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Payments and Quality of Ante-Natal Care in Two Rural Districts of Tanzania

Paper 4 from the Ethics, Payments, and Maternal Survival Project

Paula Tibandebage, Maureen Mackintosh, Tausi Kida, Joyce Ikingura and Cornel Jahari



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Ethics, Payments and Maternal Survival Project - Paper 4

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Table of Contents

Acknowledgements	iii
Table of Contents	iv
List of Tables	v
List of Figures	vi
Abstract	vii
Acronyms	viii
1.0 Introduction	1
2.0 Methods	2
3.0 Findings	4
3.1 Access to Ante-Natal Care	4
3.2 Payments for Ante-Natal Care	4
3.3 Quality of Ante-Natal Care: Quantitative Analysis of Information from Women	6
3.4 Quality of Ante-Natal Care: Quantitative Analysis of Information from Facilities ...	8
3.5 Interaction between Payments and Quality: Evidence from the Interviews	9
4.0 Discussion	21
5.0 Conclusion	23
References	24
Publications by REPOA	25

List of Tables

Table 1:	Number of facilities studied, by level and sector in each rural district	2
Table 2:	Total payments for ante-natal care for those receiving some care only for their most recent pregnancy, by district (Tanzanian shillings)	5
Table 3:	Breakdown of payments for ante-natal care for those receiving some care only for their most recent pregnancy, by rural district (Tanzanian shillings)	6
Table 4:	Percentages of women receiving some ante-natal care who reported receiving the listed items, by rural district	7
Table 5:	Percentages of those stating they had received some information about symptoms of complications in pregnancy who, without prompting, mentioned the following symptoms, by rural district	7
Table 6:	Availability of supplies and tests required for ANC: data from hospitals and lower-level facilities, public and FBO sectors	9
Table 7:	Type of facility where ANC care was sought (%), by rural district: data from interviews with women	10

List of Figures

Figure 1: Number of ANC visits during the most recent completed pregnancy, by rural district	4
Figure 2: Total payments for ante-natal care for those receiving some care only for their most recent pregnancy, by rural district (Tanzanian shillings)	5
Figure 3: Total number of relevant symptoms of complications in pregnancy, as mentioned without prompting by those receiving some ante-natal care, by rural district	8
Figure 4: Distribution of payments for supplies, tests, and treatments during ANC, by sector: Rural 1	11
Figure 5: Distribution of payments for supplies, tests, and treatments during ANC, by sector: Rural 2	12

Abstract

This paper surveys women's experiences with payments for ante-natal care (ANC) and associated issues of quality in two rural districts of Tanzania. We draw on quantitative and qualitative data from interviews in facilities and in households in the two districts to explore these issues, and discuss some policy implications.

The paper provides evidence of payments for ANC in the two rural districts. Striking differences in payments between the two districts were observed, apparently reflecting variation in charging practices in different parts of the districts. In the areas surveyed in one district, women were paying little, in both faith-based organisations (FBOs) and in the public sector. In the other district, charges were much higher in facilities that women had attended, including a district hospital and a public dispensary that seemed to have gone into business on its own account. We explore to what extent these higher charges were associated with better-quality care: The women in the higher-charging district had in general received somewhat higher levels of service than the women interviewed in the lower-charging district, with the notable exception of a low-charging FBO-owned hospital that was succeeding in combining low and predictable charges with good services.

In both districts, we found few reports of abuse at the ANC level – this appears to be more a problem at birth. The main quality issues at this level are lack of basic ANC services in some of the public health facilities, and having to pay for ANC even in some of the public facilities where these services are supposed to be provided for free. However, the problem of supply shortages seems to have generated a system of informal charging in some contexts. Sale of assets and borrowing to pay for ANC means impoverishment in order to access a payment-exempted service. We also found that health insurance appears to be creating or supporting a culture of charging for ANC.

ANC accessible to all women is a key requirement for improved maternal survival. The findings discussed in this paper suggest the need for a more concerted effort to implement effectively strategies that are already in place, and to come up with other alternative strategies that may result into better outcomes. Such strategies should not be considered in isolation, but should be part of effective strategies to improve all aspects of maternal health. Furthermore, an emerging problem needs to be looked into, and appropriate action taken. Health insurance, which is intended to promote access to health care for the poor, seems in this case to be creating a contrary effect by exacerbating the problem of payments for services that should be exempted from payment.



Acronyms

ANC	Ante-Natal Care
CHF	Community Health Fund
ESRF	Economic and Social Research Foundation
FBO	Faith-Based Organisation
IHI	Ifakara Health Institute
NBS	National Bureau of Statistics
NHIF	National Health Insurance Fund
NIMR	National Institute for Medical Research
TDHS	Tanzania Demographic and Health Survey
URT	United Republic of Tanzania

Introduction

The role of good quality ante-natal care in safe delivery cannot be over-emphasized. It ensures that pregnancy complications and risks are detected early, thus making it easy to plan for safe delivery in a timely manner. National data suggest that access to ante-natal care is very widespread in Tanzania, while skilled assistance at birth is much less accessible. According to the 2010 Tanzania Demographic and Health Survey (TDHS), 98 per cent of Tanzanian women receive some ante-natal care from a skilled health-care professional, most likely a nurse/midwife (80 per cent) (NBS and ICF Macro, 2011). The same source puts the number of births that occur in health facilities at about 50 per cent. When we began this project, therefore, our expectation had been that the most serious problems of payments and associated ethical issues would arise when women gave birth. We found however that ante-natal care presented women with many dilemmas and demands for payment, and that there were many quality problems in ante-natal care associated with payment processes.

This paper surveys some of these issues, concentrating on the experience of women in two rural districts. One of these districts has been the subject of a substantial amount of intervention to improve services (the district called Rural 2, below), while the other (Rural 1) has not. In one district, payments for ante-natal care were substantially higher than in the other, and we ask whether the qualitative interviews and other data can show whether or not the higher payments made were eliciting better care. We draw on quantitative and qualitative data from interviews in facilities and in households in the two rural districts, and discuss some implications for policy.

Methods

The sample and data collection instruments

This paper examines some results from a mainly qualitative study. Fieldwork for the study was undertaken in four districts located in two contrasting regions of Tanzania. In each region, the research included one urban and one rural district. Three wards in each district and then two streets or villages in each ward were chosen that displayed contrasting economic circumstances. Finally, ten households were selected randomly along those streets or villages. Households where no woman was pregnant and/or no woman had given birth in the last five years were replaced. A total of 240 households were selected, 60 in each district.

