

**CHALLENGES OF PROMOTING NUMBER OF DELIVERIES IN
HEALTH FACILITIES IN NAMTUMBO DISTRICT, TANZANIA**

**By
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**A Dissertation Submitted to Institute of Development Studies in Partial
Fulfillment of the Requirements for the Award of Degree of Master of Science
in Development Policy (MSc. DP) of Mzumbe University**

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CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled “**Challenges of promoting number of deliveries in health facilities in Namtumbo District, Tanzania**” in partial fulfilment of the requirements for award of the degree of Master of Science in Development Policy (Msc DP) of Mzumbe University.

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DEDICATION

I dedicate this dissertation to my favourite wife, Flora Msuya, for her presence and prayers that have been the foundation and immense powers to this dissertation

ABSTRACT

This study is about challenges of promoting numbers of deliveries in health facilities in Namtumbo district. Specifically, the study sought to explore the status of women deliveries at health facilities in Namtumbo District, people's perception on delivering at health facilities, factors influencing deliveries at health facilities, and ways of promoting deliveries at health facilities in the District. The population of study was all community members of Namtumbo district from which a sample of 65(100%) respondents was obtained whereby simple random sampling and purposive sampling techniques were used. Methods of data collection involved both primary and secondary sources. Primary data were collected by using questionnaires and interviews. Documentary review methods were used in collecting secondary data. Analysis of data was done with excel. Therefore, the report is presented using descriptive statistics, namely frequencies and percentages.

The findings revealed that the number of women delivering outside health facilities is still high. Influencing factors include negative attitudes of health providers, lack of medicine and medical supply, and budget constraints from the government on health facilities construction making the problem of home deliveries keep on persisting. This makes the pregnant women not to get proper services as guided in order to control the life of pregnant women. Also, the study revealed that the factors which lead the pregnant women to deliver at home include polite language from Traditional Birth Attendants (TBAs), services provided under a short time, short distance from home to TBAs, zero cost in services and no compulsory HIV/AIDS testing as what is practised at health facilities. Further, the government is committed towards the promotion of numbers of deliveries in health facilities all over the country but there are still some challenges such as shortage of drugs in the health facilities, lack of funds, lack of transport facilities as well as shortage of personnel.

Based on these findings, increase in the utilization of health facilities for delivery by improving education among girls, increase in accessibility to health facility and promotion of early booking as well as regular visits by women have been recommended.

ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
CCHPG	Comprehensive Council Health Planning Guideline
CDOs	Community Development Officers
CHMT	Council Health Management Team
DC	District Council
DED	District Executive Director
DHSB	District Health Services Board
DISP	Dispensary
DMO	District Medical Officer
DRCHco	District Reproductive and Child Health Coordinator
EMOC	Emergency Obstetric care
GDP	Gross Domestic Product
HAPA	Health Action Process Approach
HIV	Human Immune-Deficiency Virus
HC	Health Center
HF	Health Facility
HFMT	Health Facility Management Team
IDR	Indonesia Rupiah
IMCI	Integrated Management of Childhood Illness
KCMC	Kilimanjaro Christian Medical Center
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MOi/c	Medical Office In charge
MOHSW	Ministry of Health and Social welfare

MSD	Medical Store Department
MUCHS	Muhimbili University College of Health Sciences
NAO	National Audit Office
NBS	National Bureau of Statistics
NSGRP	National Strategy for Growth and Reduction of Poverty
OBS	Obstetric
OPD	Out Patient Department
PMTCT	Prevent Mother to Child Transmission
PNC	Postnatal Care
PO-PSM	President Office Public Services Management
RCH	Reproductive and Child Health
SPSS	Statistical Package for Social Sciences
TALGWU	Tanzania Local Government Workers Union
TBA _s	Traditional Birth Attendants
TDHS	Tanzania Demographical Health Survey
TUGHE	Trade Union of Government and Health Employees
UN	United Nation
UNICEF	United Nation International Children Fund
URT	United Republic Of Tanzania
USD	United States Dollar
WHC	Ward Health Committee

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CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 Introduction

This chapter presents introduction to the study. It specifically presents background information, statement of the problem, objectives of study, research questions and significance, scope, limitations and organization of the study.

1.2 Background Information

Globally, home deliveries are a common problem in the world which cause the complications that will threaten the health of both the mother and the newborn. Among the eight millennium development goals, the fifth goal aimed to reduce maternal mortality rate (MMR) by three quarters (75%) from 1990 to 2015 and ensure universal access to reproductive health services. Also, efforts to reduce death among women and children have been less successful than in any other areas on human development-with the result that bearing a child remains among the most serious health risks for women, About 600,000 women around the world die of pregnancy and labour related causes each year (UNICEF, 2009).

In Sub-Saharan Africa home delivery still is the problem that will threaten the health of both the mother and the newborn. When delivery is conducted at home it is difficult to manage complications that may arise during labour as some would require specialists, special equipment and even operative procedures which cannot be performed at home (Myles, 1981). About 95% of death worldwide which is 570,000 related to pregnancy and labour related occur in Sub-Saharan Africa, many of these deaths could be avoided if awareness of the problem were to be promoted through advocacy that would lead to timely intervention (UNICEF, 2009).

Tanzania is one of the 189 nations, which endorsed the Millennium Development Goals (MDGs) in September 2000 as part of the internationally agreed-upon development goals at the General Assembly of the United Nations. The MDGs initiative calls upon developed and developing countries to work in partnership

towards a world with less poverty, hunger and disease, greater improvement of maternal health, guaranteeing basic education for children, equal opportunities for women, and a healthier environment in support of the Agenda 21 principles of sustainable development. Basing on the MDG 5 improve of maternal health the Tanzania Demography Health Survey 2010 shows that 96% of women who gave birth in the five years preceding the survey received Antenatal Care at least once, whereby urban and rural women areas received Antenatal Care 99% by 95% respectively (TDHS, 2010).

Maternal mortality rate remains high in Tanzania at about 578 per 100,000 live births in the Mainland and 473 per 100,000 live births in Zanzibar. Also, about 8,100 women die every year due to pregnancy related complications (MDG REPORT, 2000/08). Furthermore, educated mothers are reported to receive antenatal care from medical professionals than the less educated mothers while traditional birth attendants (trained or untrained) were not provided ANC compared to village health workers who provide ANC by 2% (ibid).

Ruvuma Maternal and Child Health Report (2012) shows that, of 50,959 (100%) deliveries 45,666 (89.6%) delivered in health facilities; 5295 (10.4%) delivered at home. Out of six (6) District councils within the Region, Namtumbo District councils is recorded to have more pregnant women delivering out of health facilities. It is indicated that out of 5002 deliveries, 3858 (77.1%) delivered in health facilities, 1144 (22.8%) delivered at home (Namtumbo District Maternal and Child Health Report, 2011). Table 1.1 illustrates the Ruvuma region total deliveries for the year 2011:-

Table 1.1 Ruvuma Region Total Deliveries for the Year 2012

District	Delivery Place				Total of Delivery	
	Delivery at HF		Delivery at Home		No	%
	No	%	No	%		
Songea Municipal Council	10,049	97.1	304	2.9	10,353	100
Songea Rural	6339	97.7	150	2.3	6489	100
Mbinga	15528	95	820	5	16348	100
Tunduru	9104	72.3	3495	27.7	12597	100
Namtumbo	4646	89.8	526	10.2	5172	100
Total	45,666	89.6	5295	10.4	50,959	100

Source: Regional HMIS file, 2011

From Table 1.1 above, one can easily notice that Namtumbo District had 1,144 deliveries out of health facilities (home derived). Also, the table shows that Namtumbo District is the second after Tunduru District in terms of deliveries out of health facilities though the policy states that there will be free provision of health services to pregnancy women; on the other hand, Namtumbo District has high maternal mortality the situation which is against National Strategy for Growth and Reduction of Poverty (NSGRP) (2005) which emphasizes the reduction of maternal mortality and increased coverage of births attended by trained personnel from 50% to 80% by 2010 (URT, 2005).

In view of the above situation there have been a concern from leaders, ordinary and technical people about the trend of deliveries in health facilities in Namtumbo District. Some argue that distance from health facilities for a pregnant woman to get delivery service is long. There are people who complain about negative attitude of health staff to pregnant woman while seeking maternal services (harsh language). Also lack of reliable transport is another obstacle for a pregnant woman to go for a delivery service at a health facility. This study intended to assess challenges of promoting number of deliveries in health facilities in Namtumbo District as one strategy towards looking for solution of reducing maternal and child mortality rates in the District.

1.3 Statement of the Problem

Tanzania is one among 189 nations that endorsed the Millennium Development Goals (MDGs) that call upon developed and developing countries to work in partnership towards a world with less poverty, hunger and disease, greater improvement of maternal health, guaranteeing basic education for children, equal opportunities for women, and a healthier environment in support of the Agenda 21 principles of sustainable development (TDHS, 2010). However, Tanzania is still challenged by slow progress in reducing maternal mortality and infant mortality rate. Evidence shows that maternal mortality rate remains high in Tanzania at about 578 per 100,000 live births in the Mainland and 473 per 100,000 live births in Zanzibar. About 8,100 women die every year due to pregnancy related complications (MDG REPORT, 2008).

Namtumbo District is known to have high number of deliveries out of health facilities though the health policy of Tanzania directs free provision of health services to pregnancy women. This leads to high maternal mortality, the situation which is against National Strategy for Growth and Reduction of Poverty (NSGRP, 2005) which emphasizes the reduction of maternal mortality and increased coverage of births attended by trained personnel from 50% to 80% by 2010 (URT, 2005). This study intended to assess challenges of promoting deliveries in health facilities in Namtumbo District, Tanzania in order to improve service delivery in health centers.

1.4 Objectives

Objectives are basic tools that underlie all planning and strategic activities. They serve as the basis for creating policy and evaluating performance or targeted situation on findings.

1.4.1 General Objective

The overall objective of study was to assess challenges in promoting deliveries in health facilities in Namtumbo District Tanzania in order to improve service delivery to pregnant women in the country.

1.4.2 Specific Objectives

In order to accomplish the above general objective, the study focused on the following specific objectives:-

- (i) To explore the status of women deliveries in health facilities in Namtumbo District
- (ii) To explore people's perception on delivering in health facilities in Namtumbo District
- (iii) To find out factors influencing deliveries in health facilities in Namtumbo District
- (iv) To find out ways of promoting deliveries in health facilities in the District

1.5 Research Questions

A research question is a tool into a specific subject and find out as much information as needed in the field.

1.5.1 Main Research Question

What are the challenges to promoting deliveries in health facilities in Namtumbo District?

1.5.2 Specific Research Questions

- (i) What is the status of women deliveries in health facilities as compared to deliveries out of health facilities in Namtumbo District?
- (ii) What are the people's perceptions on delivering in health facilities?
- (iii) What are the factors influencing deliveries in health facilities?
- (iv) What are the ways of promoting deliveries in health facilities in the District?

1.6 Significance of the Study

This study will be of great benefit to policy makers on the issue pertaining to the challenges of promoting number of deliveries in health facilities in Namtumbo District and in Tanzania at large. The findings will help to understand the magnitude of the problem and to address it by coming up with ways of improving deliveries services. Generally, the findings will help to inform policy makers on the importance of setting appropriate strategies related to the provision of services so that deliveries services are taken on board. The findings will further be applied at lower level on other bodies interested in promoting number of deliveries in health facilities.

1.7 Scope of the Study

This study focused on challenges of promoting number of deliveries in health facilities in Namtumbo District. Due to the limitation of time and financial constraints, geographically the study covered only 4 Wards out of ten which are Luchili, Msindo, Rwinga and Namtumbo ward of Namtumbo District. The study covered only seven (7) groups which are council health management team, health services board, ward health committee, health facility management team, services providers, household members and community development officer.

1.8 Limitations of the Study

The study encountered several limitations: First, financial resources which led researcher to use only two research assistants who spent a very long time on data collection and led to delays in data analysis. The researcher was taking extra time to analyze data and compile the report. Second, the areas of the study were very far from the district headquarters which made the study very expensive whereby hiring of motorcycles become mandatory for transportation of researcher and research assistants. Third, the communication barrier was the problem because most of respondents were not conversant with Swahili language which forced a researcher to look for a translator.

In order to cover this limitations researcher was making sure proper use of financial resources which are available, To cover the data collection area by using simple transport which is motorcycles and to have translator to area which respondents not familiar with Swahili language.

1.9 Organization of the Study

This study is organized into six chapters. Chapter one is composed of introduction, background information to the problem, statement of the problem and justification, general objective, specific objectives, research questions, significance of the study, scope of the study and limitation s of the study. Chapter two presents literature review, chapter three presents methodology of the study, chapter four deals with presentations of findings and chapter five presents summary, conclusion and suggestions.

CHAPTER TWO

THEORETICAL LITERATURE REVIEW

2.1 Introduction

This chapter presents theoretical literature review on the concept put forward by different authors on challenges to promoting number of deliveries in health facilities in Namtumbo.

2.2 Conceptualization of Key Concepts

Different terms can have different meanings to different people. This work has several terminologies that could bring a misunderstanding to the people. The terms include health, policy, health policy, health facilities, morbidity, service delivery and perceptions as follows:

2.2.1 Health

World Health organization describes health as a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity. This interpretation is inclined to encouraging the people to become healthier as per the preamble of the constitution of the WHO (WHO, 1948).

2.2.2 Policy

Policy is a broad concept that embodies several different dimensions; one of the definitions is that, it is “a course or principle of action, adopted or proposed by a government, party, business or individual” to attain a specific objective (Sherri, 2005).

2.2.3 National Health Policy

Health policy refers to decisions, plans and actions that are undertaken to achieve specific health care goals within a society. An explicitly health policy can achieve several things: It defines a vision for the future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups (Sherri, 2005).

2.2.4 Health Facilities

Health facilities are places that provide health care. They include hospitals, clinics, outpatient care centers and specialized care centers, such as birthing centers and psychiatric care centers. When you choose a health facility, you might want to consider, how close it is, whether your health insurance will pay for services there, whether your health care provider can treat you there and the quality of the facility (WHO, 1948).

2.2.5 Perception

Interpretation of health basing on services delivery to the community has been described by scholars and organization on different aspects. The specific interpretation leads to differentiation with other words as well as making the concept relevant to the field. Perception is a process by which individuals organize and interpret the sensory impressions in order to give meaning to their environment (Robbins, 1998). Also, perception is an important mediating cognitive process through which persons make interpretations of the stimulus or situation they are faced with (Luthans, 2001).

2.2.6 Morbidity rate

Explanation of health basing on services delivery to the community has been described by scholars and organization on different aspects. This is explained by referring to the state of illness and disability in a population – usually the data on morbidity are obtained from death. This is one of the challenges which take place in health sector in Tanzania (CCHPG, 2011).

2.2.7 Service Delivery

The World Health Organization (WHO) defines service delivery as the way inputs are combined to allow the delivery of a series of interventions or health actions (WHO, 2001b). As noted in the World Health Report (2000), “the service provision function of the health system is the most familiar; the entire health system is often identified with just service delivery.” The report states that service provision, or

service delivery is the chief function the health system needs to perform (WHO, 2000).

2.3 The Structure of Health Services Delivery in Tanzania

Health services are the most visible part of any health system, both to users and the general public. Health services can be promotion, prevention, treatment or rehabilitation, may be delivered in the home, the community, the workplace, or in health facilities. Effective health service delivery depends on having some key resources: motivated staff, equipment, information and finance, and adequate drugs. Improving access, coverage and quality of health services also depends on the ways services are organized and managed, and on the incentives influencing providers and users (URT, 2003).

In Tanzania, the current administrative set-up, provision of health services is divided into 3, namely National, Regional and District. At the village level, where there are village health posts; ward level, there are community dispensaries; divisional level, where there are rural health centers district level, where there are district or district designated hospitals; regional level, where there are regional hospitals; zonal level, where there are referral/consultant hospitals and national level, where there are national and specialized hospitals (URT, 2003).

At the National level, the Ministry of Health administers and supervises the National Hospitals, Consultant Referral Hospitals, Special Hospitals, Training Institutions, Executive Agencies and Regulatory Authorities. At the Regional level, provision of health services is vested to the Regional Administrative Secretary with technical guidance of Regional Health Management Team. At the district level, management and administration of health services has been devolved into district through their respective Council Authorities, Health Service Boards, Facility Committees and Health Management Teams (ibid) this level described below:-

2.3.1 Community Health Services

It is the responsibility of each individual and/or household to take care of its own health. The communities have an obligation to their own health and should be involved and participate in addressing and solving health issues using the available local resources. The Village Government should recognize and enhance the pivotal role of communities in directing local health services. The communities will have the mandate to choose their own community health worker who will be the main linkage between the community and the nearest health facility. The community health worker responsibilities will include health education, and assisting in relevant public health interventions (URT, 2003).

2.3.2 Dispensary Services

This is the first formal health unit of level one health services. It is a primary health facility which offers outpatient services including reproductive and child health services and diagnostic services. A dispensary caters for 5,000 people and oversees all the village health services. The Ministry of Health standardizes these units in all parameters including the staffing level, equipment, drugs, and medical supplies and approved building plans. The Dispensary Committee and Dispensary Management Teams is level of management which control this level. Dispensaries provide comprehensive Primary Health Care services which include the following: Health Education and IEC to people being served by the dispensary, Treatment of diseases, Reproductive and Child Health Services, and Family Planning, Integrated Management of Childhood Illnesses (IMCI), School Health Services including HIV/AIDS, Immunization Services to children and mothers, Continuation of treatment for TB, Leprosy, Mental and other diseases in collaboration with higher level facilities (Rural Health Centre in particular), Outreach Services and mobile clinics with special focus to nomadic communities, Prepare Dispensary Health Plans and monitor their implementation, where appropriate provide expertise and supervision of health care activities in the villages served by the dispensary and prepare progress reports for submission to the relevant committees established by the Council (URT, 2003).

