea-Regional hospital in Ruvuma, where six (6) participants as a pre-testing sample were interviewed. No modifications were needed.

4.1.9. Data collection

The principal investigator and two research assistants were involved in the study. The interview was conducted in Kiswahili by using a standardized questionnaire that was designed for the study. Guidelines were also used. Both the English and Kiswahili version of the questionnaire and the guidelines are shown in appendices 1,2 and3.

Data collection involved a visit to each village accordingly to the work schedule planned as per timetable. Each respondent was interviewed privately after establishing a good rapport. Data on socio-demographic characteristics, socio-economical status of the women, socio-cultural and traditional beliefs. Women`s perception of the health services, health workers, TBA, and traditional healers. Community perception on home deliveries, who decides on places of delivery and reasons for home deliveries. All information was entered into the questionnaires.

4.10. Quality control of the data and data processing: -

The principal investigator made consistent visits to the field as part of supervision for data collection. The consistence of data collection was regularly checked.

Everyday after data collection, the principal investigator and other interviewers discussed problems faced during the day and made sure that the questionnaires were adequately filled, and ready for next day. The principal investigator also conducted a rapid check of all the information collected and if the questionnaires were all filled. Pre-coding to the closed questions was done before data collection.

4.11. Data analysis

The entire questionnaires were first assigned serial numbers, when the data coding for the variables to be analyzed was done. The open-ended questions were analyzed manually.

The Epi –info 6 programs was used to enter and analyze the data. Data cleaning followed this.

In this study, home delivery was used as dependent variable while age, parity, level of education; marital status, decision makers, distance and transport were independent variables.

In this analysis each of these factors was considered separately, because it is of importance to know whether all these are associated with home deliveries. For example, does level of education influence place of delivery or does parity has influence with home delivery.

4.12. LIMITATION:

1. Selection bias:

Participants were selected on random sampling, which may not be the representative sample of the whole district.

2. Interviewee bias:

The research assistants were medical personnels. The medical personnel, being familiar to the interviewee, this might have caused them fear to give right answers, assuming that they will be denied of good health care and hence giving answers in favour of health facility care.

3. Recall bias:

Respondents might not be able to remember exactly what had happened at the time of her last delivery. Women who had home delivery in the past 5 years were interviewed.

4. Selecting only those who delivered at home.

5.0. ETHICAL CONSIDERATION:

Ethical clearance for this study was sough from the research and publication committee of MUCHS. Permission to conduct the study at Songea-rural district was obtained from the district administrative leaders. In order to get informed consent, the participants were told the objectives of the whole study and how the data collected will be of use. Those who had agreed after knowing, the aim of the study were enrolled in the study and those who disagreed excluded from the study.

6.0. RESULTS:

A total of 416 women ages ranging between14—49years who had at least one delivery in the past 5 years were interviewed in Songea rural district. This is 104 % of the calculated sample of 400 women.

The age characteristic of the sample population is given in table 1. Of the 416 respondents, 98 (23.6%) were aged between 15 years and 20 years. Other respondents133 (32.0 %) were of the age between 26 years and 30 years. While, 5 (1.2 %) were between the age of 36 years and 49 years, and only 3 (0.7 %) were below 15 years.

The study showed that 313 (75.2 %) of the respondents had attained primary education and

83(20 %) had never attained formal education. Only 19 (4.6 %) had attained secondary education.

Table 1: Age characteristics of the study population who delivered at home:

Table 1: Age	Frequency	Percents
14	3	0.7 %
15____ 20	98	23.6 %
21____25	119	28.7 %
26____30	133	32.0 %
31____35	57	13.7 %
36____49	5	1.2 %
Total	415	100.0 %

Majority, 98.7 % were young women, below 35 years.

Table 2:Level of Education

Education	Frequency	Percents
Primary education	313	75.2 %
Secondary education	19	4.6 %
Above secondary education	1	0.2 %
No formal education	83	20 %
Total	416	100.0 %

Most of the respondents had attained seven years of education 313 (75.2 %). 83 (20 %) of the respondents had no formal education.

