STUDY FINDINGS

Onset of labor and the moves needed to access emergency obstetric care

Nearly all of the women in the study started labor at home and, of these, the majority went into labor in the evening or at night, when it was more difficult to access assistance. Only seven of the sixty-one women in the study delivered where they started labor – five at home, four of these with the help of traditional birth attendants (TBAs), and two at the hospital.

Table 1: Number of Moves Made by Women from Initiation of Labour to Final Delivery

<table>
<thead>
<tr>
<th>No. of moves</th>
<th>No. of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td>2</td>
<td>19</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>&gt;3</td>
<td>1</td>
</tr>
</tbody>
</table>

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%).

Fewer than half of the other women moved at least two times before receiving the emergency obstetric care they needed to deliver safely. See Table 1.

Decisions to move during labor - who made these decisions?

The majority of women were helped by others to make the decisions to move to other places for labor or delivery. Only five of the women interviewed made these decisions totally by themselves. Once a woman was in labor, family and friends were the primary decision makers. Husbands were the most frequent decision makers, followed by the parents of the women. In some instances, in-laws, neighbors, and friends were also involved in decisions to move the women to seek further care.

After family and friends, the most frequent decision makers about when and where to move the women during labor were TBAs and healthcare providers. This typically occurred when a TBA realized that she could not help the woman herself, or, in the case of formal health workers, when the...
facility where they worked was not equipped to assist the women. One woman in Songea who arrived at a health center was asked, “Why did you come here? We told you to deliver at Peramiho [Mission Hospital]”. Nonetheless, they examined her and asked her to push. In the evening, they realized she could not give birth and told her to look for transport and go to the hospital.

Why was the decision made to move?

The most common reason for making the first move was because the woman or her family realized that substantial time had passed in labor without progress. The second most common reason was because the TBA realized she could not help. The length of labor reported by women varied from 10 hours to four days. One woman said, “I realized that there was a problem after spending the whole night with no progress.” (Woman from Singida, age 35). Another woman reported that her husband decided to take her to a private hospital after she had been in labor for four days at home. In a third case, a woman’s father decided to take her to the hospital after she had been in labor for three days. Other signs of delivery problems mentioned by the women included bleeding, stopping of labor pain, and partial emergence of the baby.

Delays in reaching and receiving care - deadly barriers to maternal and infant health

The majority of the women in the study faced multiple delays in reaching facilities with the necessary services to enable them to deliver safely. Only eight women with fistula did not face any type of delay. For the majority of the women, either the woman or her family or friends delayed in identifying a problem that needed to be addressed by a skilled provider. In all of these cases, the woman began her delivery at home with only family members or friends present.

Four Days in Labor:

In Ukerewe, a 23-year-old woman spent four days in labor before reaching a hospital where she could get care. She went into labor at midnight. Her husband went to get her mother-in-law, who examined her and told her to be brave because she was experiencing labor pains. The woman wanted to be taken to the dispensary, but her mother-in-law said no and told her she was just scared. Her husband and mother-in-law stayed with her, but did little to help. After two days of labor, her mother-in-law called the TBA, who examined her and recommended that she go to the hospital. Her family decided to take her to the dispensary in the village first, before going to the hospital.

To get to the village dispensary, the woman walked for two hours with her husband and in-laws. On the way, they hit her with a stick and her mother-in-law pinched her to make her walk faster. At the dispensary, they informed her that she would have to go to the district hospital, but she had to stay overnight because it was already dark. The next day, they walked to a health center because her mother-in-law still refused to go to the district hospital.

At the health center, the providers shouted at them for not going to the district hospital and gave them a referral letter. The family finally went to the district hospital by boat and vehicle. The woman was rushed to the labor room, but she was already unconscious. The baby died and the woman had developed a fistula.

The leading causes of delay included lack of recognition of a problem by the woman or her friends/family, and lack of transportation. Additional causes of delay included by providers, including TBAs, in recognizing a problem and/or taking timely action. One woman arrived at a hospital for delivery and the doctor told her, “I can’t perform the operation, I am leaving” (Patient at Bugando, age 79). The woman left the hospital on the third day and sought help at another hospital. Another woman waited for two days at a hospital before receiving a caesarean section. She described that “some of the patients gave the doctors money in order to get fast attention” (Woman from Songea, age 20). In a third case, a woman said that her TBA agreed to go to the hospital after realizing that the baby was dead. See Table 2.
Transport and delivery costs incurred by women and their families

The majority of the women interviewed incurred some costs for transport to a health facility during labor and delivery. Transportation costs ranged from TSh 200 ($.20) to TSh 70,000 ($70.00). One woman commented that no expenses were incurred because they borrowed a neighbor’s bicycle free of charge. She elaborated that transport by bicycle was the only available option because there is no road and there is no transport system. Health providers in Songea also highlighted the chronic shortage of transport in rural areas. They reported that only two buses pass through villages; the first bus leaves in the morning, the second returns in the evening. So, only one bus goes to where the hospital is located, and most often it is full.