2.3.3 Health Centre Services

This is the second formal health unit of level one-health services. It is a primary health facility, which offers Outpatient and In-patient services, maternity care, laboratory, and dispensing and mortuary services. A Health Centre caters for 50,000 people and supervises all the dispensaries in the Division. Where the population is higher than 50,000, the level of services is increased to accommodate a higher throughput. The Ministry of Health standardizes the staffing level, equipment, drugs, medical supplies, reagents, dental oral health and building plans. A Health Centre under the Local Government Authority through the Health Centre Committee and Management Team, provides promotive, preventive, curative and rehabilitative services, acts as the first referral center from dispensaries in its catchment's area, keeps health service data and records according to given guidelines, provides feedback to other levels including dispensaries and each health centre has a communication facility including appropriate transport for referral of patients to hospitals and supervision (URT, 2003).

2.3.4 District Hospital Services

Hospital services in the district are offered by the district hospital and other level one hospital. Level one hospital services provide; out-patient and in-patient care; acts as the second referral level and performs general surgical and obstetric operations. The District Hospital under the Council through the Hospital Governing Committee and Hospital Management Team provides health care to the catchment's population; acts as referral centre for patients from lower level health facilities of the district; conducts teaching and training of middle and operational level health carder; conducts action oriented research programmes in the district, gives supportive supervision and inspection and provides technical skills to lower health facilities in the district and refers patients to the regional hospital (URT, 2003).

The Ministry of Health maintains the criteria for the establishment and standardization of all parameters of these hospitals including the staffing level, equipment, drugs, reagents, medical supplies and approved building plans. For those

districts, which do not have public hospitals, the government continues to collaborate with the designated Voluntary Hospitals usually the District Hospital has a communication and transport system appropriate for the functions and services to be rendered.

2.3.5. Regional Hospital Services

This is a hospital establishment providing level two (Secondary) referral services from level one hospital. The Regional Hospital under the management of the Regional Secretariat through the Regional Hospital Board and Hospital Management Team, has the following functions: to provide all services offered at district level but at a higher level of expertise, offer second level referral services from level one hospitals, conduct teaching and training of middle and operational level health cadre, conduct health research programmes including operational research of health systems research in the region, provide technical skills to lower health facilities in the Region and offer specialized treatment in medicine, surgery, obstetrics and gynaecology and paediatric, and shall include eye, dental, mental illnesses, orthopaedics and trauma. The Regional Hospital shall have a communication and transport system appropriate for functions and services rendered also the Ministry of Health maintains the criteria for the establishment and standardization of all parameters of these health service facilities including the staffing level, equipment, drugs, reagents, medical supplies and approved building plans (URT, 2003).

Other diseases and cases require special treatment whose facilities and equipment are not available in the country. Depending on the foreign exchange position, some patients have to be sent for treatment abroad (URT, 2003).

2.3.6 National, Referral and Specialized Hospital Services

This is level three and the highest level of hospital services in the country, which acts as referral centre for level two hospitals.

(i) National Hospital

The National hospital (Muhimbili) is supervised by the Ministry of Health through Board of Muhimbili National Hospital. It also acts as zonal referral hospital for the Eastern Zone. The Ministry will ensure that the hospital is equipped with qualified human resources, sophisticated equipment and reliable and adequate transport/communication facilities so as to provide services as required.

(ii) Zones for referral hospital

At present there are four zonal referral/consultant hospitals. These are Muhimbili National Hospital in which two voluntary agency hospitals – Bugando Medical Centre and KCMC and Mbeya Hospital owned by the government. The locations of these referral hospitals are in eastern, western, northern and southern highlands zones, respectively. Referral Hospitals will be equipped with the best mix of qualified specialists and consultants as well as sophisticated modern medical equipment so that they are able to handle cases, which are currently being referred abroad. The hospitals offers all medical services offered by level two hospitals but at a higher specialist level. Also, they conduct the training of high and middle level health personnel, health research, provide consultancy on various health and medical issues, and conduct outreach visits to other hospitals in the zone to offer specialists support services to the medical staff services. The Muhimbili College of Health Sciences (MUCHS) in collaboration with the hospital does training of high-level health personnel at Muhimbili. Referral hospitals have adequate and reliable transport/communication facilities to meet the demand to enable the specialists perform their duties better and The Ministry of Health determines service outputs and targets to be achieved by each institution (URT, 2003).

(iii) Specialized Hospital

There are two specialised hospitals, Mirembe Hospital (Dodoma) and Kibongoto (Moshi), which are directly supervised by the Ministry of Health, this continue to provide services to the mentally sick and TB patients respectively. These hospitals equipped with qualified specialists and consultants as well as sophisticated modern

medical equipment so that they can deliver as required. The hospitals have adequate and reliable transport/communication facilities to meet the demand to enable the specialists perform their duties better (URT, 2003).

(iv) Treatment Abroad

Other diseases and cases require special treatment whose facilities and equipment are not available in the country. Depending on the foreign exchange position, some patients have to be sent for treatment abroad (URT, 2003).

2.4 Home Delivery Verses Health Facility Delivery in the World

The use of health services during delivery is a complex behavioural; the preventive and curative services have often found that the use of health services is related to the availability of health facilities (Thaddaus, 1994).

2.4.1 Home Delivery

A home delivery is a common problem in many countries of the world. This is much more experienced in developing countries where the majority of births occur without the help of a skilled assistant at home or in other non-hospital settings. Home deliveries in the absence of skilled professional attendants have been associated with adverse infant and maternal mortality. It is estimated that, about 90% of maternal deaths occur in Asia and sub-Saharan Africa, *Journal of community Health* (1993). Utilization of health services during delivery is a complex behavioural phenomenon. Empirical studies of preventive and curative services have often found that use of health services is related to the availability, quality and cost of services, as well as to social structure, health beliefs and personal characteristics of the users (Health Promotion International, 2003).

In many countries home delivery is not encouraged as there may occur complications that will threaten the health of both the mother and the newborn. When at home it is difficult to manage complications that may arise during labor as some would require specialist, special equipment and even operative procedure

which cannot be performed at home (Myles, 1981). About 600,000 women around the world die of pregnancy and labor related causes each year. About 99% of these deaths occur in less developed countries, many of these deaths could be avoided if awareness of the problem were to be promoted through advocacy that would lead to timely intervention (Remakrishma, 1998).

2.4.2 Why Home Delivery

(i) Norms and Traditions

In developed nations, giving birth at home with a midwife in attendance is considered the norm, with one-third of all babies born this way. The Netherlands has the highest percentage of home births in the Western world. Some 30 percent of Dutch women deliver at home while around 60 percent do so in hospital, mostly for medical reasons, and another 10 percent deliver in special out-patient birthing clinics. Some women say that, their mothers had all her kids at home and that always went well, why they should go to hospital; attitude is that pregnancy is not an illness, that home births are the norm. Health insurance does not cover the full cost of a hospital birth unless there was a real medical imperative (Thaddeus, 1994).

(ii) Professionals of Attendants

Many people, especially in North America, are skeptical of midwifery. Some believe that, since midwives are not doctors, they are not capable of properly and safely delivering a baby. This bias is unjustly founded. Midwives have been delivering babies for thousands of year. In fact, there was a time when doctors wouldn't even consider delivering a child since that was "women's work". Midwives are highly skilled professionals who approach childbirth with the attitude that pregnancy is a natural part of a woman's life, not a medical issue. The World Health Organization has stated that having a midwife attend to a woman throughout her birth can reduce her labor time and result in her needing less medication (Ibid)

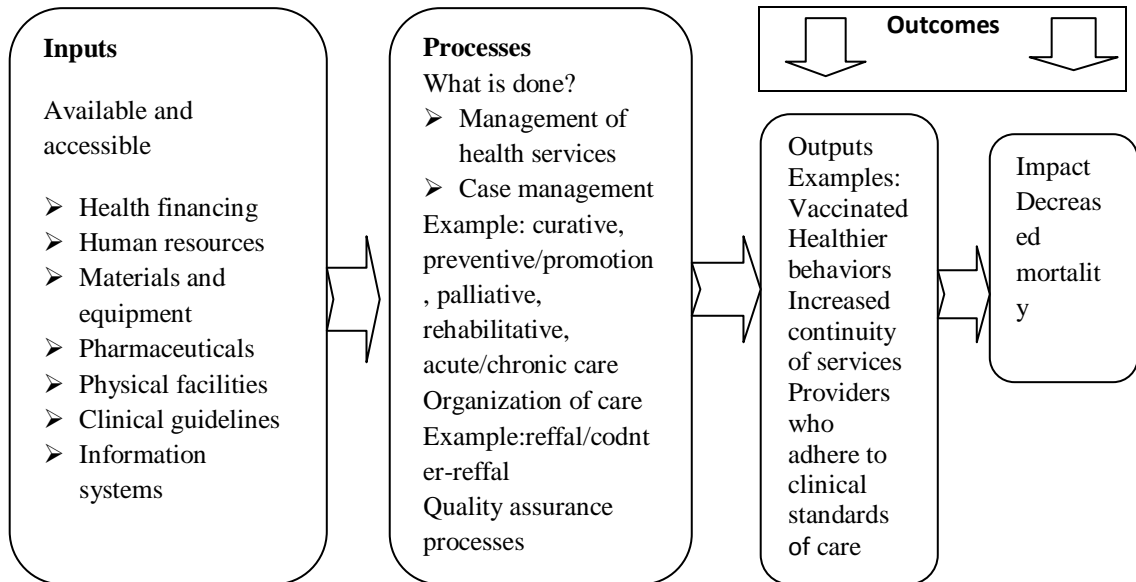
(v) Referral Management

WHO (1998) revealed that delays in referring women from community health care facilities to hospitals is one of the most important factors that prevent women from receiving care that would save their lives. Staff at the community facilities could not recognize the seriousness of the problem. Even if they did, many rural health centers did not have the means to handle complications with health care facilities offering more advanced care. In Tanzania, 21% of women delivered at home because of rudeness of health staff even though they thought delivery in a health care facility were safer (WHO, 1998). Some forms of abuse used by doctors and nurses are physical and verbal abuse. These affect health service access, compliance, quality and effectiveness. Positive interaction between expectant women and health care providers however, lead to client's confidence and compliance (D'olineira, 2002). Providing individuals and communities with information they needed through community-based strategies could help prevent harmful practices as well as promote appropriate basic care, including clean delivery (Stars, 1987).

2.4.3 Health Service Delivery Systems

Health service delivery can be represented in a system's perspective, with inputs, processes, outputs, and outcomes. Some of the core inputs that are deemed necessary for health care delivery are financial resources, competent health care staff, adequate physical facilities and equipment, essential medicines and supplies, current clinical guidelines, and operational policies. These inputs must be available and accessible to have an impact. They also must be used to properly carry out the system processes to produce desired health outcomes (Bolam et al., 1998).

Figure 2.1 Health services delivery systems



Source: Adapted from Massoud and others (2001).

2.5. Why Promoting Delivery in Health Facility is Important

Health promotion is the development of individual, group, institutional, community and systemic strategies to improve health knowledge, attitudes, skills and behavior. The purpose of health promotion is to positively influence the health behavior of individuals and communities as well as the living and working conditions that influence their health (WHO 2003).

2.5.1 Increased of Maternal Morbidity and Mortality

The promoting of deliveries in health facility is important because number of women dying due to pregnancy and childbirth, Several strategies have been done in our country to improve the access to maternal health care since the initiative of safe motherhood programme in 1987, this initiatives has improved pregnant mother to access antenatal care and slightly improve delivery in health facilities, however there is higher difference among the regions despite the higher attendance of attendance of

antenatal clinics in both regions. Low delivery in health facilities as a result of many factors leads to high morbidity and maternal mortality therefore proper interventions must be taken to increase delivery in health facilities. Home delivery if not conducted by professionals, increases the risk of transmission of HIV/AIDS to relatives or traditional birth attendants who conduct deliveries without protective equipment. Several studies have been done Worldwide including Tanzania regarding factors affecting delivery in health facilities; the factors that have been studied include Socio demographic factors, socio economic factors, availability of health services, accessibility, behavior and attitudes of health care providers and socio cultural issues (Mrisho et al., 2007).

A single most important and effective way to reduce maternal morbidity and mortality is to ensure that, trained and qualified health professionals to conduct safe normal delivery and manage complications are present during child birth. But unfortunately there is a chronic shortage of the professionals in poor and rural communities in the developing countries (Safe motherhood report, 2000). Adequate equipment, drugs and other supplies are very essential to enable skilled attendants to provide good quality health care. Good quality hospital perinatal services are made possible if health care providers have adequate clinical skills and are sensitive to women's needs, and health care centers are equipped with necessary supplies (Kaguna et al., 2008).

2.6 Factors Affecting Delivery in Health Facility

The number of births attended by skilled health personnel in the country has increased from 41 per cent in 1999, to 51 per cent in 2010, and births taking place in health facilities have increased by three percent from 47 per cent in 2004 and 50 per cent in 2010 (TDHS, 2010).

Several studies have been conducted Worldwide on the factors affecting delivery in health facilities and the following was observed, The issues of risk and vulnerability, such as lack of money, lack of transport, sudden onset of labour, short labour, staff attitudes, lack of privacy, geographical location, perception of poor quality of health

services, tradition, cultures and the pattern of decision-making power within the household were perceived as key determinants of the place of delivery (Zulfiqur et al., 2009).

2.6.1 Socio Economic Factors

Household financial capacity is one of the major factors in the determination of place of delivery, and this depends on mother occupation and husband occupation. Women who are working and earning money may be able, to save and decide to spend it on a facility delivery. Several studies find that farming women are less likely to have skilled attendance at delivery than women in other occupations (Addai, 2000). This may be due to limited financial resources and health services in rural areas. Wives of husbands with higher status occupations could be more able to use facilities for delivery. High status occupations are associated with greater wealth, making it easier for the family to pay costs associated with skilled delivery care. A limited ability to pay and high hospital costs have been identified as the major barriers for the rural poor wishing to access health care, due to economic difficulties in rural areas women are not able to afford costs related to deliveries even if the services in some places are free of charge they unable to pay for transport in case of referral or the facility is away from home (WHO, 2007). High socio economic status is associated with delivery in health facility and sometimes is confounding with level of education as those with higher education have better jobs and earning higher, so women are encouraged to participate to income generating activities in order to rise their economic status.

2.6.2 Health Services Factors

Unreliable transport is also a barrier to access skilled delivery in rural areas, failure to plan in advance for transport cause higher number of women to deliver in their homes even if they had planned to deliver in health facilities (Mrisho et al., 2007). Similar findings have been documented by study done at Nepal where by women who planned to deliver in health facilities 18% delivered in home due to lack of transport (Bolam et al., 1998). In a rural Tanzania for instance 84% of women who

give birth at homes are intended to deliver in health facility but due to transport problem and long distance to health facilities they end up delivering home (Luchock et al, 1994).

Inadequate knowledge and skills for health workers on management of obstetrics cases can be the barrier for delivery in health facilities, several study found that health workers tend to unnecessarily refer pregnant mothers to higher level because they don't know to use partogram which monitors the progress of labour and the woman ends up delivering normally. This woman will never come back to that facility due to unnecessary referral to other health facility (Shankwaya, 2008).

Lack of privacy is also documented as a barrier for delivery in health facilities because some older women they don't want to be attended by younger mid wives at health facilities who they think are like their daughters or younger women fear to be attended by male health workers during delivery. In other health facilities there is no special room for delivery; women are just delivering in OPD. This condition hinders women from delivering in health facilities (Mrisho et al., 2007).

2.6.3 Socio- Demographic Factors

Mother's literacy level is also important determinant of place of delivery as those with non-formal education tend to deliver at home, and those educated tend to give birth's in health facilities. Study conducted in Nepal shows that there is relationship between education and place of deliver as those with poor education are more like to deliver at home compared to educated women who tend to deliver at health facilities (Belam et al., 2006). Another study from Cambodia noted that women who attended at least seven years of school are six times more likely to deliver in health facilities compared to those who did not attend (Yanagasawa et al., 2006). The same findings were obtained in a study conducted in Kenya and concluded that community based antenatal education might be targeted at poorly educated mother to enable them make informed decision about the place of delivery. It has also been suggested that there may be community effects of education, with more highly educated communities organizing themselves and demanding better public services and higher

position for health on the political agenda (Grosse, 1999). In contrast, better awareness of poor quality in many facilities and higher confidence in self-care may delay care seeking among educated women. Education is likely to be associated with wealth and even residence (Bolam et al., 2006).

The age and parity are also determinants for the place of delivery. The study done in Zambia shows that 55% of women who deliver in health facilities are younger and out of that 65% are those having the first baby. Women with 35 years and above with more than five children tend to deliver at home because they consider themselves as having experience so they don't need assistance from skilled workers. This is evidenced by the study conducted by Mrisho in southern part of Tanzania and study conducted in Nepal both documented that multi para and older women tend to deliver at home compared to young women. These young women have no experience in child births and they tend to fear complications related to pregnancy and child birth (Shankwaya, 2008).