Table 3: Marital status

Marital status	Frequency	Percents
Single	111	26.7 %
Married	274	65.9 %
Stays with a man	2	0.5 %
Widow	10	2.4 %
Divorced	19	4.6 %
Total	416	100.0 %

Table 3 above show that 274 (65.9 %) of the respondents are married, compared to 111 (26.7 %) single women.

Table 4:Parity distribution among women aged 15 ____49 years.

Parity	Frequency	Percents
1----- 2	164	39.5 %
3----- 5	124	29.9 %
More than 5	127	30.6 %
Total	415	100.0 %

This table shows that 127 (30.6 %) of the respondents were multiparous having delivered more than five times.

Table 5:Place of delivery last child below 5 years

Place	Frequency	Percent
Health Unit	18	4.3 %
Home	398	95.7 %
Total	416	100.0 %

398 (95.7 %) of the respondents had home deliveries. Only 18 (4.3%) had delivered in health units.

Table 6:Shows the association of level of Education and place of delivery last child

Education	Place of delivery				Total	
	Hospital		Home			
Primary	15	(4.8%)	298	(95.2%)	313	(100.0%)
Secondary	2	(10.5%)	17	(89.5%)	19	(100.0%)
Above secondary	0	(0 %)	1	(100.0%)	1	(100.0%)
No formal education	1	(1.2%)	82	(98.8%)	83	(100.0 %)
Total	18	(4.3%)	398	(95.7%)	416	(100.0%)

Table 6 show that level of education has no association with place of delivery.

Table7: Shows marital status and place of delivery

Marital status	Place of delivery		Total
	Hospital	Home	
Single	5 (4.5%)	106 (95.5 %)	111 (100.0%)
Married	13 (4.7%)	261 (95.3%)	274 (100.0%)
Stays with a man	0 (0%)	2 (100%)	2 (100.0%)
Widow	0 (0%)	10 (100%)	10 (100.0%)
Divorced	0 (0%)	19 (100%)	19 (100.0%)
Total	18 (4.3%)	398 (95.7%)	416 (100.0%)

Unmarried women 137 (100%) had more home deliveries than the married ones.

Table 8: Shows parity and place of delivery

Parity	Place of delivery		Total
	Hospital	Home	
1 ----------2	8 (4.9%)	156 (95.1%)	164 (100.0 %)
3 ----------5	6 (4.8%)	118 (95.2%)	124 (100.0%)
More than 5	4 (3.1%)	123 (96.9%)	127 (100.0%)
Total	18 (4.3%)	397 (95.7%)	415 (100.0%)

Women who delivered in health units have been decreasing, as there is increase in parity.

Table 9: Reasons for home deliveries

Reason	Frequency	Percent
Experience of giving birth	93	22.4 %
Parents	11	2.4 %
In Laws	46	11.1 %
Told by Relatives	7	1.7 %
Financial problems	223	53.6 %
No one to escort	36	8.7 %
Total	416	100.0 %

Table 9 show that 223 (53.6%) of the respondents gave financial problem as reason for home delivery.93 (22.4%) had experience of giving birth, while 46 (11.1%) were told by their in-laws to deliver at home.

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Table10: Women's perception of maternity care provided by health workers

Perception	Frequency	Percents
Good	179	43.0 %
Fair	181	43.5 %
Poor	40	9.6 %
Do not know	16	3.8 %
Total	416	100.0 %

Despite that 360 (86.5 %) rated the quality of health services provided by health workers as good or fair, still they is low proportion of deliveries in health units.

Table 11:Women`s perception of maternity care provided by the TBA`s

Perception	Frequency	Percents
Good	93	22.4 %
Fair	303	72.8 %
Poor	4	1.0 %
Do not know	16	3.8 %
Total	416	100.0 %

Majority of the respondents 396 (95.2 %) had rated good and fair quality of maternity care provided by the TBA`s, as most of them had had home deliveries.

Table 12:Preference of source of assistance in case of emergency:

Preference source of assistance	Frequency	Percents
Nurse/midwife	283	68.2 %
Traditional birth attendants	132	31.8 %
Total	415	100.0 %

Findings shows that 283 (68.2 %) of the respondents would like maternity care assistance from health workers in case of emergencies, while 132 (31.8 %) of the respondents would go for TBA`s.

