WOMEN CONTRIBUTION TOWARDS IMPROVING MATERNAL AND CHILD HEALTH: A CASE STUDY IN MWANANYAMALA HOSPITAL

WOMEN CONTRIBUTION TOWARDS IMPROVING MATERNAL AND CHILD HEALTH: A CASE STUDY IN MWANANYAMALA HOSPITAL

By

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A Dissertation Submitted in Partial Fulfilment of the Requirement for the Award of the Degree of Master of Public Administration of Mzumbe University

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CERTIFICATION

The undersigned certificate that he/she has read and hereby recommends for acceptance by the Mzumbe University as research paper title “Women contribution towards improving maternal and child health: a case study in Mwananyamala hospital”, in partial fulfillment of the requirement for the Masters in Public Administration of Mzumbe University.

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ABBREVIATIONS

ANC	:	Antenatal Care
MDG	:	Millennium Development Goals
MOH	:	Ministry of Health
PMTCT	:	Prevention of Mother to Child Transmission of HIV
PNC	:	Post natal care
SPSS	:	Statistical Program for Social Sciences
WHO	:	World Health Organization

ABSTRACT

Background: Despite over a century's worth of knowledge that exists on how to prevent maternal mortality in reasonably simple and inexpensive ways, women in developing countries of which Tanzania is a part are still dying at an alarming rate as a result of pregnancy. Moreover, male involvement in maternal health services remains a challenge to effective health care accessibility in general and maternal health care service utilization by the pregnant women and mothers in particular.

Objective: The overall objective of the study was to examine the contribution of women towards improving the Maternal and child's health.

Material and Methods: This study was a cross sectional hospital based survey. The study employed both quantitative and qualitative techniques of data collection. Potential interview subjects were recruited using non-random sampling of women waiting to receive health services at Mwananyamala health clinic or at home around Mwananyamala suburbs. The study also interviewed health workers at Mwananyamala hospital.

Results: The sample population had a mean age distribution of 28.1 ± 0.72 and 25.5 years for those who responded to questionnaires and those who participated in an in-depth interview respectively. For those who responded to questionnaires, most were; - married (41%) and having 1-2 children (48.3%), received information about ANC services (68.7%) and were attending ANC services (61.7%). For those who participated in an in-depth interview, the mean number of children per woman interviewed was 3. Mothers who were attending hospitals and health centers for maternal, child health services: - had significantly higher time during which they started to visit ANC. Again they were significantly likely to receive pregnancy counseling, take HIV test and multivitamin consumption. The chance to take children for immunization was again significantly higher for mothers who were attending hospitals and health centers for maternal and child health services (68.4%), had significantly knowledge on exclusive breastfeeding (69.7%) and practiced

exclusive breastfeeding (76%). Male or father participation towards maternal and child health services was considered poor.

Discussion: About 61.7% reported to have attended antenatal maternity care. This was different from what has been reported in the Tanzania Demographic and Health Survey report 2010 which showed that about 96% of women indicated to have attended the antenatal maternity care. The number of mid-wives was mentioned to be inadequate and the present ones had no good skill. More mid-wives are needed to improve maternal and newborn survival. Most mothers realized that they were pregnant by 2nd and 3rd month. Discussions about pregnancy and postpartum danger signs and postpartum care could inform women about appropriate care and the types of services available. Timely and appropriate information is essential to help women make informed choices about their place of birth and the way that they use maternity services. The obstacle for proper nutrition for mothers and children is lack of nutrition education and knowledge. Nutrition education and counseling are considered to improve nutrition practices before and during pregnancy to improve maternal nutrition and reduce the risk of poor health outcomes in both mothers and their children. In Mwananyamala area, male or fathers do not offer a supportive role to their partners during pregnancy, labor and birth and after the baby is born. It is clear that in some communities, women's health is valued less than that of men.

Conclusion: It is therefore concluded that attending hospital or health center for maternal and child health services significantly contribute to improved maternal and child health as indicated in some key aspects in this study.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 Introduction

This chapter presents the background information for women contribution towards improving maternal and child health a case study in Mwananyamala Hospital. It describes the background to the problem, statement of the problem, research objectives, research questions, the significance of the study, and scope of the study.

1.2 Background of the study

Maternal health is a state of complete physical, mental and social well-being of the mother; it is a resource for everyday life of the mother.

Millennium Development Goals (MDG) cannot be explained without mentioning improvement of maternal and child health. Maternal health care services comprise of a wide range of health services given to the mother before pregnancy, during pregnancy, labor and after delivery. Maternal health services include the following, preconception care, antenatal care (Brabin et al. 1998), Prevention of Mother to Child Transmission of HIV (PMTCT), safe delivery (intra-partum care); post natal care (PNC) and emergency obstetric care/management of obstetric complications.

The United Nations estimates that 529 000 women die each year from complications during pregnancy and childbirth (AbouZahr & Wardlaw, 2001). Sub-Saharan Africa is the region in the world where maternal mortality is considerably highest, not to mention the poorest region, lagging behind in development progress compared to other regions, which is why development in Africa has become the prioritized focus of international development strategies in recent years (UNICEF., 2007). In order for African countries to achieve the Millennium Development Goal 5 of reducing maternal mortality by three quarters (MDG 5) by 2015 requires a 5.5% annual average reduction of maternal mortality. However the actual reduction in Sub

Saharan Africa between 1990 and 2005 was only 0.1 % (WHO, 2008b). Most African countries are on the whole off tract to achieving the MDGs 4 and 5 for maternal, newborn and child health by 2015. Reducing Maternal, newborn and child mortality in Africa is a challenge of the New Millennium. Each year in Sub Saharan Africa 279,000 women die due to complications of pregnancy and another 4.5 million children die before their first birthday; 1.2 million of them die in the first month of life(Mwaikambo & TAAS, 2010).

The tendency to view maternal health as a woman's issue has contributed to a narrow focus of targeting mostly women. Yet we know that the social relationships determine people's ability to manage their sexual and reproductive health lives, with important implications not only to their health but also for other life choices (Greene, 2001).

The goal of maternal health care services is to ensure that no woman or newborn dies or incurs injuries due to pregnancy and or childbirth. However to achieve this goal, maternal health service planners, service managers and providers need to view maternal health services in the context that women's potential to control and improve their wealth as well as their health is more limited than men's in most parts of the world (Peacock & Levack, 2004). This prevents women from accessing critical health information and services and can lead to poor reproductive, maternal and child health outcomes, including unwanted infections and unwanted pregnancies.

Maternal health care in Tanzanian is placed under the Ministry of Health and Social Welfare (MoHSW). It is one of the components enclosed in the national package of Essential Reproductive and Child Health Interventions explained in the One Plan aiming at addressing all the major direct causes of maternal mortality (NAO, 2011).Therefore, improving maternal, newborn and child deaths is a high priority for all, given the persistently high maternal, newborn and child morbidity and mortality rates. It is one of the major concerns addressed by various global and national commitments, as reflected in the targets of the Millennium Development Goals

(MGD), Tanzania vision 2025, the National Strategy for Growth and Reduction of Poverty (NSGRP-MKUKUTA), and the Primary Health services Development Program PHSDP-MMAM), among others (Mwaikambo & TAAS, 2010).

The component of maternal health care which includes antenatal care (ANC), delivery and postnatal care services are key features of health interventions for reducing maternal and newborn morbidity and mortality. In Tanzania, these components are as presented in Table 1:1 below.

Table 1.1: Components of antenatal, delivery and postnatal care

Antenatal care
During Antenatal period: at least 4 antenatal care visits for normal pregnancies, including one visit within the first 3 months of pregnancy. **Key ante-natal services include** Confirmation of pregnancy Monitoring of progress of pregnancy and assessment of maternal fetal well-being Prevention, care and treatment for HIV/AIDS (PMTCT). Tetanus toxoid immunization. Counseling on nutrition, breastfeeding, healthy life style. Insecticide treated bed nets Development of birth preparedness plan, emergencies, referral care in case of complication, breastfeeding and advice on danger signs. Screen for protein and anaemia including blood group Iron and folic acid supplementation. Deworming Identification and treatment of bacteria Identification and treatment of problems complicating pregnancy: hypertension, bleeding, malpresentation, multiple pregnancy, etc. Screening and treatment of syphilis and malaria. (IPT and promotion of ITN). Assessment for female genital mutilation
Services delivered during Labor, delivery, and first 1 to 2 hours
Skilled attendance at birth Monitoring progress of labour, maternal and fetal well-being with pantograph Providing supportive care and pain relief Clean and safe delivery Temperature maintenance of mother and child including Kangaroo Mother Care. Immediate and exclusive breast-feeding.

Cord and eye care.
Emergency obstetric care for complications including:
Treatment of abnormalities and complications (prolonged labour, vacuum extraction, breech presentation, episiotomy, repair of genital tears, manual removal of placenta)
Pre-referral management of serious complications (e.g. obstructed labour, fetal distress, preterm labour, severe peri- and postpartum haemorrhage)
Emergency management of complications if birth is imminent
Treatment of severe complications in childbirth and immediate postpartum period, including caesarean section, blood transfusion and hysterectomy:
Induction and augmentation of labour
Antibiotics for premature rupture of membranes
Neonatal resuscitation.
Management of newborn complications.
Prevention, care and treatment of HIV/AIDS(PMTCT)
Active management of third stage of labour
Vitamin A supplementation

Source: *The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008 - 2015*

1.3 Statement of the problem

Beside women taking the biological role of becoming pregnant and giving birth to children they are informally taking the large percent of caring the children. This role can contribute to the maternal and child mortality (Black et al., 2010). Child caring includes maintaining physical and social well-being of children. The well-being of children starts from when the child is in the womb (pregnant). However, according to Tanzania Demographic and Health Survey (TDHS 2004/05), 94% of pregnant women make at least one antenatal care (ANC) visit and only 68% of the women are reported to attend ANC the recommended four times or more ANC visits, delivery at health facilities were 47% while 83% of women who delivered a live baby outside the health facility are reported not to receive a postnatal check-up. The number of pregnant mothers in Tanzania making four or more ANC visits appears to have declined slightly from 70% in 1999.

Moreover, low level of male involvement in maternal health care services in Tanzania especially has persisted with limited interventions by the health

stakeholders which aim at encouraging male involvement in maternal health care services. In addition, the proportion of males who discuss, support or accompany their wives to seek maternal health care services in Mwananyamala has not been documented. The low male involvement in maternal health care services may be partly contributing to the low utilization of maternal health care services by the pregnant women and mothers within Mwananyamala because of the significant role men have on the health seeking behavior of their family.

Despite several efforts by the government and other health partners women attendance in ANC, delivery in health facilities and postnatal care services are still low and are perceived as barriers to improving maternal and child health. These threaten achieving the target for improving maternal health by reducing maternal mortality ratio by three-fourth and achieve universal access to reproductive health. Therefore this study was conducted in order to examine factors which affect women's contribution towards improving the maternal and child health. In addition to that this research aimed at answering the question as to how women will bear with the hospital services in improving the maternal health and ensuring child health.

1.4 Objectives of the study

1.4.1 General Objective

The overall objective of the study was to examine the contribution of women towards improving the Maternal and child's health.

1.4.2 Specific objectives

i) To determine factors affecting women's contribution towards improving Maternal and Child's Health
ii) To examine women contribution to the improvement of maternal and child's health
iii) To identify society/men and women's perception towards improvement of maternal and child's health.

1.5 Research questions

i) Are there any factors that facilitate or Hinder women's contribution towards improvement of maternal and child's health?
ii) How do women contribute to the improvement of maternal and child health?
iii) What is the perception of the society, men and women towards improvement of maternal and child health.

1.6 Scope of the study

The study established the contribution of women in improving the maternal and child health. Various aspects of practices associated with maternal and child health was covered.

The population of study was women either attending ANC in Mwananyamala hospital or those who were found around the street or not attending ANC.

1.7 Significance of the study

The findings of the study will be useful to the government, Ministry of Health (MOH) and other organizations involved in improving maternal and child health care services specifically in the urban settings. These will also foster designing appropriate strategies for the urban women and in particular those residing in Dar es Salaam city. These study findings also provide information for better planning of maternal and child health care services; which could lead to reduced morbidity and mortality in the district.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The safe motherhood initiative, launched in 1987 by World Health Organization (WHO), UNICEF, UNFPA, the World Bank and other organizations placed maternal health at the forefront of international public health.

Maternal health is a state of complete physical, mental and social well-being of the mother; it is a resource for everyday life of the mother.

Maternal health care services comprise of a wide range of health services given to the mother before pregnancy, during pregnancy, labor and after delivery. Maternal health services include the following, preconception care, antenatal care (ANC), Prevention of Mother to Child Transmission of HIV (PMTCT), safe delivery (intra-partum care); post natal care (PNC) and emergency obstetric care/management of obstetric complications. However for this study maternal health services refers to antenatal care, delivery and postnatal care.