2.6.4 Antenatal Clinic Attendance

Insufficient counseling during antenatal visit is another factor for low delivery in health facility, minimal time used by health workers for counseling pregnant mothers during antenatal clinic is the missed opportunity to educate women on the importance of health facilities delivery. Also, information that all pregnancies carry risk and labour complications that are unpredictable are not communicated during antenatal clinic visit .In some places providers are not informing pregnant mothers the meaning of expected date of delivery as the result when the labour pain starts early before that date they end up delivering in their homes even if they were interested to deliver in health facilities. According to Pembe and Urrasa, majority of women who attended antenatal clinic had low awareness about the danger signs of obstetric complications. This lack of adequate information about danger signs and complication related to delivery is one of the factors for low delivery in health facilities (Pembe and Urrasa, 2010).

2.6.5 Cultural Factors

Perceived quality of care, which only partly overlaps with medical quality of care, is thought to be an important influence on health care-seeking and place of delivery. Assessment of quality of services largely depends on personal experience with health system (Duong et al, 2004). Elements such as less waiting times, satisfaction with the service received – including staff friendliness, availability of supplies and waiting times are perceived as good quality. In many cases, the medical 'culture' may clash with the woman's, for example, when family members are not allowed to be present, supine birthing position is imposed or privacy not respected; this may lead to perceptions of poor quality (Thaddeus, 1994). Some studies mention that women report better quality of care in private facilities but that cost deters them from using those services (Mrisho et al, 2007).

Perceived interpersonal quality of care overlaps to some extent with traditional beliefs and possibly sometimes with ethnic discrimination. The concern about quality of services sometimes interacts with other barriers, for example with distance or cost. Perceived quality of services plays a major role in choice of place of delivery. In some areas, women decide to go to private health facilities, where they pay instead of going to government health facilities which are closer to their homes and services are provided free (Mrisho et al, 2007).

Community beliefs on health facilities delivery are important on the choice of place of delivery. In other places they believe that normal delivery should be conducted at home and delivery at health facilities are beneficial for those with complications only (women identified with problems and risk factors during antenatal clinic). The availability of delivery assistance by TBAs has been reported to be associated with non-utilization of a health facility for delivery in rural areas, Study conducted in northern part of Tanzania shows that traditional births attendants are the ones who determine the place of delivery among Masai tribe and they also arrange for the kind of diet required by the women after delivery, in order to improve health facilities

deliveries TBAs must be involved, well informed and fully participate (Magoma et al, 2010).

They believe that TBAs and relatives are affordable and able to meet their expectation during delivery and postpartum period, these services cannot provide at health facilities (Magoma, 2010). Another findings in Tanzania shows that labour is kept secret because any complications develops it means the women is adulterous and remedy for that is to mention all men have slept with her (Mrisho, 2007). In Zambia, it is believed that placenta must be buried in certain manner for a women to continue bearing children, this is contrary to health facilities where placenta is burned by incinerator (Shankwaya, 2008). Different ethnicities have different cultural values and these cultural values may prevent women to access health facility for delivery. Knowing these values and addressing them in the community could improve delivery in health facilities.

2.7. The Vision, Mission and Objectives of the Health Policy

The vision, mission and objectives of health policy provide the directions on what the implementations of policy can be link with provision of better health services (URT, 2003).

2.7.1 The Government Development Vision and the Health Policy

The Health Sector is one of the priority sectors of the Tanzania Government as is reflected in the annual incremental increase in budgetary allocation to the sector. Presently the share of the budget for health is at 11% and which is set to rise to the target of 14% (URT, 2003).

In addition, the Tanzania Development Vision 2025 also identifies Health as one of the priority sectors. Among its main objectives is achievement of high quality livelihood for all Tanzanians. This is expected to be attained through strategies, which will ensure realization of the following health service goals: -

- (i) Access to quality primary health care for all;

- (ii) Access to quality reproductive health service for all individuals of appropriate ages;
- (iii) Reduction in infant and maternal mortality rates by three quarters of current levels;
- (iv) Universal access to clean and safe water;
- (v) Life expectancy comparable to the level attained by typical middle-income countries.
- (vi) Food self-sufficiency and food security;
- (vii) Gender equality and empowerment of women in all health parameters.

In line with the Government Development Vision 2025 goals, the Ministry of Health shall strive to raise and improve the health status and life expectancy of the people of Tanzania by ensuring delivery of effective, efficient and quality curative, preventive, promotive and rehabilitative health services at all levels (URT, 2003).

2.7.1.1 Policy Vision

1. The vision of the Health Policy in Tanzania is to improve the health and well-being of all Tanzanians with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people (URT, 2003).

2.7.1.2 Policy Mission

1. To facilitate the provision of equitable, quality and affordable basic health services, which are gender sensitive and sustainable, delivered for the achievement of improved health status.

2.7.2 Policy Objectives

- (i) Reduce the burden of disease, maternal and infant mortality and increase life expectancy through the provision of adequate and equitable maternal and child health services, facilitate the promotion of environmental health and sanitation, promotion of adequate nutrition, control of communicable diseases and treatment of common conditions.

- (ii) Ensure the availability of drugs, reagents and medical supplies and infrastructures.
- (iii) Ensure that the health services are available and accessible to all the people in the country (urban and rural areas).
- (iv) Train and make available competent and adequate number of health staff to manage health services with gender perspective at all levels. Capacity building of human resource at all levels in management and health services provision will be addressed.
- (v) Sensitize the community on common preventable health problems, and improve the capabilities at all levels of society to assess and analyze problems and design appropriate action through genuine community involvement.
- (vi) Promote awareness among Government employees and the community at large that, health problems can only be adequately solved through multisectoral cooperation involving such sectors as Education, Agriculture, Water, Private Sector including Non Governmental Organization, Civil Society and Central Ministries, as Regional Administration and Local Government, and Community Development, Gender and Children.
- (vii) Create awareness through family health promotion that the responsibility for one's health rests in the individuals as an integral part of the family, community and nation.
- (viii) Promote and sustain public-private partnership in the delivery of health services.
- (ix) Promote traditional medicine and alternative healing system and regulate the practice.

2.7.3 Tanzania Health Policy on Pregnant Women Deliveries Services

In this area the researcher need to link between the health policy and pregnant women services. The area covered was the mother and child health and Reproductive health.

2.7.3.1 Mother and Child Health

Mother and child health is a process of providing services to women who in the age of reproductive and under five children especial newborn to 28 days. The policy objective to reduce maternal mortality and maternal morbidity as millennia targets (URT, 2003).

Furthermore, the ministry of health and private sector not for profit services and FBOs provides free services to pregnant women, user of reproductive services and less than five children. Likewise, the Ministry of Health collaborates with relevant sector ministries to achieve these aims through formulation of appropriate guidelines. Special emphasis is targeted on reduction of maternal and under-five morbidity and mortality.

Also, it collaborates with relevant sector ministries to achieve these aims through improving the infrastructure for health services to reach every area. Additionally, the Ministry collaborates with relevant sector ministries to achieve these aims will continue to educate people especial women importance of using health services.

2.7.3.2 Reproductive Health

Reproductive health interventions target on improving maternal conditions, family planning and addressing the needs of the groups with focus on priority areas. This incorporates family planning, pregnant delivery problem, and sexually transmitted diseases. Policy targeted on improving services to all groups especial men, youth and disabled (URT, 2003).

The Ministry of Health will collaborate with relevant sector ministries to achieve these aims will provider equitable and attractive services in order to encourage pregnant women to attend in health facilities. The Ministry of Health will collaborate with relevant sector ministries to achieve these aims through formulation of appropriate guidelines. Special emphasis will be targeted on reduction of maternal and under-five morbidity and mortality.

2.8 Empirical Literature Review

A study conducted in Kenya on factors for home deliveries indicated that, decisions towards home deliveries included sudden onset of labour or short labour. Health facility delivery was perceived to be desirable for prolonged labour. Similar results are documented in a study conducted in rural Cambodia, where prolonged labour was one of the strongest determinants of birth attendant change; with those experiencing it being 12 times more likely to change birth attends than those who did not (Yanagisawa et al., 2006). Similar experiences have been documented for instance in Ghana, where women changed their place of delivery, and recommended the same to others when they experience degrading and unacceptable behavior. Staff attitudes were an important component in deciding where to deliver. Lack of privacy in some health facilities was mentioned as a contributing factor for home delivery (D'Ambruso et al, 2005).

In Bangladesh Unbaidur Rob (1998) did a study on financial support for poor pregnant women. The objective of the study was to test the feasibility and effectiveness intruding voucher scheme for poor women to improve utilization of ANC and delivery. Findings revealed that financial support to poor pregnant women can notably increase the utilization of maternal health care services from the health facilities. About 85% of babies are born at home in the country. The frequently cited reasons for not delivering at a facility are the perceived absence of need followed by the cost of treatment, poor quality of services and transportation problems.

In many parts of the world women's power to make decision is limited even over matters related to their own health. For example, in Bangladesh, it is usually mother in laws and husbands who make decision to seek or not to seek for health care. They are often the least likely to know about pregnancy related complications and their possible fatal consequences (Safe motherhood Report 1997).

Brieger et al. (1994) show that despite adequate local provision of maternity services, 65% of women still delivered at home. The authors pointed out that this was mainly because of fees for delivery services, level of income, cultural beliefs and education. In Uganda, access to maternity services was one of the influencing factors in choosing the place of delivery (Bryman et al., 1997). The provision of relatively accessible services did not guarantee their use, and other social and cultural considerations governed decision-making. Ensor and Cooper (2004) mentioned important barriers, such as financial, geographical and cultural factors, which, combined with inadequate quality of care within the formal health sector, affect the demand for care-seeking and serve to discourage service use.

A study done in Tanzania by Eijk et al. (2006) found that a total of 64 women (10%) never attended an ANC during their most recent pregnancy. The most frequently mentioned reasons for not attending were not seeing the need to attend (36%), expenses of transport or the cost of the ANC (27%), belief that the care was not adequate (22%), and distance to the ANC (14%). For the 64 who did not attend, 27% sought alternative care during pregnancy from sources such as TBAs, religious persons, or herbalists. Among all women, only 17% were attended to by a professionally trained provider (doctor, nurse, midwife, or clinical officer) and TBAs assisted another 36% of women. A disturbingly high proportion of women (29%) were attended to by an untrained family member, friend or neighbour, and 18% of women delivered completely unattended.

A study done in Indonesia to find out the reasons why pregnant women preferred the use of Traditional Birth Attendants showed that there are various factors; cost was one of the main reasons stated by participants in all villages for using the services of traditional birth attendants. The average delivery cost for a midwife of IDR 350,000 (USD 35) was perceived as unaffordable by some community members. In addition, the flexibility of the payment method for traditional birth attendants was more convenient.

Another factor that influenced the use of traditional birth attendants was being told by other family members such as the older sister, parents, or husbands to use their services. A long-time tradition in the community of using the service of traditional birth attendants who had been the only delivery service providers for many years before the national health system started, was also mentioned as a reason for community members to use their services during childbirth. The study found that being part of the community, speaking the local language, living in the community and sharing the same culture meant that traditional birth attendants have developed the feeling of trust in the community.

Another factor that influenced the use of traditional birth attendants was being told by other family members such as the older sister, parents, or husbands to use their services. A long-time tradition in the community of using the service of traditional birth attendants, who had been the only delivery service providers for many years before the national health System started, was also mentioned as a reason for community members to use their services during childbirth. Some participants argued that the services of a health professional (a village midwife) are required only for those experiencing obstetric complications. Some community members stated that the midwife's services would be sought only if the condition could not be handled by the traditional birth attendants.

A study by Magedi et al. (2000) in Africa identified socio-economic, cultural, demographic and reproductive behavior as well as availability of other forms of reproductive health care services within communities as determinants of home deliveries preferably to institutional or supervised deliveries in the hospital by qualified health staff in Kenya. A study done in Rural Kenya by Kyeri (2006) found that, even if it is was a general requirement in most health facilities to subject expectant mothers to an HIV test as women attend antenatal clinics or just before child birth so that health staff can put in place measures to handle the newborn and the mother in case they test positive, a bigger proportion of women said they did not want to deliver at health facilities because they feared to take an HIV/Aids test.

Also, a study which was conducted in Dar es Salaam showed that, it is possible that pregnant women of older age are not as aware of the issues surrounding HIV infection when compared with younger women and therefore may be less inclined to accept testing. Additionally, older women are more likely to have more children and responsibilities at home and would be less likely to want to return to the clinic or devote time to addressing potential HIV infection. This is further supported in the findings analysis, in which there was a significant association of increased household size with decreased testing acceptance, and in the multivariate analysis, in which women with 3 children at home were significantly less likely to accept testing.

A study that was done in North Gondar zone, North West Ethiopia on Assessment of safe delivery service utilization among women of childbearing age, it revealed that, a total of 13.5% of mothers gave birth to their last babies in health facilities. Only about 25% of the rural women gave birth in the health institutions. Untrained traditional birth attendants and relatives attended 76.4% of the deliveries. The reported reasons were: absence of health problems, short duration of labour, preferring the attention of relatives and trust in traditional birth attendants. Educational status of the mothers, place of residence, access to radio, monthly income and prenatal care (WHO, 2004).

A study done by Michuki (2003) on utilization of Maternal health Care Services in Kenya, showed that Meru North District lack adequate maternal health care facilities and more particularly delivery services. It was observed that some women had to walk an insurmountable distance of over 25 km to the nearest maternal health care facility. Regarding the level of utilization, the results indicate that prenatal care coverage in Meru North District stands at 90% and deliveries at the health facility was estimated at 43%.

In Benin the government tried to put significant pressure on women to have institutional deliveries including fines but still women continued to deliver at home due to honour brought to families if they were seen to show strong control during

labour and child birth (Maine, 1996). Kalibbala, (2001) did a study on maternal deaths to examine how deliveries kits save rural women in Uganda. The study revealed that, most of women in rural areas do not deliver in health facilities; they continue delivering at home in unhealthy conditions which sometimes lead to death. The findings showed that, 23% deliver with help of TBAs, 25% are helped by relatives or friends while 10% deliver without any assistance. This is due to the reasons that, r is a problem, high hospital bills, lack of skilled personnel and poor services offered in the health centers.

A study which was done in four countries of Africa, findings were that 61% of home deliveries in the four countries were handled by traditional birth attendants (TBAs), 20% by nurses, 15% by midwives and 4% by doctors. The study also identified reasons for the high percentage of home deliveries in the four countries which represent Africa's four sub-regions. These range from fear of surgical procedures, to the negative attitude of staff in health facilities where services are expensive and often unaffordable to the purely cultural, as communities regard the arrival of a new baby as a joyful occasion which should take place in the home, rather than outside it (WHO, 2003).

A study conducted in Bangladesh showed that there are several social, religious and economic barriers which prevent pregnant women from seeking services from health facilities. The frequently cited reasons for not delivering at a facility are the perceived absence of need (68%) followed by the cost of treatment (18%), poor quality of services (10 percent) and transportation problems, as reported by another six percent. Only 21 percent of the mothers received any checkups from trained providers within 42days of delivery. The primary reasons for not receiving postnatal care (PNC) are the perceived absence of need (56%) and the cost of treatment, as reported by one-fifth (WHO, 2002). Another study done by Kolinsky (2000) noted that some families said that child birth in a hospital setting is an event from which families are excluded to some extent, something they did not appreciate. The reason is that the mother goes through labour without support of a family, timing of

delivery is sometimes controlled by use of drugs, and the artificial rupture of membranes and the active pushing from the time of full cervical dilatation are dangerous.

A research conducted in sixteen sites of eight west African countries on maternal mortality and obstetric care in rural Senegal, Guinea Bissau, the Gambia, Burkina Faso, La Cote D'Ivoire, Mali, Mauritania and Niger revealed that in urban areas, vast majority of births took place in a health care facility (83.0)% or with a skilled provider (69.0%) while 90.0% of the rural women gave birth at home without any skilled care (Ronsmans et al., 2003). In 1999, Laston reported that in rural Bangladesh, a woman must remain in seclusion for at least seven days after delivery, the woman should movement from home and neighbourhood during pregnancy, being around strangers for example, in a health facility increases labour pain and that problems in pregnancy are the result of supernatural causes. At the same time many elderly women interviewed indicated that, health problems and problems of pregnancy occurred because young women don't obey the elderly especially their mothers-in-law.

The poverty levels are generally high in developing countries. Poverty has been identified as a major barrier to skilled supervised delivery in Kassena-Nankana district in Ghana (Afful, 2004). Information on financial barriers to skilled delivery in urban Ghana is limited. However, it has been established that, the economic situation of a household is a significant predictor for chosen home birth (Hadgkin, 1966). A study done by Roosmalen (2005) has shown that in many of the delivery rooms of health facilities in sub-Saharan Africa and Asia, women in labor are generally not allowed to bring a relative with them into the labour ward. In his observational study in Tanzania the author was dissatisfied with the child birth experience, as women in labour lay in bed in complete isolation, in pain, without support. In Nepal, maternal education was among the important independent factors in determining the place of delivery (Bolam et al., 1998). Yanagisawa et al. (2006) also documented that woman who had at least 7 years of school attendance being six

times more likely to deliver babies at a health facility than those who did not attend. Quality of services was perceived to play a major role in choice of place of delivery. For example, some women decided to go to private health facilities, where they had to pay, despite government health facilities with free delivery services being closer to their homes. This decision to pay for services was associated with perceived good quality of care, and the presence of relatives available for post-delivery assistance. The study also provides evidence that women's decisions about the place of delivery are not only determined by the risk associated with pregnancy but also by a combination of factors, such as household income and quality of service. This suggests that improving women's access to income might strengthen their bargaining power to influence place and timing of delivery.

