EXAMINATION OF CHALLENGES FACING MATERNAL CARE AMONG WOMEN: A CASE OF BUGANDO REFERRAL HOSPITAL

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CERTIFICATION

The undersigned certifies that, she has read and hereby recommends for acceptance by The Open University of Tanzania a dissertation titled, **"An Examination of Challenges Facing Maternal Care Among Women: A case of Bugando Referral Hospital"**. In partial fulfillment of the requirements for the degree of Master of Social Work of The Open University of Tanzania.

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Dr. Fauzia Mohamed

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……..

Date

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DECLARATION

I, **John Paul Fulli**, declare that, the work presented in this dissertation is original. It has never been presented to any other University or Institution. Where other people's works have been used, references have been provided. It is in this regard that I declare this work as originally mine. It is hereby presented in partial fulfillment of the requirements for the degree of Master of Social Work of The Open University of Tanzania.

……..

Signature

……..

Date

DEDICATION

This work is dedicated to my beloved wife Ms. Edith Rabson Kwayu, daughters and sons who spared neither encouragement nor a word of wisdom to help me realize my full potential.

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I express my sincere appreciation to all people who in one way or another contributed to the completion of this work. My first and foremost thanks are directed to God, who is the source and owner of all creatures in this world, without HIM the dream for having this dissertation written and completed will be in vain. Second my appreciation goes to my loved family (Wife and Children) for their encouragement and perseverance during my study life. I would further express my sincere appreciation and gratitude to my supervisor Dr. Fauzia Mohamed, Course Coordinator during enrollment Dr. Johnas Buhori for their tireless support, guidance, assistance, facilitation, encouragement, and criticism which have led to the completing of this dissertation, and course lecturers for their assistance on the learning process. Lastly is my gratitude to all my fellow students in Arusha region Master of Social Work class of 2017 for their motivation since the study-journey we ventured. Despite above acknowledgement and contributions from different individuals in this study work, I remain solely responsible for errors and mistakes which might be found in this dissertation.

ABSTRACT

The study entitled "Examination of Challenges Facing Maternal Care among Women: A case of Bugando Referral Hospital" is informed by Social Learning theory and three specific objectives, namely, to identify demographic factors related to maternal care; to assess the challenges facing women during antenatal care period and to assess the challenges facing women during post-natal care period. With a sample size of one hundred and twenty, the study employed descriptive approach to collect qualitative and quantitative data from research subjects. The study finds that women age of 20 – 29 age categories to be leading among other in visiting hospital for both ACP and PCN services. Additionally, it reveals that the common challenge identified is the abuses from the health practitioners. Furthermore, it indicates that during post-natal care women were confronted with inadequate family support and poor economic status of the family. The study recommends that medical practitioners and social workers should observe the ethics when providing services during ACP and PCN period.

Keywords: *Examination of Challenges, Maternal Care, Women, Bugando Referral Hospital.*

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LIST OF ABBREVIATIONS

ANC	Antenatal Care
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
MDGs	Millennium Development Goals
MHS	Maternity care Health Services
MoH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
PNC	Postnatal Care
SA	South Africa
TBS	National Bureau of Statistics
TDHS	Tanzania Demographic and Health Survey
TRCHS	Tanzania Reproductive and Child Health Survey
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URT	United Republic of Tanzania
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE RESEARCH PROBLEM

1.1 Introduction

This chapter focuses on the background information to the study, statement of the problem, research objectives and significant of the study. Further, the chapter presents the definition of key terms and concepts.

1.2 Background to the Study

Prenatal and antenatal periods are essential and recognized by goal three of sustainable development. It highlights of the basic health services that have to be provided to both the pregnant women and the unborn child (Mendy, 2018). It is therefore important not only for the government but also the communities and families to make sure, during this period; women have access to quality health care. Its provision ensures the mother and the unborn child to improve on their health status, hence showing commitment of the government and accountability of each citizen towards the achievement and sustainability of goal three (Orwa, *et al.* 2019).

Mendy (2018) further noted that in order to accomplish the goal of ensuring accessibility of quality health care services and reduction of death for both pregnant women and unborn child, the health services have to be reinforced and made available during antenatal and postnatal. It is worth noting that the pre-birth period is a fundamental stage to aid healthy performances and childcare services.

It is a common practice; good antenatal care is associated with a woman and her close relatives to support her by becoming part of accessing the health services and identify accessible health facilities. It is therefore the role of each family member to be part of the health services provided during the said period. Adding on, Mendy (2018) commented on the important of family members becoming part of this period, when noted that each of them not only become aware of the life cycle of pregnancy but it's demand it has to each of them.