Interviews with heads of households or their representatives in these 240 households collected basic data on the households' socio-economic conditions, while interviews with women collected data on payments and maternal care, including birth experiences. In the sampled households all eligible women were interviewed. In total, interviews were conducted with 248 women who had given birth in the last five years and/or were currently pregnant. The five-year cut-off point was applied to limit recall problems. The interviews captured information on the women's experiences of ante-natal care, care at birth, and post-natal care, including payments made and their perceptions of the quality of care they received.

In addition, the fieldwork also included health-care facility interviews that were conducted with health workers in 59 health-care facilities in the selected districts. The health-care facilities in the survey were at different levels and were drawn from three sectors – public, private, and those owned by faith-based organisations (FBOs). In total, 11 hospitals, 16 health centres, and 32 dispensaries were visited. Interviewees included medical directors and clinicians incharge, managers responsible for maternal care, and midwives. Some traditional birth attendants were also interviewed.

Semi-structured questionnaires with provisions for in-depth probing were used in both household and health facility interviews. In addition, for household interviews a separate structured questionnaire was used to capture the households' socio-economic characteristics. Fieldwork was undertaken in September and October 2011.

In this paper we present case studies of the quality of ante-natal care experienced by women in the two rural districts. A total of 17 health facilities were visited in Rural 1, and 15 in Rural 2. In each rural district, a total of 62 women were interviewed about their experience of care during pregnancy and birth.

In these two rural districts, women relied for maternity care mainly on public and FBO-owned facilities. Table 1 shows the distribution by level and sector of the facilities sampled in each district. There are relatively more FBO-owned facilities sampled in Rural 2, a reflection of the characteristics of the particular districts selected.

Table 1: Number of facilities studied, by level and sector in each rural district

Level and sector	Rural 1	Rural 2
Public hospital	1	1
FBO hospital	1	1
Public health centre	6	3
Public dispensary	6	5
FBO dispensary	2	4
Private dispensary	1	1
Total	17	15

Data analysis

Qualitative data on women's maternal health-care experiences were coded and sorted into themes by using Nvivo software. Systematic analyses were carried out to identify patterns and commonalities and/or differences in experiences. Patton (2002) explains in detail this method of qualitative data analysis. Background data for health facilities and households and data on payments were analysed with Stata software, using descriptive methods such as graphs and cross tabulations. We triangulated data sources, e.g. responses from women and responses from maternal health workers, so as to identify similarities or divergences in their responses regarding issues of payment and what is considered ethical maternal care. We also triangulated quantitative data, e.g. on payments, with qualitative data to assess whether issues emerging from the qualitative interviews were consistent with the quantitative findings.

Ethical considerations

This study was undertaken with the approval of the National Health Research Ethics Review Committee. In undertaking primary data collection and analysing the findings, efforts were made to ensure anonymity and objectivity. Respondents were informed about the study's objectives, and their informed consent was obtained. Participants were assured of anonymity during the data analysis and in the presentation of the findings. Accordingly, data were coded to protect identities and ensure privacy.

Findings

3.1 Access to Ante-Natal Care

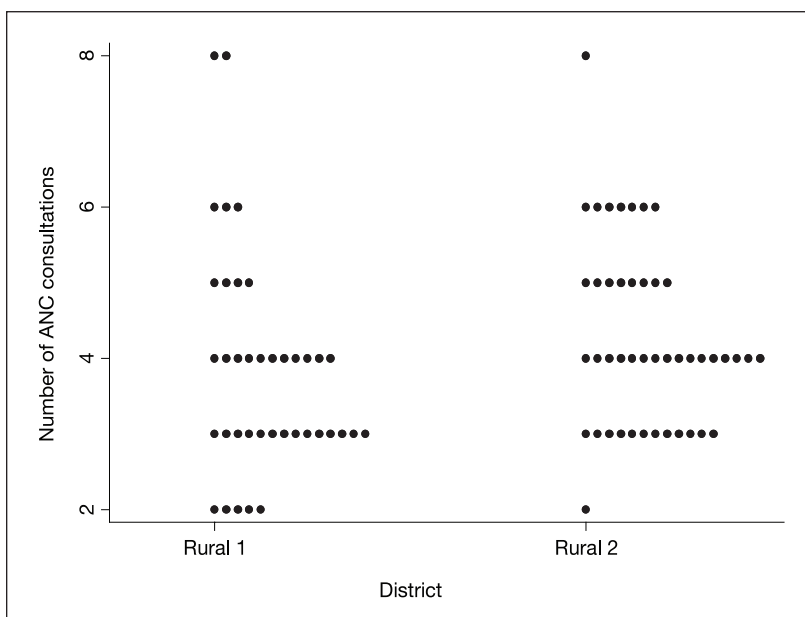
Recorded attendance at some ante-natal care visits was, as expected, almost universal among our interviewees. Of the 10 per cent (six women) in Rural 1 who had not received ANC for the most recent or current pregnancy, half had not yet started for the current pregnancy but intended to go. Of the others, two cited expenses, being unable to find the money, as a reason for non-attendance; one of these also said she had been ill. The third had been forbidden by her husband to attend, having been beaten on an earlier occasion when she had tried to go. The woman who had been ill elaborated as follows:

I have not visited a clinic for ante-natal care because I never got time to go and there is no one to take me to the facility. I depend on my husband to take me, but all the time he is fully involved in his income-generating activities. I cannot walk to the facility because it is far and I cannot ride a bicycle because I often suffer from pain in my waist. [103]

In Rural 2, 3 per cent (two women) had not yet been to ANC, and both intended to go.

Numbers of attendances varied substantially. In each district, the median and mean number of visits by those who had completed pregnancies was four; the number of visits varied between two and eight. In Rural 2, visits were slightly more numerous, and it was very unusual to go for two visits only (Figure 1).

Figure 1: Number of ANC visits during the most recent completed pregnancy, by rural district



3.2 Payments for Ante-Natal Care

Table 2 summarizes the total payments for ante-natal care recorded in interviews with women in all four districts who had received *some* ante-natal care. We discuss below the situation of women who did not receive care or who received inadequate care.

Of the women who had received some ante-natal care in Rural 1 and Rural 2, 41 per cent and 33 per cent, respectively, paid nothing. The payments in both rural districts were much lower than the payments in the two urban districts studied. The totals include all payments: those payments to facilities, and also transport costs and payments to private shops for items required for ANC and not available at the facility. These were all cash payments. The few very high payments in urban areas were for ante-natal emergencies.

Table 2: Total payments for ante-natal care by those receiving some care during their most recent pregnancy, by district (Tanzanian shillings)

District/ data	Urban 1	Rural 1	Urban 2	Rural 2	Total
Median	8,000	500	4,350	1,850	2,700
Mean	14,137	2,323	15,084	3,501	8,772
% zero	13.8%	41.1%	15.5%	33.3%	25.9%
Maximum	143,000	20,000	500,000	20,000	500,000
N	58	56	58	60	232

The distribution of the payments is skewed, as Figure 2 shows, with a minority of people in the rural areas paying quite substantial amounts.