The following section will first review the determinants of maternal and child health services and effectiveness of various policy actions which suggests the most successful methods to deliver maternal and child health services. Literature will be reviewed in order to Understand effective methods for reducing maternal mortality so as to be able to draw a picture of what is currently understood about maternal health and what is known about the conditions that need to be provided by macro-level actors.

2.2 Determinants for Maternal and Child Health services

Many different factors have been considered to affect the maternal and infant choices for health services (See figure 2.1 below). In some part, these factors were divided into three categories: pre-pregnancy factors (those characteristics belonging to the

mother); individual responses (the choices a women makes after conception and the attitudes that shape them), and system responses (how health care and other service providers care for the pregnant women)(Wolfe, 2006). While many strategies have attempted to address some of the economic, social, and physical factors and barriers contributing to poor maternal health outcomes, women's utilization of maternal health services is often influenced by perceived social cultural, economic, and health system factors operating at the community, household, and individual level as well as within the larger social and political environments and health care infrastructure (Griffiths & Stephenson, 2001; Ram & Singh, 2006).

A woman's chance of dying or becoming disabled during pregnancy and childbirth is closely connected to her social and economic status, the norms and values of her culture, and the geographic remoteness of her home. Generally speaking, the poorer and more marginalized a woman is, the greater her risk of death.

2.2.1 Pre-pregnancy factors

One major factor in the health outcomes of the mother and child is the health status of the mother prior to becoming pregnant. An evaluation of the outcomes of childbirth must consider genetic predispositions, including a woman's health behaviors. For example, a woman's pre-conception diet, particularly consumption of folic acid, can have a tremendous impact on infant health outcomes(Wolfe, 2006). Pre-pregnancy factors are not limited to physical health; they include mental health as well. Women that are lower in income, unmarried, less educated and live in an urban setting tend to have higher incidence of depression (Seto, Cornelius, Goldschmidt, Morimoto, & Day, 2005). Apart from health, age, poverty level, marital status, and minority status are other important demographic factors. Teen mothers are at an increased risk of obtaining late or no prenatal care(Wolfe, 2006).

2.2.2 Individual responses

Antenatal care and health seeking behavior: Health seeking behavior refers to any activity undertaken by individuals, who perceive them to have a health problem or to be ill for the purpose of finding an appropriate remedy.

Once a woman is pregnant, she engages in a set of behaviors that can have tremendous consequences on her health and the health of her child. To realize the importance of her actions, a woman must first know she is pregnant (Wolfe, 2006). Most pregnant women do not initiate prenatal care in the first trimester because they are unaware that they are pregnant. Intuitively, a woman cannot seek prenatal care until she knows she is pregnant.

Antenatal care improves some outcomes through the detection, management of, and referral for potential complications. Evidence from high income countries suggests that adequate ANC may improve birth weight (Alexander & Korenbrot, 1995) (Reynolds, Wong, & Tucker, 2006). Antenatal care can also assist in the prevention, identification and treatment of iron deficiency anemia in adolescent mothers (Brabin et al., 1998). This is crucial as severe anemia is linked to maternal and child mortality (Stoltzfus, 2001) (Thato, Rachukul, & Sopajaree, 2007). The purpose of ANC is to improve pregnancy outcomes for both the mother and the fetus. The aim of the first ANC visit is for health staff to establish rapport with the client and to collect information to evaluate the client's health status and preparedness for motherhood.

High rate of maternal death is one of the major public health concerns in Tanzania. Most of maternal deaths are caused by factors attributed to pregnancy, childbirth and poor quality of health services. More than 80% of maternal deaths can be prevented if pregnant women access essential maternity care and assured of skilled attendance at childbirth as well as emergency obstetric care(Shija, Msovela, & Mboera, 2012).

Over the years, maternal mortality has remained one of the major public health problems in developing countries. According to the World Health Organization (WHO, 2005) half a million women are still dying annually as a result of pregnancy

and complications related to pregnancy and childbirth. Available figures show that 99% of maternal births take place in the developing world, and 60% of maternal deaths take place in Commonwealth countries. In spite of the efforts taken globally and locally, Tanzania is among the top 20 countries with the highest maternal mortality rates. Additionally, for each one woman who dies as a result of pregnancy or childbirth, a further 20 women suffer serious or chronic health consequences. These can have severe physical, psychological, social and economic repercussions for both the woman and her family.

According to the 2012 World Health Organization (WHO) statistics on global trend of maternal mortality, Tanzania is now considered to be making progress but not on track in the processes to achieve Millennium Development Goal 5 (MDG 5) which targets to reduce maternal death by two-thirds by 2015.

According to TDHS (2004/05), 94% of pregnant women make at least one antenatal care (ANC) visit and 62% of women have four or more ANC visits. The number of pregnant mothers in Tanzania making four or more ANC visits appears to have declined slightly from 70% in 1999. However, the quality of antenatal care provided is inadequate. The four visits ANC as outlined in WHO clinical guidelines is also adopted in Tanzania (Table 2:1).

Table 2.1 The four visit model outlined in WHO clinical guidelines

Period of visit	Service required
First visit **8-12 weeks**	Confirm pregnancy and EDD; classify women for basic ANC (Four visits) or more specialized care. Screen, treat and give preventive measures. Develop a birth and emergency plan Advice and counsel.
Second visit **24-26 weeks**	Assess maternal and fetal well-being. Exclude PIH and anaemia. Advice on preventive measures.

	Review and modify birth and emergency plan. Advice and counsel.
Third visit **32 weeks**	Assess maternal and fetal well-being. Exclude PIH, anaemia, multiple pregnancies. Advice on preventive measures. Review and modify birth and emergency plan. Advice and counsel.
Fourth visit **36-38 weeks**	Assess maternal and fetal well-being. Exclude PIH, anaemia, multiple pregnancy, malpresentation. Advice on preventive measures. Review and modify birth and emergency plan. Advice and counsel.

Source: *A report of the controller and auditor general of the united republic of Tanzania*

Knowledge on Pregnancy and Childbirth: Home birth remains a strong preference and often the only option, for many women in the developing world. A large proportion of these home deliveries take place without professional attendants (Coleman, Manneh, & Walraven, 2002). Provision of a health worker with midwifery skills at every birth is considered a crucial intervention for safe motherhood (De Brouwere, Tonglet, & Van Lerberghe, 1998), yet the WHO estimates that 47% of births in the developing world are currently assisted only by traditional birth attendants, family members, or no one (WHO, 1997).

Perceptions on pregnancy and childbirth: Women's perceptions on pregnancy, recognition of early signs of pregnancy and of malaria in pregnancy, and the cultural context in which treatment seeking takes place varies from one community to another.

Partner participation towards the Improvement of Maternal and Childs Health: Most maternal and child health programs seek to address the health needs of women and children by engaging and educating pregnant women and mothers in appropriate care seeking and care giving practices for themselves and their children. This focus on women, and a tendency to think about family planning, pregnancy, childbirth and

child health as 'women's business', has often led to men being excluded from spaces and services in which they could learn more about reproductive, maternal and child health. Men tend to be the decision-makers within families and often govern behavior regarding use of contraceptives, the availability of nutritious food, women's workload, and the allocation of money, transport and time for women to attend health services (Roth & Mbizvo, 2001).

Men can positively influence maternal and child health in a variety of ways and have a right to the information they need to make decisions to protect their own health and that of their family, (Holmes, Davis, & Luchters, 2009). Male involvement includes men making informed decisions with their partners about family planning or seeking and sharing information about appropriate health behavior's and care during pregnancy, childbirth and postpartum. Men can encourage and support antenatal care (Brabin et al.) attendance, ensure good nutrition and reduced workload during pregnancy, assist with birth preparations, and provide emotional support.

Since the mid-1990s, when the International Conference on Population and Development in Cairo and the International Conference on Women in Beijing highlighted the importance of involving men in reproductive health programs, there has been an increasing appreciation of the potentially significant benefits for the health of men, women and children. Despite growing awareness and political will in some settings, actual progress towards increasing the engagement of men in maternal and child health has been slow in developing countries. In developed countries, the role of the expectant father has only recently begun to be addressed (Condon, 2006).

Male participation is a crucial component in the optimization of Maternal and Child Health (MCH) services. This is especially so where prevention strategies to decrease Mother-to-Child Transmission (MTCT) of Human Immunodeficiency Virus (HIV) are sought. This study aims to identify determinants of male partners' involvement in MCH activities, focusing specifically on HIV prevention of maternal to child transmission (PMTCT) in sub-Saharan Africa, (AMREF 2008)

Most maternal and child health programs seek to address the health needs of women and children by engaging and educating pregnant women and mothers in appropriate care seeking and care giving practices for themselves and their children. This focus on women, and a tendency to think about family planning, pregnancy, childbirth and child health as 'women's business', has often led to men being excluded from spaces and services in which they could learn more about reproductive, maternal and child health. Men tend to be the decision-makers within families and often govern behaviour regarding use of contraceptives, the availability of nutritious food, women's workload, and the allocation of money, transport and time for women to attend health services (Greene M. 2004).

Men can positively influence maternal and child health in a variety of ways and have a right to the information they need to make decisions to protect their own health and that of their family.13 Male involvement includes men making informed decisions with their partners about family planning or seeking and sharing information about appropriate health behaviours and care during pregnancy, childbirth and postpartum. Men can encourage and support antenatal care (ANC) attendance, ensure good nutrition and reduced workload during pregnancy, assist with birth preparations, and provide emotional support. A man can encourage and support good infant nutrition, including early and exclusive breastfeeding, and childhood immunisation. He can take steps to prevent infection with STIs and HIV and transmission to his partner and child. (Holmes W. 2001)

2.2.3 System responses (Accessibility and utilization of maternal health services)

The next set of processes describes how the healthcare system and related services respond to the need for prenatal care. Birth is an important physiological event by which the human race has perpetuated itself and that it must take place in a medical institution or environment(Tew & Damstra-Wijmenga, 1991). Research has shown that most maternal deaths and disabilities can be prevented if women have access to good quality services during pregnancy and delivery(Tew & Damstra-Wijmenga, 1991). Unfortunately, most women do not receive these care, just about half of all

deliveries in the developing countries are seen by a skilled attendant, with low rates in some countries. Nurses need to educate the women during the antenatal period on the process of labor and delivery. They need to establish relationship that conveys concern and care. Women in labor should be informed about progress of labor and allow them to participate in decision making. Caring behavior is a simple action that maternity health service providers can take to show women kindness, respect, give them privacy, and make them feel comfortable. Women receive good care and feel assured when providers respond to their needs promptly, give reassurance and provide information on how to help themselves and what to expect during labor and child birth. Women in labor have better birth outcome and a decrease in labor when they have a supportive person with them during labor.

2.3 Policy options

This section includes information about what policy choices these determinants may signal. These policy interventions form two categories: pre-conception and prenatal. These are obviously not exhaustive, as there is a whole range of neonatal and early childhood interventions that may have an impact on the child's health(Wolfe, 2006).

2.3.1 Preconception Interventions

As the pre-pregnancy determinants indicate, the health of the mother and child does not begin at conception. Therefore, a large potential arena for improving the condition in which women arrive for their first prenatal care appointment is to not limit social programs to pregnant women. Rather, policymakers should take a more expansive approach to include all women of or nearing childbearing age (Wolfe, 2006).

Education: As educational attainment is an important factor in initiation of prenatal care and birth outcomes, one option would be to increase the educational attainment of women of childbearing age, either by improving the public education system as a whole or by targeting programs toward this population. These interventions would not only yield a better educated group, and thus a more productive group, but also have a residual impact on maternal and child health outcomes (Wolfe, 2006).

Health insurance: Having health insurance prior to conception would serve two main purposes: It would build a bridge between women and healthcare providers and decrease the lag-time between conception and enrollment in “pregnancy” insurance (Wolfe, 2006).