Antenatal care (ANC) consists of protective and health-giving care the facilities provide for the course of prenatal period. During the ANC period, health providers are in a good position to prevent for and recognize any possible danger that can bring any health-related complications, some of these complications can be influenced by poor maternal and birth consequences. It is a common practice in many health systems, when the health supporter sees some limitation around any pregnant women, are in a position to recruit suitable curative. They can also extend their services by using the scholastic interventions, which in most cases decreases the dangers for maternal-neonatal illness and death (Okedo-Alex IN et al, 2019).

Moreover, the ANC facilities, particularly at the first visit, comprises important display for health in essential circumstances such as human immunodeficiency virus (HIV) and Syphilis; for HIV-infected antenatal women, the extreme advantage of antiretroviral therapy (ART) to prevent mother to child transmission (PMTCT) of HIV call for primary performance to the health systems. Furthermore, vaccinations,

like Tetanus toxoid, set for the period of pregnancy can be life saving for all mother and newborn (Ebonwu et al, 2018).

Insufficient care throughout maternal time pauses a critical link in the range of care, and affects both women and babies. Therefore, Maternal Care focuses much on all the common and essential complications that take place for the period of prenatal period, labour, delivery, and the puerperium.

Globally, every year, 289 000 women pass away due to complications in prenatal period and during delivery; of the children survived death during delivery, 6.6 million of them under 5 years age dies of complications especially of childhood diseases (WHO, 2013). It is observed that a lot of these deaths could be stopped by providing quality health care services. Progress in numerous areas have to be identified, namely, the coverage of numerous important reproductive services, motherly, neonatal and child health involvements over the past two decades. On the other hand, there has been a partial development in improving motherly and pediatrics results for the reason of dealing with the identified gaps around quality of care delivered and well-being services. For that reason, cultivating the quality of facility in addressing health care services, it is important to build quality facilities which have capacity to provide quality services. The services provided can as well focus on essential element of scaling up interventions to progress health results of mothers, neonates and children is of paramount significance*(ibid)*.

Furthermore, ANC is said to be a success story in a sense that it represents a period of heightened vulnerability for both women and their unborn babies. It is noted that every day, preventable causes related to pregnancy and childbirth lead to the deaths of over 800 women with 99% of these maternal deaths occurring in low and lower middle-income countries. Although by 2015, maternal mortality had decreased by over 40% from the 1990 levels, maternal mortality levels have continued to remain unacceptably high in sub-Saharan Africa. It is further revealed that inadequate access to quality antenatal care (ANC) contributes significantly to the preventable maternal deaths. On the other hand, it has been observed that between 2006 and 2013, there was a remarkable development in combating maternal mortality ratio (MMR) at the universal levels. This specifies that countries with low ANC coverage are the one with very high MMR.

For instance, ANC coverage in United Arab Emirates was 100% with MMR of 8 per 100,000 and Ukraine had 99% ANC coverage and MMR of 23 currently, 71% of women worldwide receive any ANC. Adding on, in technologically advanced countries, more than 95% of pregnant women reported to have access to ANC. Flora (2017) portrays that, adequate utilization of prenatal health care services is accompanied with better-quality maternal and newborn health outcomes. It is recommended that pregnant women have to attend antenatal care services as early as in the first trimester; however, WHO (2016) noted that many women due to numerous reasons were unsuccessful to meet the recommendations. Pointing out on the challenges facing women in developing countries, Niguss (2011) opinioned that many women in these countries are exposed to high risk. Their risks are associated

with maternal illness and mortality and other factors related to pregnancy and childbirth.

Adding on, other factors related to socio-economic were identified to increase the risk of maternal illness and mortality among women. Moreover, most women during pregnancy due to various uncertainties, takes much of their time in various socio-economic activities, which is very demand, hence cannot find time to attend to ANC services. Furthermore, to the mothers who reside in rural, higher parity and being homemaker are at high risk of not attending for ANC and end-up delivery at home. It is these practices which increases the risks as about 71% of deliveries took place at home (*ibid*). From the surroundings of the residential environment, there are numerous factors that can be uncertainty during maternal care that results to home delivery, namely, presence of relatives nearby, transportation, and lack of privacy.

World Bank (2003) portrays that, women are required to make a number of antenatal care visits before giving birth. The number of pregnant women attends hospital or clinics increased when they make the first visit during early pregnancy. The number of ANC visits required seen as a challenge. In relation to that, pre- or post-pregnant women fail to visit hospitals or clinics because some of them have no person to take care of their older children at home; adding on, others feel they had to make progress in their occupations and could not stop working on the farm.