Figure 2: Total payments for ante-natal care by those receiving some care during their most recent pregnancy, by rural district (Tanzanian shillings)

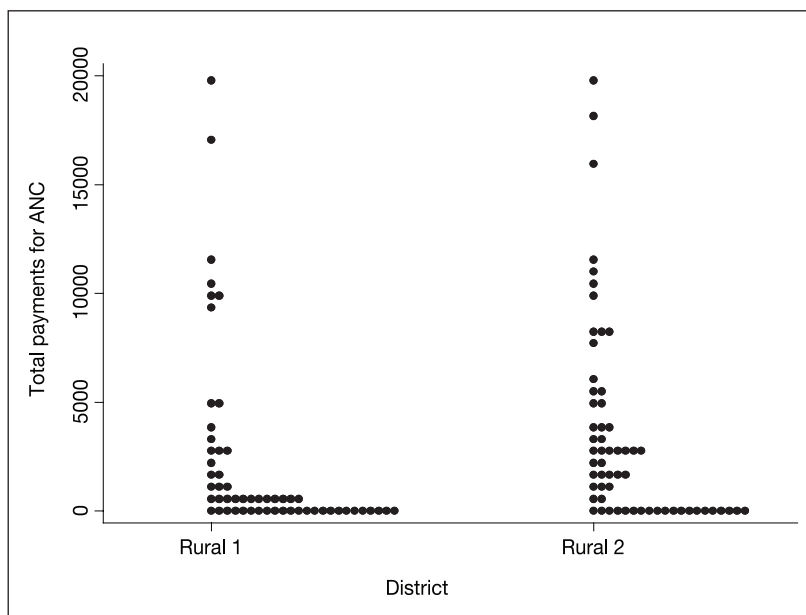


Table 3 presents the breakdown of these payments in the rural districts. The table shows that quite high percentages of women paid nothing for each item – over half, except for payments for tests and treatment in Rural 2. However, as Table 2 shows, a majority of women interviewed paid something in each district.

Transport and gifts and payments to staff were higher on average in Rural 1, and indeed cash payments to staff are recorded as zero in Rural 2. Otherwise, payments were higher in Rural 2 (the intervention district) than in Rural 1. An interesting question addressed below using the qualitative data is whether these lower payments in Rural 1 reflect access to more services for free – or rather reflect fewer services available to purchase, or an inferior level of purchasing power in Rural 1 than in Rural 2.

Table 3: Breakdown of payments for ante-natal care by those receiving some care during their most recent pregnancy, by rural district (Tanzanian shillings)

Item	Rural 1 (n=56)		Rural 2 (n=60)	
	Mean (Tshs)	% zero	Mean (Tshs)	% zero
Transport	1,386	79	267	97
Self-purchased supplies and medicines	91	89	438	82
Supplies and medicines bought at facility	75	91	754	75
Payments to facility staff or TBAs	68	100	0	100
Payments for tests and treatment	513	84	1,963	43
Gifts to staff and/or helpers	41	96	0	100
Other payments	132	80	78	88

Note: Items may not add to totals because of lack of a complete breakdown in a few cases.

3.3 Quality of Ante-Natal Care: Quantitative Analysis of Information from Women

In Tanzania, the basic, essential health-care package consists of an integrated collection of interventions that addresses the main diseases, injuries, and risk factors. The package extends to all health-care provision levels, including dispensaries. Dispensaries are expected to provide comprehensive primary health-care services, including, among others, the following: treatment of diseases, reproductive and child health (RCH) services and family planning, and immunization services to children and mothers (URT, 2003: p.10, p.20). Dispensaries are, therefore, supposed to be provided with essential drugs, reagents for basic diagnostic tests, and medical supplies and equipment required for dispensary-level services.

According to the national package of essential health interventions (URT, 2000), essential maternal care for a pregnant woman includes, among others, ante-natal, obstetric, and perinatal care; prevention and treatment of STDs, including HIV/AIDS; and any other gynaecological problems. At the dispensary level, health workers are supposed to provide all prenatal care, including risk assessments and follow-up on risky pregnancies; treatment of all existing diseases, e.g. STDs; provisions of supplements such as folate, irons, etc.; and tetanus toxoid immunization. Some of these services imply that dispensaries should be equipped to do basic diagnostic tests (Ibid: p. 23).

In this study the women interviewed were given a list of the key ANC services and then asked which ones they had received. This list was compiled with the assistance of the project's clinical advisers and reflects current standards. Responses show that women in Rural 2 stated that they had received a much larger percentage of those ANC services than women in Rural 1 (Table 4). Over 80 per cent of women interviewed in Rural 2 reported receiving each of the key services, with the exception of iron supplements and information on danger signs in pregnancy. In Rural 1, the

services reported were received by 75 per cent or below, with less than 40 per cent reporting blood test for syphilis or deworming.

Table 4: Percentages of women receiving some ante-natal care who reported receiving the listed items, by rural district

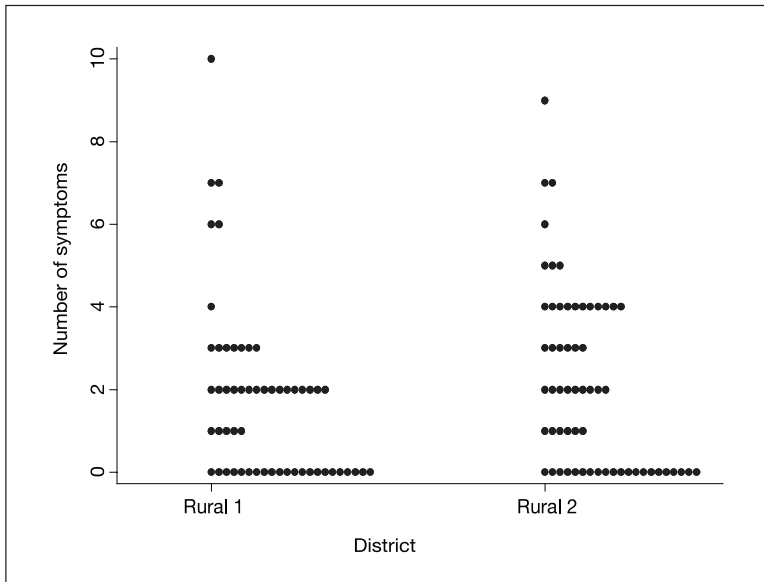
Service item	Rural 1 (n=56)	Rural 2 (n=60)
Information on danger signs and complications	62.5	65.0
Blood pressure measurement	60.7	91.7
Urine test	59.9	96.7
Blood test for anaemia	64.3	95.0
Blood test for syphilis	39.3	90.0
Iron/folate supplements	53.6	65.0
Malaria prevention medicines	62.5	83.3
Deworming	37.5	88.3
Anti-tetanus injection	64.3	85.0
HIV test	75.0	95.0

As shown in Table 4, over a third of women interviewed in each district said that they had not been given information about the danger symptoms of complications in pregnancy. Of those who had been given information, Table 5 shows the percentages of women who, without prompting, were able to mention different symptoms. Women were a little more informed in Rural 2 than Rural 1, but the difference was not great. Including all those who received some care, the median number of symptoms mentioned was two in each district, and very few women mentioned more than three in Rural 1 or more than four in Rural 2 (Figure 3). This finding matches other evidence: The 2010 TDHS shows that only about half (53%) of the women were informed of signs of pregnancy complications during an ANC visit.