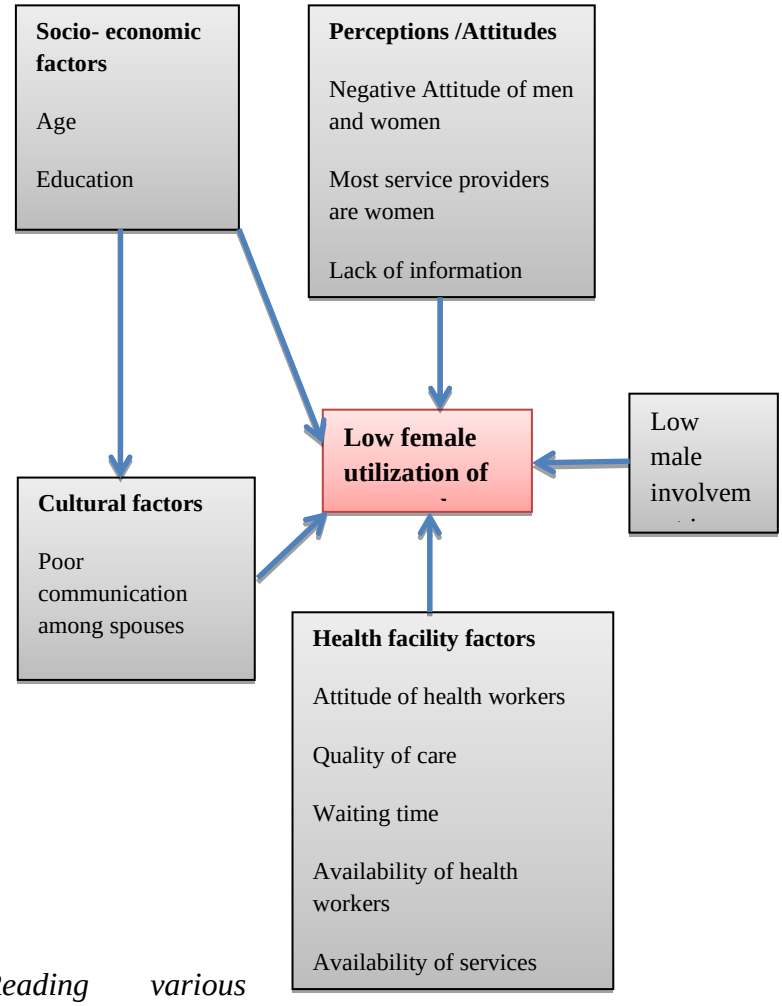
Nutrition: Because women’s dietary circumstances prior to conception play a contributing role in health outcomes, certain nutrition programs should be extended to women who are of childbearing age.

Access to contraception/family planning: A major contributor to the desirability of the pregnancy is the availability of family planning services. As the population experiences a great deal more unwanted and unplanned pregnancies, it points to a need for expanded family planning resources (DAngelo, 2002). Services that provide access to family planning should be expanded.

2.3.2 Prenatal Interventions

These policies are restricted to the treatment of women once they discover they are pregnant. They represent the bulk of efforts to improve maternal and child health outcomes. They generally call for expanding the access to prenatal care, the content of the services, and quality of care (Wolfe, 2006).

Figure 2.1 Determinants affecting women's utilization of maternal services



Source: *Reading various*

2.3.3 Tanzania Government Policy on Maternal and Child health

The overall objective of health policy in Tanzania is to improve the Health and well-being of Tanzanians with a focus on those most at risk and to encourage the health system to be more responsive of the objectives of the policy is to reduce Infant and Maternal mortality and increase life expectancy through the provision of adequate and equitable maternal and child health services, promotion of adequate nutrition, control of communicable diseases and treatment of common conditions (MoH, 1990).

According to Tanzania National Health Policy, women of child's bearing age are the prime targets for health care delivery. Maternal health will continue to be a top priority in health care in Tanzania, through Mothers, children are reached and consequently their health situation will also be improved (MoH, 1990)

Maternal and child health care is a key element in health care delivery. It must be provided in all health facilities through the country. It is an integrated curative, promote, and preventive service which; reduces death, diseasesand disability among children and women of child bearing age, provide comprehensive health education to mothers, promotes proper health care to families through home visits and health and education, provide opportunities for family planning to men and women, provide care for women before during and after delivery (MoH, 1990).

A study done on women accounts of maternity services during labor revealed that women expect humane and courteous treatment from health professionals, and have a change in their minds about place of delivery and recommendation to others if they experience degrading and unacceptable behavior (d'Ambruoso, Abbey, & Hussein, 2005). In addition findings reveal that patient's satisfaction with care is an important element of quality care, and there is growing evidence that patient perceived quality of maternal health services particularly provider attitudes has a significant influence on the women's willingness to use skilled childbirth services.

2.4 Initiatives to improve maternal, newborn and child health in Tanzania

Reduction of maternal, newborn and child deaths is a high priority for all, given the persistently high maternal, newborn and child morbidity and mortality rates over the past two decades in African countries, Tanzania included. It is one of the major concerns addressed by various global and national commitments, as reflected in the targets of the Millennium Development Goals, Tanzania Vision 2025, and the National Strategy for Growth and Reduction of Poverty (NSGRP-MKUKUTA), and the Primary Health Services Development Program (PHSDP-MMAM), among others(MoHSW, 2008).

The Ministry of Health and Social Welfare in Tanzania has been advocating for safe motherhood through attendance at Reproductive and Child Health (RCH) clinics before, during and after deliveries, as well as delivery with skilled health care providers, the ultimate goal being to achieve the MDG 5 targets.

In Tanzania, specific attempts have been made to address maternal, newborn and child health (MNCH) challenges through the National Health Policy (revised in 2003), the Health Sector Reforms and the Health Sector Strategic Plan (2003-2007). Furthermore, the Reproductive and Child Health Strategy (2005-2010) and the National Road Map Strategic Plan to Accelerate the Reduction of Maternal and Newborn Mortality (2006-2010) were also formulated to respond to these challenges. Improving MNCH is also a major priority area in the National Strategy for Growth and Poverty Reduction (NSGPR/MKUKUTA) 2005-2010 which has three major interlinked clusters. One of the goals clearly outlined in the second cluster of the strategy is to improve the survival, health and well-being of all children and women and of especially vulnerable groups. Under this goal, there are four operational targets related to maternal and child health for monitoring progress towards achieving MDGs 4 and 5 (NAO, 2011).

i) The Health Sector Support Programme III (2008 – 2012) incorporate and addresses Maternal, Newborn and Child Health issues in terms of alignment with Government policies, resource mobilization and donor harmonization.
ii) The newly initiated Primary Health Service Development Programme, (PHSDP/MMAM) 2007 – 2017, addresses the delivery of health services to ensure fair, equitable and quality services to the community and is envisioned to be the springboard for achieving good health for Tanzanians.

iii) The Tanzania Maternal Newborn and Child health Partnership launched in April 2007 re-focuses the strategies for reducing the persistently high maternal, newborn and child mortality rates, through adopting the One Plan and setting

clear targets for improved MNCH. One Plan is about using health system packages to deliver lifesaving care.

Tanzania is committed to achieving the Millennium Development Goals 4 and 5 by the year 2015. To that effect Tanzania has developed the MNCH Strategic Plan to accelerate reduction of MNC deaths in response to the New Delhi Declaration of April 2005. The mission of the plan is to promote, facilitate and support in an integrated manner the provision of comprehensive reduction of maternal, newborn and child morbidity and mortality. The goal is to accelerate the reduction of MNC mortality and morbidity in line with MDG 4 and 5.

Objectives of the Plan are three:

- To reduce maternal mortality from 578 to 193/100,000 deliveries
- To reduce neonatal mortality from 32 to 19/1000 live births
- To reduce under five mortality from 112 to 54/1000 live births

Operational targets to be achieved by 2015

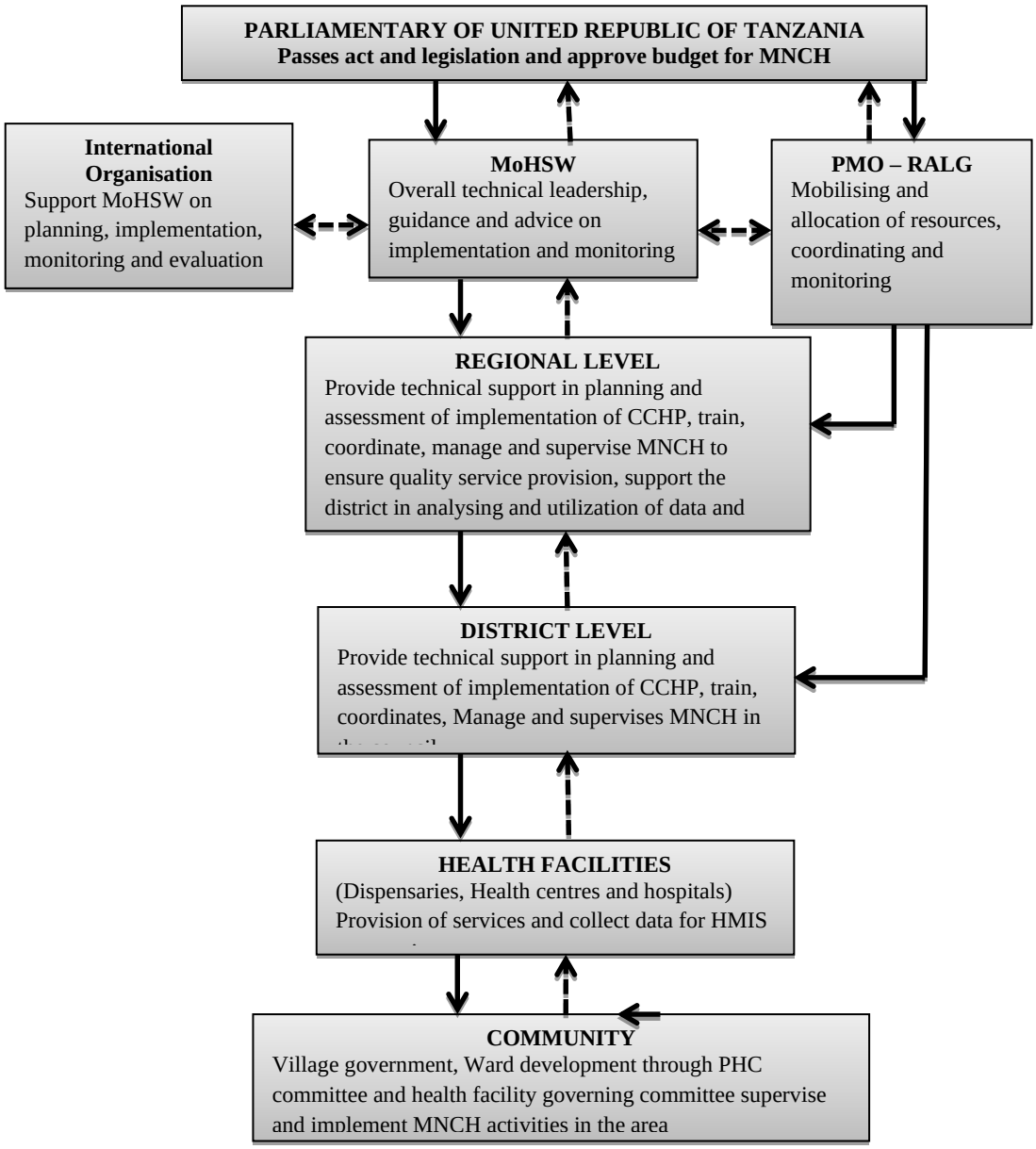
- Increased coverage of birth attended by skilled attendants from 46 to 80%
- Increased immunization coverage of DTP-Hb3 and measles vaccines to above 90% in 90% of the districts.

However, the year 2015 is next door and in order to reduce the current MMR of 578 to 193/100,000 by 2015. The Maternal mortality rate has remained persistently high in the past 10 to 15 years and we are expecting to reduce it by two thirds in 5 years(Mwaikambo & TAAS, 2010).

2.5 Maternal Health Care System description in Tanzania

This explains systems set up at the National, Regional and District levels with the support from international organizations, civil society and private sectors, as multi-sartorial strategy for comprehensive reproductive and child health implementation(NAO, 2011). The system of Maternal Health Care in Tanzania is as indicated below (Figure 2:2).

Figure 2.2 Diagrammatic presentation of Maternal Health care provision in Tanzania



Source: ***A report of the controller and auditor general of the united republic of Tanzania(NAO, 2011)***

2.5.1 Specific roles and responsibilities of key actors on Maternal Health Care are

The following are the specific roles and responsibilities of key actors on maternal health care as explained in the report of the controller and auditor general of the united republic of Tanzania(NAO, 2011).

Ministry of Health and Social Welfare: The Ministry of Health and Social Welfare (MoHSW) is responsible for developing policies and standards for health care entities. It is also responsible for the overall technical leadership, guidance and advice on the implementation and monitoring of the strategic plan.

The Prime Minister's Office - Regional Administration and Local Government: The Prime Minister's Office – Regional Administration and Local Government (PMO-RALG) – deals with the implementation of the country's health policies. This task includes monitoring of the use of funds and also administration of human resources at the Regional and Council levels when it comes to the implementation of the maternal health care policies.