In some circumstances, some women during early pregnancy, become ill and cannot travel or visit the health facilities for health-related consultation. In the same

category of pregnant women, some of them indicated that their health was satisfactory; hence there was no reason to seek for medical attention from the qualified personnel. It is for these reasons; many women were observed to attend to ANC only during their late pregnancy for several reasons. Some of these reasons includes the early pregnancy especially among societies that still cling on traditional practices, they commonly perceived the first three months of pregnancy as a lamp of blood; where the unborn child still perceived as not a human being, therefore not in need of care. It is for this reason therefore, about 45 million women do not use ANC care services (Mendy, 2018).

Moreover, International Development Committee (2008) shows that every year an approximate of 210 million women have life complications of pregnancy, which in some women leads to serious disability; half a million of pregnant women pass away during the period of pregnancy, giving birth and the puerperium. Furthermore, more than 99% of these deaths are in third world countries. Moreover, more than 120 million couples have an unmet need for contraception and 80 million of women each year have unwanted or unplanned pregnancies; 45 million of these pregnancies are terminated, and of these 45 million abortions, 19 million are unsafe of their health. In relation to health, maternal care is aimed at improving and protecting healthcare status of pregnant women in all levels of either one hospital or clinics.

In the part of sub-Saharan Africa, 68% of women described to make at least one antenatal visit, whereas ANC said to be a fundamental plan to improving maternal and infant health globally (Mendy, 2018). Nevertheless, information from an

assessment done in sub-Saharan Africa indicated that women often initiate ANC late; consequently, they are unsuccessful to come across the suggested number of ANC visits (*ibid*). In addition, about 900,000 children pass away as the result of miscarriages for the period of the last twelve weeks of pregnancy. Consequently, the estimated children who pass away before the onset of labour or ante partum miscarriages, interprets for two-thirds of all miscarriages in countries where the death rate is more than 22 per 1,000 childbirths almost in all African countries. It was further observed that unborn child are affected by complications in the course of pregnancy as well as preterm birth and limited fetal growth, together with other influences affecting the children's development such as inherited infections and fetal alcohol syndrome.

In South Africa, all governmental health facilities give unrestricted basic antenatal care (BANC) services. Despite the fact that utmost women cannot meet the expense of the complete charge of ANC and delivery in the private sector, a good number of them still look for initial ANC services in the private sector (Ebonwu et al, 2018). Once referred after the private to public sector for care services, these women are likely to bring letters or cards that review all relevant ANC. It is the general practice of the health workers to recommend all pregnant women to visit at least 20 weeks earlier of maturation. The rate of performance for first ANC earlier 20 weeks is seen to be a core national sign used to evaluate the performance of the state PMTCT plan (Okedo-Alex IN et al, 2019). In relation to that, popularly in 2015/16 about 61.2% of antenatal women in SA show up their first ANC earlier 20 weeks gestations, as well as 94% show up at least one ANC visit to public sector healthcare services for that

confinement. Nevertheless, 75% of South Africa (SA)'s from 52 health districts attained the 60% national goal of introducing ANC earlier 20 weeks of confinement.

A very disappointing side towards the observed achievement is on high dominance of HIV during antenatal period to women; recently it has been documented at 29.5% infection rate among pregnant women. Eventually, getting late on attendance for ANC delays HIV identification and ART commencement. At the end of the day, delayed ART commencement falls the span of time presented for best virus-related load defeat earlier to delivery, thus growing the possibility of mother-to-child transmission (MTCT) of HIV (*ibid*).

In the context of Tanzania, through the Ministry of Health, Community Development, Elderly and Children (MOHCDGEC), it has implemented various plans which were geared toward supporting safe maternity and develop kid survival. In the same way, in an effort to develop maternal and kid wellbeing, Tanzania has acknowledged maternal and child health services to be discharged from consumer charges in government services. According to Orwa, *et al* (2019), there is a significant difference in ANC attendance and health facility delivery by area of residence, whereas women from urban districts showing higher use of ANC services compared to those in rural areas.

Tanzania Demographic Health Survey (TDHS) results suggested that area of residence may play a role in ANC visits and facility delivery, with those living far away from urban centers being less likely to receive or use care. A reason for this

variation can be attached to women in rural areas still have overriding cultural and social norms guiding their health care-seeking behavior, such as strong faith in traditional birth attendants or desire to bury the placenta near their home. These factors may have negative influences on maternal health services use, compared with urban women who may be more educated and less influenced by traditional beliefs.

The low use of maternal health services in rural areas may also be attributable to health system factors such as scarcity of health facilities, poor infrastructure, and lack or inadequate of healthcare officers in low volume facilities, especially in island districts, as well as abusive and disrespectful maternity care. For that reason, identification of factors that may explain these differences and maternal care contributing factor is important as Tanzania works to achieve higher rates of maternal health services use.