Table 13: Community perception towards home deliveries

Perception	Frequency	Percents
Normal	96	23.0 %
Despised of ignorance	71	17.1 %
Highly esteemed for brave act	238	57.3 %
Do not know	11	2.7 %
Total	416	100.0 %

334 (80.3%)were highly esteemed for they're bravely act, 71 (17.1%) thought that women who delivered without assistance were ignorant, and only 11 (2.7 %) knew nothing.

Table 14: Decision makers on the place of delivery

Decision maker	Frequency	Percent
Husband	258	62.0 %
Parents	72	17.3 %
In Laws	74	17.8 %
Do not know	12	2.9 %
Total	416	100.0 %

Husbands, parents and the in-laws were the decision makers.

Table 15: Availability of transport at night.

Transport	Frequency	Percent
Yes	12	2.9 %
No	404	97.1 %
Total	416	100.0 %

Majority of women 404 (97.1%) had no access to transport especially at night. Only 12 (2.9%) had access to transport.

Table 16: Type of transport commonly used to transport women to health facilities.

Transport	Frequency	Percents
Bicycle	287	69.0 %
No transport	97	23.3 %
Vehicle	19	4.6 %
Local made stretchers	12	2.9 %
Cart	1	0.2 %
Total	416	100.0 %

The commonest means of transport are bicycles.

Table 17: Distance traveled to health units in kilometers.

Distance in kilometers	Frequency	Percents
1--------5	397	95.4 %
6--------20	19	4.6 %
Total	416	100.0 %

Findings in table 17, show that 397 (95.4 %) of the respondents are within 5 kilometers to the nearest health unit, while 19 (4.6 %) of the respondents are within 10 kilometers and more from the nearest health unit.

7.0. DISCUSSION:

This study has shown that home delivery is very common. There is low utilization of maternity health services by women in Songea-Rural District. This is a life-threatening situation in the community. These women report at the health units only to weigh their babies and get examined if they have any major problems.

The findings from this study have shown that home births are linked with age of the women, their parity, traditional and cultural norms related to women's social status and roles. From the study 98.0 % women of childbearing age between 14 years and 20 years had given birth before the age of 20 years. Although not all childbirths occur within marriage, young age at marriage is closely linked to first birth due to cultural norms and expectations.

Findings of this study are in agreement from those by N.Sadik, 1997,that, young girls in traditional societies are often bound by cultural norms that equate marriage and motherhood with female status and worth. In other cases, cultural traditions encourage young women to prove their fertility before marriage (J.Sendorowitz, 1995).

The study has shown that both age and parity were highly associated with home deliveries. Increasing of both age and parity act as a factor of being experienced in unassisted home childbirth. This was supported by the in-depth interview that, increasing age and parity is when more experience is gained on signs of labour and delivery.

One of the participants had total of six (6) home deliveries. She said, "I had been only

assisted twice by the traditional birth attendant, otherwise, I give birth alone and I feel proud of it". Another respondent who had a total of thirteen (13) home deliveries had Said," I always feel happy, when my husband comes home to find me already having a baby". Most of them feared that during their absence something wrong might happen at home, as they have no one to leave behind.

It was also revealed that increase in domestic responsibilities make them fear to go to health units early as in their absence things might go wrong at home.

When in labour, they still can supervise home activities, and arrange for traditional birth attendants or any other one, to come and assist her in labour.

Similarly observations were found by Kowalski (2000) in Southern Tanzania, Okojie (1994) and Bolam (1998) in Nepal who had suggested that increased home responsibilities prevent multiparous women to reduce or receive adequate care during pregnancy or delivery, making them unwilling to go to deliver to the hospital because it could disrupt household organization. These responsibilities and there experience of giving births contribute to the factors of home delivery. These women are not willing to walk or travel a distance away from their home so they deliver at home.

Early pregnancy and childbirths limits educational opportunities and achievements. Young women are often expelled from school if they became pregnant, and fewer ever return. This was supported on the in-depth interview as some girls failed to complete the seven years of schooling because of pregnancies and were expelled from schools. This was because most parents delayed the enrollment of their children in school. Girls are

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enrolled in standard one when they are seven to ten years of age, as they are to perform important domestic tasks, taking care of their even younger siblings while parents are away from home or working in the farm. By the time they are in class two (2) they are already involved in sexual relationship before they know their reproductive biology.