In addition, advice from the partner, nurse and parents, emerged as important in influencing the place of delivery. Consequently, any measure aimed at encouraging women to deliver in health facilities will have to involve people who influence their decisions if they are to be successful. Although women carry the major share of the responsibility for the well-being of the household in most societies (Tanner & Vlasso, 1998), this responsibility is rarely matched by the autonomy to make decisions, or by access to the necessary resources. Women may have to ask permission from husbands, mothers-in-law or and senior household males before being permitted to seek care.

According to the study done in Kenya, results revealed that, an even bigger proportion of women, 30 percent, said they did not want to deliver at health facilities because they feared to take an HIV/Aids test. Some women's groups in Coast and Western provinces said they were afraid even to attend antenatal care for fear of being tested for HIV. In Zanzibar, health reports show that, less than half Zanzibar's mothers deliver their children at health facilities; the rest give birth at home with assistance from traditional birth attendants, thus maternal mortality in Zanzibar (IRIN, 2009). A study done by the WRA for safe motherhood in 2006, in Tanzania showed that, 54% percent of Tanzanian women choose to give birth at home alone,

with a relative or a traditional birth attendant (TBA) for a variety of reasons – among them: distrust of the level of care that will be provided at a health facility, distance from the nearest facility, lack of finances and social norms which promote the practice of home delivery. In 2004, 47% of women and 33.6% of women in rural areas had a facility delivery.

Again in Tanzania Rucker (2008) did a study on source of ANC influences facility delivery. The objective of this study was to determine whether the frequency of antenatal Care visits were associated with Facility delivery. The study was a population based study with representative sample of households in a rural district of western Tanzania. Women who had given birth within five years were asked about their most recent delivery and ANC. The study results revealed that, 99.3% made at least one ANC visit and out of which only 36.4% delivered in health facility. Therefore the poor quality of ANC offered in government health facilities did not encourage mothers to deliver in such hospitals. There is need to improve quality of ANC services that may in turn encourage women to return to facilities for delivery (Rucker et al, 2008). In South Africa, majority of women in Isiolo and Marsabit give birth at home with risk of contracting HIV/AIDS during birth in the hands of traditional birth attendants. Most of these women prefer midwives because of the low cost involved. This is despite of successful attendance in anti-natal clinics. Mothers were only referred to hospitals in case of complications during child birth; one of the reasons for this was long distance to the health facilities (Hussein, 2011).

2.9. Theories which Support the Study

A theory is based upon a hypothesis and backed by evidence. A theory presents a concept or idea that is testable. A theory is a fact-based framework for describing a phenomenon. In psychology, theories are used to provide a model for understanding human thoughts, emotions and behaviors (WHO 2000).

2.9.1 Harrod Domar model Economic Development Growth

In order for a country to have a growing economy, it must save and invest a certain portion of its GDP. The more the country can save and invest the faster the country can grow economically (Economic Development Growth, 1930). This implies that the pregnant women health can be improved when the National GDP is distributed equally in building health facilities and use technology through applying modern tools. In developing countries Harrod Domar model assume labour force is abundant (Todaro, 2009). In this case Namtumbo District needs to have enough professional health workers. This model assisted this study in the analysis and applicability of the pregnant women health at Namtumbo District. Harrod Domar model is represented by the following equation $\frac{\Delta y}{Y} = \frac{s}{K}$ whereby $\Delta y/Y$ is rate of Growth of GDP, S is saving and K represents the capital output ratio.

The model therefore suggests on the available capital to Namtumbo District which supports them on accommodating the payment of health services, the healthier man can be able to produce and save again, therefore Harrod Domar model in this research help to advise people on the importance of saving and that saving may lead to the Economic growth and later economic development. For the case of this study, theory suggests that if Namtumbo women are to be Healthier, the result will be to deliver healthier children and result in having healthy citizens for development. For that case development can be defined as capability to be well functioning, whereby for individual to be health, be happy as a state of being- valued, being able to live long, being well nourished, being able to take part in the life of the community. Health has been seen as the best expression of the achievement of development goals (WHO, 1993). The International Conference on Primary Health Care held in Alma Ata in 1990s, which has influenced much of the debate on health policy, proclaimed health as a basis of 'Human Right' and urged governments to take responsibility for the health of their people. Following this conference, several governments adopted policies aimed at the public provision of free medical care for their entire population.

2.9.2 Behavioural Change Theory on Improving the Health Status of the Community

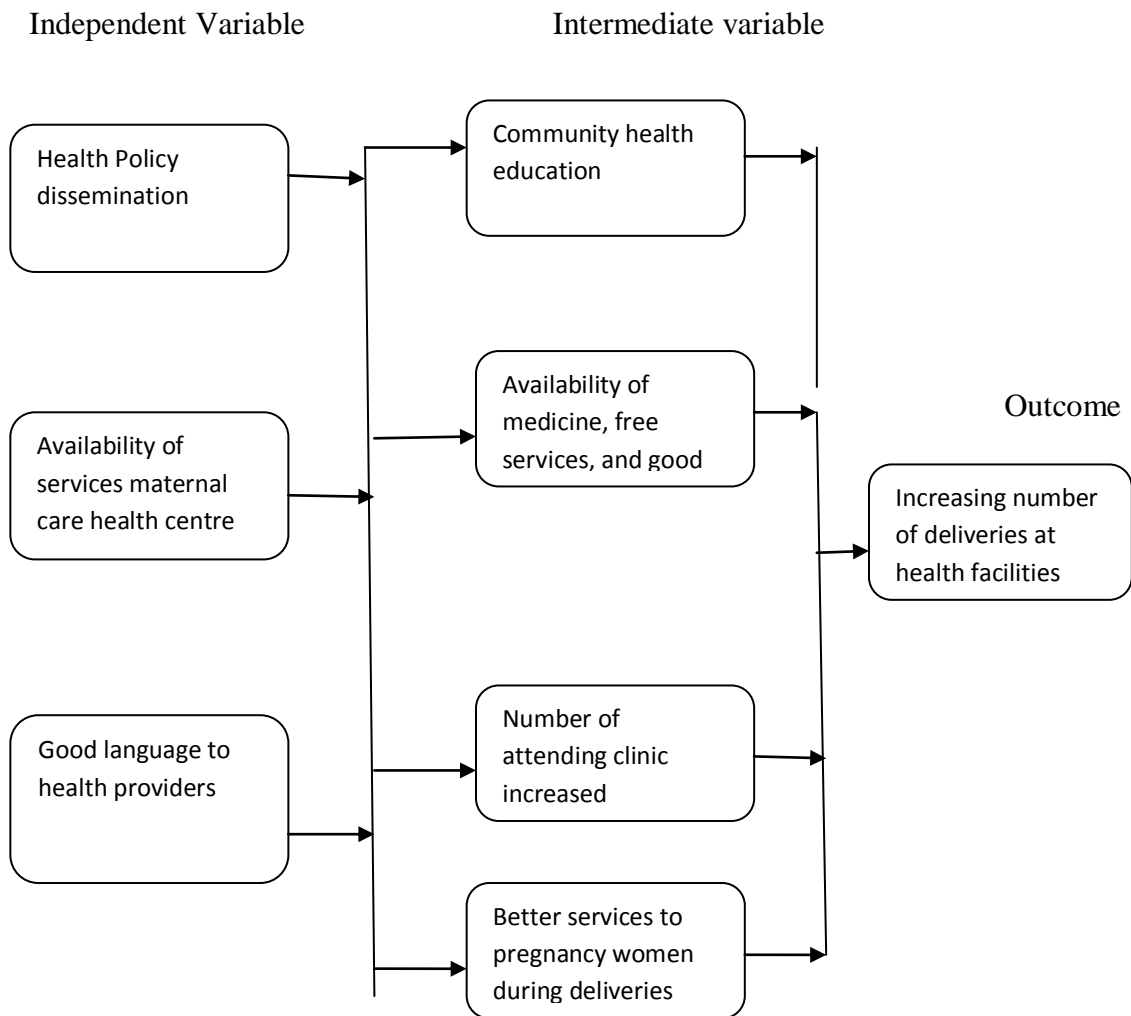
Fishbein, (1908s) behavioural change theories on improving the health status of the community are attempts to explain why behaviours change. These theories cite environmental, personal, and behavioural characteristics as the major factors in behavioural determination to deal with individual health. In recent years, there has been increased interest in the application of these theories in the areas of health, with the hope that understanding behavioural change will improve the services offered by providers in provision of services. Many of the original works outlining the major theories that are the basis for current knowledge about behavioural change, theories were published in the 1970s and 1980s.

The Health Action Process Approach (HAPA) is designed as a sequence of two continuous self-regulatory processes, a goal-setting phase (motivation) and a goal-pursuit phase (volition). The study as well as the theory need an individual to change in manner that can improve the health status of individual. The pregnant women must take into consideration that the clinic visit can give awareness on some of issues related to its pregnant. Also, the change in behaviour of providers can give the attraction to the pregnant women to attend services provided at the health facilities.

2.10 Conceptual Framework

This study focused on challenges to promoting number of deliveries in health facilities in Namtumbo district Tanzania as challenges of promoting number of deliveries has great impact to the achievement. The increasing number of deliveries at health facilities is the result of community health education, availability of medicine, number of attending clinic increased and better services to pregnancy women during deliveries. Figure 2.2 illustrates the relationship between different variable that interact to influence the number of deliveries at health facilities.

Figure 2.2 Conceptual framework



Source: Author's construction, 2012

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the methodology that was used in the study. It includes the study area, target population, research design, sampling process, techniques used for data collection, as well as data processing analysis and presentation, and finally conclusion.

3.2 Research Design

Research design provides a framework for the collection and analysis of data (Bryman et al., 2007). A choice of research design reflects decisions about the priority being given to range of dimensions of the research process.

A cross-sectional research design was chosen in this study due to the reason that it saves time and enhances collecting data at a single point in time (Kothari, 2004). The design provided useful information for simple statistical description and interpretation and is a one short design best suited to studies aimed at finding out the prevalence of a phenomenon, situation or problem and since this study design is one-stop study it is therefore comparatively cheap to undertake. Therefore, due to constraints in time and money this was best choice for this study. The aim of using this kind of research design was to help the researcher to cover characteristics of the people, social economical characteristics and explanation of behaviour and events that occurred in the area.

3.3 Study Area

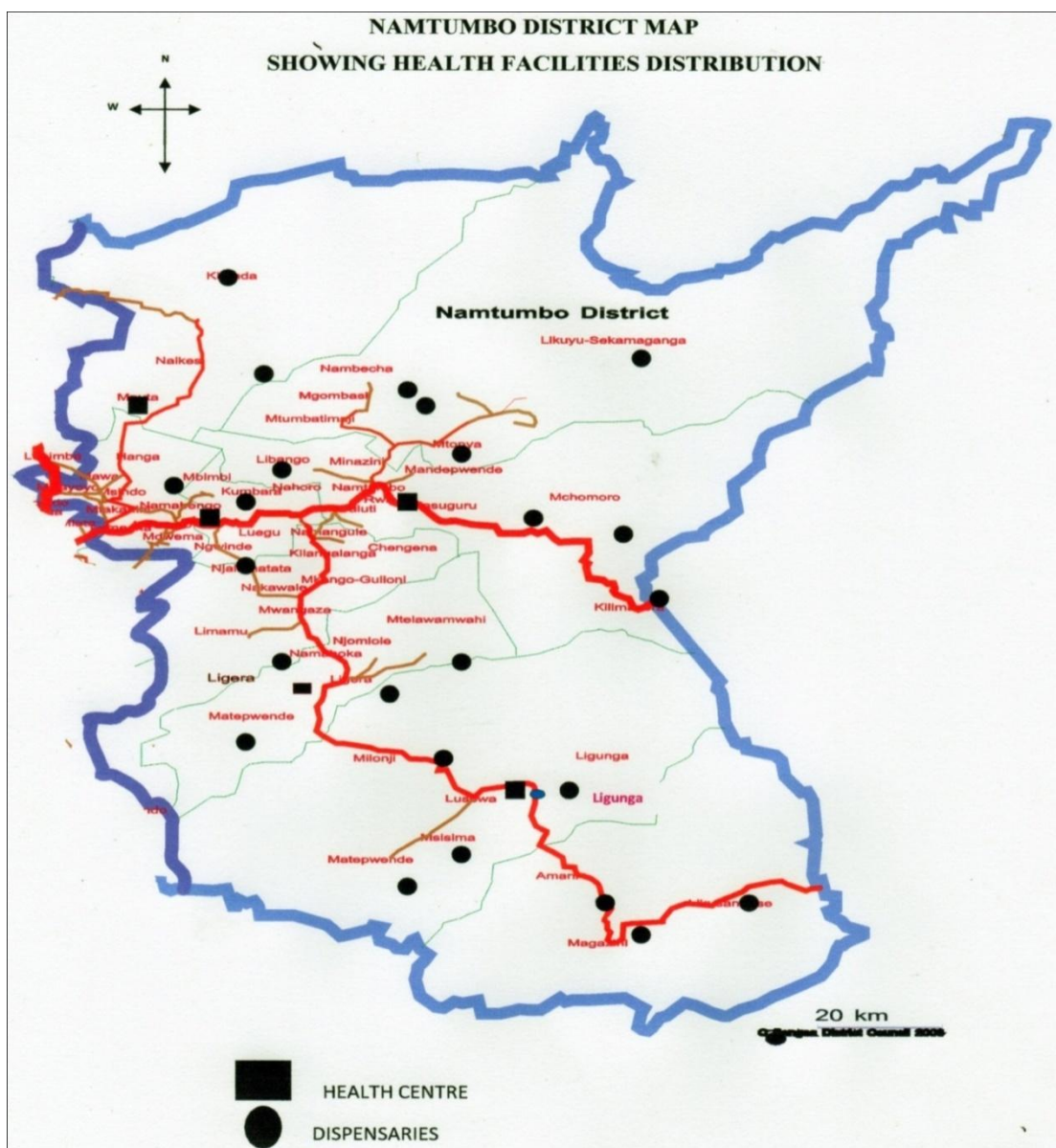
Intended to gather and relate data on various aspects of a geographical region and its inhabitants, as natural resources, history, language, institutions, or cultural and economic characteristics; a field investigation into human ecology, (WHO 2001).

3.3.1 Location of the Study

The study was conducted at Namtumbo district in Ruvuma region. Namtumbo District is one of the six districts which are Mbinga, Tunduru, Songea Rural, Songea

DC and Mbambabay that form Ruvuma Region. Namtumbo District was split from Songea District in the 1st July 2002. The District area of jurisdiction covers 20,375 sq km. The district shares the borders with the Republic of Mozambique in the South, in which the Ruvuma River forms an International Boundary. It borders with Songea District in the West, Tunduru District in the East and Ulanga District (Morogoro Region) in the North. Figure 3.1 illustrates the location of the study area.

Figure 3.1 Map of Namtumbo show the location of the study area



Source: Namtumbo Profile 2013

3.3.2 Climate

Namtumbo District is characterized by cool climate with an average annual rainfall of between 800 mm – 1200mm, which is generally favourable for agriculture. There is a variation of temperature, which ranges from 200C to 250C during the hot season and between 150C to 170C during night.

3.3.3 Economic Activities

It is estimated that about 97% of people engage in agricultural activities which constitute the main source of income with very little animal husbandry. The type of agriculture is still very traditional (Shifting cultivation) with low yields in subsistence crops per hectare. Individual peasant undertakes farming on cash and food crops production. Cash crops are tobacco, cashew nuts, sunflower, simsim, coconuts and groundnuts. Whereas maize, cassava, beans, finger millet, rice, potatoes are food crops. However; nowadays maize, rice and beans are dual crops. According to the Regional statistics of 2006/2007 the per capita income of people in Namtumbo District is Tsh. 426,417.00. The current statistics of poverty for Namtumbo District are still being processed by the Ruvuma Regional Statistics Bureau, however per capita income of Ruvuma Regional as per 2008 statistics stand at Tsh. 912,180.00.

3.3.4 Study Population

According to 2012 Census, Namtumbo District has a total population of 201,639 of which 98,335 or 48% are males and 103,304 or 52% are females (NBS, 2012).The study population was the people of Namtumbo District. Table 3.1 illustrates total study population:-

Table 3.1 Total population of Namtumbo District

Sn	Ward	Population by sex		Total
		Male	Female	
1	Rwanga	6,491	7,177	13,668
2	Mkongo	3,420	3,592	7,012
3	Ligera	5,855	5,941	11,796
4	Lusewa	9,137	9,746	18,883
5	Magazini	4,136	4,503	8,639
6	Msindo	3,369	3,513	6,882
7	Luchili	6,654	7,170	13,824
8	Namabengo	4,883	5,172	10,055
9	Kitanda	5,221	5,277	10,498
10	Luegu	3,732	4,022	7,754
11	Namtumbo	9,462	9,813	19,275
12	Mgombasi	4,830	5,166	9,996
13	Iitola	5,207	5,545	10,752
14	Likuyuseka	5,452	5,359	10,811
15	Mputa	5,427	5,690	11,117
16	Hanga	6,998	7,220	14,218
17	Limamu	3,106	3,182	6,288
18	Mchomoro	4,955	5,216	10,171
Total		98,335	103,304	201,639

Source: Namtumbo Profile, 2013

3.3.5 Units of Inquiry

The units of analysis for this study focused at district and community level. At the district level the study included Council Health Management Team, health facility management team, services providers and community development officer. At the community level the study focused on household's members, ward health committee and health service board. Table 3.2 describes the units of inquiry.