Table 5: Percentages of those stating they had received some information about symptoms of complications in pregnancy who, without prompting, mentioned the following symptoms, by rural district

Symptom	Rural 1 (n=56)	Rural 2 (n=60)
Vaginal bleeding	65.7	79.5
Fever	34.3	51.3
Swollen face or hands	22.9	30.8
Tiredness or breathlessness	14.3	10.3
Headache or blurred vision	25.7	7.7
Convulsions	5.7	2.6
Gush of fluid from vagina	17.1	33.3
Severe abdominal pain	31.4	33.3
Foul smelling vaginal discharge	8.6	15.4
Reduced foetal movement	42.9	66.7

Figure 3: Total number of relevant symptoms of complications in pregnancy, as mentioned without prompting by those receiving some ante-natal care, by rural district



3.4 Quality of Ante-Natal Care: Quantitative Analysis of Information from Facilities

Interviews in facilities included questions concerning facility capability to provide maternity services, and also a survey of the availability of a set of tracer medicines and supplies on the day of the visit. In all public sector facilities, interviewees stated that they provided ANC services. The lower-level public facilities in these rural areas were operating in difficult conditions. Very few had running water in the facility: just four out of 12 facilities in Rural 1 and two out of eight in Rural 2. Half of the facilities in Rural 1 and three out of eight in Rural 2 had some form of electricity. In almost all, interviewees stated that they had a working refrigerator: the exception was a dispensary in Rural 1, which had no refrigerator and which, according to local women interviewed, was not in fact providing ANC services at all.

Table 6 shows the recorded availability of supplies and tests required for ANC in public hospitals, and in public and FBO health centres and dispensaries, in the two rural districts. The availability was markedly better in the public hospital in Rural 2 than in Rural 1 (Table 6). In the FBO hospital in each district, *all* of these supplies and tests were available at the time of the visit. In the public health centres and dispensaries, the low level of availability of soap, disinfectant, and gloves in Rural 1 was alarming in terms of infection control, and many other items were missing (see Table 6). Availability was better in the public health centres and dispensaries in Rural 2, but not complete. In the lower-level FBO facilities, only one of two facilities in Rural 1 which provided data had most supplies, while the availability of supplies in FBO facilities in Rural 2 was similar to that in the public sector.

Table 6: Availability of supplies and tests required for ANC: data from hospitals and lower-level facilities, public and FBO sectors.

Item	Public hospital (1=Yes; 0=No)		Public health centres/ dispensaries (% Yes)		FBO health centres/ dispensaries (1= Yes) (% Yes)	
	Rural 1 n=12	Rural 2	Rural 1 n=12	Rural 2 n=8	Rural 1 n=1*	Rural 2 n=4
Soap	1	1	42	75	1	100
Clean latex or sterile gloves	0	1	42	100	1	75
Disinfectant	0	1	67	100	1	100
Blood pressure equipment	1	1	83	100	1	100
Foetoscope	1	1	92	100	1	100
Iron tablets	0	1	33	50	1	75
Folic acid tablets	1	1	83	88	1	50
Tetanus toxoid vaccine	1	1	67	100	1	100
Oral antibiotic: amoxicillin, ampicillin, or cotrimoxazole	0	1	75	100	1	100
Anti-malarial	0	1	67	88	1	100
Albendazole or mebendazole	0	1	83	100	1	50
Methyldopa (Aldomet)	0	1	8	13	1	25
Metronidazole or tinidazole	0	1	58	38	1	100
Doxycycline, tetracycline, or erythromycin	0	1	75	100	0	50
Penicillin (oral or injectable)	0	1	92	100	1	75
Nystatin, miconazole, or clotrimazole cream or suppository	0	0	33	50	1	75
Vitamin A tablets	0	1	83	88	1	75
Laboratory capacity to test for anaemia	1	1	33	50	1	75
Laboratory capacity to test for urine protein	1	0	25	50	1	50
Laboratory capacity to test for urine glucose	1	0	17	50	1	25
Laboratory capacity to test for HIV	1	1	92	100	1	100
Average % of items (max=21)	43%	86%			95%	

* Note: Data for one FBO dispensary are missing.

3.5 Interaction between Payments and Quality: Evidence from the Interviews

In this section we bring together information from the interviews with women and with facility staff for a small number of facilities in each district, to explore the reasons for payment for ante-natal care, and the impact of payment, in each district. We look at the hospitals – one public, one FBO-owned and -run – in each rural district, and also several of the lower level facilities in each district. We are seeking to answer the research questions identified above from the quantitative evidence:

- What are the reasons for the higher recorded payments for ante-natal care in Rural 2 as compared to Rural 1?

- Are those higher payments associated with higher levels of care, and if so, why and how?

3.5.1 Choice of facility for ANC

We address this question by comparing the women’s reports on payments for ANC and its link to the quality of care received between the two districts. Most ANC, as expected, was sought at the dispensary and health-centre level, although in one area of Rural 1 an FBO hospital was providing ante-natal care to many local residents (Table 7).