A national study in Botswana showed that one in seven women who dropped out of school did so because of pregnancy and only one in five dropouts returned to school (A. Tinker, 1994). Although level of education has influence with early childbearing, but the study has shown, in table 6, not to have significant association with home deliveries.298 (95.2) % of women who had seven years of education and 82 (98.8%) of women who never had formal education, both had given birth at home. Each women having other associated factor.

This study revealed that of the 398 who had home deliveries 265 (66.5 %) would prefer to be assisted by a nurse/midwife during delivery. Husband's, parents and the in-laws make decisions of place of delivery in 404 (97.1 %). Other studies conducted in Nigeria and Bangladesh, showed that decision belongs to their mother's in-law, husbands or family members (Juncker and Vanneste, 1994). The in-laws and Parents have all powers of making decisions.

Parents are the decision makers to young unmarried women who have the responsibility of caring for a young child and have limited access to income-earning opportunities. This mean that, the pregnant women is under control of the husband, Parents or her in-laws. In support to this, in the in-depth interview it showed that when husband was away,

pregnant woman was left with her in-laws or her parents.

The study showed that financial problem was an obstacle for not seeking maternity health care. Majority of women 223 (53.6 %) in table 9, were not able to encure costs of health services. These women do not have economic power, so they lack influence on their husbands and families to make decision of their own health.

One woman said, "I was advised to deliver at the health center, but my husband had no money, so he sent me to his parents. When I was in labour they called an old women to assist me, the experience I had I will never forget."

Another women had said," he told me, the money is for buying fertilizers, I should choice to go alone to health center or give birth at home. I had no money, I delivered at home, and my neighbour assisted me". Husbands do provide money to pay for health care and this means that no money, women cannot seek maternity care in the health unit. Findings from this study agrees with that done by Greese, A. (1990) in Ghana, Niger, Nigeria and Zaire, that showed, user charges for health services introduced or raised in developing countries lead to decline in use of health services.

The study found out that, in Songea rural district, the health units are within reach of the villagers. In table no.17, shows that, 397 (95.4 %) of women live within 1 to 5 kilometers from the health unit, while 19 (4.6 %) of the respondents live as far as 20 kilometers from the nearest health unit. It was found that, women do not utilize the maternity care services because, the services are provided in old, ruined buildings, with very limited

space and the environmental surrounding does not offer privacy and enough shelter for women. They are few essential types of equipment, most of which are worn-out and beyond repair. Health facilities in rural areas are with low qualified health attendants. TBAs and relatives are conducting deliveries.

In the in-depth interview, some women had commented that, the health units had no health personnel (nurse/midwifes) to assist them in labour. Others had said, "after childbirth, you have to send someone to buy drugs in town or give the money to nurse and you get everything here".

Many facilities lacked basic supplies and equipments. This finding relates to that study done in Jamaica, which found that, nurses at the main maternity hospital in Kingston were continually frustrated by a lack of basic supplies like gloves, bleach and pens. This frustration affected their interactions with patients seeking care (J.Leslie, 1989).

Some claimed that it took time to get the health workers, especially, after working hours. Other study showed similar findings, that they are long waiting time and inconvenient opening hours, and this is an important factor of not using or seeking health services (Thaddeus, et al 1994).

Further interview revealed reasons why they did not utilize the nearby health facilities. Most of the women had said, it was due to bad relationship they had with the health providers and the poor quality of services. Many studies have found that health care workers often treat women in an insensitive manner, not paying adequate attention to their concerns and treating them rudely, particularly when they come late for treatment or

do not comply with medical advice. (C.AbouZahr, 1996).

In the study, women were interviewed on their knowledge of danger signs that might develop at the time of pregnancy or delivery. It showed that respondents knew more than one sign. Among the signs which were mentioned included, anaemia, unexpected vaginal bleeding during pregnancy, edema of the lower extremities, ceasing of fetal movements, excessive bleeding during delivery, eclampsia and breech presentation. One of the respondent, had said, "We get good health information's and teachings at the clinics."