1.3 Statement of the Problem

Prenatal and antenatal periods are essential and recognized by goal three of sustainable development as narrated in the background of this study. The prenatal care services include but not limited to monitoring the development of pregnancy, provision of immunization and HIV testing and counselling. Despite the related challenges with the health system, all pregnant women are encouraged to get the maternal health services. The benefits of these services do not end to the pregnant mothers but also their unborn children. In order to ensure the delivery of quality health related services to pregnant women, these services are free of charge in the context of Tanzania. The provision of ANC health related service is of great

significant as to help reducing possible delivery related complication; when not dealt with, consequently leads to death of the pregnant women. Despite the global, regional, and local efforts undertaken to counteract the situation, pregnant women during ANC and PNC are still exposed to the health-related challenges which are partly associated with available services and the service providers which amount to deaths of women and infants. The quality of health services provided during ANC is witnessed looking at the level of mortality among infants and maternal death.

The question that this study would like to deal with is why there is increasing number of deaths among pregnant women despite the availability of free health services as indicated? Further, this study would like to examine more on the demographic, social-cultural, norms, and socio-economic challenges encountered by pregnant women when accessing the ANC and PNC services.

1.4 General Objective

The general objective of this study is to examine maternal care determinants among pregnant women who access health related services at Bugando Hospital.

1.4.1 Specific Objectives

The specific objectives are to:

i) To identify demographic factors related to maternal care

ii) To assess the challenges facing women during antenatal care period.

iii) To assess the challenges facing women during post-natal care period.

1.4.2 Research Questions

i) What are the demographic factors related to maternal cares?

ii) What are the challenges facing women during antenatal care period?

iii) What are challenges facing women during post-natal care period?

1.5 Significance of the Study

Improvement and successful implementation of maternal health care platforms anywhere in the world depend on comprehensive examination in maternal health. Inappropriately, small information exists on what influences demographic, social-cultural, norms, and socio-economic challenges encountered by pregnant women when accessing the ANC and PNC services. The study undertakings to bridge the prevailing gap in knowledge on demographic, social-cultural, and socio-economic determinants of maternal care practice.

Understanding the demographic, social-cultural, norms and socio-economic determinants of maternal care would be worthwhile for the growth and putting into practice of interventions that would improve the usage of maternal care among reproductive women and thus weaken maternal mortality to adequate levels.

Furthermore, this study will add understanding that could be applicable to women, family, communities, medical and social welfares professionals, and policy makers for the most part in maternal health cares.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

A *literature review* covers exclusively the summary of the previous studies on the topic under research. The presentation of the information is guided by the three specific objectives as shown from chapter one. Its major role is to give ground on the current state, in a subject **(**Onwuegbuzie & Rebecca, 2016). The literature review assumes that by going through number of research works such as scholarly articles, books, other sources relate to research problem, it portrays an in-depth understanding of the author around the topic of the current study. Further, literature review acknowledges effort and influence made from previous areas of investigators' focus. Therefore, this chapter goes through different literatures relating to maternal care issues worldwide including Tanzania. The chapter further, covers key parts that is the definitions of key terms, theoretical framework; empirical literature review; and lastly concludes by identifying the research gap.

2.2 Theoretical Framework

The *theoretical framework* is the organization that involves organized concepts with their descriptions and reference to appropriate learned literature, existing theory that used for a specific study (Adom, et al, 2018). Additional, theoretical framework introduces and defines the way theory has to be understood, supports the current work under study, helps in mobilization and selection of information, as well as other resources that can enhance knowledge on the current work.

Moreover, social workers have to be acquitted with various theories so they can guide their thinking and intervention, and in this case, issues related to pregnancy. Theoretical framework therefore is very useful in presenting issues related to maternal care and its determinants.

2.2.1 Social Learning Theory

Social learning theory which was developed by Albert Bandulla suggests that through interaction of human being they socialize in one way or the other. The process can impact and impart on them the positive and negative traits of behavior of the significant others involved in the interaction. Further, the socialization and interaction process take place through observation, imitation, and modelling. The theory is perceived as the connector or catalysts between the behaviorists and those who strongly holds on cognitive learning theories. The sides see it to combine the attention, memory, and motivation. It is from this point of view, the theory argues that an organism can learn by observing the significant others' behavior, attitudes, and outcomes of each of these traits (Akers 1985).

This theory finds its relevant and significant position in the current work as to deals with the determining reasons for seeking health related services of pregnant women during and after pregnancy. It further observes the influence of the surrounding environment among them, and the type of behavior is likely to be observed and later imitated regardless of the outcomes. This can be further argued that it is common for all human being to learn from other through observation and modelling their actions.