Table 7: Type of facility where ANC care was sought (%), by rural district: data from interviews with women

Facility level and sector	Rural 1	Rural 2
Public dispensary	31	39
Public health centre	35	5
Public hospital	2	8
FBOdispensary		36
FBOhospital	32	9
Private dispensary		3
Total	100%	100%

The varying pattern of use of public and FBO facilities between the two districts was largely determined by distance, with women generally attending the facility closest to their home. This emphasis on the nearest facility was reinforced by the difficulty of travelling and high costs of travel if required in Rural 2, which is remote. As a result, women had spent virtually no money on transport for ANC in Rural 2 (Table 3), going instead to the nearest facility by foot or by bicycle. The following are typical comments by the women:

I went to [a public dispensary] for pregnancy services because it is near home, and I walked on foot. It is also the only dispensary in our ward. [Rural 2:211]

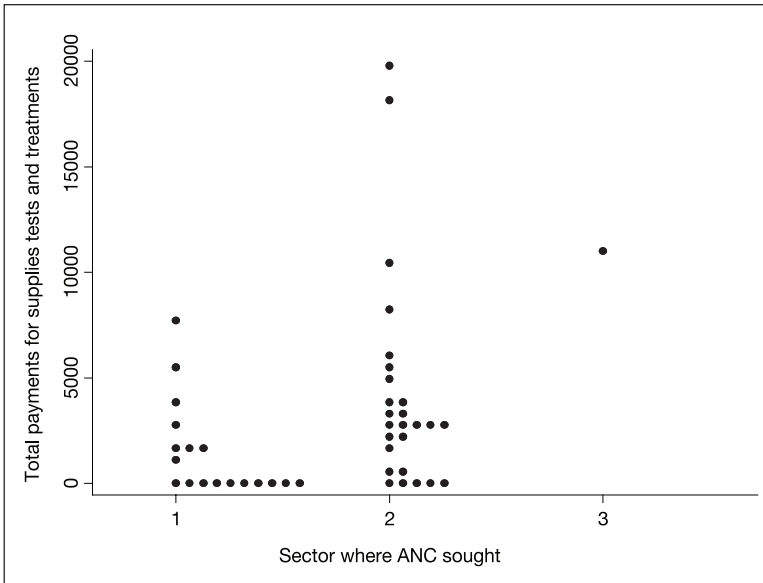
My husband carried me on his bicycle to the facility. [Rural 1:100]

In both districts the main reason for paying for transport to ANC had been the need to go to a more distant facility, health centre, or hospital for tests or treatments unavailable in the local dispensary. When supplies and capabilities were missing in local dispensaries, women thus had a choice between paying for transport or not receiving some of the essential tests and treatments such as those listed in Table 5. In these circumstances, transport costs became a barrier to treatment for some women.

Furthermore, in both districts, but more frequently in Rural 2, women recounted that, were they to choose to go to the hospital for ANC, they would be sent back to the dispensary level. Only those living very close by went unchallenged to ante-natal care at most of the hospitals; others were sent back to dispensary level. This pressure to go to the local dispensary and to no other facility appeared to be much stronger in Rural 2 than in Rural 1. The following was quite a typical comment in Rural 2, in the most remote part of the district:

I went to [a public dispensary] for my ANC services because there was a boundary for accessing ANC in our Ward. For example, my village was supposed to access ANC at [a public dispensary] unless referred to [the FBO hospital]. I started to go to [the FBO

Figure 5: Distribution of payments for supplies, tests, and treatments during ANC, by sector: Rural 2



Note: Sector 1=Public; Sector 2=FBO; Sector 3=Private

3.5.2 Payments and quality in the public sector: Rural 1 district

In Rural 1, women reported fewer charges made by public dispensaries and health centres than in Rural 2. In Rural 1 a common experience was for a woman to go to her local public dispensary, find that many tests and treatments were not available there, and either be sent on to a more distant health centre or stay without the treatments. The following were some typical statements; they refer to three different public dispensaries in the Rural 1 district:

I only managed to get two types of ANC service : information on danger signs and symptoms of pregnancy complications and a check-up for blood pressure at [public dispensary 1]. For other tests and services, I was told to go to [public health centre 1], so I went there and managed to get other services, and the services at [public health centre 1] were also free of charge. [Rural 1: 75]

Women from this local area had spent around Tshs 3,000 – Tshs 5,000 in transport to get to the health centre. No one recorded payments for services at this health centre. In some cases, women from public dispensary 1 were not referred to the health centre – or did not go – so they paid nothing, but as a result received limited service:

I did not make any payments [in public dispensary 1]....It is not a good service, because I did not get medicine and blood test for syphilis, HIV, and anaemia. Their services are very poor; we are just going there because there is no alternative. [Rural 1: 76]

I did not make any out-of-pocket paymentsThe matron is harsh, but the rest are not. So many services like blood test for syphilis, malaria prevention medicines, deworming, HIV test, urine test, information on danger signs and symptoms of pregnancy,

just to mention a few, were not available in the facility, apart from checking my weight and anti-tetanus injection, which were provided. [Rural 1: 77]

One woman commented that the services at public dispensary 1 had deteriorated when staff had changed. There was discussion about why the services were so poor, with some women feeling that they were silenced if they complained:

I do not know why they did not provide those other services[at public dispensary 1]Other pregnant women were there, but no one received medicine; even buying them [medicine] is not possible since they have never prescribed any medicine....They are so rude and they do not care. [Rural 1:79]

I do not know why there are no supplies They usually do not do tests, and when you ask they will abuse you and tell you “you think you know a lot about tests” so you have to keep quietNurses are few, so we are given services by a TBA who is not as expert as a nurse. [Rural 1: 81]

One person was more willing to apportion blame elsewhere, as follows, but in general noone was happy with this dispensary:

Actually they are trying to offer a good service ... because in rural areas we do not know why the services are unavailable, but I do not think unavailability is their mistake. They are not responsible for buying medicines but simply for reporting to the authority to ensure availability, but for me I think they are trying to provide what is available. [Rural 1: 78]

In an area near a different public dispensary, there was a similar experience:

The service is not good in [public dispensary 2], simply because the facility lacks important services, including the blood and HIV test services. We are tired of being referred to [health centre 1] every time, although I was given malaria drugs, deworming, and folic acid in the dispensary. [Rural 1: 69]

Those who relied on public dispensary 2 agreed that although the staff was good and did not ask for payment, many services were unavailable. Unlike public dispensary 1, this dispensary often sent women to purchase items in the private sector:

I was not investigated for syphilis, urine infection or anaemia, or HIV. Due to my ignorance, I did not ask why the investigations were not carried out. But I was given medicines for preventing malaria (SP), anti-worm tablets, [medicines for] preventing anaemia, and [a] tetanus vaccination. I bought gloves for Tshs 2,000 from the pharmacy. [Rural 1: 66]

More payments made to the private sector were recorded by women who went to a second public health centre. Some women had paid nothing and received few services, although several said health workers were polite. Others had been sent to the private sector:

I received ANC care, but I did not receive some of the services you have mentioned to me. I did not ask because I did not know that it is necessary to be given those services

such as malaria prevention medicines, blood test for syphilis, deworming, iron/folate supplements for blood, and information on danger signs and symptoms for pregnancy complications. [Rural 1: 96]

You know, the last time I thought the attendants were too occupied, but later I realized that most of these services were not available in [public health centre 2], and we were even sometimes told to get them in private health facilities or a pharmacy. For my 2009 pregnancy, service was at least encouraging I got a blood test, a urine test, malaria drugs, anti-tetanus injections, and was weighed, but the 2011 pregnancy was full of suffering because the services were unavailable; I did not get any service apart from being weighed and check-up for pregnancy. [Rural 1: 100]

I was told to go and buy medicine in the pharmacy where I bought Ferrous (two times), Folic Acid (once), SP (twice), totalling Tshs 1,300. I did not get any other service apart from being instructed to go and buy these medicines. The nurse directed me to Mama ... shop, which is nearby the facility to buy the medicine. [Rural 1: 101]

One woman had paid Tshs 1,000 for a “hospital card”. One had been asked to pay for gloves:

When I arrived they told me ... I should pay Tshs 1,000/= for a pair of gloves to be used during drawing of blood for HIV testing. I did not know of this payment and therefore could not undergo the test. I will do the testing during my next visit and I will have Tshs 1,000/=. [Rural 1:97]

One woman attributed her better experience at health centre 2 to her membership of the Community Health Fund (CHF); however ANC should be free, according to the rules, whether or not women are members. Hence, this suggests some local confusion concerning the scope of CHF insurance.