Table 3.2 Summary of Units of Inquiry

Level	Category of unit of inquiry
District Level	Council Health Management Team
	Health Facility Management Team
	Service Provider
	Community Development Officer
Community Level	Households Member
	Ward health Committee
	District Health Services Board

Source: Prepared by Researcher, 2012

3.4 Sample Size and Sampling Techniques

This provides the number of the respondents which used in the study and the technique used to get that sample size.

3.4.1 Sample Size

The study employed the formula of $K=N/n$ in order to get the sample size. Among important considerations include time and cost, no-response rate, heterogeneity of the population, kind of analysis intended, the magnitude of acceptable error and the confidence level (Zikmud et al, 2010). This study constituted a sample size of 65 respondents. At district level 4 Council Health Management Team, 4 health facility management team, 9 services providers and 4 community development officer at the community level the study focused on 37 household's members, 4 ward health committee and 3 district health service board. The selection of respondents based on the factor of different on the need of the study not homogeneous on providing information. Table 3.3 illustrates the categories of respondents:-

Table 3.3 Categories of Respondents

Category of respondents	No of respondents by sex		Total	
	Male	Female	Number	Percentage
Council Health management team	2	2	4	6.15
Health facility management team	2	2	4	6.15
Services providers	2	7	9	13.9
Community Development Office	2	2	4	6.15
House hold members	13	24	37	56.9
Ward health committee	1	3	4	6.15
Health services board	1	2	3	4.6
Total	23	42	65	100%

Source; Prepared by Researcher, 2012

3.4.2 Sampling Techniques

Two main sampling techniques known as probability and non- probability sampling techniques were used in obtaining the sample. Probability sampling is a type of sampling whereby every member of the population has equal chance of being selected to the study (Kamuzora 2008). Probability sampling was used to obtain respondents who provided information regarding the study. In regard to probability sampling, simple random sampling and systematic sampling techniques were employed whereby first respondent was chosen randomly by using simple random sampling and rest were selected by using systematic sampling.

Non-probability sampling is the type of sampling whereby every member of population has no equal chance of being selected to the study (Kamuzora, 2008). It was used to obtain respondents who were chosen purposively to give out information which cannot be obtained from other respondents. This information was collected from DRCHco, MOi/c, (4) Labor in charge and DMO. Table 3.4 Illustrates the sample technique and respondents:-

Table 3.4 Sampling Technique and Respondents

NO	Type of Sampling	Sampling Technique	Respondents
1	Probability Sampling	Simple Random sampling and systematic sampling	CDOs, households, health services board, ward health committee
2	Non probability sampling	Purposive Sampling	CHMT, HFMT, services providers

Source: Prepared by Researcher, 2012

3.5 Type of Data and Methods of Data Collection

This area provides the types of data which is primary and secondary data and the methods which are questionnaire, interview and documentary review.

3.5.1 Types of Data

(i) Primary Data

Primary Data are those data collected fresh and for the first time and thus happen to be original in character because they were collected by researcher him/herself from the field (Rwegoshora, 2006). This is important because it is a basic data, unbiased data based on interview in a primary population (Kothari, 2004). The primary data gathered through interview, questioners and documentary review.

(ii) Secondary Data

Secondary data are those data obtained from literature sources or data collected by other people for some other purposes (Rwegoshora, 2006). In other words these are data which have already been passed through the statistical process. These are economical because they do not needs efforts and not expenses (Kothari 2004). Table 3.6.2 illustrates summary of data collection and means:-

Table 3.5 Summary of Data Collection and Means

Type of Data Collection	Means of Data Collection
Primary Data	Interview Questioners Documentary Review
Secondary Data	Document from DMO Document from DED

Sources: Prepared by Researcher, 2012

3.5.2 Data Collection Methods

(i) Questionnaire

Questionnaire is the method of data collection that consists of a number of questions printed or typed in a definite order or a form or set of forms (Kothari, 2004). This is scientific method of data collection involving question that was carefully constructed and arranged in order to give the respondents time to answer questions at their own. In this method of data collection both closed-ended and open-ended questionnaires were used, the researcher gathered information from CHMT, DHSB, ward health committee, health facility management team, services providers, household members and community development officer.

(ii) Interview

Interview is the method of data collection that involves presentation of oral-verbal stimuli and reply in terms of oral verbal stimuli responses. In this method, both structured and unstructured interviews were used to gather information. Structured interview refers to the set of pre-determined questions of highly standardized technique of recording. Un-structured interview is characterized by flexibility approach to questioning they do not follow as system of pre-determined questions and standardized technique of recording information (Kothari, 2004). In this method unstructured interview was employed whenever the researcher needed more classification from respondents. Interview as a tool for data collection was employed to those who can't read and write, (Kamuzora 2008). The health workers from management level DMO, DRCHco, OBS and Gynecologist, RCH provider's

services was interviewed due to the fact that they have no enough room to fill questioners.

(iii) Documentary Review

The method helped the researcher to understand the magnitude of the problem in previous time and how it has recently increased. Pamphlets, journals, annual reports, magazines and web sites of different authors were visited. The approach helped the researcher to get supportive information which complemented primary data. Table 3.6 illustrates summary of data collection methods and respondents sources:-

Table 3.6 Summary of Data Collection Methods and Respondents Sources

Data collection methods	Respondents/ Sources
Questionnaire	Ward Health Committee Community Development Officer Health facility Management Team House Hold Members Services Providers District health services board DHSB
Interview	District Medical Officer District Reproductive and Child Health Coordinator Doctor in charge in Obstetric and Gynaecologist unity
Documentary Review	Pamphlets Journals annual report Magazines Web Sites

Source: Prepared by Researcher, 2012

3.6 Data Analysis and Presentation of Findings

In analyzing the data, the study employed both qualitative and quantitative methods. Quantitative research is based on the measurement of quantity or amount, qualitative research is especially in the behavioural sciences where the aim is to discover the underlying motives of human behaviours (Kothari, 2004). Data were gathered and organized in manageable units, through simple hand coding. Data were analyzed by using descriptive statistics in which frequency distribution tables and cross tabulations were used. Furthermore, discussion was based on what was revealed by presented data.

CHAPTER FOUR

PRESENTATION OF FINDINGS AND DISCUSSIONS

4.1 Introduction

This chapter presents research findings and discussions on challenges to promoting numbers of deliveries in health facilities at Namtumbo district in Tanzania. The study findings address the research objectives which were raised before the research was conducted which were (i) to explore the status of women deliveries in health facilities in Namtumbo district, (ii), to explore people's perception on delivering in health facilities (iii) to find out factors influencing deliveries in health facilities and, (iv) to find out ways of promoting deliveries in health facilities in the District. Thus, this chapter specifically, presents background of information of respondents, status of deliveries in health facilities in Namtumbo District, perception on deliveries in health facilities, factors influencing service deliveries at Namtumbo District and solution on how to improve services on deliveries at Namtumbo District.

4.2 Background Information of Respondents

This part provides the summary of the study population characteristics. It specifically describes sex, age, level of education, marital status and occupation of the respondents.

4.2.1 Sex of Respondents

This study involved a total of 65 (100%) respondents. They included 23(35.4%) males and 42(64.6%) females. The researcher included both male and female in the study in order to get different opinions. In order to improve the delivery services the government encourages male involvement during antenatal clinics in order to get different information related to pregnancy development. Table 4.1 illustrates number of respondents by sex.

Table 4.1: Number and Sex of Respondents

Sex	Frequency	percent
Female	42	64.6
Male	23	35.4
Total	65	100

Source: Compiled From Research Finding, 2013

4.2.2 Age of Respondents

The researcher wanted to know the age structure of the respondents because it is important in analyzing the relationship within the group members. The age of respondents was considered necessary to be included in this study simply because the age of respondents has the impact to the responses made by respondents. From the sample of the study the age of respondents was ranked from eleven years to above sixty years. The researcher decided to take the respondents at this age range because documentary reviews show that child bearing starts from that age or above. The findings showed that the age of respondents that falls between 15- 20 years were 6 (9.2%), between 25- 30 were 25 (38.4%), between 35-40 were 18 (27.7%), between 45-50 were 9 (13.9%),and between 55- 60 were 2 (3.2%). Table 4.2 illustrates age of respondents:-

Table 4.2: Age of Respondents

Age Group(Yrs)	Respondents by sex				Total	
	Male		Female		No	%
	No	%	No	%		
15 – 20	2	3.1	4	6.2	6	9.2
25 - 30	6	9.2	19	29.2	25	38.4
35- 40	5	7.7	13	20	18	27.7
45 – 50	6	9.2	3	4.6	9	13.9
55-60	2	3.1	3	4.6	5	7.6
60 +	2	3.1	0	0	2	3.2
Total	23	35.4	42	64.6	65	100

Source: Compiled From Research Finding, 2013

4.2.3 Education Level of Respondents

The researcher sought information about education level of the respondents because education was taken into consideration during research work. This helped in understanding awareness, ability to handle emergencies on pregnant women, confidence on asking for delivery services and to carry out community sensitization on delivery services. The level of education of the respondents ranged from never to school to university. The study found that 7 (10.7%) respondents never went to school, 31(47.7%) had primary education, 18(27%) had secondary education and 9(13.9%) had college/university level. The table 4.3 illustrates education level of respondents:-

Table 4.3 Education level of Respondents

No	Education Level	Respondents by Education level				Total	
		Male		Female		No	%
		No	%	No	%		
1	Never to School	0	0	7	10.8	7	10.7
2	Primary Education	9	13.8	22	33.8	31	47.7
3	Secondary Education	12	18.5	6	9.2	18	27.7
4	College/ University	7	10.8	2	3.1	9	13.9
Total		28	43.1	37	56.9	65	100

Source: Compiled From Research Finding, 2013

4.2.4 Marital Status of Respondents

The study sought information about marital status of respondents. The respondents were given options to choose whether they were single, married, divorced and widow. This was important because marital status is associated with the responsibilities. The study found that 9 (13.8%) respondents were single, 48(73.9%) married, 5(7.6%) divorced, 3(4.7%) widow. Table 4.4 illustrates the marital status of respondents:-

Table 4.4 Marital status of Respondents

No	Marital Status	Respondents by marital status				Total	
		No	%	No	%	No	%
		Male		Female			
1	Single	7	10.8	2	3.1	9	13.8
2	Married	26	40	22	33.8	48	73.9
3	Divorced	1	1.5	4	6.2	5	7.6
4	Widow	2	3.1	1	1.5	3	4.7
Total		36	55.4	29	44.6	65	100

Source: Compiled From Research Finding, 2013

4.2.5 Economic Activities of Respondents

The researcher was interested to know the economic activities of respondents due to the fact that household financial capacity is one of the major factors in the determination on the place of delivery. High productivity in economic activities is associated with greater wealth, making it easier for the family to pay costs associated with delivery care. The findings show that 59(90.8%) engaging in farming activity, 41(63.1%) animal husbandry, 48(73.8%) gardening and petty business 19(29.2%). Table 4.5 illustrates economic activities of respondents:-

Table 4.5 Economic Activities of Respondents

Types of activities	Number of respondents	Percentages
Farming	59	90.8
Animal husbandry	41	63.1
Gardening	48	73.8
Petty business	19	29.2

Source: Compiled From Research Finding, 2013

4.3 Status of Deliveries in Health Facilities in Namtumbo District

The researcher was also interested in exploring the status of health services in the district in general. Literatures indicate that status can be obtained by number of health facilities, medicine and medical supplies budget, quality, trend, procedure and components of services.

4.3.1 Health Facility Resources in Namtumbo District

In this area researcher needs to know the number of health facilities in the District. This was helped to know the relationship between the population and distribution of health facilities.

4.3.1.1 Number of Health facilities in Namtumbo District

The researcher was interested in knowing the number of health facilities in the district. This is because the distribution of the health facilities can be one of the factors which can pose challenges on promoting number of deliveries in health facilities. Through review of documents, findings showed that Namtumbo district had a total of 79(100%) health facilities. They include 6(14) health centers and 37(86) Dispensaries. Table 4.6 illustrates number of health facilities in the district:-

Table 4.6 Health Facilities in Namtumbo District

HEALTH FACILITIES	Ward	Village/Mtaa	Type of Health facility
Namtumbo	Rwinga	Rwinga	Health Center
Lusewa	Lusewa	Lusewa	Health Center
Mputa	Mputa	Mputa	Health Center
Mkongo	Luchili	Mkongo Gulioni	Health Center
Namabengo	Namabengo	Namabengo	Health Center
Mgombasi	Mgombasi	Mgombasi	Dispensary
Nambecha	Mombasi	Nambecha	Dispensary
Mtonya	Likuyuseka	Mtonya	Dispensary
Likuyuseka	Likuyuseka	Likuyuseka	Dispensary
LibangoF	Namtumbo	Libango	Dispensary
Likuyu 'A'	Likuyuseka	Likuyu 'A'	Dispensary
Masuguru	Mchomoro	Masuguru	Dispensary
Mchomoro	Mchomoro	Mchomoro	Dispensary
Kilimasera	Mchomoro	Kilimasera	Dispensary
Suluti	Namtumbo	Suluti	Dispensary
Luegu	Luegu	Luegu	Dispensary
Litola	Litola	Litola	Dispensary
Ngwinde	Litola	Ngwinde	Dispensary
Mbimbi	Litola	Mbimbi	Dispensary
Magazini	Magazini	Magazini	Dispensary
Likusanguse	Magazini	Likusanguse	Dispensary
Milonji	Lusewa	Milonji	Dispensary
Msisima	Lusewa	Msisima	Dispensary
Mate..Lusewa	Lusewa	Mat...Lusewa	Dispensary
Ligunga	Lusewa	Ligunga	Dispensary
Amani	Magazini	Amani	Dispensary
Chengena	Luchili	Chengena	Dispensary
Njalamatata	Mkongo Nakawale	Njalamatata	Dispensary
Mdwema	Namabengo	Mdwema	Dispensary
Utwango	Namabengo	Utwango	Dispensary
Mkongo nakawale	Mkongo Nakawale	Mkongo	Dispensary
Limamu	Limamu	Limamu	Dispensary
Ligera	Ligera	Ligera	Dispensary
Naikesi	Kitanda	Naikesi	Dispensary
Kitanda	Kitanda	Kitanda	Dispensary
Hanga	Hanga	Hanga	Dispensary
Mtakuja	Limamu	Mtakuja	Dispensary
Mtelemwahi	Ligera	Mtelamwahi	Dispensary
Mate...Ligera	Ligera	Mate—Ligera	Dispensary
Mtakanini	Msindo	Mtakanini	Dispensary
Lumecha	Msindo	Lumecha	Dispensary
Mlilayoyo	Hanga	Mlilayoyo	Dispensary
Msindo	Msindo	Msindo	Dispensary

Source: Compiled From Research Finding, 2013

4.3.2 Medicine and Medical Supplies Budget in Health Facilities

The researcher was interested in knowing the medicine and medical supplies budget of health facilities in the district in past three financial years. This is because the distribution of the health facilities medicine and medical supplies could be one the factors which could pose challenges on promoting number of deliveries in health facilities. Table 4.7 illustrates medical supplies in health facilities budget:-

Table 4.7 Medical Supplies in Health Facilities Budget

Year	No	HF	Budget per Quarter	Budget per Year	No HF	Total	Received	%
2010/2011	1	Disp	1,170,000	4,680,000	37	173,160,000	92,393,220	53.4
	2	HC	2,430,000	9,720,000	6	58,320,000	34,706,000	59.5
	Total		3,600,000	14,400,000	43	231,480,000	127,099,220	54.9
2011/2012	1	Disp	1,170,000	4,680,000	37	173,160,000	134,837,916	77.9
	2	HC	2,430,000	9,720,000	6	58,320,000	36,113,720	61.9
	Total		3,600,000	14,400,000	43	231,480,000	170,951,636	73.9
2012/2013	1	Disp	1,170,000	4,680,000	37	173,160,000	136,822,310	79.1
	2	HC	2,430,000	9,720,000	6	58,320,000	35,863,450	61.5
	Total		3,600,000	14,400,000	43	231,480,000	172,685,760	74.6

Source: Compiled From Research Finding, 2013

4.3.3 Quality of Services on Deliveries

The researcher was interested in knowing about the quality of health services in the district in general. This was important because it may happen that services are being delivered to the clients but being of low quality. The researcher asked respondents question in order to find out if there was presence of quality services in order to improve status on health services at Namtumbo district, the options given were very good, good, satisfactory, and bad, worth. The findings show that 9(13.8%) respondents responded very good, 6(9.2%) responded good, 10(15.4%) responded satisfactory, 28(43.1%) responded bad and 12(18.5%) responded worse. Table 4.8 illustrates quality of deliveries in health facilities:-

Table 4.8 Variation on Responses on Quality of Deliveries in Health Facilities

No	Category of variation	Frequency	Percentage
1	Very good	9	13.8
2	Good	6	9.2
3	Satisfactory	10	15.4
4	Bad	28	43.1
5	Worse	12	18.5
Total		65	100

Source: Compiled From Research Finding, 2013

4.3.3.1 Environmental Services

The researcher after assessing the quality of deliveries in health facilities was also interested in knowing if there was availability of drugs, cleanliness, affordability and waiting time. The respondents were given option to asses. The findings show that 46(70.8%) mentioned shortage of drugs, 51(78.5%) environment not clean, 43(66.2%) Not affordable and 61(93.8%) long waiting hours. Table 4.9 illustrates the

Table 4.9 Variation on Responses on Environmental Services

No	Reasons	Frequency	Percentage
1	Shortage of drugs	46	70.8
2	Environment not clean	51	78.5
3	Not affordable	43	66.2
4	Long waiting hours	61	93.8

Source: Compiled From Research Finding, 2013

4.3.4 Trends of Pregnant Women Delivery In and Out of Health Facilities

The researcher was interested in knowing the trend of attending ANC in order to know if the community has awareness on the importance of attending clinic. The researcher studied the trend of women attending clinics over past six years in order to see if the visit was increasing or decreasing. The documentary review showed that in the year 2012 out of 5172(100%) only 4646(89.8%) attended clinic, 2011 out of 5508(100%) only 5090(92.4%) attended clinic, 2010 out of 4945(100%) only 4375(88.5%) attended clinic, 2009 out of 5475(100%) only 4830(88.2%) attended

clinic and 2008 out of 5002(100%) only 3858(77.1%) attended clinic and 2007 out of 5063(100%) only 4061(88.2%). Table 4.10 illustrates the responses on attending clinic:-

Table 4.10 Trends of Pregnant Women Attended and Not Attended Clinics

Year	Trends on attending clinic				Total	
	Attending ANC	%	Not attending ANC	%	Deliveries	%
2012	4646	89.8	526	10.2	5172	100
2011	5090	92.4	418	7.6	5508	100
2010	4375	88.5	570	11.5	4945	100
2009	4830	88.2	645	11.8	5475	100
2008	3858	77.1	1144	22.9	5002	100
2007	4061	88.2	1002	19.8	5063	100

Source: Compiled From Research Finding, 2013

Figure 4.1 Provider provides services to pregnant women in one of the health facility during clinic visit in Namtumbo district.