A minority of the women also reported having to pay some type of fee for the delivery. The lowest fee paid was TSh 1,755 ($1.75) and the highest was TSh 62,000 ($62.00), which was charged by a private hospital where the woman underwent a cesarean section.

Roles of family and friends

All of the girls and women received support of some kind from their family or friends during labor and delivery, and in most cases, the role these people played was very positive. Nonetheless, a few study participants had negative experiences with family and friends. In one case, a woman, did not inform her family that she was supposed to deliver at the district hospital because she was afraid that her father would have shouted at her.

Table 2: Types of delays experienced by women with fistula

<table>
<thead>
<tr>
<th>Type of delays</th>
<th>No. of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of recognition of a problem by woman or friends/family</td>
<td>31</td>
</tr>
<tr>
<td>Delays by TBAs in identifying problem and/or taking action</td>
<td>18</td>
</tr>
<tr>
<td>Delays in care seeking by women or family/friends after a problem was identified</td>
<td>16</td>
</tr>
<tr>
<td>Delays in transportation</td>
<td>30</td>
</tr>
<tr>
<td>Delays at site due to lack of supplies, equipment, etc.</td>
<td>6 *</td>
</tr>
<tr>
<td>Delays by providers at the site</td>
<td>15 **</td>
</tr>
</tbody>
</table>

* 4 delays occurred at hospitals; 1 each at a dispensary and health center
** 6 delays occurred at hospitals; 9 at either dispensaries or health centers

Multiple Delays with Tragic Consequences

In Singida, a 39-year-old woman started labor at midnight. Her husband went to the dispensary to get an attendant. She examined the woman and told her husband that she was not ready to deliver. The attendant then went to sleep after telling the husband to call the TBA living nearby. When the TBA arrived, she examined the woman and told her that she was ready to deliver. The woman’s labor pains lessened, and the TBA gave her traditional medicine to accelerate the labor. By morning, she still had not delivered. The TBA then realized there was a problem, and that she could not deliver at home.

Her husband and relatives decided to take her to a dispensary. They managed to find a wagon pulled by an ox. At the dispensary, she was examined and told that they could not help her. She had to go to the regional hospital in Singida. Her husband hired a car to take her to the hospital. When she arrived at the hospital, the doctors decided that she needed a caesarean section. However, there was no electricity at the hospital, so she was sent to a mission hospital, where she finally received a caesarean section about 24 hours after the onset of labor. She was unconscious, and the baby had died by the time the caesarean section was completed. The woman had developed a fistula.
Reactions of family members

During the study, family members were also interviewed to understand their perspectives on experiences related to the pregnancies that resulted in fistula. Interviews focused on the actions that women and their families and friends took to seek care during labor and delivery.

From statements made by family members, it was clear that they felt a sense of guilt for not having done more to access the necessary treatment to prevent the development of fistula. Several wished they had gone to the hospital earlier, either before or right after the beginning of labor. For example, one husband said that his wife sustained her fistula because he made a mistake calling the pharmacy attendant and the TBA, rather than going directly to the hospital. Had he known there was a problem, he would have taken her to the hospital, and, therefore, likely prevented the fistula. He also explained other constraints he faced. He had wanted his wife to be transferred to a hospital and stay there until she delivered because she had been sick during the pregnancy. However, he had no money for the hospital charges and no one else at home to take care of the family.

One set of parents had longed to reach the hospital in time so they could save the life of the baby. Another mother said that there had been negligence on the part of her husband who refused to send their daughter to the hospital early (though the husband did not directly admit this). Another set of parents blamed the medical attendants at the local dispensary since they had examined their daughter earlier.

Roles of traditional birth attendents and opinions of care provided by them

Of the women who started their labor at home, fewer than half of the women were assisted by a TBA, while the rest were generally assisted by family or friends. In two cases, women were assisted by community-based providers – one pharmacy assistant and one nurse – who were not TBAs. Of the women who were assisted by a TBA, nearly all had to seek care elsewhere after experiencing complications during labor and delivery.