Regional level (Regional Authorities)

- Regional authorities (specifically the Regional Medical Officers) are supposed to:
- Provide technical support for effective planning and implementation of the integrated Maternal, Newborn and Child Health care activities in the Comprehensive Council Health Plan (CCHP);
- Coordinate, monitor and supervise Maternal, Newborn and Child Health care; and
- Support districts in the analysis and utilization of Maternal, Newborn and Child Health care data and disseminate/report to the national level.

District Level (Local Authorities)

- Local Government Authorities (specifically the District Medical Officers) are responsible for:
- Disseminating Maternal, Newborn and Child Health care Strategic plan to all stakeholders in the District Council including Non-Governmental Organizations (Watson-Jones et al.), Faith Based Organizations (FBO) and other private sector partners;
- Incorporate Maternal, Newborn and Child Health care activities planned and implemented by all stakeholders in the district;

- Provide technical support for quality Maternal, Newborn and Child Health care services;
- Capacity development for facility and community Maternal, Newborn and Child Health care interventions;
- Follow up maternal, prenatal, neonatal and child death reviews at the health facility and communities level;
- Council management teams and district health boards to ensure adequate resources allocation for implementation and monitoring of the Maternal, Newborn and Child Health care interventions.

Health Facility (Dispensaries, Health Centers and Hospitals)

In-charge of health facilities are responsible for:

- Incorporating Maternal, Newborn and Child Health care activities into facility health plans;
- Providing quality Maternal, Newborn and Child Health care services;
- Ensuring timely availability of essential equipment, supplies and drugs in providing services for Maternal, Newborn and Child Health care
- Conducting maternal, prenatal, neonatal and child death review by involving the community;
- Provide technical and supportive supervision to community interventions

Health facilities committees

- Health facilities committees are responsible for:
- Monitoring and ensuring quality Maternal, Newborn and Child Health care service provision;
- Providing technical and supportive supervision to community interventions;
- Link community and Health Care facilities.

Development Partners

- The development partners have a role to play by doing the following:
- Provide technical and financial support under coordination of the Ministry of Health and Social Welfare (MoHSW) for the planning, implementation, capacity

development and monitoring and evaluation of Maternal, Newborn and Child Health care services;

- Advocate for increased global and national commitment to the reduction of maternal, newborn and child morbidity and mortality; and
- Mobilize and allocate resources for the implementation of the Maternal, Newborn and Child Health care intervention.

Private Sector

- Equally the private sector has a role to play when it comes to maternal, newborn and Child health care by doing the following:
- Complement Government efforts in provision of quality Maternal, Newborn and Child Health care services; and
- Invest in commodities and supplies for Maternal, Newborn and Child Health care interventions.

Civil Society Organization, NGOs, FBOs and CBOs

- Work in close collaboration with the CHMT for the implementation of maternal, Newborn and Child care activities/ interventions.

Community

- Maternal, newborn and Child health care principally touches on pregnant women and newly born babies who are living in the community. Therefore, the community has a responsibility when it comes to maternal, newborn and child health care and is expected to do the following:
- Participate in development and monitoring of community Maternal, Newborn and Child Health care actions plan;
- Participate in community interventions;
- Leverage community resources for implementation of Maternal, Newborn and Child Health care interventions;
- Link with Health Facilities; and
- Demand for Health Care in Maternal, New Born and Child Care.

2.5.2 The model of utilization of maternal health services

The model of utilization of maternal health services used in this analysis is based on the conceptual framework of health-seeking behavior developed by Anderson and

Newman (Andersen & Newman, 2005) (see figure 2.2). This behavioral model proposed that the use of health care services is a function of three sets of individual characteristics (i) predisposing characteristics, e.g. age, household size, education, number of previous pregnancies, health-related attitude; (Helin et al.) enabling characteristics, i.e. income, characteristics of health care system and accesses, and availability of health facilities; and (iii) need characteristics, i.e. characteristics of illness, perceived health status, and expected benefit from treatments. It is somewhere argued that the predisposing factors reflect the fact that families with different characteristics have a different propensity to use health care services, while the enabling factors reflect the fact that some families, even if predisposed to use health services, must have some means to obtain them, i.e. income, access, and availability of health services (Fosu, 1994).

According to Andersen and Newman, the need factor is the most immediate cause of health service use(Andersen & Newman, 2005). The need factor reflects the perceived health status, as indicated by severity of the morbidity conditions or the number of morbidities. The presence of predisposing and enabling components may not be enough for a mother to seek health care. She must perceive the disease as serious and believe that the treatment will provide the expected benefits (Fosu, 1994). Need represents the most immediate cause of health service use. The need for health care can be measured in a variety of ways: self-perceived health status, number of morbidity symptoms, or duration and severity of disability(Fiedler, 1981). Perceived severity or number of episodes of diseases have a positive association with health care utilization (Fosu, 1994).

2.5.3 Theory Governing Improvement of Maternal and Child Health

Social Market theory

In the preface to Marketing Social Change, Andreasen A. 1995, defines social marketing as “the application of proven concepts and techniques drawn from the commercial sector to promote changes in diverse socially important behaviors such as drug use, smoking, sexual behavior... This marketing approach has an immense

potential to affect major social problems if we can only learn how to harness its power."

Improvement of Maternal and Child health being one of the health behaviour, Social marketing is widely used to influence health behaviour. Social marketers use a wide range of health communication strategies based on mass media; they also use mediated (for example, through a healthcare provider), interpersonal, and other modes of communication; and marketing methods such as message placement (for example, in clinics), promotion, dissemination, and community level outreach. Social marketing encompasses all of these strategies. (Backer T. et al 1992)

Communication channels for health information have changed greatly in recent years. One-way dissemination of information has given way to a multimodal transactional model of communication. Social marketers face challenges such as increased numbers and types of health issues competing for the public's attention; limitations on people's time; and increased numbers and types of communication channels, including the internet. A multimodal approach is the most effective way to reach audiences about health issues. (Hornik RC. 2002)

2.5.4 Variables

Independent Variable: is that factor which is measured, manipulated, or selected by the experimenter to determine its relationship to an observed phenomenon. For this study Women contribution is a dependent variable as it direct affects the dependent variable.

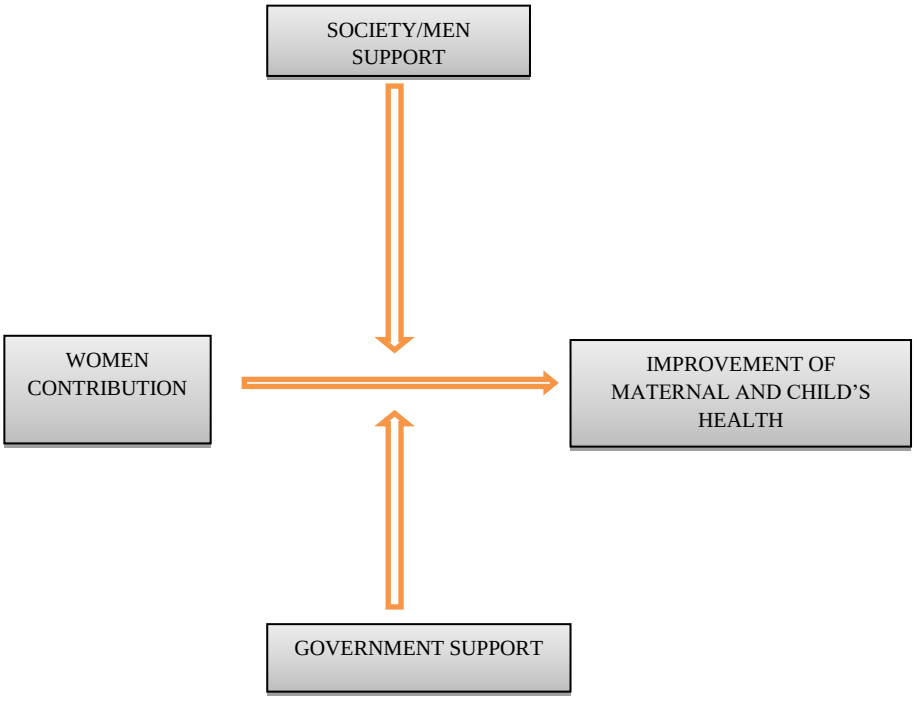
Dependent Variable: That factor which is observed and measured to determine the effect of the independent variable that is that factor that appears, disappears, or varies as the experimenter introduces, removes, or varies the independent variable. In this research study Improvement of maternal and child's health is a dependent variable as it is the participant's response. Improvement of maternal and child's health is affected by women contribution towards the achievements of the maternal and child's health.

In addition to that this study has some variables which affect the dependent variables either by accelerating its effect or decelerating it. That is making it achievable or none achievable.

Moderate Variable: That factor which is measured, manipulated, or selected by the experimenter to discover whether it modifies the relationship of the independent variable to an observed phenomenon. It is a special type of independent variable, for this study a moderate variable is Government Contribution. The improvement of maternal and child health depends also on the government support

There is also Intervene variables these are independent variables that have not been controlled. They may or may not influence the results. In this case presence or absence of society contribution may or may not influence the improvement of maternal and child health.

Figure 2:3: Conceptual framework



Source; *Author's Own Construction*

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This study was carried out in Mwananyamala Referral Hospital located in Dar es Salaam Region. Dar es Salaam is the largest city in Tanzania and the main business center in the country. The Dar es Salaam region is located on the east coast of Tanzania and includes the municipalities of Ilala, Kinondoni and Temeke. It borders on the Indian Ocean to the east and all other sides the cost region. Mwananyamala which is a major referral hospital in Dar es Salaam was chosen because it serves an average of 3100 expectant mothers in a month and also have a relative large number of births with an average of 70-90 births a day. The study involved both medical workers in Mwananyamala Hospital and mothers who were either attending or not attending maternity cares. A cross sectional descriptive study, using both quantitative (questionnaires) and qualitative (in-depth interviews) were used to collect information.

3.2 Research design

This study was a cross sectional hospital based survey. The study employed both quantitative and qualitative techniques of data collection. Potential interview subjects were recruited using non-random sampling of women waiting to receive health services at Mwananyamala health clinic or at home around Mwananyamala suburbs.

3.3 Area and Population of study

The study employed purposeful sampling technique. The study population comprised of all mothers in the study area who were attending hospitals and health centers for maternal, child health services and the health officials in Dar es Salaam region Tanzania and mothers who were not found at the health center. Sampling of key Informants included also the medical personnel who were responsible for the area of the study.

3.4 Methods of Data collection: Quantitative

In this study data were collected through questionnaire administration. On the other hand, secondary data were obtained through documentary review whereby relevant documents like maternal and child health policies and reports, national policies and progress reports on implementing MDG 4 and 5 were reviewed to determine the impact of those policies on improving maternal and child health. Research reports and other publications related to the study were also reviewed to provide secondary data.

3.4.1 Questionnaire administration

A questionnaire was the main data collection tool to obtain quantitative data from both the selected women and health officials with a total sample size as indicated in table 3:1 below. A questionnaire consisted of a number of questions printed or typed in a definite order. The respondents answered the questions either on their own or by responding to an enumerator. In this study structured questionnaires was given to respondents and guided for each category. The questionnaires comprised close-ended questions. The method was the best because it involved low cost. It is widely spread geographically, free from the bias of the interviewer and answers are in respondents' own perceptions. Before the actual data collection, the questionnaires were pre-tested and improved accordingly.

Table 3.1: Summary of data collection by number of respondents

Methods	**Sample**	**Total responded**
Quantitative/Questionnaire	Women who were found attending ANC in health centers	30
	Health center officials	25
	Women who were not found from Health centers	30
	`Total	**85**

Source: *Author's own construction*

3.4.2 Sampling

The study population comprised of 60 women all from 18 years of age and above in the study area, who attending maternal health services at the Mwananyamala Hospital. Those consented to participate in the study were selected to participate in the quantitative survey

3.4.3 Data Management and analysis

Data from questionnaire were entered and analyzed using an SPSS program version 19.0, Chicago, IL. Descriptive data analyses were reported as n or mean ± Standard Deviation.

3.4.4 Ethical considerations

Permission to conduct the study in the area was obtained from the Mwananyamala hospital administration and Ward Executive Officer. Written informed consent from all the respondents was sought before administering questionnaires. Participants were informed that there were no or minimal risks to participating in this study. They were also informed that refusing to participate would not affect the usual services they normally access at health units.

3.5 Methods of Data collection: Qualitative

The study data were also collected using qualitative method by conducting in-depth interviews with women informants who were either attending antenatal care in Mwananyamala hospital or were not attending this service.This qualitative study aimedto explore the perceptions and factors that influence women's decisions to seek maternal health care in urban within Mwananyamala hospital, Dar es Salaam.

Examining how delays in seeking andreceiving care are augmented by individual and community attitudes and perceptions toward maternal health care is necessary to improve the health of pregnant women in urban settings and to provide the information needed for more effective targeting of public health interventions aimed at reducing maternal mortality.