It is from this point where the observed traits or actions are used to form an idea and later on new behavior is developed and performed (Bandulla, 1977).

Generally, the theory of Social Learning denoted to present the human behavior as depending on the interaction of cognitive, behavior and the influence of the surrounding environmental. According to Akers (1985) organism or human being learn through observation and later imitates the same practices or actions. In the context of this work, pregnant women can learn not to attend to clinic during and after pregnancy after seeing others doing the same while ignoring the outcome of their actions.

On the other hand, the health practitioners may ill-treat pregnant women emotionally, psychologically, and physically; when others see no sanctions taken against such actions, may imitate it by reproduce the same practices to other pregnant women. Moreover, significant others are very influential during formation of interaction from friends, parents, and family members (Peralta & Steele, 2010). It is this influence, which is emphasized among health workers and pregnant women, that regardless of the benefit offered by the services provided, it is not enough to make all women to seek the pre- and post-natal services. In the same way, regardless of the sanction presented among all health practitioners, it is not enough to stop all of them or to modify the behavior on their attitude around pregnant women (Akers, Krohn, Lanza-Kaduce, & Radosevich, 1979).

2.3 Definitions of Key Terms

To try and standardize the interpretations or meanings of various concepts used in the study; this section presents a list of definitions of terms used.

2.3.1 Maternal Care

Maternal Care is a comprehensive program for healthcare professionals, covering all the common and essential difficulties that happen for the period of confinement, labour, delivery and the puerperium (Zahn, et al. 2018). Maternal Care is particularly significant for midwives and doctors working in labour wards in level 2 hospitals. To the context of this study maternal care refers to the maintenance or improvement of health through the prevention, diagnosis, treatment, recovery, or cure of disease, illness, injury, and other physical and mental damages in people.

2.3.2 Maternal Health

According to Kifle, *et al.* (2017), maternal health is the health of women during pregnancy, childbirth, and the postpartum period. It includes the health care opportunities for family planning, predetermination, prenatal, and postnatal care in order to reduce maternal morbidity and mortality. To this study, maternal health is the health of women during antenatal period, childbirth, and the postnatal period. It incorporates the health care dimensions of family planning, preconception, prenatal, and postnatal care in order to ensure a positive and fulfilling experience, in most cases, and reduce maternal morbidity and mortality, in other cases.

2.3.3 Antenatal Care

Antenatal care is the clinical valuation of mother and fetus during maternal period, for the purpose of obtaining the best possible outcome for the mother and child (Kevin Harrington Healthcare, 2014). According to this study antenatal care can be referred as a type of preventive healthcare that delivered in the form of medical checkups, comprising of recommendations on managing a healthy way of life and the provision of medical information.

2.3.4 Postnatal Care

Postnatal care refers to the care given to a mother and her newborn child from time of delivery to six weeks after delivery. Postnatal care specifically aimed at preventing or stopping any difficulties or infections that occur during the process of delivery or within 6 weeks after delivery (Kevin Harrington Healthcare, 2014). To the context of this study, postnatal care is the period arises immediately after childbirth as the mother's body, including hormone levels and uterus size, returns to a non-pregnant state.

2.4 Influence of Socio-economic and Demographic Characteristics of Mothers on Maternal Use

Generally, WHO, UNICEF and UNFPA indicated that more than half a million women pass away every year due to the problems related to maternal during the period pregnancy and childbirth. It was further revealed that more than 50% of the same population occurs in Africa. Adding on, WHO (2012) stated despite the given recommendations that all home deliveries should visit a health facility for postnatal

care as soon as possible after birth but it was observed that over 70% of all children born outside the hospital in Africa do not receive any postnatal care. The guidelines by WHO (2015) on accessing facility based care during and after delivery; recommend for at least two home visits for all home births. It further indicates that the first visit should occur within 24 hours from birth; while the second visit on day 3. This is because about 60% of maternal deaths occur within the first 48 hours of delivery, most of which are due to postnatal hemorrhage. However, Gongi (2007) pointed that due to the social-cultural context surrounding childbearing in Africa, many home babies do not utilize professional health care in time.

Several studies that investigated the possible determinants of utilization of healthcare services have shown factors such as: age and children ever born (Timyan, 2003); household income (Hove, 2004); knowledge (Akunga, Menya, & Kabue, 2014); distance and mode of transport to health facility, and social-economic status (Gongi, 2007); cultural beliefs (Sibanda, Saungweme, & Nleya, 2001); accessibility of health services (Chakraborty, 2002) among others.

Looking specific on age, Banke-Thomas, et al., (2017) portrays that early mother aged 15–19 years are recognized to have more risks of maternal morbidity and mortality unlike women who are with the age 20–24 years, mostly due to their exceptional biological, sociological, and fiscal position.