I have insurance that covers ante-natal care (CHF), which we normally pay 10,000/= yearly for the card of CHF.... I used my insurance card that covers ante-natal care. The service was not bad; it was good. They received me and attended me, and the supplies were available. [Rural 1: 91]

A couple of women, dissatisfied with the services in health centre 2, had gone instead to the district public hospital. One felt she had been given insufficient information at the health centre, so she went to the hospital, and another said:

I was examined [at health centre 2], and some tests were done, but other tests were not available, so I went to [the district hospital] for urine and stool tests. I had UTI, and I paid Tshs 500 for the test. I was given some tablets. [Rural 1: 99]

Many women were thus selecting their ANC location according to the services available; the public hospital was charging for tests. One public dispensary studied was not providing ANC services at all, requiring women to go to a rural FBO hospital for treatment:

I went at [the FBO hospital] for ANC care because they do not offer it at our dispensary (public dispensary 3). [Rural 2:107]

3.5.3 Charging and quality in an FBO hospital in Rural 1

Our interviewees in Rural 1 included a number of people who went to just one FBO facility, an FBO hospital in a quite remote area. This hospital's charging practices diverged sharply from those of the FBO facilities in Rural 2 described below. The interviews with women who went to ANC at this hospital are strikingly consistent in their reports on quality and charging.

A number of women had gone to this hospital because their local public dispensary was not providing ANC services at all. Some had to make substantial transport payments to get to the hospital and wished they could get the services closer to home. But the comments on the hospital services were consistently positive, while all agreed that the payments levied were low. Here are some examples demonstrating the consistency of response.

I paid 200/= for tests (blood test) and Tshs 500/= for a mosquito net, but I did not make any other out of pocket payments....My husband gave the money to me because he knows that we are required to go with Tshs 200/= in every attendance. [Rural 1: 106]

They offer good services. I received most of the services including checking BP, urine tests, blood test for anaemia, blood test for syphilis, iron/folate supplements SP (malaria medicine), and the HIV testing, which was free of charge. I just paid Tshs200/= for those. [Rural 1: 108]

And this is an example of the positive comments:

The staff are humane, ... the way they treated me was from the heart. [Rural 1: 107]

3.5.4 Payments and quality in the public sector: Rural 2 district

In Rural 2, women who went to a public dispensary in the less remote part of the district reported generally good experiences of staff but few available services:

I can say that the services were good. The nurses were always available and they could be reached easily. ...if anyone sought their assistance on weekends, they were always there to respond and assist. [Rural 2: 236]

As in Rural 1, many services required a trip to a health centre; a bicycle was a common means of transport.

There are some services that I did not get at all, e.g. information on the danger signs of pregnancy, and I did not know why....For other tests –HIV, urine, stool, HB, and syphilis – I had to get them done at [health centre 1] because they were not available and also they said they did not have an expert for blood tests at the dispensary, and even the machine for blood test was not available. [Rural 2: 239]

This respondent was found to have syphilis and paid Tshs 1,500 for syringes in order to be treated, financed by selling part of a bean harvest.

Otherwise, in both this dispensary and the health centre, women generally reported receiving services that were available for free, but missed a number of services.

I did not spend any money during my ANC care visits, neither for medicine nor for the tests. [Rural 2:240]

I did not receive [in public dispensary 1] any information on the danger signs of pregnancy. They said folic acid was not available at that time, and also I did not receive anti-tetanus injection and they did not give a reason....I only got the HIV test and HB test, but I had to seek other services from [health centre 1], for example urine test and stool.... I have not made any payment until now when my pregnancy is 9 months old. [Rural 2: 241]

I only incurred costs for transport during my pregnancy, to and from [health centre 1], 10,000 shillings by motorcycle because it is far from home. [Rural 2: 243]

One woman had been sent away from health centre 1 because “they said they had no clean water” on the day she went; she was sent on to an FBO health centre that charged (see below).

In this part of Rural 2, the district hospital was also providing ANC, and there women had paid more.

I received all services including all tests, medicines, and education on pregnancy....

I went to the hospital laboratory for tests so the nurse who was on duty in the laboratory asked me to payTshs 3,000/= for the services. [Rural 2: 188]

One woman stated that her treatment was covered by insurance; her insurance had been charged for some of her tests.

Folic acid supplements, they told me that they were not available, so I had to buy them. I bought them from the pharmacy for Tshs 2,500. For clinic cards we pay for Tshs 1,000/= when we start going to the clinic, but for tests and treatment they told me to pay Tshs 12,500. But some of the payments, e.g. for tests and treatment, were covered by health insurance....So when I go to the clinic, payments are covered by insurance and they give me a form which shows the costs which are being covered. However, the medicines are usually not available, so I have to buy them myself at the pharmacy. [Rural 2: 190]

It thus appears that this public hospital is charging some insurance funds for ANC services.

One woman had a very positive experience of this hospital; she also had an explanation:

For sure I received all services All of them were good to me but I think it's because of my brother ... who is a surgeonHe was telling his fellow doctors and nurses that I am his relative so they should take a good care of me. [Rural 2:197]

In a more remote part of the Rural 2 district, a third public dispensary appeared to have an arrangement whereby patients were directed to buy tests and treatments in a nearby shop. One currently pregnant woman said:

They told me that those services were not available at the dispensary, so I should get them done in a private facility and bring back the results to continue with the ANC. Every test that was supposed to be done was written in the card, e.g. malaria test, syphilis,

stool, and urine. I went to have the tests done but I did only the test for urine since I did not have enough money to undertake all of them.... I went on foot to where the services are provided, and the urine test was done for Tshs 2,000/=, and I bought a clinic card by Tshs 500/= at the dispensary. [Rural 2: 210]

Another offered a more detailed explanation of the situation, from a pregnancy in 2009:

In my ANC I got some services at [public dispensary 3], but all tests and check-up services were not available at this dispensary. So we were directed to... the nearby private pharmacy which belongs to one of the nurses working in this dispensary. The following services were not offered to me: information on danger signs and symptoms of pregnancy complications, iron/folic acid supplements, malaria prevention medicines, and deworming. I did not know why ... and I could not ask because that was my first pregnancy; I did not know the kind of services I was supposed to get. [Rural 2: 216]

A third woman told a similar story for a 2011 pregnancy:

Services are not good because tests are not available. When we go there we have to contribute Tshs 500/= for every test so that we can get clinic cards which are sold at... dispensary [a private dispensary/drug shop, not visited for this study]. For tests they tell us we have to go to this dispensary to take these tests, and if you don't go to ... laboratory, they send you back and they tell you "go and get those maternal services where you have taken the tests". Even medicine, you have to go buy them at ..., dispensary, since the nurse named Mama ... who works at the [public dispensary 3], her husband is the owner of ... dispensary. [Rural 2: 223]

This kind of experience was repeated. Another woman had spent Tshs 3600 on tests in a "private pharmacy", plus Tshs 300 given to the nurse for a card. Another had paid Tshs 1,600. Reported prices for tests varied between Tshs 300 and 500. Several women, instead of going to the private facility when services were unavailable at the dispensary, had gone instead to an FBO hospital, where the charges were even higher (see below).

Just two women interviewed had paid nothing at this dispensary while receiving ANC services, one for a pregnancy in 2009 and one in 2010. Both attributed this to their membership of a CHF. This statement refers to the 2010 pregnancy.

Services are good; they provided all the tests; also they allow CHF, which we use to cover all the services. CHF costs Tshs 5,000 for a year. If you have insurance you receive good service. Also at the dispensary they have all the supplies needed so there is no hassle when you arrive there. [Rural 2: 213]

As noted above, in principle this insurance should not be relevant; the evidence suggests those not in the CHF are being refused free services.

3.5.5 Charging and quality in FBO facilities in Rural 2

In the remote part of the Rural 2 district, where the public dispensary just discussed was located, there was also an FBO hospital providing ANC services. This hospital also levied quite substantial charges for ANC. One of the women who went to the hospital from public dispensary 3 said:

I have used a total of Tshs 8,500/= All tests are done at [the FBO hospital] because such services are not available at [public dispensary 3]. I was asked to pay Tshs 1,500/= for registration and Tshs 6,500/= as payment for tests and medicines I also bought a card for Tshs 500/=. [Rural 2: 217]

From an earlier pregnancy in 2007, another woman had paid

... a total of Tshs 1,600/= for all tests; each test was Tshs 400/=. The HIV test was free....Money for this medical test was difficult to get, so we decided to sell part of our harvest, and that crop was paddy; my husband is the one who sold the paddy. [Rural 2: 227]

There were complaints about the quality of service, and payments recorded were high enough to require sale of food crops.

I was not taught about the danger signs of pregnancy, and I did not know who to ask. I bought medicine during ANC in the pharmacy for Tshs 1,000/=; then I paid Tshs 2,000/= for all tests plus buying a clinical card from the nurse who came for outreach for Tshs 500/=. ...I sold my paddy to cover the costs from the family savings. [Rural 2: 218]

The payments appeared to be rather erratic:

I paid for some tests and services while others were freely provided, e.g. I paid for the urine test and stool, but the blood tests were free. So I paid Tshs 1,200/= only for tests, and also I bought drugs for Tshs 500/=. [Rural 2: 219]

One woman argued of this hospital:

Getting pregnancy services is full of corruption in order to get the best and quality health treatment or service that is required. [Rural 2: 220]

One woman felt she had been well treated, but in general there was a low level of expressed satisfaction.

In the less remote area of this district there were two FBO dispensaries that were attended by a number of our interviewees. Both also levied quite substantial charges. The woman (above) who was sent away from the public health centre had gone to FBO health centre 1 and said:

They gave me all tests, and they told me I had to pay 4,000 shillings. Iron supplement which they gave me cost 1,000 shillings, together with deworming drugs which I bought for 300 shillings for a single dose. Transport cost ... 2,000 shillings. [Rural 2:246]

The following was a description of payments for ANC in 2009:

When I arrived for the first time for ANC visit they told me I have to pay 7,000 Tshs as payments for all tests. Iron supplements for blood, they cost 2,000 Tshs for the first dose, and the second dose which I took the last week of pregnancy, they cost 2,000 Tshs; deworming drugs cost 1,000 Tshs and anti-malaria drugs cost 2,000. [Rural 2:231]

This interviewee had been sent to public health centre 1 for the HIV test, which the FBO dispensary could not provide, but she had not gone because of the distance, thus missing the test.

The following quote concerns a 2011 pregnancy:

I paid 4,000/= to cover the costs for tests and a clinical card.... The service is good because it is easily accessed, but the problem comes with the payment, which means that you cannot get it until you have cash to buy it. [Rural 2: 228]

All those interviewed who had been to ANC at this facility, from 2007 to a current pregnancy, had paid several thousand shillings; the amount varied by interviewee, but everyone paid something. On the whole, there was agreement that the services for these payments were good. Here are further examples; the first concerns a current pregnancy at the time of interview:

When you attend ANC for the first time you have to pay 4,000 Tshs ... for the clinic card and all tests. When you go back for each ANC visit, every test you receive cost 500 Tshs, and I had a blood test two times, so I paid 1,000; anti-malaria drugs one dose cost Tshs1,500, iron/folic acid supplements one dose cost Tshs1,200. [Rural 2: 232]

Similar payments are mentioned from earlier pregnancies. The following refers to 2008

When you go for ANC for the first time you have to pay 5,000 Tshs as payments for all tests and medicine. [Rural 2: 233]

This was 2007:

I paid a total of Tshs 6,000 for all tests, a check-up, and medicines. I cannot remember the cost of each, but I only remember that the test of blood urine and stool was charged Tshs 200 per each test. [Rural 2: 237]

And finally, this refers to a 2010 pregnancy:

I paid a total of Tshs 3,000 for the blood test, stool test, urine test, SP for malaria prevention, iron supplements, and without forgetting the ANC card....This payment is essential because the health facility is a private facility. [Note: in fact it is an FBO facility.] Generally speaking the ANC I got was good. I was given a good welcome, tested; we were not abused or anything bad. [Rural 2: 238]

The second FBO dispensary in the less remote area charged similarly for ANC. One woman said she had received ANC services without payment in 2010; otherwise everyone had paid. The following refers to a 2011 pregnancy:

I paid for a clinic card Tshs 1,000/=; I also did blood test, urine, stool and syphilis tests giving a total amount of Tshs 3,500/=. I went to the shop to buy indocid for Tshs 1,500/=:, half a dose since I had back pains and the tablets were not available in the dispensary. [Rural 2: 189]