3.5.1 Sample size for in-depth interview

The selection criteria for women informants involved women who were full utilizers (ANC, delivery and postnatal care from Mwananyamala hospital which is a public health facility and also those either partial utilizers (used any of the services from Mwananyamala hospital) or those who had not used any kind of the service from any health facility. At least five women were selected randomly from each group to conduct an in-depth interview. As the study was exploratory type, thus, if selected woman did not showed up at appointed time or was not ready to participate in the study then she was replaced by a woman from the same category and with similar socio-cultural characteristics. Therefore a total of fifteen (15) women were interviewed.

3.5.2 Methods

The interviews were conducted in Swahili language (interpreted from English by investigator) using a pre-designed interview guide pretested for cultural appropriateness and clarity. The interview guide consisted of multifaceted open-ended questions covering arrange of issues related to maternal mortality, prenatal care activities, community and familial support, knowledge of pregnancy danger signs, and access to care. The interview guide included specific questions regarding the mother's maternal healthcare and delivery care experiences (For instance, "Where did you give birth to your child, and who was present during the birth?", and "Who accompanied you to the birth?") and broader questions related to community and individual beliefs about maternal health (e.g. "Is it important to seek care during pregnancy?", and "Do others in your community think it is important to seek care during pregnancy?"). The interviewer used probing and question-rephrasing techniques to clarify questions and obtain details from the mothers. Participants were not required to answer all of the questions. Interviews were written down on field notes served as a backup method of retrieving data. Interviews were conducted until a saturation point was reached when no new information or insight into women's health-seeking behaviors and perceptions was obtained. Interview field notes were written in Swahili by the researcher throughout the in-depth interviews. Preliminary

analysis was conducted throughout the data collection process, allowing for early recognition of themes. All interviews were transcribed into English.

3.6 Limitations to the study

Some people are evasive about their social lives and in particular reproductive health issues; the interviewer used expert knowledge and experience in order to obtain more reliable information since it was a sensitive area of study. Most of the people interviewed were characterized by majority who are not educated hence cannot read and write English. The questions were to be translated into the Swahili language and asked by the interviewee. This process was time consuming but gave reliable information.

CHAPTER FOUR

QUANTITATIVE AND QUALITATIVE RESULTS

4.1 Introduction

This section give results obtained statistical analysis using SPSS program (quantitative) and an in-depth analysis of qualitative information gathered from study participants. The results are presented in 2 sections. Section 4.2 deals with quantitative results and section 4.2 focuses on the qualitative results.

4.2 Findings from Quantitative Data

4.2.1 Socio-demographic characteristics

Out of 60 questionnaires administered among women aged from 18 years and above, all 60 were found usable for the study. The sample population has a mean age distribution of 28.1 ± 0.72 years. Again, 22 respondents, or 36.7 percent of the total sample population, belonged to age group between 25-29 years old. Most women were; - married (41%) and having 1-2 children (48.3%), received information about ANC services (68.7%) and were attending ANC services (61.7%). (See table 4:1).

Table 4.1: Percentage distribution of respondents by selected socio-demographic characteristics

Variable		Frequency (n)	Percentage %
Where found	Women at Health centers	30	50.0
	Women not from Health centers	30	50.0
Age categories (years)	≤ 19	3	5.0
	20-24	12	20.0
	25-29	22	36.7
	30-34	17	28.3
	35-39	3	5.0
	40-44	3	5.0
	≥ 45	0	0.0
Marital status	Single	15	25.0
	Married	41	68.3
	Divorced	4	6.7
Number of children	Not yet	7	11.7
	1-2	29	48.3
	3-5	20	33.3
	>5	4	6.7
Information about ANC services	Yes	41	68.3
	No	19	31.7
Attending ANC services	Yes	37	61.7
	No	23	38.3
Total		**N= 60**	**% = 100**

Source: *Field Data (2014)*

Then questionnaires were administered to health professionals with the following characteristics: - Most of these health personnel were medical doctors 13 (52%), single 15 (60%), attended university 15 (60%) and have between 0-2 years in the health sector 14 (56%) as shown below (Table 4:2).

Table 4:2: Proportion distribution of health professionals

Variable		Frequency (n)	Percent
Marital status	Single	15	60.0
	Married	10	40.0
Number of children	Not yet	16	64.0
	1-2	8	32.0
	3-5	1	4.0
Occupation	Medical doctor	13	52.0
	Clinical officer	1	4.0
	Nurse	8	32.0
	Mid-wife	2	8.0
	Hospital attendant	1	4.0
Education level	College	10	40.0
	University	15	60.0
Years in health sector (years)	0-2	14	56.0
	3-5	5	20.0
	6-8	3	12.0
	9-10	2	8.0
	>10	1	4.0
Total		**25**	**100**

Source: *Field Data (2014)*

4.2.2 Antenatal care services during pregnancy

Among 60 women responded to questionnaire; -14 (56%) of mothers in ANC and 11 (44%) of mothers not attending ANC respectively reported to use artificial planning method. However, there was no significant difference between those attending ANC and those not attending. Mothers who were attending hospitals and health centers for maternal, child health services: - had significantly higher time during which they started to visit ANC. Again they were significantly likely to receive pregnancy counseling, take HIV test and multivitamin consumption. Mothers who were attending hospitals and health centers for maternal, child health services had higher possibility of delivery at the hospitals as compared to their counterparts. A close examination of data show that only few women who participated in this study have

reported one form of violence or the other in the hands of their husbands or a close male partner. This indicator was non-significant however. Other variables were not significant as well (Table 4:3).

Table 4.3: Percentage distribution of respondents by selected prenatal care characteristics.

Variable		**Area during interview (N= 100)**		
		Mothers in ANC	**Mothers not from ANC**	**Chi Square (χ^2)**
Use of artificial family planning method	Yes	14 (56.0)	11 (44.0)	0.6
	No	16 (46.7)	19 (54.3)	
Knowledge of family planning	Yes	16 (57.1)	12 (42.9)	0.57
	No	8 (42.1)	11 (57.9)	
	A little	6 (46.2)	7 (53.8)	
Pregnancy awareness	1st Month	9 (52.9)	8 (47.1)	0.557
	2nd – 3rd Months	15 (57.7)	11 (42.3)	
	4th – 6th Months	2 (25.0)	6 (75.0)	
	>6 Months	1 (33.3)	2 (66.7)	
	I don't remember	3 (50.0)	3 (50.0)	
Physical abuse by partner	Yes	8 (72.7)	3 (27.3)	0.095
	No	22 (44.9)	27 (55.1)	
Physical abuse by outsiders	Yes	5 (50.0)	5 (50.0)	1.0
	No	25 (50.0)	25 (50.0)	
Time started to visit ANC	1st Month	3 (42.9)	4 (57.1)	0.0
	2nd – 3rd Months	9 (81.8)	2 (18.2)	
	4th – 6th Months	7 (87.5)	1 (12.5)	
	>6 Months	5 (83.1)	1 (16.7)	
	I don't know	6 (85.7)	1 (14.3)	
Pregnant charges	Government	27 (54.0)	23 (46.0)	0.149
	Personal income	3 (30.0)	7 (70.0)	
Pregnancy counseling	Yes	18 (69.2)	8 (30.8)	0.018
	No	12 (35.3)	22 (64.7)	
HIV Test	Yes	28 (75.7)	9 (24.3)	0.0
	No	2 (8.7)	21 (91.3)	

Multivitamin consumption	I didn't take	6 (21.4)	22 (78.6)	0.0
	1 to 3 times a week	13 (81.2)	3 (18.8)	
	4 to 6 times a week	8 (100.00)	0 (0.0)	
	Every day of the week	0 (0.0)	1 (100)	
	Not applicable	3 (42.9)	4 (57.1)	
Place delivered	At the hospital	10 (83.3)	2 (16.7)	0.046
	At home	5 (31.2)	11 (68.8)	
	At the local mid-wife	5 (35.7)	9 (64.3)	
	On the way to hospital	7 (63.6)	4 (36.4)	
	I haven't yet given birth	3 (42.9)	4 (57.1)	

Source: *Field Data (2014)*

4.2.3 ANC for Children and Exclusive Breastfeeding

Out of 60 women included in the analysis; - 16 (76.2%) of mothers who were attending hospitals and health centers for maternal and child health services had significantly higher chance of bringing their children to clinic. The chance to take children for immunization was again significantly higher for mothers who were attending hospitals and health centers for maternal, child health services (68.4%), significantly knowledge on exclusive breastfeeding (69.7%) and practice exclusive breastfeeding (76%) as shown below (Table 4:4).

Table 4.4: Differences between mothers who were attending hospitals for maternal and child health services against those who were not attending across selected variables

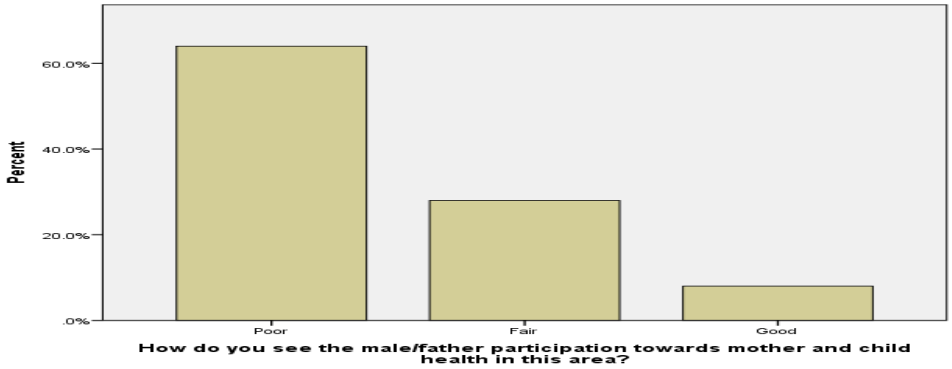
Variable		Area during interview		
		Mothers in ANC n	Mothers not from ANC n	Chi Square (χ^2)
Bring child to clinic	Yes	16 (76.2)	5 (23.8)	0.0
	No	14 (35.9)	25 (64.1)	
Bring child for immunization	Yes	26 (68.4)	12 (31.6)	0.0
	No	4 (30.8)	9 (69.2)	
	Sometime	0 (0.0)	9 (100.0)	
Knowledge on exclusive breastfeeding	Yes	23 (69.7)	10 (30.30	0.002
	No	7 (25.9)	20 (74.1)	
Do you practice exclusive breastfeeding	Yes	19 (76.0)	6 (24.0)	0.001
	No	11 (31.4)	24 (68.6)	

Source: *Field Data (2014)*

4.2.4 Male/Father participation towards maternal and child health services

Out of 25 health professionals responded to questionnaire mentioned that male or father participation towards maternal and child health services was poor (60%) as shown in figure 4:1 below.

Figure 4:1: Male/Father participation and child health services

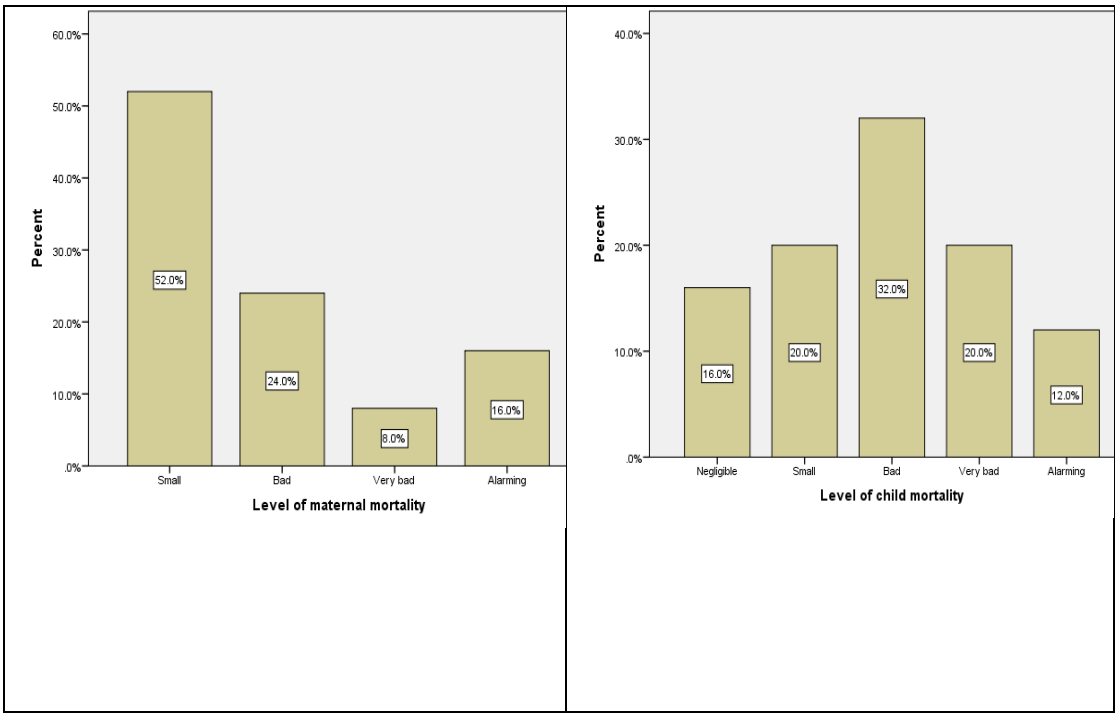


Source: *Field Data (2014)*

4.2.5 Maternal and Child mortality

Again, health professionals revealed that level of maternal mortality was small (52%) and level of child mortality was considered bad (32%) as shown in figure 4:2 below.