Adding on, the problem of illness is seen to be superior in low- and middle-income countries (LMICs). Consequently, accepting aspects that impact teenage use of

necessary maternal health services (MHS) would be critical in improving their results.

Additionally, women's current age show an important role in the utilization of medical services (Timyan, 2003). Mother's age may sometimes serve as a proxy for the women's collected knowledge of health care services, which may have a positive influence on the use of health services. On the other hand, because of development of modern medicine and improvement in educational opportunities for women in recent years, younger women might have enhanced knowledge of modern health care services and place more value upon modern medicine.

Drawing attention from Nepal, Gongi (2007) noted that about 80 percent of mothers aged below 30 years are more likely to attend ANC and PNC services.

Likewise, health care utilization declined abruptly as age increased because older women seem to be familiar with childbearing evidenced by children ever born. Furthermore, about 70 percent of women aged 30 years and above women preferred traditional care, which mainly recommended by elderly family members and relatives, as opposed to professional health care. However, Ayana, et al. (2015) found that no significant relationship between women's current age and use of maternal healthcare services; this includes the ANC and PNC services.

The correlation among birth order and use of maternal health services reveals on the influences of age. As from Gongi (2007), women aged below 30 years were more

likely to utilize maternal care whereas those aged above 30 years prefered traditional care separate from the health care system as the order of birth increased there was a lower chance that a woman will attend maternal care.

In Tanzania, women aged 15 – 49 years are mostly faced with maternal death. The reason attached to it is that most of the births occur at home grounds where there are limited maternal health care. It is for these reasons, more than half of the births occurred at home direct causes the raise of maternal mortality rate (Tanzania-WHO, 2015). Similarly, maternal death of about 578 per 100 000, that presents 18% mostly occurs at home; where the leading reasons of maternal death were hemorrhages, infections, unsafe abortions, hypertensive disorders and obstructed labour. Furthermore, the existence of these grounds is worsened by HIV and malaria, which are the Tanzania's leading killer (*ibid*).

Relating the residential location and maternal among women, William (2016) indicated of a good utilisation of maternal health care services by women.

Adding on, the Nigeria Demographic and Health Survey conducted among 33,385 women aged 15-49 years, observed of little significant association between place of residence and postpartum care use. Likewise, urban residents were more likely to get a postnatal examination surrounded by the recommended time frame of six weeks after deliver.

Highlighting the situation in Kenya, Akunga (2014) noted that there is a significant relationship amongst place of residence and postnatal care use among women aged 15 to 49 years. Additionally, there are unimportantly different between urban and rural residents, that is to say, women in rural areas are less likely to utilize maternal care services. Furthermore, the gap of ANC and PNC use arises between women in rural areas and urban areas is because, women in rural areas have more challenges in accessing health care services than urban residents. Moreover, the likelihood factors that reduce utilization of health services in rural areas are as distance to health center, indirect and direct costs of accessing health services among other factors.

To the context of Tanzania, distance to health care centres was recognized to impact on the rate of up taking the health services provided. In general, pregnant women who live far from a health facility are the least likely to meet the cost involved in travelling (Hanson, et al., 2017). Likewise, distance to the nearest hospital has also been seeing as a positive allied with direct obstetric mortality. Moreover, relatively little is known about the correlation among antenatal care or caesarean section and distance to the nearest facility. On marital status, marriage is seen to be among the major important social institutions around pre and postnatal.

This is due to the fact that marriage partakes to various implications in the health sector. It is worth noting that marital status affects maternal health service use among other socioeconomic variables (William, 2016). For instance, in Ethiopia, marital status remainedto be considerably associated to postnatal care use. It was found that, married women were two times more likely to use postnatal care than never married,

divorced, separated or widowed women (Dagne, 2010). However, in Uganda, women who were never married own a higher chance of using postnatal care services (Kango, 2006).

Conferring to Paudel (2013), education is an important contributing factor of maternal and child health; it enables an individual to increase access to health promotion message, information to acquire services and the significance of the available services. Likewise, educated persons are likely to be able to process the health message. Adding on, education of mothers has been found to be significant allied with increased uptake of maternal services in several other studies around the globe.

Moreover, in Kampala the level of education between those who never had school to those who had tertiary/university education affects the access to maternal health services, this is because postnatal services being improved with the level of education despite having more mothers in the primary and secondary schools. The mothers who had tertiary/university education attended postnatal services most while those who had no education; only a few attended the services. From the mothers who had no education, many of them did not attend postnatal services. Contrary to that, Timyan (2003) portrays that there is a positively weak correlation between number of years spent in school and number of PNC visits.