One woman was paying this FBO dispensary for ANC for a current pregnancy via insurance – presumably the National Health Insurance Fund (NHIF). This fund is used to pay for medical

treatment, which can include treatment in an FBO-owned facility, and here it is being used for ante-natal care:

Folic acid supplements, they told me that they were not available, so I had to buy them. I bought them from the pharmacy for Tshs 2,500/=; clinic cards, we pay Tshs1,000/= when we start going to the clinic, but tests and treatments, they told me to pay Tshs 12,500/=. But some of the payments, like those for tests and treatment, were covered by health insurance.... So when I went to the clinic ...they gave me a form which showed the cost to be paid. But for the medicines not available at the dispensary, I had to buy them with my own funds at the pharmacy. [Rural 2: 190]

The following payments were made in 2011:

I paid Tshs 3,500/= to [FBO dispensary 1] for the tests I was asked to undertake – blood, urine, stool test, and malaria. I had to buy the card from [the public hospital] at Tshs 200/= because there were no cards at [the dispensary] ... I struggled to get the amount. I sold local brew at home. [Rural 2: 193]

These payments are echoed in a 2008 experience:

I paid for every test for Tshs 300/=, but an HIV test was not provided at the dispensary, so we went to take a test at the district hospital and the test was provided for free. Malaria prevention drugs and deworming, we paid Tshs 2,250/=; Malaria prevention drugs, we paid Tshs 1,500/=, and de-worming cost Tshs 750/=. But iron/folate supplements for blood were provided for free. [Rural 2: 199]

These are 2011 payments:

I was given SP for prevention of malaria, and I was told to pay Tshs 600/=, and this money was paid to a nurse. [Rural 2:204]

Finally, this account refers to 2010:

At the mission [FBO dispensary 2], I pay for all the services except for the HIV test. Payment for all tests was Tshs 3,000/= I think I receive good service. At the mission hospital [FBO dispensary 2], they provide good care, unlike other hospitals. Maybe it's because we pay for them, and they have enough supplies. [Rural 2: 191]



Discussion

The difference in payments observed between the two districts seems to reflect a number of factors. These factors are not necessarily district wide – we did not sample in a manner that can be generalised. Rather, they reflect different kinds of charging practices that had emerged in different parts of the two districts and some of the consequences of these practices.

In Rural 1, in the areas surveyed, women were paying little, in both FBO and public sectors. In the FBO hospital – the only well-functioning FBO facility visited in this district – the relatively cheap services were associated with good experienced quality ante-natal care.

In the public sector in Rural 1, by contrast, charging was limited, but the extent to which services were available was erratic. A few women were sent to buy items at private shops, but this was not widespread. Rather, if services were not available, women went without. However, a public dispensary in Rural 2 illustrated a different pattern: A nurse appeared to have gone into business, supplying (for profit) the tests and treatments that should have been available for free. This pattern was also visible to a smaller extent in a health centre in Rural 1. Furthermore, we have more interviews concerning the ANC services at the public hospital in Rural 2, which was charging for its services.

The level of charges reported in Rural 2 for the facilities doing the charging – the public hospital, the public dispensary that had apparently gone into business on its own account, and the FBO facilities – are strikingly higher than in Rural 1. The FBO hospital in particular appeared to be charging substantial sums. As the interviews indicate, a local culture of charging had developed, where the charges were consistently higher than those reported in Rural 1 for the FBO hospital or any of the public facilities. For these payments, the women interviewed had received somewhat higher levels of service than women in Rural 1, with the striking exception of the FBO hospital in Rural 1 that was succeeding in combining low and predictable charges with good services.

An interesting question that arises from the data is the role of insurance in creating or supporting a culture of charging for ANC. We have examples where public facilities seem to have developed a practice of charging those *not* in a Community Health Fund, and an example of an FBO hospital charging (presumably) the NHIF for ANC services at quite a high rate. It does seem from this that insurance was being used in a way that was associated with perverse outcomes, such as higher charges for women without insurance for services that are supposed to be provided free to begin with.

In general, higher payments seem to be associated with better quality care, but women were finding the payments hard to find. In Rural 2 there is some evidence that the public sector is some what better supplied than in Rural 1. There have been interventions in this district to improve care, which may be contributing to better quality care. Some of the interventions, e.g. those by Ifakara Health Institute (IHI), are intended to, among other things, improve the quality of health care at public health facilities through training and improved supervision.

In both districts, we found few reports of abuse at the ANC level – abuse appears to be a greater problem during childbirth. The main quality issues at ANC level are lack of basic ANC services in some of the public health facilities and having to pay for ANC even in some of the public facilities where they are supposed to be provided for free. However, the problem of supply shortages seems to create opportunities and incentives for a system of informal charging, as evidenced by payments

made to staff in Rural 1. Furthermore, having to pay for transport to go to a more distant health facility for tests and treatments that were not available at nearby dispensaries increased the financial burden for women seeking ANC, if they found the funds to travel, or otherwise formed a barrier to accessing quality ANC. The fact that missing essential tests and treatments might be a cause of fatal outcomes to both a pregnant woman and the unborn child cannot be over-emphasized.

5

Conclusion

Quality ANC accessible to all women is a key requirement for improved maternal survival. As one of the four pillars of safe motherhood (WHO, 1994), ante-natal care plays a pivotal role in reducing maternal deaths and morbidity. The evidence provided in this study regarding the lack of essential supplements and tests, along with having to pay for this supposedly free service, identifies constraints on efforts to reduce maternal mortality. The fact that this study's findings are similar to a study conducted about 15 years earlier in a different region of Tanzania (Eseko 1998)¹ should indeed raise great concern, and calls into question the effectiveness of various interventions that over the years have been put in place to improve maternal health care.

As the present findings indicate, there is still a long way to go in improving the quality of ante-natal care. There is need for a more concerted effort to implement effectively the strategies that are already in place and to devise alternative strategies that may result into better outcomes. Such strategies should not be considered in isolation, but should be part of effective strategies to improve all aspects of maternal health.

Furthermore, an emerging problem that is likely to adversely affect ANC attendance rates needs prompt action. The evidence above suggests that health insurance, which is intended to promote access to health care by the poor, is creating a contrary effect by exacerbating the problem of payments for services that are officially exempted from payment. This needs to be looked into, and appropriate action taken to avert this emerging problem.

¹ In this earlier study, of the women interviewed, blood pressure was never measured in 24% of them, 61% never had their urine tested, while blood was never examined in 55%, and 71% never had any health education at the clinic.

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Brief 5	Children Participating in Research	LGR 6	Low awareness amongst citizens of local government reforms
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		LGR 1	About the Local Government Reform Project