Figure 4.2: Maternal and Child mortality

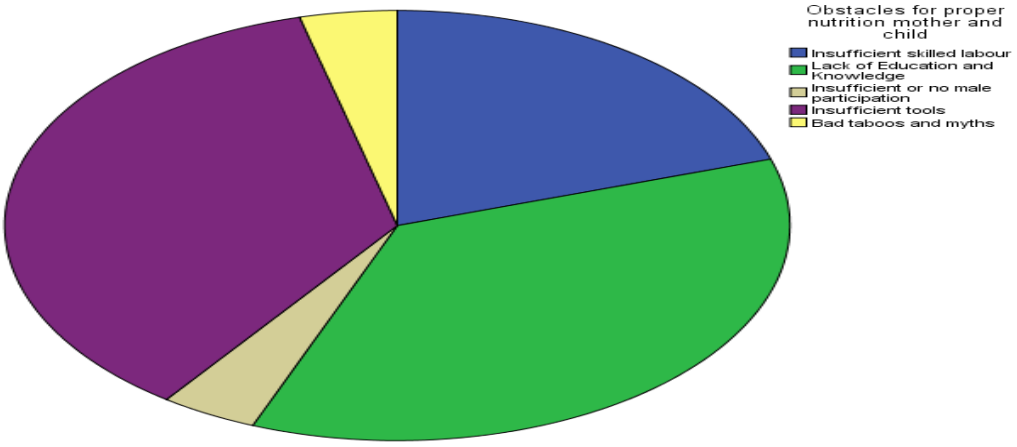


Source: *Field Data (2014)*

4.2.6 Obstacles for proper nutrition for mothers and children

Health professionals indicated that Lack of education and insufficient tools are obstacles (36%) for proper nutrition for mothers (Figure 4:3).

Figure 4.3: Obstacles for proper nutrition for mothers and children

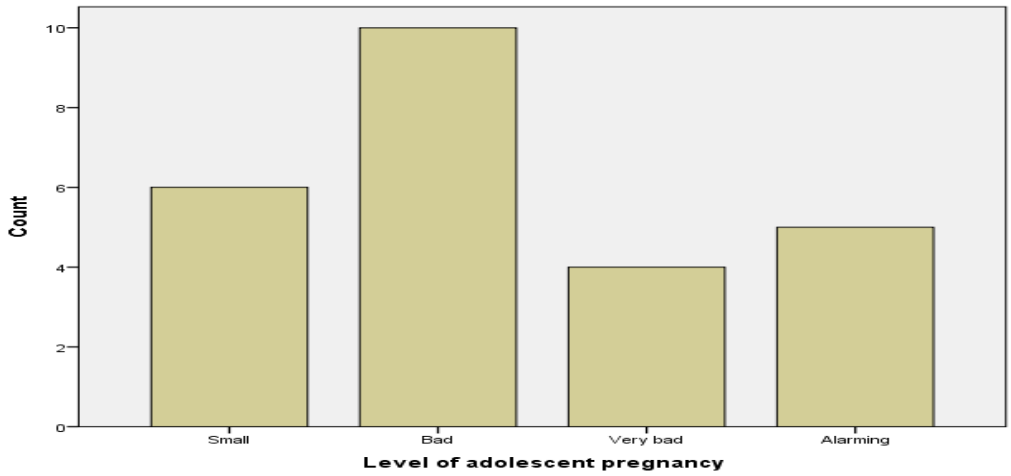


Source: *Field Data (2014)*

4.2.7 Adolescent pregnancy

The level of adolescent pregnant was considered bad (40%) by health professionals (Figure 4:4).

Figure 4:4: Adolescent pregnancy

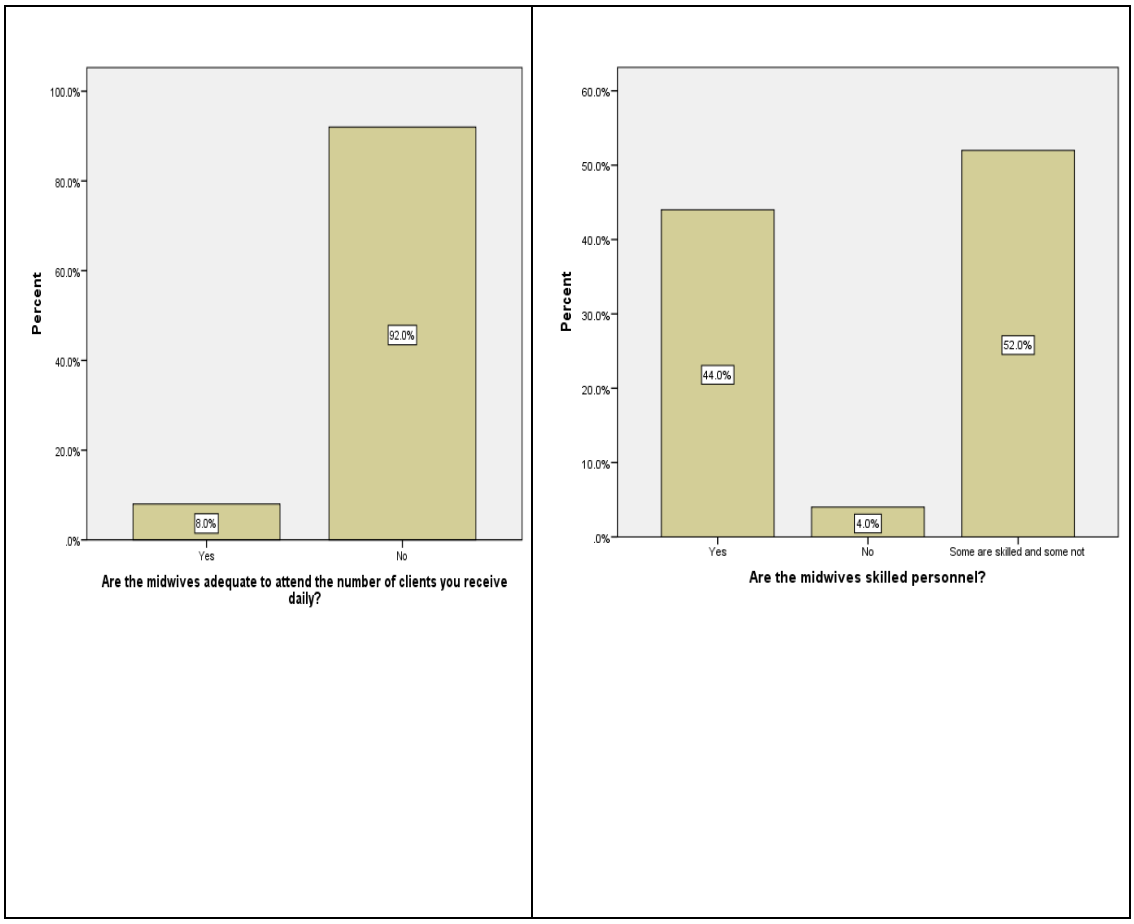


Source: *Field Data (2014)*

4.2.8 Mid-wife availability and skills

Among 25 Health professionals responded to questionnaire, ninety two per cent considered that mid-wives are inadequate and other said that 52% of mid-wives are either skilled or not (Figure 4:5).

Figure 4.5: Mid-wives availability and skills



Source: *Field Data (2014)*

4.3 Findings from Qualitative Interview

4.3.1 Use of prenatal care and delivery services

The patterns of maternal health care use among the women interviewed are presented in table below. The self-reported age of participants ranged from 18-40, with a mean age of 25.5 years. The mean number of children per woman interviewed was 3. Majority of women interviewed (11out of 15, or 73.3%) reported seeking prenatal

care at health facilities. The mean total number of prenatal care visits among participants was 4. Among 12 women reported accessing prenatal care services, only 7 (58.3%) of those women delivered in health facilities. Among fifteen women, only three reported having a parity of one and all gave birthing a health facility. However, only two(50%) of the four biparous women reported delivering their second child in a health facility. Only one (25%) of the four women who reported a multifarious birth order of three or greater delivered in a health facility. All of the four women who did not attend any prenatal visits delivered at home. (See table 4:5).

Table 4.5: Antenatal care utilization and place of delivery

Interview place	Age of Mother	Number of children	Received prenatal care at hospital	Reported number of visits	Place of last delivery
Mwananyamala hosp.	19	1	Yes	3	Hospital
Mwananyamala hosp.	32	4	Yes	6	Hospital
Mwananyamala hosp.	19	1	Yes	7	Hospital
Mwananyamala hosp.	22	2	Yes	4	Home
Mwananyamala hosp.	20	1	Yes	8	Hospital
Mwananyamala hosp.	36	5	Yes	3	Hospital
Mwananyamala hosp.	22	2	Yes	5	Hospital
Mwananyamala hosp.	20	2	Yes	7	Home
Mwananyamala hosp.	20	2	Yes	9	Hospital
Mwananyamala hosp.	35	5	Yes	6	Home
Mwananyamala hosp.	38	6	Yes	2	Home
Mabatini street	22	3	No	0	Home
Mabatini street	25	4	No	0	Home
Mabatini street	24	3	No	0	Home
Mabatini street	29	5	No	0	Home

Source: *Field Data (2014)*

4.3.2 Value of health care

Women's knowledge and acceptance of the importance of maternal health care and healthy pregnancy practices are shaped by previous experiences as well as formal and informal communication within the community and households(Lubbock &

Stephenson, 2008). Many women who mentioned to use maternal health services said it was important as they believed that ANC visits reduce the risks of complications and ensuring the health of the child in the womb. Women for example those who gave birth to healthy babies were very positive to the quality of care and attention they received during pregnancy and delivery, insisting on the importance of receiving vitamins, vaccinations, and examinations during pregnancy and the benefits of such care in regard to the healthy delivery of the new baby.

“When you attend maternity services they give you iron supplements. They examine you to see if the baby is in proper position. This motivates me to go to the hospital to check for my health and the health of the baby”, 23-years-oldmother; Mwanahawa, Mwananyamala.

“I am happy especially with the nurses who escort me to the place for the birth. I was treated well and my baby was delivered safe and healthy”, 29-years old mother, Chiku.

4.3.3 Social communication

It was mentioned by most of the women that their knowledge of pregnancy and delivery practices in part came from health workers, before experience, or other more experienced women in the community, especially their mothers and mother’s in-law. Some mentioned that they received open communication from their husband about the importance of seeking care. Women who scared of complications and risks related to poor maternal and infant outcomes said that they were willing to communicate their feelings to people who were close to them so that they receive encouragement to seek care to avoid complications. Only few women talked about their desire for family planning to minimize the risk of complications due to birth spacing and high parity.

“When someone is not aware what we do is to ask the older women who had have several deliveries and they know a lot about pregnancy issues”, 19 years old pregnant woman, Mariam.

“When I got first pregnant I couldn’t realize until when I got sick and my mother took to the hospital for check-up as I was vomiting and feeling dizzy. She ordered nurses to check me for pregnancy and HIV status. Then I was confirmed with pregnancy, since then my mother kept advising me to attend maternity care and receive immunizations as required in the hospital” 24 years old, Saida.

I am married by a doctor, therefore during pregnancy, my husband kept reminding me every month to attend for prenatal care. He used to say that you have to go to your prenatal visits as you will be informed about your health and the health of the foetus”, 25 years old, Mwanajuma.

4.3.4 Male involvement in ANC, delivery and postnatal care

Lack of knowledge of the benefits and need of male involvement in maternal health care were reported to contribute to low male involvement in maternal health care services. This is emphasized by some of the responses from in-depth interviews with women.

“I have had five children but I have always gone for ANC, delivery and postnatal care without my husband, I wonder why these days you want women to come with their partners yet ANC and delivery is intended for the pregnant women alone.” 35 years old mother, Jamila.