Source: Compiled From Research Finding, 2013

4.3.4.1 Number of Deliveries in Health Facilities

The researcher went further to assess the number of deliveries over past 6 years. The researcher reviewed documents related to women deliveries at the district. The information sought was number of deliveries in health facilities and out of health facilities over the past six years. Findings indicated that the number of pregnant women delivering in health facilities has been increasing and decreasing over years. Table 4.11 illustrates findings on deliveries in-health and out-health facility:-

Table 4.11 In-Health and Out- Health Facility Delivery

Year	Deliveries				Total	
	In Health Facilities		Out Health Facilities		No	%
	No	%	No	%		
2012	4673	90.4	499	9.6	5172	100
2011	5108	92.7	400	7.3	5508	100
2010	4397	88.9	548	11.1	4945	100
2009	4843	88.5	632	11.5	5475	100
2008	3879	77.5	1123	22.5	5002	100
2007	4093	80.8	970	19.2	5063	100

Source: Compiled From Research Finding, 2013

4.3.4.2 Number of Pregnant Women Attended Clinic and their Delivery

The researcher also reviewed documents related to women attending clinic but delivered in health facility or out health facility at the district. The information sought was the number of attending clinics but delivered in health facilities and out of health facilities over the past six years. It was learnt that all pregnant women who attended clinics gave birth in health facilities. Table 4.12 illustrates number of deliveries in health facilities:-

Table 4.12 Pregnant Women Attending Clinics

Year	Attended Clinic		Total	
	Delivery in H F	Delivery out H F		
2012	4646	0	4646	0
2011	5090	0	5090	0
2010	4375	0	4375	0
2009	4830	0	4830	0
2008	3858	0	3858	0
2007	4061	0	4061	0

Source: Compiled From Research Finding, 2013

4.3.4.3 Number of Women Not Attended Clinics and delivery

The researcher went further assessing the number of women who did not attend the clinic for over the 6 years but delivered in health facility. Findings show that trend of women who were not attending clinic but delivered in health facilities increased to 27(5.1%) compared to previous year which was 18(4.3%) Table 4.13 illustrates the responses for not attending clinics:-

Table 4.13 Women Not Attended Clinic but delivered in health Facilities

Year	Not Attended Clinic				Total	
	Delivery in Health Facilities		Delivery out Health Facilities		No	%
	No	%	No	%		
2012	27	5.1	499	94.9	526	100
2011	18	4.3	400	95.7	418	100
2010	22	3.9	548	96.1	570	100
2009	13	2	632	98	645	100
2008	21	1.8	1123	98.2	1144	100
2007	32	3.2	970	96.8	1002	100

Source: Compiled From Research Finding, 2013

4.3.5 Procedure of Attending Pregnant Women in Health Facility

The researcher was interested in knowing the procedures of providing services to pregnant women in health facilities when attending antenatal clinic and during deliveries. The interest was to understand if the procedures for attending pregnant women were encouraging the women to attend deliveries in health facilities or not. The question was directed to all respondents in order to get findings which can support the study. The procedure which mentioned was attending reception for card registration, couples counseling, compulsory HIV testing.

(i) Card Registration

Means that pregnant women during attending services in the first time to health facilities must provide her information which was documented in a card for references. Card registration is the procedure which was mentioned by 62(95.4%)

respondents. This is very important because it keeps records regarding the clinic visits.

(ii) Couples Counseling

Means the health providers provide important information related to reproductive health to both men and women who have relationship that led to pregnant. Couples counseling is the procedure that was mentioned by 59(90.8%) respondents. This counseling provides the room for both men and women to understand the reasons which can lead to dangerous consequences among pregnant women and children.

(iii) Compulsory HIV/AIDS testing

Means the pregnant women who attended services with couple must have compulsory HIV/AIDS testing. Compulsory HIV/AIDS testing is the procedure which was mentioned by 57(87.7%) respondents. This compulsory HIV/AIDS testing is done to prevent the mother-to-child transmission if the mother affected by HIV/AIDS. Table 4.14 illustrates the results on procedure of attending pregnant women:-

Table 4.14 Responses on Procedure of Attending Pregnant Women

No	Perception	Frequency	Percentage
1	Card registration	62	95.4
2	Couples Counseling	59	90.8
3	Compulsory HIV/AIDS testing	57	87.7

Source: Compiled From Research Finding, 2013

4.3.6 Components of Services Provided to Pregnant Women in Health Facility

The researcher was interested in knowing the components of services provided to pregnant women in health facilities when attending antenatal clinic and during deliveries. The interest was to understand if the services provided to pregnant women were encouraging the women to attend deliveries in health facilities or not. The question was directed to all respondents in order to get findings which can support the study. The services provided as mentioned by respondents were

reproductive education, health education, vaccine, subsidies net, family planning, and PMTCT.

(i) Reproductive Education

Reproductive education means services given to the client for the case of services on deliveries. This may be given regarding all requirements for reproduction and preparation which must be made by a family or pregnant women before giving birth. Reproductive education concerns what women can do during pregnancy and after birth so as to prevent possibilities of succumbing into health problems. The reproduction education was mentioned by 51(78.5%) respondents.

(ii) Health Education

Health education means any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes (WHO, 2013). The health education was mentioned by 42(64.6%) respondents, who argued that health education can help pregnant women to control themselves and take precaution in terms of selection of food and other aspects that are important for enhancing their health.

(iii) Vaccine

Vaccine means a biological preparation that improves immunity to a particular disease. A vaccine typically contains an agent that resembles a disease causing microorganism, and is often made from weakened or killed forms of the microbe, its toxins or one of its surface proteins (WHO, 2013). The vaccine services were mentioned by 56(86.2%) respondents, who said when the pregnant women get vaccine it helps them to increase immune so as to protect themselves and the newborn from infection.

(iv) Subsidized nets

Subsidized net means a grant or financial assistance given by government in order to support the reproductive health to get mosquito nets at low cost which now is the five hundreds as a contribution. The subsidized nets were mentioned by 58(89.2%) respondents, who said when the pregnant woman is given the subsidized net it helps her to protect herself from malaria because the costs are already subsidized by the government and the pregnant women only cover five hundreds.

(v) Family Planning

Family planning means an education of planning about when to have children, and the use of birth control and other techniques to implement such plans. The family planning was mentioned by 49(75.4%) respondents who argued that the family planning provided to pregnant women in order to give the knowledge on the importance of having the family of controllable size.

(vi) Prevention Mother to Child Transmission

Prevention of mother-to-child transmission means services which are given pregnant women in order to protect children from being affected by HIV, when the pregnant women are affected there is high degree for the child to be affected during delivery and time of breathing especially if the pregnant women are not given services (WHO, 2013). The PMTCT was mentioned by 62(95.5%) of respondents. Table 4.15 illustrates the responses on attending pregnant women in health facility:-

Table 4.15 Variation of responses on attending pregnant women in health facility

No	Kind of Response	Frequency	Percentage
1	Reproductive education	51	78.5
2	Health Education	42	64.6
3	Vaccine	56	86.2
4	Subsidies Net	58	89.2
5	Family Planning	49	75.4
6	PMTCT	62	95.5

Source: Compiled From Research Finding, 2013

4.4 People's Perception on Deliveries

The study was interested in ascertaining people's perception on deliveries in health facilities in order to understand whether the community has positive or negative perceptions regarding the services provided. This was asked because perception of the people provides the rooms for understanding the factors limiting the number on deliveries in health facilities. The question was whether there was any importance in getting delivery services in health facilities or at home. To start with, respondents were asked to state whether would like to see women delivering their children at home or in health facilities. The question was directed to all 65(100%) respondents. The Table 4.16 illustrates the results:-

Table 4.16. Variation of Responses on Perception on deliveries

No	Category of variation	Frequency	Percentage
1	Yes	50	76.9
2	No	15	23.1
Total		65	100

Source: Compiled From Research Finding, 2013

Table 4.16 above indicates the number of those who preferred delivery to take place in health facilities and those at home. The researcher went further to ask those who chose to deliver in health facilities to give reasons. The reasons were perception of good care, management of complications, and vaccination. Those chose who deliver at home mentioned the factors like; perception of poor care, confidentiality of birth attendants, attitudes of birth attendants and long waiting hours.

4.4.1 Reasons for Choosing Delivering In -Health Facilities

The researcher wanted to know the reasons for choosing delivering in-health facilities in the district in order to get the findings which could support the study. During the study respondents mentioned different factors as follows; perception of good care, management of complications and child vaccination.

(i) Perception of Good Care

This means services provided are in a good standard compared to home delivery service. This reason was mentioned by 57(87.7%) whereby the respondents perceived that the care they received during antenatal was largely good because they were given advice on what to take when going for delivery. They received medicines as prophylaxis against anemia, malaria as well as actual treatment of malaria when they were ill. For some women, the prophylaxis they received reduced malaria attacks and dizziness. Additionally, they received mosquito nets that protected them from malaria.

(ii) Management of Complications

This refers to controlling of any action which can cause problems to pregnant women which can needs referral or operation. The management of complications was mentioned by 42(64.6%) respondents. They argued that this tends to be very important when transportation and issues of operation crop up..

(iii) Child Vaccination

Vaccine means a biological preparation that improves immunity to a particular disease. A vaccine typically contains an agent that resembles a disease causing microorganism, and is often made from weakened or killed forms of the microbe, its toxins or one of its surface proteins (WHO, 2013). The vaccine services were mentioned by 53(81.5%) respondents, when the pregnant women get vaccine it helps to increase immunity so as to protect herself and the newborn from infection. Table 4.17 illustrates the perception on deliveries in health facilities:-

Table 4.17 Responses on Perception on deliveries in Health Facilities

No	Perception	Frequency	Percentage
1	Perception of good care	57	87.7
2	Management of complication	42	64.6
3	Child vaccination	53	81.5

Source: Compiled From Research Finding, 2013

4.4.2 Reasons for Choosing Delivering at Home

Researcher wanted to know the reasons for choosing delivering at home in the district in order to get the findings which could support the study. During the study respondents mentioned different factors as follows; perception of poor care, confidentiality by birth attendants, attitudes of birth attendants and long waiting hours.

(i) Perception of Poor Care

This means the services to be provided to pregnant women are in low standards. Participants perceived poor care as being shouted at when receiving care. This reason was mentioned by 39(60%) respondents Participants expected health workers to be friendly in providing care and not shouting at them.

(ii) Confidentiality by Birth Attendants

This means all services provided to pregnant women may remain to be secret to TBAs and patients. This reason was mentioned by 36(55.4%) respondents whereby women who were delivered by TBAs stated that TBAs maintained confidentiality, as they did not say anything about delivery issues. TBAs were said to be very secretive about what happened during delivery.

(iii) Attitudes of Birth Attendants

This means behaviour of TBAs is attractive compared to health providers. Participants who delivered at TBAs reported they were well received when they went for delivery. This reason was mentioned by 42(64.6) respondents whereby respondents compared care they received at traditional birth attendants with that at health facilities. Participants expressed that care at the TBA was not adequate and that they preferred to deliver at a health facility.

(iv) Long Waiting Hours

Participants' stay at the health facility varied from leaving immediately after assessment to spending a day. This reason was mentioned by 52(80%) respondents

whereby some women who came in the morning were discharged the same day in the afternoon, while others were given a choice to stay or go back home. Table 4.18 illustrates perception on deliveries at home:-

Table 4.18 Responses on Perception on deliveries at Home

No	Perception	Frequency	Percentage
1	Perception of poor care	39	60
2	Confidentiality by birth attendants	36	55.4
3	Attitudes of birth attendants	42	64.6
4	Long waiting hours	52	80

Source: Compiled From Research Finding, 2013

Figure 4.2 Pregnant Women Waiting for service in one of the health facility in Namtumbo district.



Source: Compiled From Research Finding, 2013

4.5 Factors Influencing Delivery of Services to Health Facility

The researcher was interested in knowing the factors influencing delivery services in health facilities in Namtumbo district. The researcher sought for both promoting factors and inhibiting factors.

4.5.1 Factors Promoting Deliveries in Health Facilities in Namtumbo District

The researcher wanted to know the factors that promote deliveries in health facilities in the district in order to get the findings which could support the study. During the study respondents mentioned different factors as follows: availability of skilled personnel, management of complications, specialized equipment, supplies and medicines, and distance from health facilities.

(i) Availability of Skilled Personnel

Availability of skilled personnel means presence of trained persons who are specialized in providing services during delivery. The 58(80%) respondents mentioned these factors by focusing on of the fact that providing better services also is also accompanied with availability of personnel on different carders. Basing on the health staffing level of 1999 the dispensaries are supposed to be headed by clinical officer but most of the dispensaries are headed by medical attendants.

(ii) Management of Complications

This refers to controlling of any action which can cause problems to pregnant women that call for referral or operation. The management of complications also are the factors that were mentioned by 47(72.3%) respondents. It was argued that management of complications has to take into consideration some aspects like transportation and operating when there are dangerous signs regarding the health of a pregnant woman.

(iii) Specialized Equipment

The specialized equipment are the equipment which are used during the deliveries services. These are important because they help to provide the quality services and

minimize the risk of disease transmission. Availability of specialized equipment was mentioned by 45(69.2%) respondents. The equipment include: delivery kit, delivery bed and cesarean seat.

(iv) Supplies and Medicines

This refers to medicines and materials which are used during deliveries. A total of 38(58.5%) respondents mentioned these as factors that contribute deliveries in health facilities. This also is important because delivery services are accompanied with supplies and medicines which support the delivery services. The respondents mentioned this as the factor because most of health facilities have no medicine force patients to procure out of the facility.

(v) Distance from Health Facilities

This refers to length from home to health facility in meters or kilometers. This factor of distance from health facilities was mentioned by 59(90.8%) respondents. Distance from health facility provides the room for pregnant women to deliver in health facility or not. Table 4.19 illustrates the results on factors that promote deliveries in health facilities.

Table 4.19 Responsiveness of Respondents on the factors that promote deliveries

No	Factors for promoting	Frequency	Percentage
1	Availability of skilled personnel	52	80
2	Management of complications	47	72.3
3	Specialized equipment	45	69.2
4	Supplies and medicines	38	58.5
5	Distance from health facilities	59	90.8

Source: Compiled From Research Finding, 2013

4.5.2 Factors that Inhibit Deliveries in Health Facilities

The study found out the factors that inhibit deliveries in health facilities in the District. This was important in order to get the findings which could support the researcher to understand the reasons. The factors that were mentioned include: bad

language for health providers, poor referral system, lack of specialized equipment, shortage of drugs, and long distance from health facility.

(iv) Bad Language for Health Provider

This means the language used is not polite which can attract pregnant women to deliver in health facilities. Bad language for health provider is the factor which was mentioned by 62(95.4%) respondents. If the language of health providers was polite it could encourage the pregnant women to deliver in health facilities and reduce maternal mortality.

(v) Poor Referral System

This means to transfer the pregnant women to above level of services compared to the first one. Poor referral system to the health facilities was mentioned by 36(55.4%) respondents. When the referral system is improved the pregnant women will be attracted to deliver in health facilities.

(vi) Lack of Specialized Equipment

This means equipment which are used for procedures during deliveries are not available in health facilities. This factor was mentioned by 54(83.1%) respondents. It was argued that this situation forces pregnant women to procure materials which are used during delivery.

(vii) Shortage of Drugs

This means drugs used for pregnant women during delivery and after delivery are not enough. This factor was mentioned by 52(80%) respondents whereby the shortage of drugs forces the pregnant women to buy drugs outside health facility which makes the pregnant women refuse to attend services at health facilities.