Nearly all the women who were assisted by TBAs reported that the TBA used her hands to ascertain if the cervix had dilated and then tried to help them to deliver. In fewer than half of the cases, TBAs also gave traditional medicine to ease labor pains or to stimulate the labor process. In several cases, when the TBAs realized they could not help the woman deliver, they referred the women to health facilities, but this was often after several hours of labor. One woman was highly critical of the skills of her TBA, saying “The TBA care was bad because she forced [me] to deliver at her place while she didn’t have the skills. She didn’t wear gloves; she used her bare hands” (Patient at Bugando, age 21).
Roles of healthcare providers and opinions of care provided by them

The type of care given by healthcare providers depended on the level of health facility that a woman reached. Fewer than half of the women interviewed who sought help at a dispensary or health center mentioned that the providers examined and referred them to another facility. One young woman told interviewers about a positive experience at a peripheral facility: “Health services at the health center are good. They even discovered I had a problem and told me to go a bigger hospital” (Woman from Songea, age 18).

At the tertiary sites, the majority of women said that the providers’ main role was to help deliver the baby. Fewer than half of the women delivered vaginally; a similar number delivered by caesarean section. A minority of the women had vacuum delivery. Nearly all of the women had a stillbirth. However, most women were satisfied with the care they received at their final place of delivery. The principal reasons given by respondents were that these providers had saved their lives and/or their babies’ lives, or simply because they were able to identify the problems the women were experiencing.

At the same time, the majority of girls and women believed the fistula was caused by factors related to the delivery process itself, and fewer than half were not satisfied with their treatment. One woman reported that inadequate care and the high charges at the private hospitals contributed to the loss of her baby. She explained bitterly that when she called the nurses at the hospital where she delivered, they did not care. The nurses said to her, “You keep calling. Do you call us so that we can carry you on our backs? Don’t disturb us, and you go” (Patient at Bugando, age 24). Another woman who went to a hospital during her pregnancy was told she would need a blood transfusion. The nurse told her “If you don’t pay TSh 15,000 (US $15) you will never get a blood transfusion. If you have to die, better die” (Patient at Bugando, age 24). In a third case, a woman remarked that nurses were asking for sodas before they would provide service.

Data does indicate that fistula can be caused in hospital settings through improper caesarean section and negligence [3]. This raises serious questions about the provision of quality health care within facilities and the need for rigorous attention to improving the skills, working conditions, and attitudes of healthcare providers.
CONCLUSION

The majority of the women faced multiple delays in reaching facilities with the necessary services to enable them to deliver safely. In the majority of cases, either the woman or her family or friends delayed in identifying a problem that needed to be addressed by a skilled provider. About half of the women in the study reported transport delays during delivery, and fewer than half reported a delay at the site itself due to lack of supplies and equipment, or delay caused by the provider at the site. The majority of the women also incurred costs for transport, and a minority reported having to pay some type of fee for the delivery.

The 2004–2005 Tanzania DHS states that Tanzanian women have insufficient access to essential maternal health services such as caesarean section. Key barriers faced by women seeking health care include “getting money for treatment”, distance to the health facility, and the need to take transport. Striking differences were reported between rich and poor women facing these obstacles, and between urban and rural women [2].

Delays and barriers to care seriously impede women’s access to EmOC services, and care by skilled personnel. The results can be grave: death or disability, including fistula.

RECOMMENDATIONS

Girls and women, particularly in rural areas, urgently need access to emergency obstetric care provided by trained health workers. Additionally, the financial and logistical barriers to EmOC services must be eliminated.

Urgent action is needed to expand effective access to emergency caesarean section down to the health centre level. Priority should be given to instituting EmOC in the most underserved regions of the country, and building upon that foundation in the long-run.

Effective action is required to address key barriers that women face in accessing care for labor and delivery. This includes:

- Instituting transportation schemes to help women reach an appropriate facility promptly;
- Monitoring compliance with the Government’s statement that services for pregnant women are free and that ‘delivery kits’ are available in health facilities for all expectant mothers [4];
- Hiring, training, and equitably deploying health workers throughout the country, including those who can perform caesarean section; and,
- Providing supplies and equipment for EmOC services consistently.

By ensuring effective access to high quality and affordable EmOC services, particularly in underserved areas, the incidence of maternal mortality and morbidity in Tanzania, including fistula, could be greatly reduced.
Bibliography


Other briefs in the series

Overview  Risk and Resilience: Obstetric Fistula in Tanzania
An Overview of Findings and Recommendations from the Study
Brief 1  Preventing Obstetric Fistula: Antenatal Care, Birth Preparedness and Family Planning
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Brief 3  Living with Obstetric Fistula: The Devastating Impacts of the Condition and Ways of Coping
Brief 4  Mending Lives and Recovering Livelihoods: Repair of Obstetric Fistula and Reintegration

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