This is the good result of antenatal clinic in the country. In Tanzania 97 % of pregnant women attend antenatal care (TDHS, 1996). There attendance had gained them enough knowledge of dangers that are pregnancy related. With that knowledge 283 (68.2%) in table 14 would prefer assistance from nurse/midwife in case of emergency, and that is in the health unit.

The community viewed women who delivered at home to be brave 334 (80.3 %) in table13, but Findings in table 10 show that 86.5 % had rated good or fair the quality of health services which is they would have preferred to delivery in health facilities than delivered at home were they are highly esteemed for their act.

These are women who have delivered at home more than once and had no problems during pregnancy and are highly esteemed by their husbands, parents and the in-laws.

In Songea-Rural the study found that women delivery at home not to achieve status but due to poor quality of maternity care services at the health facility units. This finding differs from that of Sargent, 1985, that had revealed that, a women who delivery in

hospital has failed in her essential role as a women and that a woman's efforts to gain esteem and raise her status have direct implication for home childbirth.

In Songea rural district, most of health units have no nurse/midwifes. This is a chronic shortage of personnel with midwifery skills. In developing countries, like Tanzania, most midwives work in hospitals, and therefore most live and practice in urban areas in or near regional and district hospitals. In Kenya, for example, 56 % of all health workers, including nurse/midwives, are based in urban areas, with 25 % located in Nairobi alone. (W.Graham, 1997).

From the study, women deliver home assisted by the Traditional birth attendants. These TBA`s are recognized in the community. In the in-depth interview, most of the women had said, that, "Home is more relaxing, easier, satisfying, fulfilling, being in control, no disruption, husband or parents more involved, private, family event, and with TBAs, showing respect, confidence, relaxed attitude, enthusiasm and support."

Most of them had one month or less training in Safe Motherhood-safe delivery techniques. In developing countries, developing culturally appropriate home birth aids help TBA`s to make births safer. For example, PATH (Program for appropriate technology in health) has worked with groups in Bangladesh and Nepal to develop an inexpensive, single-use delivery kit that pregnant women can purchase in their communities. (Outlook vol.16, Special issue.1998). It is suggested to develop a portable

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delivery kit, which will consist of pictorial instructions with new clean materials as, pairs of gloves, a mackintosh or a plastic delivery sheet, razor blade, gauze or cotton-wool, cord ties and a bar of soap.

As from the study, it was revealed that women have to purchase the materials, while or during labour; this causes a lot of inconveniences, both to the nurse and patient.

TBAs have a role in supporting women during labour, but generally are not trained to deal with complications (WHO, 1992). Studies in Africa and Asia have found that training TBAs in the absence of skilled back-up support did not decrease woman's risk of dying in childbirth(A.Tinker,1993).TBA`s are not substitutes for skilled attendants. Training and working with TBAs is one of the strategies to which many countries in the world have resorted to, for improving maternal health. They are needs to train more nurse/midwifes, TBAs and to supervise them. Studies show that, systems for supervising health care workers and providing refresher training are often inadequate (WHO, 1990). It is important to increase personnel with midwifery skills, revise the resources they have (or lack), and the complication they face. When qualified staffs are working with adequate resources and other support, they are able to manage health problems more effectively, reducing deaths. In addition, when services are appreciated and valued by community members, they are more likely to be used on a timely basis, reducing the need for home deliveries.

Among the study findings were the ill characteristic and perception of the community

towards diseases occurring or related with pregnancy and deliveries. When pregnant is sick, they first consult a traditional healer, as they believe that the cause of their problem might be associated with witchcraft, ancestral spirits or prostitution. They regard traditional healers as the only appropriate protector to their problem. A change in harmful social-cultural beliefs and traditional norms is very important.

Pregnant women consult traditional healers. They receive local herbs medications and they are advised to delivery were maternity care is available.

Most important, changes lie in the structure of the society and changes must occur from bottom-up and not up-bottom. People in health programs and the government must put community demands into action and to ensure women status become crucial at the cabinet meetings.