(viii) Long Distance from Health Facility

This refers to long length from home to health facility in meters or kilometers. This factor of long distance from health facility was mentioned by 51(78.5%)

respondents. Distance from health facility provides the room for pregnant women to deliver in health facility or not. The table 4.20 below illustrates the factors that inhibit deliveries in health facilities:-

Table 4.20 Factors that Inhibit Deliveries in Health Facilities

No	Factors that prohibiting	Frequency	Percentages
1	Bad language	62	95.4
2	Poor referral system	36	55.4
3	Lack of specialized equipment	54	83.1
4	Shortage of drugs	52	80
5	Long distance from facility	51	78.5

Source: Compiled From Research Finding, 2013

4.6 Solution on Improving Deliveries in Health Facilities

The researcher was interested in knowing the community's suggestions on how to improve deliveries of services in health facilities. The factors which were mentioned by respondents were polite language for health providers, availability of drugs, privacy for HIV positive, increasing number health facility to all villages, availability of trained staff and minimizing waiting hours.

(i) Polite Language

This means the language used is polite which can attract pregnant women to deliver in health facilities. Polite language for health providers is the factor which was mentioned by 59(90.8%) respondents. If the language of health providers could be polite it can encourage the pregnant women to deliver in health facilities.

(ii) Availability of Drugs

This means drugs used by pregnant women during delivery and after delivery should be enough in health facilities. This factor was mentioned by 61(93.8%) respondents whereby the availability of drugs makes the pregnant women not buy drugs out of health facility. Adequate availability of drugs can attract pregnant women to deliver in health facilities.

(iii) Privacy for Services

This means privacy for services could be confidentiality during delivery and on the result of HIV testing. This factor was mentioned by 32(49.3%) respondents whereby it was argued that the privacy on services provided during deliver and on HIV testing could attract pregnant women to deliver in health facilities.

(iv) Increasing number of health facility

This means health facility could be in every village in order to reduce the burden of travelling or walking long distance looking for health services. This factor was mentioned by 47(72.3%) respondents who argued that if every village can have health facility it could attract pregnant women to deliver in health facility.

(v) Availability of Trained Staff

Availability of trained staff means presence of skilled personnel who are specialized on providing services during delivery. The 41(63.1%%) respondents mentioned this factor by arguing that, the provision of better services is also accompanied by availability of staff of different carders. Basing on the health staffing level of 1999 the dispensaries are supposed to be headed by clinical officer but most of the dispensaries are headed by medical attendants.

(vi) Minimizing Waiting Hours

This means health providers must reduce the waiting hours to the patients. This factor was mentioned by 38(58.5%) respondents who argued that if the pregnant women could get services at reasonable time it would attract pregnant women to attend services. Table 4.21 illustrates the solution on improving deliveries in health facilities.

Table 4.21 Solution on improving deliveries in health facilities

No	Solutions	Frequencies	Percentages
1	Good language	59	90.8
2	Availability of drugs	61	93.8
3	Privacy for services	32	49.3
4	Increasing number of health facility	47	72.3
5	Availability of trained staff	41	63.1
6	Minimizing waiting hours	38	58.5

Source: Compiled From Research Finding, 2013

4.7 Discussion of Findings

The findings of the study are discussed basing on specific research objectives which were: to find out the status of women deliveries in health facilities in Namtumbo district, people's perception on delivering in health facilities, factors influencing deliveries in health facilities and solution of promoting deliveries in health facilities in the District.

4.7.1 Specific Objective Number One

The first specific objective intended to explore status of deliveries in health facilities in Namtumbo district. Through review of documents findings shows that Namtumbo district has 6(14%) health centers and 37(86%) dispensaries which make a total of 43(54.4%) health facilities out of 79(100%) which are required. The distribution of health facilities in district shows that there is no proper distribution which can help the pregnant women to get services within the five kilometers. These findings indicate that distance to the health facility covers to more than 25 to 30km which make pregnant women fail to cover transport costs for finding health services. Also, documentary review in the district shows that the district has only 3(42.9%) vehicles used for referral system out of 7(100%) which are needed for services provision. This makes the referral system fail to be achieved because ambulances fail to cover the area which can provide services in the district. One of the respondents was quoted saying:-

I delivered all my children at home with the help of TBAs of this village, saying the first delivered was at night and it was difficult to walk a long distance to dispensary while in pain , second I could not also walk to the dispensary in this area there is no ambulance to help clients.

Review of documents shows that the budget which was planned to cover medicines and medical supplies for the past three years was not provided to MSD as planned. The findings show that in the year 2012/2013 only 172,685,760 (74.6%) was provided out of 231,480,000 (100%) which was planned as medicine and medical supplies budget. This revealed that the medicines which are provided from MSD fail to cover services as per total population and catchments area.

The findings revealed that on the quality of services on deliveries 10(15.4%) respondents said it was satisfactory, 28(43.1%) responded bad and 12(18.5%) responded worse. This means the quality of services provided in health facilities was not satisfied to pregnant women the factors that mentioned by respondents were 46(70.8%) shortage of drugs, 51(78.5%) environment not clean, 43(66.2%) not affordable and 61(93.8) long waiting hours.

On trend of women attending clinic documentary review shows that in the year 2012 out of 5172(100%) only 4646(89.8%) were attending clinic, 2011 out of 5508(100%) only 5090(92.4%) were attending clinic, 2010 out of 4945(100%) only 4375(88.5) were attending clinic, 2009 out of 5475(100%) only 4830(88.2%) were attending clinic and 2008 out of 5002(100%) only 3858(77.1%) were attending clinic and 2007 out of 5063(100%) only 4061(88.2%). These findings revealed that the percentages of attending clinic increased and decreased in the year 2012 and 2011 which show that in the year 2011 was 7.6 and 2012 was 10.2. These findings could be associated by the characteristics of the respondents because the study found that 7 (10.7%) respondents never went to school, 31(47.7%) had primary education which shows that the ignorance was one of factors that was inhibiting ANC.

4.7.2 Specific Objective Number Two

Specific objective number two intended to explore people's perception on delivering in health facilities. Perception of good care, about 57(87%) respondents perceived that the care they received during antenatal was largely good because they were given advice on what to take when going for delivery. They received medicines as prophylaxis against anemia, malaria as well as actual treatment of malaria when they were ill. For some participants, the prophylaxis they received reduced malaria attacks and dizziness. Additionally, they received mosquito nets that protected them from malaria. The participants' narrations indicated that because of the antenatal care they received, they did not experience any problems. The delivery process went well and they had healthy babies. The management of complications also is the factor that was mentioned by 42(64.6%) respondents. Regarding this perception it was argued that if management of complications is handled well it can eliminate home deliveries because the pregnant women will be attracted to deliver in health facilities.

Perception of poor care, about 39(60%) respondents perceived poor care as being shouted at in receiving care in health facilities and 36(55.4%) mentioned confidentiality after receiving delivery services woman who were delivered by TBAs stated that TBAs maintained confidentiality, as they did not say anything about delivery issues. TBAs were said to be very secretive about what happened during delivery. One of the respondents was quoted saying:-

“Regarding TBAs after delivery you do not hear them telling other people about a patient. It ends with delivery and you never hear anything”.

4.7.3 Specific Objective Number Three

Specific objective number three intended to find out factors influencing deliveries in health facilities. On management of complications, 58(80%) respondents mentioned this factor by arguing that provision of better services is also accompanied with

availability of personnel of different cadres. The management of complications also was mentioned by 47(72.3%) respondents, availability of specialized equipment was mentioned by 45(69.2%) respondents. The equipment include; delivery kit, delivery bed and cesarean seat, 38(58.5%) respondents mentioned as factors that contribute deliveries in health facilities. This also is important because delivery services are accompanied with supplies and medicines which support the delivery services and 59(90.8%) distance from health facilities.

Also, about 59(90.8%) respondents revealed that distance is one of the determinants for place of delivery among pregnant mothers especially in rural areas whereby health facilities are scarcely distributed. It is irrelevant to have health facility which is well equipped and properly staffed but not accessed by the women for delivery due to long walking distance. Several studies have been done in developing countries and found close relationship between distance and delivery in health facility, in this study the preventive effect of distance in delivering services in health facility is stronger when combined with lack of transport and long distance.

After discussing the factors influencing deliveries in health facilities the inhibiting factors were: language used was one of the factors that inhibit pregnant women to deliver in health facility. The 62(95.4%) of respondents said that the language used by health providers was not good compared to the language used by TBAs. They further narrated that the TBAs were also able to communicate in a local language which clients could understand well. Some of the respondents said that they were not happy with the harsh language used by the nurses when they attended the ANC which made them not attending again. Another factor is distance to health facility; this mentioned by 51(78.5) respondents. They argued that health facilities are located far compared to TBAs who are within 500meters from their home. This finding indicates that distance to the health facility is more than 25 to 30km one of the respondents quoted saying:

I delivered all my children at home with the help of TBAs of this village, saying the first delivered was at night and it was impossible to walk the long distance to dispensary while in pain , second I could not also walk to the dispensary in this area there is no ambulance for help client.

By implications, these findings indicate that all the women who delivered out of health facility with the assistance of TBAs were due to the short distance from their home.

Poor referral system to the health facilities was mention by 36(55.4%) respondents who argued that when the referral system is improved the pregnant women will be attracted to deliver in health facilities. The finding shows that the district has only 3 ambulances out 7 which are needed in the district to cover all health centers. Drugs used for pregnant women during delivery and after delivery are not enough, 52(80%) respondents mentioned that shortage of drugs makes the pregnant women to buy drugs out of health facility due to meager budget which was planned for medicine and medical supplies are not released as planned to MSD. This makes facilities to lack medicines hence force the pregnant women to buy.

4.7.4 Specific Objective Number Four

Specific objective number four intended to find out ways of promoting deliveries in health facilities in the District. Polite language for health provider is one of the factors which were mentioned by 59(90.8%) respondents. The use of polite language was one of the factor that attracted pregnant women to deliver in health facilities. They further narrated that the harsh language used by health providers could make pregnant women to fear services. Some of the respondents said that they were not happy with the getting deliver to TBAs but the language used is polite, and attractive drugs used for pregnant women during delivery and after delivery should be enough in health facilities. This factor was mentioned by 61(93.8%) respondents whereby the availability of drugs can make the pregnant women not buy drugs out health facility and this can attract pregnant women to deliver at health facility. Privacy for

services should enhance confidentiality during delivery and on the result of HIV testing. This factor was mentioned by 32(49.3%) respondents whereby the privacy in services provided during deliver and on HIV testing could attract pregnant women to deliver in health facilities.

Health facility could be in every village in order to reduce the burden of travelling or walking long distance looking for health services. This factor was mentioned by 47(72.3%) respondents who argued that if every village can have health facility it could attract pregnant women to deliver in health facility. Availability of trained staff means presence of skilled personnel who are specialized in providing services during delivery. The 41(63.1%) respondents mentioned this factor by focusing on the issue that, the provision of better services are also accompanied by availability of staff on different carders. Basing on the health staffing level of 1999 the dispensaries are supposed to be headed by clinical officer but most of the dispensaries are headed by medical attendants. Health providers must reduce the waiting hours to the patient. This factor was mentioned by 38(58.5%) respondents who argued that if the pregnant women could get services at reasonable time would attract pregnant women to attend services.

4.8 Conclusion

In general all main and specific objectives was accomplished successfully as discussed in this chapter in a detailed manner. The government is committed towards the promotion of numbers of deliveries in health facilities all over the country but there are still some challenges such as shortage of drugs in the health facilities, lack of funds, lack of transport facilities as well as shortage of personnel on the one hand and on other hand bureaucratic and political influence have hindered the promotion of deliveries in health facilities in Namtumbo district.

CHAPTER FIVE

SUMMARY, CONCLUSION AND POLICY IMPLICATIONS

5.1 Introduction

This chapter introduces the summary, conclusion and suggestions of the study. The chapter is organized as follows: summary, conclusion, suggestions and areas for further research.

5.2 Summary

The study was conducted with the intention to assess challenges to promoting number of deliveries in health facilities in Namtumbo District, Tanzania in order to improve service delivery in health facilities. This study was carried out with the view of attaining the following specific objectives (1) to explore the status of women deliveries in health facilities in Namtumbo district, (2) to explore people's perception on delivering in health facilities (3) to find out factors influencing deliveries in health facilities and (4) to find out ways of promoting deliveries in health facilities in the District.

Data collection was guided by the following research questions (1) What is the status of women deliveries in health facilities in Namtumbo District (2) What are the people's perceptions on delivering in health facilities (3) What are the factors influencing deliveries in health facilities and (4) What are the ways of promoting deliveries in health facilities in the district.

Findings indicate that, poor community sensitization and policy implementation in Namtumbo district have affected deliveries in health facilities by increasing number of home deliveries. In the study the findings revealed that there has been negative attitude to health provider, lack of medicine and medical supply, budget constraints from the government on the health facilities construction leading to persistence of the problem of home deliveries. This make the pregnant women not get proper services as guided in order to control the life of pregnant women.

Also, the study revealed that the facilitating factors which lead the pregnant women to deliver at home include polite language from TBAs, services provided under a short time, short distance from home to TBAs, zero cost in services and no compulsory HIV/AIDS testing as what practiced to health facilities.

5.3 Conclusion

In general all main and specific objectives were accomplished successfully as discussed in chapter four in a detailed manner. The government is committed towards the promotion of numbers of deliveries in health facilities all over the country but there are still some challenges such as shortage of drugs in the health facilities, lack of funds, lack of transport facilities as well as shortage of personnel on the one hand and on other hand bureaucratic and political influence have hindered the promotion of deliveries in health facilities in Namtumbo district.

The roles of the government in constructing health facilities have been seen as in the area of study there were about 43 health facilities of which 7 are health centers and 36 dispensaries. This indicated that services are being delivered but the challenge remained on the availability of essential equipment to support the provision of quality health services to the pregnant women so as to reduce the maternity and mortality rate in Namtumbo district.

5.4 Recommendations

Despite the challenge facing the service delivery and management in general at Namtumbo district, the following recommendations are much helpful if the district could plan with different stakeholders within the community to overcome the situation.

5.4.1 Specific Recommendations for the District

The government has committed resources towards the promotion of Numbers of deliveries in health facilities all over the country but there are still some challenges such as shortage of drugs in the health facilities, lack of funds, lack of transport

facilities as well as shortage of personnel on the one hand and on other bureaucratic and political influence have hindered the promoting of deliveries in health facilities in Namtumbo district. Therefore, the following have to be taken into account.

(i) Availability of Adequate Resources

The district should mobilize its resources particularly financial resources for purchasing transport facilities that will be used for various purposes such as supplying medicines and other medical equipment to those health centers and dispensaries which are located in solitude areas, also this will help in the supervision activities in health facilities.

(ii) Staff Motivation

There should be effective communication and feedback between health facilitators and the clients, this will create awareness to the clients on what kind of services are being provided to the pregnant women in the health facilities, through this it may become possible to increase the number of deliveries in health facilities in Namtumbo district, furthermore, the District human resource officers should work together with the representatives of health workers union like TALGWU and TUGHE to educate and explain to its health workers their rights and obligation, and enhance an effective and strong community link through health unit management committee on the quality of services related to deliveries in health facilities.

(iii) Community Sensitization

There should be community sensitization on delivery services at different levels. This can help the majority to understand the importance of deliveries in health facilities. The situation will help even the men to know the importance of attending clinic for diagnosing the dangerous signs which can take place during or after deliveries.

5.5 Policy Implications

There is a need to strengthen the service delivery to the pregnant women by encouraging exemption system, if they will be exempted as policy stated, they will be in a better position of attending in health facilities for the delivery issues, because due to unofficial payment they have become reluctant to deliver at health facilities and they decide to deliver at their homes. Improving communication between management and the community is essential toward the promotion of numbers of deliveries in health facilities, when there will be communication barrier clients will not know the available services to the pregnant women.

Medical Supply Department (MSD) is a problematic agency; inadequacy of medicine and medical supply has been triggered by this agency. Many health facilities are functioning without essential medicine in Tanzania simply because MSD is lacking those medicines; there is a need for the government to take action of changing the system and allowing the hospital to be give money to buy from other agencies if MSD is lacking those items.

There is a need to provide incentives in order to improve providers' behaviours as this can increase uptake of maternity health care services among the pregnant women. This should go hand in hand with provision of transport facilities, better working condition as well as housing facilities.

Policy makers should a set policy on customer care in public health facilities in order to render better services. Also, the management of women service delivery should be improved through involvement of various departments in the facility and creating other sources of funds so as to ensure that funds are not a constraint in service provision.

5.6 Areas for Further Research

The following are the researcher's recommended areas for further research

- i) Research on the status of customer care for public hospitals in Tanzania
- ii) Research on the assessment of strength and weakness of service delivery to pregnant women.

