1 Preventing Obstetric Fistula:
Antenatal Care, Birth Preparedness and Family Planning

High quality antenatal care (ANC) is fundamental to protect the health of women during pregnancy and childbirth. Regular ANC visits offer critical opportunities for women to receive information and counseling on pregnancy, labor and deliver. Some serious problems that individual women may face during birth – such as malposition of the baby, signs of eclampsia, and chances of early labor – can be detected and preparations made to ensure safe delivery at an appropriate health care facility. As a result, the risks of maternal and infant death and injury, including obstetric fistula, can be decreased.

ANC visits are also an important opportunity for health workers to talk with women about danger signs in labor and delivery, and emergencies which require urgent care. Proper counseling can encourage women and their families to arrange sufficient financial and other resources for the delivery, including transportation in case of emergency. Lastly, knowledge of, and access to, family planning methods are also vitally important to improve maternal and infant health outcomes. Delaying early pregnancies, extending the space in time between successive births, and choosing to limit the total number of pregnancies all contribute to reduce maternal and infant mortality and morbidity [1].

This policy brief is based on the study Risk and Resilience: Obstetric Fistula in Tanzania by the Women's Dignity Project and EngenderHealth, in collaboration with Health Action Promotion Association, Kivulini Women's Rights Organization, and Peramiho Mission Hospital. The study included 61 Tanzanian women with obstetric fistula, members of their families and communities, and local health care providers. This brief, the first in a series of four thematic briefs developed from the study, describes the women's experiences of antenatal care during the pregnancies that led to fistula, what steps were taken by the women and their families to prepare for birth, and whether family planning methods were known and/or utilized.

STUDY FINDINGS[1]

Quality of Antenatal Care

Nearly all of the women in the study had attended ANC at least twice, but findings show that services were inadequate and inconsistent. Moreover, the services received varied significantly by individual. About half of the women were weighed, but fewer than half had their height measured or were given some type of medicine. Only two women reported that they were given medication for malaria. No hemoglobin tests, urine analysis, or blood grouping were reported.

The story of one woman who accessed fistula care at Bugando Medical Centre illustrates a typical ANC experience. She reported that during her first and second visits, her abdomen was examined, she was given an inoculation, and her height was measured. During her fourth and fifth visits, her abdomen was examined and her height was measured, but she received no other type of care.

Quality of Care Experienced, Compared to National Guidelines

The ANC services received by women in the study differed greatly from the Ministry of Health guidelines (See Table 1 overleaf.) According to guidelines issued by the Tanzania Ministry of Health, a woman should have at least four focused antenatal care visits during her pregnancy [2]. A woman's first visit should be at week 16, the second visit should take place between weeks 20 and 28, and the third and fourth visits should be scheduled between week 28 and the time of delivery. Table 1 presents an overview of recommended antenatal services to be performed at each of the four visits.

The following descriptive indicators with associated percentages of respondents (in brackets) are used to report findings: Nearly All (80-90% of respondents); The Majority (more than 50%); About Half (around 50%); Fewer than Half (25-45%); A Minority (10-25%); and A Few (less than 10%).

Table 1: Services to be Provided at Each Antenatal Care Visit

Recommended Antenatal Services Visit	1	2	3	4
Take history of the health of the woman	X			
Do physical examination, checking the woman from head to toe	X	X	X	X
Check her hemoglobin and provide iron supplements	X	X	X	X
Check her blood group	X			
Screen the woman for syphilis	X			
Screen for HIV/VCT for HIV	X	X	X	X
Give tetanus toxoid vaccine	X	X *	X **	
Check her blood pressure and urine	X	X	X	X
Counsel the woman and provide health education	X	X	X	X
Ensure the woman has an individualized birth plan	X	X	X	X
Listen for the fetal heartbeat, position and presentation of the baby		X	X	X
Provide a dose of anti-malaria medicine		X	X	
Inform her about pregnancy, labor, and delivery danger signs		X	X	X

* If not done at the first visit.
** This would be the second dose and should be four weeks after the first dose
Source: United Republic of Tanzania. Ministry of Health. Orientation Package for Service Providers. (RCH/NMCP) JHPIEGO. October 2004.

Knowledge of pregnancy and labor

None of the women participating in the study had a discussion related to pregnancy or labor and/or delivery during ANC visits, except that in a few cases, the woman was simply told to deliver in a facility. One woman was told during a routine health education session to deliver at a hospital; another was advised to deliver at a hospital because of her age. A third respondent said that she attended ANC clinics regularly, but when she asked clinic staff why she was one month past her delivery date, they were unable to explain why. As a result, the woman decided to deliver at home.

All the women who mentioned having any knowledge about pregnancy, labor, and delivery had gained this knowledge from previous experience of pregnancy. A few women also indicated being taught during traditional rites of passage, or learning from friends or relatives. One respondent from Ukerewe remarked, "I didn't know much about pregnancy because I was too young, but my sister-in-law explained to me what labor was like." Another woman from Songea explained that she did not know she was pregnant until a friend of hers commented, "You look so beautiful and your skin is so smooth, you might be pregnant. You need to go for a check up at the hospital to be sure." (*Woman from Songea, age 20*)

Decision-making and access to antenatal care

Of the women who indicated how decisions were made to attend ANC, fewer than half said they decided by themselves to go for ANC. For these women, their decisions were largely influenced by having seen other women go to ANC, or because their friends had encouraged them to attend. Of the remaining women, fewer than half went to ANC because a family member – parents, husbands or in-laws – had decided that they should go, while a few decided jointly with their husbands.