Home deliveries, in Songea rural district are a problem that will take a considerable amount of time, money and political will to solve. There are several comparative inexpensive measures that could reduce home deliveries. Some of the measures were already in use and others were not in use. These are pregnant women having close health units (buildings) with poor quality of services. High quality maternity health care can be provided in a variety of settings and does not refer only to hospital-based treatment. High quality care must be assured in whatever environment maternity health care takes place: the home, rural or urban health centers, or well-equipped hospitals in large cities. (M.Koblinsky 1997). In order to assure high quality, maternity health services should be

evaluated at regular intervals, from both service provider and client perspectives, and improved as needed (WHO 1993).

High quality maternity health services must be part of a continuum of care that spans from the pre-pregnancy to the postpartum period, and in which women and health providers are partners in care. (WHO 1995).

Songea rural pregnant women, living far from health units, hospitals were implementing the measure by moving to live with their relatives who live close to the hospital, others stayed in maternity waiting home. Unfortunately, the maternity waiting home is available at the mission owned hospital, while the regional hospital has no maternal waiting home. Worse enough the Songea rural district has no district hospital, and its health centers have no maternal waiting homes. Having maternal waiting homes in each health center, will at least reduce home deliveries. In table 15,the majority (97.1 %) of the respondents had no access to transport when in labour, especially at night. These women knowing their expected days of delivery, they will arrange early to stay in the maternal waiting homes. The commonest type of transport used is bicycles (69.0 %). This is a difficult means of transport, when a woman is in labour. Roads are impassable in most areas, so women walk (23.3 %) to health units. This is shown in table 17.

World Health Organization endorsed another measure, "programs should be provided at most peripheral level of the health system at which this can be effectively (WHO, 1985). The local government and the community should see that the district has a district hospital. Renovations and construction of new health centers and dispensaries, equipping

them with essential equipments and supplies should be given priority, in the district plans. More staff with midwifery skills must be trained to meet existing needs and deployed in under-served areas. More Traditional birth attendants are to be trained, so as to be able to identify danger signs and encourage women to deliver in health units. Moreover, TBAs are already in the rural areas where people have less access to modern maternity care. The 1978 Alma Ata declaration on PHC reiterates the importance of building of teams with the traditional practitioners. Furthermore, TBAs are accepted and trusted members of the community and are reimbursed by women and their families, and so do not add to the government payroll. It is also important to establish strong links between the traditional birth attendants and the health units, and there referrals be accepted. They should be given regular training and supervisions. Poor supervision of health workers contributes to unsatisfactory services. This was also identified in the study reported in Zimbabwe (Fawcus et al, 1996). These supervisions should not be for health workers only, but should include TBAs, as they deliver most of the babies. With close links they will be reduction in home deliveries.

Community knowledge on reproductive health and sexual education, knowledge on the dangers of early marriages and early childbirths, and the dangers of home deliveries is an important part in reduction of home deliveries.

8.0. CONCLUSION:

This study was conducted in Songea rural district, where home delivery is very common. Women delivery at homes, inspite of maternity care services being within their reach. They do so because of the poor quality of care and services. The health units need to be renovated and equipped with basic equipments and supplies. The District Health Committee and Local government leaders should consider employing staffs with skills in midwifery and train the existing health workers in nurse/midwifery skills. As this might be a long –term program, emphasizes be made to train, supervise and equip TBAs who do conduct most of the home deliveries. Skilled attendants are needed to work in every health units in the district.

The study has shown that, home deliveries can be reduced with raised community awareness, improved maternity care services which should go hand in hand with effective antenatal care.

9.0. RECOMMENDATIONS:

1.Improve the quality of maternity services in the existing health units, improve the facility structures to provide privacy and make sure they are constant and regular supplies of drugs and equipment in all health units, as a step towards intervention of home deliveries.

2.Local government and District leaders and the District Health Committee should arrange training of more health workers; nurses/ midwives and TBAs, and to employ attendants with skills in midwifery.

3.Local government, District leaders and District Health Committee, should see that something is done to improve socio-economic status of the women in Songea-rural.

4.Ministry of health, Local government and District leaders, together to plan to build a District hospital and provide a functioning system of communication and transportation between all levels of health system.

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