REFERENCES

- Adam, J. and Kamuzora, F. (2008); *Research Methods for Business and Social Studies*, Mzumbe Book Project, Mzumbe Tanzania
- Addai (2000) *Determinant of use of Maternal Child Health Services in Rural Ghana*, Cambridge University press, United Kingdom.
- Afful (2004) *Better Health Information for Better Health Policy*, Namongo HDSS, Ghana.
- Bolam A, Manandhar, D,S, Shrestha p, Elis M, Malla K &Costello A (1998) Factors Affecting Home Delivery in the Kathmandu Valley, Nepal. *Health Policy and Planning* 13
- Bolam A, Manandhar, D,S, Shrestha P, Ellis M, Malla K, Costello AM (2006).
Centre for International Child Health, Institute of Child Health,
London: Factors Affecting Home Delivery in the Kathmandu Valley,
Nepal.
- Brieger WR,luchock KJ,. Eng E & Earp j (1994) Use of Maternity Services by Pregnant Women in Small Nigerian Community. *Health Care Women International* 15, 101-110
- Bryman, A and Bell, E. (2007), **Business Research Methods**, 2nd ed. Oxford University Press. Cabral (1992) *Training of TBAs. Guide for TBAs Trainer of WHO*, Geneva.
- CCHP (2011) *Ministry of Health Social Welfare the Comprehensive Council Health Planning Guidelines*, Tanzania.
- Coverage of Maternity Care (1997) *A List of Available Information “Fourth Edition”* WHO Geneva.

- Descehenes (2003) Comprehensive Approaches to School Health Promotion International, How to Achieve Broader Implementation. *Health Promotion International*.
- D'Ambruso, Joana A. Schellenberg, Adiel k. Mushi 2005; Factors Affecting Home Delivery in Tanzania.
- D'elineira, Joana A. Schellenberg, Adiel K. Mushi et al 2002; Factors Affecting Home Delivery in Tanzania.
- Duong.V,D, Binns. C, W, Lee. H, A and. Hipgrave. B,D (2004), Measuring Client Perceived Quality of Maternity Services in Rural Vietnam. *International Journal for Quality in Health Care*; Volume 16.
- Eijik, V (2006), Use of Antenatal Service and Delivery Care Among Women in Rural: A Community Based Survey, Western Kenya.
- Ensor & Cooper, (2004); Overcoming Barriers to Health Service Access Influencing the Demand Side, Developing Countries.
- Falkingham, (2003): Factors that Determine the place of Delivery in Tajikistan, Geneva.
- Germano E et al (1998) Home Birth and Short Stay Delivery. Lessons in Health Care Financing for Providers of Health Care for Women. *Journal of Nurse Midwifery*.
- Giandomenico Majone and Aaron Wildarskyy, (1973) " Implementation as Evolution " As cited by Stella Z. Theodoulou, on How Public Policy is Made, Sir Lanka.

- Graham C. (1997) A Review of Safe Motherhood. Ministry of Health Kenya.
Option Consultancy Ltd, London.
- Hadgkin (1966) Neighborhood Socioeconomic Status and Hodgkins Lymphoma
Incidence in California.
- Health Promotion International (2003) Settings System and Organization
Development: The Health Living and Working Model. Vol. 18, No.
4, 327-337. Sage, London.
- IRIN (2009) Zanzibar Health Report on Health Facilities Deliveries and HIV/AIDS
Testing.
- Jamison DT (1993) Journal of Community Health; Disease and Mortality in Sub-
Saharan Africa 2nd Edition, Washington, Press.
- Kalibbala G (2001) Maternal Deaths to Examine How Deliveries Kits Save Rural
Women, Uganda.
- Kaguna, B and Nuwaha (2008) Factors Influencing Choice of Delivery Sites in
Rakai District of Uganda. Social Science and Medicine 50,203-213
- Kamuzora, J.A, (2008), *Research Methods for Business and Social Studies*,
Morogoro: Mzumbe Book Project.
- Koblinsky, Campbell O; Heichelhelm J, (2000) Quality of Care what Does it Mean
for Safe Motherhood? Safe Motherhood Consultation, Sri Lanka.
- Koblinsky et al (2000) *Mother and Broader Perspective on Women Health*.
Westriew Press Oxford.

Kothari, C.R. (2004), *Research Methodology & Methods & Techniques*, Second Edition New Age International (P) Limited Publishers, New Delhi India

Kyeri (2006) Country Health System Fact, Expectance Mothers to an HIV Test. Capital City, Kenya

Luchock KJ, Eng, E and Earp, J, (1994) Use of Maternity Services by Pregnant Women in Small Nigerian Community. *Health Care Women International* 15,101-110

Luthans P.(2001) “Strategies for Reducing Maternal Mortality; Getting on With what Works” *Lacent* 368(9543) 1284-1299

Maine D, (1996) “Too Far to Work; Maternal Mortality in Context” *Social Science and Medicine* Vol 33, No. 11,Pp. 1072-1107. International (P) Limited Publisher, New Delhi India

Magadi, M., Diamond, I., and Madise, N. (2001). Analysis of Factors Associated with Maternal Mortality in Kenyan Hospitals. *Journal of Biosocial Science*, Kenya

Magoma, M., Requejo, J., Oona M.R, Simon, C, and Filippi,V,(2010). High ANC Coverage and Low Skilled Attendance in a Rural Tanzanian District: a Case for Implementing a Birth Plan Intervention.

MDG Report (2008) Assessing Progress of Halving Poverty in Africa , Economic Commission for Africa, United Nations.

- Massoud, R. ,K Askov, J Reinker, L.M France (2001)A Modem Paradigm for Improving Healthcare Quality. Bethesda, MD; Quality Assurance Project (For USAID)
- Michuki, (2003) On Utilization of Maternal Health Care Services in Meru North District, Kenya
- Mpembeni, R.N.M., Killewo, J.Z., Leshabari, M.T., Massawe, S.N., Jahn, A., Mushi, D. & Mwakipa, H. (2007) Use Pattern of Maternal Health Services and Determinants of Skilled Care During Delivery in Southern Tanzania: Implications for Achievement of MDG-5 targets. BMC
- MoHSW, (2008b). *Health Sector Performance Profile Report: Mainland Tanzania*, Dar es Salaam, Tanzania
- Mrisho, M, Schellenberg, J.A, Mushi, A.K, Obrist, B., Mshinda, H., Tanner, M., and Schellenberg, D, (2007). Factors Affecting Home Delivery in Rural Tanzania.
- Munga, M.A. & Maestad, O. (2009) Measuring Inequities in the Distribution of Health Workers: The Case of Tanzania.
- Munga, M.A., Songstad, N.G., Blystad, A. & Maestad, O. (2009) The Decentralisation-Centralization Dilemma: Recruitment and Distribution of Health Workers in Remote Districts of Tanzania.
- Myles D.J. and Kumar, K (1981) Collection Analysis and Use of Monitoring and Conceptual Mode Review in Journal of Adolescent Research, 3, 285-303

- Namtumbo District Maternal and Child Health Report (2010). The Factors Contributing on Improving Health Centers. Namtumbo, Tanzania.
- NAO (2011). A Performance Audit on the Monitoring, Evaluation and Budget Allocation for Maternal Health Care Activities in Tanzania.
- NSGRP (2005) Explanation for Poverty Mobility in Tanzania, Light of Country Presentation on Social Protection, Tanzania Mainland.
- Pembe AB, Urassa DP, Carlstedt A, Lindmark G, Nystrom L, Darj E,(2009). Rural Tanzanian Women's Awareness of Danger Signs of Obstetric Complications. BMC Pregnancy Childbirth
- Rana Jawad (1999). Obstetric Complication and Role of Tbas in Developing Country. World Health Forum Volume 9 (1) Pg. 55 – 57.
- Remakrishma (1998) Social, Economic and Cultural Factors Associated with Pregnant. Non governmental Organisational Assachuswetts, Republic of China
- Ronsmans, C (2003) Maternal Mortality and Obstretric Care in Rural Senegal, Guinea, Bukina Faso and La Cote D'Ivoire.
- Roosmalen (2005). An International Journal of Obstetric and Gynecology, Pernatal mortality, Vol 96, Tanzania.
- Safe Motherhood Report (2000) Ensure Skilled Attendant at Delivery and Promote Appropriate Basic Care, Washington DC

- Stars (1987) Health Calling for Improving Services Delivery, New World Bank
Health Services Delivery Mode. Developing Countries: An agenda for
Reform
- Sankwaya (2008). Study to Explore Barriers to Utilization of Maternal Delivery
Services in Kazungula, 45th Internatinal Course in Health Development
Zambia.
- Sherri Torjman (2005). What is Policy Caledon Institute of Social Pollicy 16000
Scott Street Ottawa Outario Canada.
- Tanzania Demographic and Health Survey (2010),Linking Reproductive Health and
Family Planning. ICF Macro Calverton, Maryaland, USA.
- The Millennium Development Goals Report (2008). *Maternal and new Born*, New
York.
- Thaddeus, S. and Maine, D. (1994), "Too Far to Walk: Maternal Mortality in
Context",*Social Science and Medicine*, Vol. 38, No. 8, Pp. 1091-
1110.
- Todaro, M and Smith, S (2009) Economic Development, 10 Ed London, New York.
- UNICEF, (2009). The State of The World Children, Matenal and Newborn Health
- United Republic of Tanzania, (2010). Tanzania Demographic and Health Survey,
ICF Macro Calverton, Maryaland, USA.
- URT ,(2003). National Health Policy; Ministry of Health and Social Welfare; Dar es
Salaam

- URT,(2005). National Strategy for Growth and Reduction of Poverty (NSGRP),
Vice President. Office, Dar Es Salaam
- URT,(2011).Comprehensive Council Health Planning Guidelines, Ministry of
Health and Social welfare, Prime Ministerr's Office Regional
Administration and Local Government, Dodoma
- Voorhoeve, C. Kars, J.K. Van Ginneken Et Al, (1984): A Longitudinal Study on
Factors that Determine Place of Delivery in Kenya.
- WHO (2013) Universal Health Coverage, Geneva, Switzerland.
- WHO (2007) A Safe Future: Global Public Health Security in 21st Century. New
York
- WHO, (1993). Estimates of Maternal Mortality a New Approach by WHO and
UNICEF Geneva.
- WHO, (1998). Mother-baby package. Implementing Safe Motherhood in Countries
(WHO/FHF/MSM/94.11) Geneva.
- WHO (2000). *World Health Report 2000*. Geneva: WHO
- WHO (1948) Teen Pregnant in New York, Department of Health and Mental
Hygiene, New York City USA.
- WHO (2001b) Report of the Scientific Peer Group on Health Systems Performance
Assessment World Health Organization (2007), Maternal Mortality:
Estimates of WHO, UNICEF, UNFPA, and World Bank, WHO,
Geneva, Switzerland.
- WHO, (2002) *Complications of Home Delivery, a Retrospective Analysis*. World

Health Report, Geneva, 27th edition. Geneva.

WHO (2004) On Assessment of Safe Delivery Services Utilization Among Women of Child Bearing North Gonar Zone and North Ethiopia.

WHO (2007) A Safe future: Global Public Health Security in the 21 century.

WHO and UNICEF (2000) Countdown to 2015 Maternal, Newborn and Child Survival United Nations New York.

Yanagisawa et al (2006); Determinants of Skilled Birth Attendance in Rural, Cambodia.

Zikmund, e al, (2010) Business Research Methods, 8th ed. South- Western Cengage Learning.

Zulfiqal Bhutta (2009) Collaborating to Improve Child Health Globally, Programme for Global Paediatric Research, The Aga Khan University Karach Pakistani.

(v) What is your economic activity? Please mention

Please mention

.....
.....
.....

SECTION B: STATUS OF DELIVERIES IN HEALTH FACILITIES

Please tick/Rate what is appropriate

(i)How many health facilities in the district?

.....

(ii)What are the budget of medicine and medical supplies in your district?

.....

(iii)What is the quality of services deliveries in health facilities?

- (a) Very good [] (b) Good []
- (b) Satisfactory [] (c) Bad []
- (e) Worse []

(iv)What are the environments of services in the health facilities?

- (a) Drugs are available Yes [] No []
- (b) Environment are clean Yes [] No []
- (c) Cost of services affordable Yes [] No []
- (d) Time for services waiting Long [] Short []

(v)What are the trends of women delivery in and out of health facilities over past 6 years?

.....

(vi) What are the numbers of pregnant women attending clinic and delivery in health facilities past 6 years ?

.....

(vii) What are the numbers of not attending clinic and delivery in health facility over past 6 years?

.....

(viii) What are the procedures of attending pregnant women in health facilities?

.....

(ix) What are the components of services provided to pregnant women in health facilities?

.....

SECTION C: PERCEPTION ON DELIVERIES IN HEALTH FACILITIES

Please Tick/Rate what is appropriate and Fill the blanks below.

(i) Do you think the delivery in health facilities is important?

(ii) Yes []

Explain.....

(iii) No []

Explain.....

(ii) What do you think are the peoples Altitude on delivering at home?

Please mention

1.....

2.....

3.....

4.....

SECTION D: FACTORS INFLUENCING DELIVERISE IN HEALTH FACILITIES

(i)What do you think are the factors that promoting deliveries in health facilities?

Please mention

1.

.....

2.....

3.....

4.....

(ii)What do you think are the factors that inhibit deliveries in health facilities?

Please mention

1.....

.

2.....

3.....

4.....

SECTION E: IMPROVING DELIVERING SERVICES

(i) In you view how can deliveries in health facilities can be improving?

Please mention

1

2

3

4.....

THANK YOU FOR YOUR COOPERATION

(v) What is your economic activity? Please mention

Please mention.....
.....
.....

SECTION B: STATUS OF DELIVERIES IN HEALTH FACILITIES

Please tick/Rate what is appropriate

(i)What is the quality of services deliveries in health facilities?

- (c) Very good [] (b) Good []
- (d) Satisfactory [] (c) Bad []
- (e) Worse []

(ii)What are the environments of services in the health facilities?

- (e) Drugs are available Yes [] No []
- (f) Environment are clean Yes [] No []
- (g) Cost of services affordable Yes [] No []
- (h) Time for services waiting Long [] Short []

(iii)What are the trends of women delivery in and out of health facilities over past 6 years?.....
.....

(iv)What are the procedures of attending pregnant women in health facilities?

.....
.....

(v)What are the components of services provided to pregnant women in health facilities?

.....
.....

SECTION C: PERCEPTION ON DELIVERIES IN HEALTH FACILITIES

Please Tick/Rate what is appropriate and Fill the blanks below.

(i) Do you think the delivery in health facilities is important?

(iv) Yes []

Explain.....
.....
.....

No []

Explain.....
.....
.....

(ii) What do you think are the peoples Altitude on delivering at home?

Please mention

- 1.....
...
- 2.....
...
- 3.....
.
- 4.....

SECTION D: FACTOR INFLUENCING DELIVERISE IN HEALTH FACILITIES

(i)What do you think are the factors that promoting deliveries in health facilities?

Please mention

- 1.....
- 2.....
- 3.....
- 4.....

(ii)What do you think are the factors that inhibit deliveries in health facilities?

Please mention

- 1.....
- 2.....
- 3.....
- 4.....

SECTION E: IMPROVING DELIVERING SERVICES

(i) In you view how can deliveries in health facilities can be improving?

Please mention

- 1
- 2
- 3
- 4.....

THANK YOU FOR YOUR COOPERATION

SEHEMU B: HALI YA HUDUMA YA UZAZI KATIKA VITUO VYA HUDUMA YA AFYA

Weka alama ya vema sehemu inayohusika.

(i) Hali ya huduma ya uzazi katika kituo chako cha huduma ikoje

(a) Nzuri sana [] (b) Nzuri []

(c) Inaridhisha [] (d) Mbaya []

(e) Mbaya sana []

(ii) Je mazingira ya upatika huduma yakoje?

(a) Dawa zinapatikana ndiyo [] Hapana []

(b) Usafi unaridhisha ndiyo [] Hapana []

(c) Gharama za matibabu zinaridhisha ndiyo [] Hapana []

(iii) Kwa mtazamo wako unaonaje mtiririkowa akinamama kujifungulia katika vitou vya huduma ya afya

(a) Unaongezeka sana []

(b) Unaongezeka []

(b) Upo kama mwanzo []

(c) Unashuka []

(d) Unashuka sana []

(iv) Ni huduma gani unazotoa kwa akina mama wajawazito katika kituo chako

Elezea.....
.....
.....

(v) Je wakinamama wajawazito wanaridhika na huduma unayotoa

(a) Ndiyo [] (b) Hapana []

(c) Sifahamu []

(vi) Je ni idadi gani ya akinamama wajawazito wanaopata huduma katika kituo chako cha kutolea huduma ya afya

.....

SEHEMU C: MTAZAMO WA HUDUMA ZITOLEWAZO KATIKA VITUO VYA HUDUMA

Tafadhali weka alama ya vema na jaza sehemu wazi

(i) Je unazani kujifungulia katika kituo cha kutolea huduma ya afya ni vizuri?

Ndiyo []

Elezea.....

.....

Hapana []

Elezea.....

.....

(ii) Je unadhani upi ni mtazamo wa jamii juu ya kujifungulia katika vituo vya kutolea huduma ya afya?

5.

6.

7.

SEHEMU D: SABABU ZINAZOPELEKEA KUPANDA NA KUSHUKA

Je unazani ni sababu zipi zinazovutia wakinamama wajawazito kupata huduma ya uzazi katika vituo vya huduma ya afya.

Tafadhali taja

1.

2.

3.

4.

Je unazani ni sababu zipi zinazozuia wakinamama wajawazito kupata huduma ya uzazi katika vituo vya huduma ya afya

Tafadhali taja

1.

2.

3.

4.

2.

SEHEMU E: NJIA YA KUBORESHA HUDUMA ZA AFYA

Kwa maoni yako ni kwa vipi huduma ya afya inaweza ikaboreshwa?

.....
.....
.....
.....
.....

NASHUKURU KWA USHIRIKIANO WAKO