Another factor that was mentioned to inhibit male involvement was health workers demand for payment for services.

“We are told that health services for mothers and children are free but sometimes health workers ask for money for gloves from mothers. That is why men fear to go to

the health unit and they leave the women to go alone. They even think that if the woman goes alone she will be charged less compared to when she is with the husband."36 years old mother, Husna.

Long waiting time at the health unit coupled with concurrent job demand were the other factors mentioned by mothers as contributing to low male involvement in ANC.

"Sometimes when we go to the health unit for ANC and we end up spending the whole day at the health facility that is why my husband does not wanttoattend ANC or accompany me for postnatal care."20 years mother, Krusum.

4.3.5 Family practices and traditional norms

Household position and its environment are significant determinants of use of any maternal and child care either it is just a visitto health center, choice of place of delivery or immunization of children. Women who did not seek prenatal or delivery care stated that they were not accustomed to using prenatal care and were familiar with delivering at home like other women in their families.

One woman said "I didn't prefer to go to hospital as I am used to deliver at home with the assistance of the local mid-wife and my mother in-law." 24 years old, Halima.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

The overall aim of this study was to examine the contribution of women towards improving the Maternal and child's health among mothers either attending or not attending hospitals or health centers for maternal and child health services. With the general objective the research also came with specific objectives some of them being: to determine factors affecting women's contribution towards reaching MDGs 4 and 5, How do women contribute to the improvement of maternal and child's health and the effects of poor maternal and child health to the society. As maternity services change and the population of women and families served also changes, there was a need to document the views of women and health officers with recent experience of care. Maternity services are evolving and the information from this study provides a picture of current practice and point of comparison for the future especially in the Dar es Salaam city.

It is clear that some aspects of care can be assessed only by asking women, or are more practical to get this way. Women need to be the ones to say whether they received sufficient information, whether they were able to understand what was said to them, whether or not they were treated kindly, and to describe the quality of the services and facilities (Redshaw & Heikkila, 2010). The results from quantitative and qualitative survey were more or less similar.

5.2 Factors that facilitate or Hinder women's contribution towards improvement of maternal and child's health

5.2.1 Access to antenatal maternity care

When a woman undertakes her biological role of becoming pregnant and undergoes childbirth, the health system (health care providers in particular) has the sole role of making sure that the whole process remains safe; ultimately saving thousands of lives of mothers who die due to delivery related complications. It means provision of

goods and services for safe motherhood such as sexual and reproductive health and information(NAO, 2011).

Education and health services provided during the Antenatal period can reduce pregnancy and delivery complications and improve birth outcomes in resource-poor settings; however, these benefits are contingent upon user compliance. Information like danger signs during and after-birth complications, and plan for delivery is important to be given to the antenatal women. Health education provided in antenatal care is aiming at preparing the woman and family physically, psychologically and socially for birth, with emphasis on encouraging facility delivery(NAO, 2011).

Women's utilization of prenatal and delivery services is influenced by communal and individual perceptions regarding maternal care. For women, prenatal care is considered necessary primarily to ensure the health of a child rather than to protect one's own health.

There is a disconnect in how women view prenatal and delivery care in relation to the health and security of their child, which may result in the difference in their utilization of antenatal and delivery services (Lubbock & Stephenson, 2008). In this study, about 68.7% of women reported to have received information on antenatal maternity care. Women can obtain information about pregnancy and childbirth from a range of sources and by different methods, including formal and informal interactions with health professionals. For example, women may use clinic appointments, drop in sessions, or parent education groups and some may use written material or websites (Redshaw & Heikkila, 2010). According to MoHSW, the health education is not adequately emphasized in the health facilities. Though the role of the MoHSW is to issue policy and guidelines regarding health issues, the Ministry has not adequately made follow up to ensure that maternal health education is appropriately delivered.

About 61.7% reported to have attended antenatal maternity care. This is different from what has been reported in the Tanzania Demographic and Health Survey report 2010 which showed that about 96% of women indicated to have attended the

antenatal maternity care. It is not clear as to why this variation has occurred, however it might be due to number of sample which is minimal or respondents may vary in one way or another especially in terms of education status (Takwimu & Macro, 2011). It is clear that educated mothers are more likely to receive antenatal care than mothers with less education. Maternal education status was not assessed in this study.

Shortage, poor distribution and retention of health care workers, along with shortage of medicines and supplies for maternal services; unprofessional conduct among health care providers, poor ambulance system are reported to contribute to poor quality of maternal health care delivery. According to one report in Tanzania, inadequate implementation of pro-poor policies, weak health infrastructure, limited access to quality health services, inadequate human resource, shortage of skilled health providers, weak referral systems, low utilization of modern family planning services, lack of equipment and supplies, weak health management at all levels and inadequate coordination between public and private facilities affect initiatives to reduce maternal, newborn and child morbidity and mortality. In addition, a closer analysis of the referral system shows some serious challenges including: limited number of ambulances, unreliable logistics and communication systems; and inadequate community-based facilitated referral systems. The high rate of home deliveries is attributable to a malfunctioning referral system, inadequate capacity of health facilities in terms of available space, skills attendants and commodities, and other socio-cultural aspects affecting the pregnant women.

Additional factors include gender inequalities in decision-making and access to resources at household-level. On the other hand, inadequate community involvement and participation in planning, implementation, monitoring and evaluation of health services, some social cultural beliefs and practices, gender inequality, weak educational sector and poor health seeking behavior are among other factors affecting maternal and child health issues in Tanzania(Mwaikambo & TAAS, 2010).

5.2.2 Presence of skilled mid-wife

According to findings gathered from health officials, it was shown that the number of mid-wives is inadequate and the present ones had no good skill. More mid-wives are needed to improve maternal and newborn survival. This can be the reason for failure to achieve MDG goals 4 and 5. Lack of skilled attendance at birth remains a major cause of maternal mortality because countries do not have adequate numbers of midwives to provide the needed care. In Tanzania, estimates show that 17,000 babies die on their first day of life, according to Save the Children's State of the World Mothers Report released in 2013. In addition, health officials indicated also that the level of child mortality was bad as compared to maternal mortality.

5.3 How do women contribute to the improvement of maternal and child health?

5.3.1 Pregnancy awareness

Women's awareness of pregnancy is critical in the timing and initiation of pregnancy care. Many women recognized very early on that they were pregnant, although some took considerably longer (Redshaw & Heikkila, 2010). In this study most had realized that they were pregnant by 2nd and 3rd month. In one study it was explained that discussions about pregnancy and postpartum danger signs and postpartum care could inform women about appropriate care and the types of services available while initiating a dialogue about concerns women may have regarding these issues(Lubbock & Stephenson, 2008). Alleviating misconceptions and fears and reducing the gap in maternal health knowledge during prenatal care may contribute to an increase in the utilization of delivery services.

5.3.2 Choice and place of birth

Mothers who reported to be attending hospitals or health centers for maternal and child health services were found to give birth mostly in hospitals (83.3%) unlike their counterparts who happened to give birth at home (68.8) and at the local mid-wives (64.3). Timely and appropriate information is essential to help women make

informed choices about their place of birth and the way that they use maternity services. Access to information that can support choice is enhanced by early and easy contact with antenatal services and the healthcare professionals involved (Redshaw & Heikkila, 2010). This is true as observed in the results where mothers attending ANC had a clear choice to give birth at hospital.

5.3.3 Support for infant feeding

According to this study results, mothers who were attending hospitals and health centers for maternal, child health services were observed to have significantly higher chance of bringing their children to clinic 76.2%, take children for immunization 68.4%, knowledge on exclusive breastfeeding 69.7% and practice exclusive breastfeeding 76%. A key aspect of postnatal care in hospital and at home is the provision of support for infant feeding (Redshaw & Heikkila, 2010). This was more common among women who were attending hospitals for maternal and child health services compared to those who were not attending to these services.

This study found that one of the obstacles for proper nutrition for mothers and children is lack of nutrition education and knowledge. Nutrition education and counseling are considered to improve nutrition practices before and during pregnancy to improve maternal nutrition and reduce the risk of poor health outcomes in both mothers and their children (Rush, 2000).

5.4 Father and partner engagement in improving maternal and child's Health

Partners have a valuable support role to play during pregnancy, labor and birth and after the baby are born. During labor particularly they may function as advocates for their partner. Effective communication at this time is critical to a sense of wellbeing and in a practical way can enable women's needs to be better recognized (Redshaw & Heikkila, 2010). Responses to a structured questionnaire indicated that male or father participation towards maternal and child health services was poor (60%). This shows that in Mwananyamala area, male or fathers do not offer a supportive role to their partners during pregnancy, labor and birth and after the baby is born. It is clear

that in some communities, women's health is valued less than that of men. Parents may prioritize their sons' over their daughters' lives and health. Girls and women often do not have control over financial resources or access to transportation, and are thus dependent on male relatives or mothers-in-law for mobility and access to health services (WHO, 2008a). The findings of our study is in agreement with findings from several studies that have reported long waiting time at the health facility as being one of the reasons for low male accompanying their partners for maternal health services (Mullick, Kunene, & Wanjiru, 2005). It is possible that if waiting time at the health facility were reduced it will result in increased male accompanying the wife and child for postnatal care. This is because many men have long working hours and long waiting time makes it difficult to find time off to attend maternal health services.

The low level of male involvement in decision-making on matters related to labor and postnatal care if not addressed will continue to delay referral of the mothers in labor from home to the health facility because they may need to consult their husbands late when labor begins. The health workers therefore need to encourage inter-spousal communication during sensitization of the community on the importance of male involvement in maternal health care services.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

Most African Countries including Tanzania are off track to achieving the MDGs 4 and for MNCH by the year 2015. In Tanzania the Maternal mortality rates and Neonatal Mortality rates have remained unchanged since 1990. The year 2015 is only 1 year from now and what is needed now is strategic, data-based prioritization of interventions to accelerate the progress. It is recommended that science evidence-based interventions to reduce maternal newborn and child deaths are applied. Funding and human resources should be focused on rapid scaling up of the highest impact interventions (Mwaikambo & TAAS, 2010).

This report is based on data collection and analysis of items of interest, particularly those relating to factors affecting women's access, choice and information on maternal and child health services. This study came up with important information on the knowledge, perceptions, practices, and how women cope with pre-pregnancy, pregnancy and childbirth. It also provides implications for policy and programming relating to health seeking and utilization of maternal and child health services. This study examined the perceived determinants affecting women utilization of maternal health services within the cultural context of Dar es Salaam, Tanzania. The study has identified a range of factors, beginning from individual factors and family issues, health provider's attitudes towards maternal and child health services to seeking care that have also been shown to be important in other countries and cultural contexts (Lubbock & Stephenson, 2008).

The findings provide a broad picture of women's experience and their views on how they access maternal services in hospitals, issues related to child immunization, knowledge and practice of breastfeeding. In addition, the analyses are presented by comparing responses obtained from mothers who reported to attend hospitals and

health centers for maternal and child health services against those who reported not to have attended these services. In recent decades, many strategies have been implemented in an attempt to improve maternal health outcomes around the world. Programs aimed at reducing the three delays in seeking care include: improving primary prevention through education and services; developing secondary prevention through early detection and treatment of conditions; and advancing tertiary prevention through treatment of conditions to reduce case fatality (Berg, Danel, Atrash, Zane, & Bartlett, 2001). While many strategies have attempted to address some of the economic, social, and physical factors and barriers contributing to poor maternal health outcomes, women's utilization of maternal health services is often influenced by perceived socio cultural, economic, and health system factors operating at the community, household, and individual level as well as within the larger social and political environments (Lubbock & Stephenson, 2008).

Improving health systems and promoting high impact interventions involves every one, everybody and especially requires partnership between scientists and health care providers, the government, the development partners, the policy makers civil society and communities and household (Mwaikambo & TAAS, 2010).

6.2 Summary and conclusion

The overall objective of the study was to examine the contribution of women towards improving the Maternal and child's health.This study was a cross sectional hospital based survey. The study employed both quantitative and qualitative techniques of data collection.

The sample population had a mean age distribution of 28.1 ± 0.72 and 25.5 years for those who responded to questionnaires and those who participated in an in-depth interview respectively.

Male or father participation towards maternal and child health services was considered poor.

It is therefore concluded that attending hospital or health center for maternal and child health services significantly contribute to improved maternal and child health as indicated in some key aspects in this study. As indicated in this study, better understanding of women's perceptions about prenatal care, the quality of maternal and child health services, and women's health needs may improve the efficacy of public health interventions and contribute to increased utilization and effectiveness of maternal health services.

The high level of utilization of prenatal care services provides an opportunity to improve the content and effectiveness of prenatal care while encouraging healthy maternal care practices, including delivering in health facilities. Incorporating prenatal and delivery education and counseling into standard prenatal visits will allow health workers to address women's questions and misconceptions regarding care and delivery.