Moreover, some women, although having attained higher education also fail to attend PNC clinics due to negative health beliefs and lack of maternal health information. In

the context of wealth, education and domestic income were two of the most significant socio-economic factors known to influence health service exploitation between other socioeconomic variables, not to mention the strong association between the two aspects. Adding on, economic stability has been recognized by numerous health practitioners as well as the social scientists as significant factor in influencing maternal health care service use by women.

For instance, on average more than 80% of births to women in the highest wealth population attended by skilled health personnel compared with women in the lowest wealth population. Moreover, Dagne (2010) cited Ethiopia, when portrays that there is a statistically important relationship among household wealth as well as maternal health care use with women in the rich and richest wealth groups more likely to attend ANC and PNC.

Likewise, in India, women of average and high standard of living owns more chances of using ANC and PNC respectively than those of women with a low standard of living.

According to William (2016), more women in households of the lowest wealth quintile have low chance of using maternal health services rather than in the households of higher wealth quintiles. That is to say, the level of women who used maternal care increased constantly as the level of wealth increased, even though the chances of using maternal facilities increased with the increase in wealth. It is for this reasons, Dagne (2010) recommends that besides paying for the direct services

offered by clinics, women also have to pay for indirect and associated charges like transport fee and foodstuff for them to access maternal health services.

Furthermore, this has resulted in inequalities in accessing PNC services as majority of women in most African countries are poor. Therefore, wealthy household have the ability to afford good quality health care with few financial obstacles while less wealthy families struggle with indirect costs of accessing health care services. In ANC utilization, there is a direct connection between utilization of ANC services and utilization of PNC services by women (William, 2016). It is hardly the case that a woman who utilizes ANC services would fail to use PNC services because both services are designed for a similar purpose to protect, notice, also/or else clear of possible causes of death to the mother and her infant. Furthermore, antenatal care use is significantly linked with the non-utilization of postnatal care services. On the other hand, utilization of ANC service remains to be set up to positively influence of PNC service use. Attending ANC offers pregnant women essential health information on possible preparation for childbirth, and also need of further service use.

A woman gets counseling along with ANC examinations part of the counseling also takes account of delivering at health facility. As a result, a pregnant woman may perceive that maternal service is significant and is accessible in her residence. Further still, women who attend ANC are well informed of the significance of delivering in health facilities while attended by the skilled health professions. For this reason, PNC utilization is influenced by a woman’s place of delivery whether it is at home or health center grounds. It is more noted that, women who deliver at

home are less likely to attend PNC clinics than those who delivered from a health center grounds. Despite these facts, there is a tough relationship among place of delivery and PNC use (William, 2016).

Generally, in any given population, one of the most influential factors is culture and education. Traditional, illiterate mothers, literate mothers are commonly most aware about maternal health services and are more motivated to using them. An understanding of the significance of gaining professional health care services influences women's need for them. On the other hand, there are exemptions whereas even the mean educated women observe to the recommendation of health care providers to attend ANC and PNC at least four times during pregnancy and after delivery.

2.5 The Challenges Facing Women during Antenatal Care Period

According to Adewuyi, et al. (2018), supporting paramount health for women and decreasing maternal and childhood mortalities have remained an important concern for the international community for years. This special concern remained established by the high priority given maternal and child health care in the Millennium Development Goals (MDGs), and further in recent times, the Sustainable Development Goals (SDGs).

Additional, in the succession of the millennium goal, the provision of antenatal care (ANC) services brings with it a positive impact on pregnancy as it enables the realization of risk factors and timely identification of pregnancy difficulties such as

preterm delivery and proper controlling (Ali, 2018). Since ANC is a major health intervention aimed at ensuring safe pregnancy outcomes to pregnant women, as a result the positive impact can be attained through screening for pregnancy complications, evaluating pregnancy danger, treating difficulties that may perhaps rise throughout the antenatal period, giving medication that may improve pregnancy outcomes, providing information to the pregnant woman, preparing physically and psychologically meant for childbearing as well as parenting (Adewuyi, 2018).

It is the common practices that at the first ANC visit to a healthcare facility, a pregnant woman have to be supplied with an ANC card. This card is the major consists of record of the pregnancy and is filled in each and every time the woman goes for an ANC appointment (Christopher, 2013). More, after the first call, the woman is reflected to be engaged for succeeding ANC calls to recognize the difficulties such as preterm delivery and manage these difficulties in well-timed way. The main appointment is significant for the reason that; it is when a woman is given a whole assessment of gestational age and the risk influences. A complete and correlated medical details is taken from the pregnant woman comprising of current pregnancy, prior pregnancies, prior details of preterm birth, difficulties and results, medical difficulties, as well as psychiatric complications and earlier operations, family and inherited illnesses, allergies, consumption of medicines, usage of alcohol, tobacco, and other matters as well as family and social environments (Isaac, 2012). A physical check is done and is distributed into three sorts together with an overall check, which includes weight, height, heart rate, the color of mucus membranes, blood pressure, check for edema, and palpitations of lymph nodes (Ali, 2018). In

addition, a systematic examination includes examination of teeth, gums, breasts, thyroid, and heart and lung functions.