One adolescent girl, aged 15, said she had no power to decide to attend the clinic. Another respondent only decided to attend ANC when she was seven months pregnant. Her mother-in-law had told her that pregnancy was not a disease; therefore, there was no need for her to seek services. However, her father- in-law intervened and told her that she "should attend clinic because it was important to have regular check-ups." (*Woman from Ukerewe, age 23*)

For the women who did not attend ANC, distance to health facilities was cited as the most common barrier to access. One woman from Ukerewe explained that she never attended ANC because it was far away, and that she had never gone to the clinic during all of her previous pregnancies.

Birth preparedness

The majority of women planned to deliver at a health facility of some type, although the specific type of facility (e.g., hospital, health center, or dispensary) was not always clearly defined by respondents. In the end, most of these women started at a lower level health facility, with a traditional birth attendant (TBA) at home, or went to the hospital too late after trying to deliver at home. About half of the women who

had planned to deliver at a facility had set aside some funds for labor, delivery, post-delivery and/or transport. However, among all the women with fistula, fewer than half had set aside funds for some aspect of labor, delivery, post-delivery and/or transport. A minority had set aside funds only for transport.

Participants cited serious constraints when planning for facility-based delivery. Lack of money, excessive distance to a hospital, and lack of access to transportation facilities were the barriers noted most frequently. These challenges are confirmed by findings of the 2004/05 Tanzania Demographic and Health Survey, which found that money, distance and transport are the leading barriers for women seeking health care [2]. Other women felt that they did not have sufficient knowledge about the importance of delivering at a facility.

"Money determines where one gives birth because if you go to the hospital before going into labor it means you have to stay with someone, or rent a place to stay close to the hospital, and that costs money."

(*Patient at Bugando, age 28*)

The majority of the women also did not prepare for the baby in any way. Participants often stated that preparing for a baby was against their customs. Preparations were not made until the baby was born because they did not know if the baby would be born alive. Indeed, one woman from Songea explained that it was improper to make preparations before delivery as this could result in stillbirth.

The amount of money that women or their families had saved for costs associated with some aspect of labor, delivery, or post-delivery ranged from a low of Tanzanian Shillings (TSh) 3,500 (US $3.50) to a high of TSh 50,000 (US $50). One woman said she had set aside TSh 2,000 (US $2.00) for delivery fees, TSh 1,500 (US $1.50) for gloves, and TSh 1,500 (US $1.50) for baby clothes.

Of the women who indicated how decisions were made on where to deliver, the majority had decided in conjunction with their husband or their family.

Family Planning

Nearly all the women who mentioned family planning had never used a family planning method. Fewer than half of these women said they did not use family planning because they did not know about methods. A similar number indicated that the pregnancies that resulted in their fistula were their first pregnancies, so family planning was not needed. A few women also did not use family planning due to perceived side effects.

CONCLUSION

Antenatal care services were widely used by women in the current study, but the quality of these services was highly inconsistent and inadequate. Standards of care were found to differ markedly from Tanzania Ministry of Health guidelines. Nearly all of the women had attended ANC at least twice, but there was no substantive discussion of pregnancy, labor, and delivery during ANC visits. Participants said that their knowledge of pregnancy and birth had been gained from experience of earlier pregnancies and deliveries. As such, ANC visits represent 'missed opportunities' to provide women with critical health services and information regarding pregnancy and delivery.

The majority of women had planned to deliver at a health facility of some type. Yet, participants reported serious constraints when planning for these deliveries. Lack of money, lack of access to transportation facilities, and excessive distance to a hospital were the barriers noted most frequently. Fewer than half of the women had set aside funds for some aspect of labor, delivery, post-delivery and/or transport, so when problems emerged the necessary preparation was lacking.

RECOMMENDATIONS

Health providers need training, supplies and equipment, as well as supportive supervision, to implement high quality and consistent ANC services.

Clear, evidence-based information on antenatal care, labor, delivery, and post-partum care is important for the adequate training of health care providers. In addition, health workers require specific training in effective and non-discriminatory communication with a diverse clientele, including vulnerable populations such as poor, disabled, and other marginalized girls and women. ANC services should also provide adequate information on family planning. Nearly all the women in the study who spoke about family planning had never used family planning, and one of the main reasons given for non-use was lack of knowledge about family planning methods.

Concrete information on birth preparedness that is understood and acted upon is critical to avoid delays in time of emergency.

Health care providers, women, and their families need comprehensive information on birth preparedness to help in times of emergencies. It must include the 'danger signs' that indicate obstetric complications, the imperative to take quick action when signs and symptoms of obstetric complications first present, and the importance of adequate planning (e.g., saving funds for delivery-related expenses and arranging emergency transport plans) to avoid delays in times of emergency. Traditional birth attendants and health workers in peripheral facilities (including lower level cadres) must also have this basic knowledge so that quick and proper referrals can be made to facilities with qualified medical personnel, supplies, and equipment to manage complications. By understanding and swiftly acting upon complications arising during pregnancy and delivery, the risks of maternal and infant death and injury, including obstetric fistula, will be significantly reduced.

Bibliography

[1] United Nations Population Fund (UNFPA). Renew: The Campaign to End Fistula. http://www.endfistula.org/family_planning.htm

[2] United Republic of Tanzania. National Bureau of Statistics and Macro International. Tanzania Demographic and Health Survey 2004/5. Dar es Salaam: 2005

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