Discussions about pregnancy and postpartum danger signs, adequate nutrition during pregnancy, delivery care services, maternal utilization, and postpartum care could inform women about appropriate care and the types of services available while initiating a dialogue regarding these issues. Alleviating misconceptions and fears and reducing the gap in maternal health knowledge during prenatal care may contribute to an increase in the utilization of delivery services.

Communication with women about their expectations and perceptions of health facility deliveries, along with other issues, could improve community awareness of the importance of delivery services in regard to the health of their unborn children.
In order to maximize community understanding and acceptance of maternal health services, public health interventions must target men, who often control women's health-seeking practices.

In order to Scale up these high impact interventions to save the lives of mothers and newborn children it requires attention and action from many actors including:

government, health policy planners, health care professionals, development partners, researchers, civil society, and communities.

6.3 Recommendations

The main strength of the study deserves mention: the study is based on current information collected during antenatal follow-ups, which requires less memory recall. Maternal deaths are caused by factors attributable to pregnancy, childbirth and poor quality of health services. Newborn deaths are related to the same issues and occur mostly during the first week of life. Child health depends heavily on availability of and access to immunization, quality management of childhood illnesses and proper nutrition. Improving access to quality health services for the mother, newborn and child require evidence-based and goal-oriented health and social policies and interventions that are informed by best practices(Mwaikambo & TAAS, 2010). Therefore;-

The government especially Ministry of Health and Social welfare should take steps to raise awareness on the importance and benefits of attending maternal health care services for both mothers and their partners. The Ministry of Health and Social Welfare should ensure that it appropriately monitors all activities related to maternal health care. This can be done by ensuring that, there are:

- Prepare plans for supervision and monitoring of maternal health;
- Identified key issues related to maternal health based on supervision and monitoring outcomes;
- Set targets related to maternal health key issues to be achieved at different levels of the Health care system in Tanzania;
- Enough information system and data in place that are available for the Ministry to identify the possible points of intervention in the maternal health care system in Tanzania
- All maternal deaths are counted and investigated; and
- Appropriate plans for data collection, analysis, reporting and use

In order to ensure quality provision of health education during antenatal care visit, there must be a specific plan at national and council's level. The MOHSW with the assistance of RHMT must ensure that all councils and their respective health facilities develop a plan for education about maternal health care issues and strictly and effectively adheres to it.

Family values and support should be cherished. Men should be encouraged to support their partners in all aspects of reproductive health. Particularly important includes accompanying them to seek healthcare at health facilities, providing and taking care of the pregnancy period, during delivery and the period after birth.
In the meantime, un skilled local mid-wives could be given short and skills tailored trainings that enable them provide essential services as majority of women still prefer to deliver at home usually unsupervised by skilled attendants.

6.4 Further research

Further research is warranted to examine the impact of maternal care role and the degree to which it extends to the unborn child. Better understanding of how the expectations of other women, and husbands, influence women's perceptions of their duties as a caretaker may shed light on women's use of institutional delivery services and its influence on neonatal survival and overall child health.

As the inclusion of men in maternal health programs has proven controversial, more research and comprehensive monitoring and evaluation of programs involving men are needed to ascertain the male influence on women's utilization of maternal health services.

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APPENDICES

Appendix 1

Questionnaire to examine the contribution of women towards improving the Maternal and child's health

A: ANTENATAL CLINIC VISITS

1.0. Please use your knowledge and experience to answer the following questions.

No.	Questions
1.1.	Have you ever heard about antenatal and post natal clinic? (If not applicable go to question 1.4) □ Yes □ No □ Not applicable
1.2.	Have you attended any of the above in question 1.1? □ Yes □ No □ Not applicable
1.3.	If "Yes" in question 1.2 above which one you have attended? □ Antenatal □ Postnatal □ Both □ Not applicable
1.4.	When did you start to attend antenatal clinic? □ 1st month □ 2nd – 3rdMonths □ 4th -6th Months □ > 6th Months □ I don't remember □ Not applicable
1.5.	Do you have knowledge on family planning? □ Yes □ No □ A little bit
1.6.	Have you ever used any of the family planning method? □ Yes □ No
1.7.	Where did you give birth? □ At the hospital □ At home □ At the Local midwife □ On the way to the hospital □ I haven't yet give birth
1.8.	Do you bring your child for immunization as scheduled by your physician? □ Yes □ No □ I sometimes miss visits
1.9.	Do you have knowledge on exclusive breastfeeding? □ Yes □ No

1.10. Do you exclusively breastfeed your child?

□ Yes □ No

1.11. Are you used to bring your child to clinic?

□ Yes □ No

1.12. When you got pregnant with your new baby, were you or your husband or partner did anything to keep you from getting pregnant?

□ Yes □ No

1.13. What were you or your husband's or partner's reasons for not doing anything to keep you from getting pregnant?

□ I didn't mind if I got pregnant

□ I thought I could not get pregnant at that time

□ I had side effects from the birth control method I was using

□ I had problems getting birth control when I needed it

□ My husband or partner didn't want to use anything

1.14. How many weeks or months pregnant were you when you were sure you were pregnant? (For example, you had a pregnancy test or a doctor or nurse said you were pregnant)

□ 1st month

□ 2nd – 3rdMonths

□ 4th -6th Months

□ > 6th Months

□ I don't remember

1.15. During your most recent pregnancy, did your husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way?

□ Yes □ No

1.16. During your most recent pregnancy, did anyone else physically hurt you in any way?

□ Yes □ No

1.17. At any time during your most recent pregnancy or delivery, did you have a test for HIV (the virus that causes AIDS)?

□ Yes □ No

1.18. How was your prenatal care paid for?

□ Government support

□ Personal income (cash, check, or credit card)

1.19. During the month before you got pregnant with your new baby, how many times a week did you take a multivitamin, a prenatal vitamin, or a folic acid vitamin?

□ I didn't take a multivitamin, prenatal vitamin, or folic acid vitamin at all

□ 1 to 3 times a week

□ 4 to 6 times a week

□ Every day of the week

1.20. Before you got pregnant with your new baby, did a doctor, nurse, or other health care worker talk with you about how to prepare for a healthy pregnancy and baby?

□ Yes □ No

B: PERSONAL INFORMATION

2.0. Please put "x" in the box provided or fill in the blank for an answer which is related to you.

2.1. How old are you? ……..

2.2. What is your marital status?

□ Single □ Married □ Divorced

2.3. How many children do you have?

□ Not Yet □ 1 -2 □ 3-5 □ >5

Thank you for your participation. If you are interested to get feedback on the outcomes of the research do not hesitate to contact me at: sylvia.imalike@gmail.com.

Appendix 2

Questionnaires- Health Officials

Hello, my name is Sylvia B. Imalike and I am a Master student at Mzumbe University. I am conducting a survey about Women contribution towards improving Maternal and Child Health a case study in Mwananyamala hospital. I would very much appreciate your participation in this survey. The survey will take between 40 and 60 minutes to complete.

As part of the survey I would first like to ask some questions about your personal information. If you decide to participate you would have to answer some questions.
All of the answers you give will be confidential. Participation in the survey is completely voluntary. If I should come to any question you don't want to answer, just let me know and I will go on to the next question, or you can stop the interview at any time. However, I hope you will participate in the survey since your views are important.

At this time, do you want to ask me anything about the survey?
May I begin the interview now?
Date:

SECTION 1: PERSONAL INFORMATION		
ID101.	How old are you?	□ □
ID102.	What is your marital status? [1]. Single [2]. Married [3]. Divorced	□
ID103.	How many children do you have? [1]. Not Yet [2]. 1 -2 [3]. 3-5 [4]. >5	□
ID104.	What is your occupation? ……. [1]. Medical Doctor [2]. Clinical Officer [3]. Nurse [4]. Midwife [5]. Nurse [6]. Hospital attendant	□
ID105.	Education level [1]. College [2]. University	□
ID106.	How long have you been practicing Health and Medical servicers [1]. 0 – 2 years [2]. 3 -5 years [3]. 6 -8 years [4]. 9 – 10 years [5]. > 10 years	□

SECTION 2: HEALTH SITUATION		
H201.	How do you see the male/father participation towards mother and child health in this area? [1]. Poor [2]. Fair [3]. Good [4]. Very Good [5]. Excellent	□
H202.	What is the level of maternal mortality in your area? [1]. Negligible [2]. Small [3]. Bad [4]. Very Bad [5]. Alarming	□
H203.	What is the level of child morbidity in your area? [1]. Negligible [2]. Small [3]. Bad [4]. Very Bad [5]. Alarming	□
H204.	Do women get supplements in this health center? (iron supplements) [1]. Yes [2]. No	□
H205.	What are the obstacles in achieving proper health of mother and child? [1]. Insufficient skilled Labor [2]. Lack of Education and knowledge [3]. Insufficient or no male participation [4]. Insufficient tools [5]. Bad taboos and Myths	□
H206.	What is the level of adolescent pregnancy in your area? [1]. Negligible [2]. Small [3]. Bad [4]. Very Bad [5]. Alarming	□
H207.	Many midwives are on duty in the labor ward every day? [1]. One [2]. Two [3]. Three [4]. > Three [5]. Sometimes None	□
H208.	Are the midwives skilled personnel? [1]. Yes [2]. No [3]. Some are skilled and some are not	□
H209.	Are the midwives adequate to attend the number of clients you receive daily? [1]. Yes [2]. No	□
H210.	Do you provide Education to mothers who attend the Antenatal clinic [1]. Yes [2]. No	□
H211.	What is the likely age that most women stop bringing their under-five children to clinic? [1]. After 9 months [2]. After 2 years [3]. After 5 years [4]. After their deliver [5]. After 1 year	□

Appendix 3

Interview guide

Dear Respondent;

You are requested to participate in a research study which aims to assess "Women contribution towards improving maternal and child health in Mwananyamala hospital". I want to know how women are working together with their male partners in utilizing maternal health services, so as to improve utilization of maternal health services by the pregnant mothers in the hospital.

The answer given to the interview questions will not be passed over to any other third party that you do not allow to the access of such information. Information collected from interviews will be transformed into statistical data and will be used for the purpose specified only. Therefore, you are kindly requested to take some few minutes to participate in the interview and answer questions based on your ideas and experience and give your honest response to every question. You are free to withdraw from the study at any time. But I am urging you to take part to the end to make the study successful. This interview will approximately take 30 minutes to complete.

Sincerely,

……

Sylvia B. Imalike

I have been told of this study and I understand the objectives of the study as the eventual participation in this study is by choice not coercion. I have understood that I am allowed to withdraw from the study any time I feel like and my withdrawal will not affect my right to access to information and health services in the Mwananyamala hospital.

……

Participant's signature

Date……./…...2014

Please note that we record the interviewee's information only in case we want to contact them later for more details, or to ask permission to quote them. If they do not want their information recorded, that is Ok.

The questions I am going to ask today are about topics related to maternal health services. The purpose of this discussion is for you to share your ideas and experiences with us so that we can understand your views that will help in improving the maternal health services for women as well as increase male involvement in maternal health. There is no right or wrong answers to the questions that I will be asking you. Please feel free to answer exactly as you feel.

i) Let's start with an introduction. Please start by telling your name, how many children do you have? Are all present now? Would you mind if you provide your age?

ii) What do you know about ANC, delivery and postnatal care services?

PROBES

- Who is the intended user?
- Who should attend?
- What are the services offered?

iii) Do you think it is important for your partner/husband to attend ANC,delivery and postnatal care services?

PROBES

- Are there any benefits to your social/psychological well-being during pregnancy and delivery?
- What services directly benefit men?
- Would their involvement affect ANC, delivery and postnatal care?

iv) Think about your experiences and the experiences of your family and neighbors. Do men in this area accompany their wife for ANC, labour and delivery and postnatal?

PROBES

- What are the benefits of men attending these with their spouses?
  - To the mother?
  - To unborn baby and the newborn?
  - To the father?

v) What could be the reasons that prevent men to accompany the wife for ANC, labour and delivery and postnatal?

PROBES

- Culture issues? Any social economic issue?
- Health unit related factors?
- Knowledge gaps of what is done at the health facilities?

vi) What do you suggest that the health service leaders and the health workers need to do to encourage male involvement in maternal health care services?

vii) Why is it that some pregnant women do not attend ANC; postnatal care services and delivery in health facilities?

PROBES

- Any influence from the husbands?
- Any power /social economic issues?
- Any community issues?
- Any health facility issues?

viii) What should be done to improve health facility deliveries and attendance of postnatal care services?

PROBES

- Any issues on male involvement?
- Any health facility issues?
- Any community issues?

Thank you very much for your time and information