To sum up, pregnancy associated check comprises examination and tremor of the pregnant uterus, with measurement of the symphysis-fundal height in centimeters. After that, pregnant women undergo essential screening investigations, which include syphilis serology, rhesus (D) blood group, hemoglobin (Hb) level, human immunodeficiency virus and protein and glucose levels in urine. All pregnant women are given supplements of ferrous sulphate tablets to prevent anemia, calcium tablets to prevent complications from pre-eclampsia, folic acid, and tetanus toxoid to prevent neonatal tetanus. In addition, ANC along with family planning, skilled delivery care, and emergency obstetric care, is a key component of the platform of services intended at improving maternal and neonatal health.

The scope of utilizing ANC facilities in emerging countries is affected by several aspects. According to Ali (2018), the personal determinants of maternal health care use may be distributed into influencing, enabling and need components. These determinants facilitate us to conceptualize the factors linked with ANC utilization.

In Zambia, antenatal care services being provided free of charge or sometimes at a minimal cost, despite of being provided free of charge but still only 19% of women attend ANC by their fourth month of confinement, as recommended by (Isaac, 2012). Further, an estimated 21% of pregnant women in urban and 18% in rural districts make their first ANC visit by 4 months of pregnancy. Young age, low educational level, shortage of a paid job, poor language proficiency, support from a social

network and shortage of knowledge of the health care arrangement are related with insufficient ANC utilization. The absence of health coverage, the planned pattern of ANC, hospital type at booking, personalized communication, and knowledge of cultural practices of the care provider have been found to be associated with inadequate ANC services utilization (Gross, et al, 2012).

In Tanzania, maternal health care is one of the elements of the National Package of Essential Reproductive and Child Health Interventions Package centered on improving quality of life of women and young mothers. One of the areas the maternal health care element discourses is declining maternal deaths. Almost 9,000 women in Tanzania pass away every year in line for to pregnancy associated reasons and furthermore, around 250,000 women come to be incapacitated in line for the same grounds extremely compromising their reproductive health (Gross et al., 2012). Nevertheless, the initial outcomes of Demographic and Health Survey (2010) shows that the Estimated Maternal Mortality Ratio is 454 for every 100,000 live births in Tanzania.

More, one among the key essentials of Maternal Health is ANC; this aims on screen the woman's physical and emotional condition and foetus' physical condition for the period of pregnancy, but also ensure the early discovery of common difficulties and complications. According to the TDHS (2004/05), 94% of pregnant women make at least one antenatal care (ANC) visit and 62% of women have four or more ANC visits. The number of pregnant mothers in Tanzania making four or more ANC visits appears to have declined slightly from 70% in 1999. However, the quality of

antenatal care provided is inadequate. About 65% of the women have their blood pressure measured and 54% have blood samples taken for haemoglobin estimation and syphilis screening.

About 41% have urine analysis done and only 47% are informed of the danger signs in pregnancy (URT, 2010). Challenges facing Antenatal Care services include inadequate essential screening services such as laboratory services for syphilis screening, testing for haemoglobin and albumin, as well as lack of privacy and few skilled service providers. The TRCHS (1999) portrays that 44% of births take place at health facilities however 56% take place in home deliveries. Further, to all births informed in health facilities merely skilled personnel support 36% births. Moreover, the high degrees of home births are accredited by insufficiency access to health services, deficiency of working referral system, insufficient capability in terms of expert personnel, provided with tools and other socio-cultural influences near by the pregnant women.

Other factors comprise gender inequities in resolution making authority and access to resources at family level give to poor access and use of existing health care facilities and delay in referrals. Likewise, emergency obstetric carefulness facilities are still poor due for weak referral system, insufficient expert personnel and apparatus (*ibid*).

2.6 Assessment on the Challenges Facing Women in PNC Period

Globally women pass away due to childbirth every year. Likewise, in the context of the developed countries such as the United Kingdom and United States of America

there is a low Annual maternal mortality rate as compared to live births correspondingly (Chimtembo, et al. 2013). On the other side, in some African countries such as South Africa, maternal mortality rate is seen to be high relating to live births. However, the situation is different from other countries, in the Sub Sahara African countries there is high rates of maternal mortality as compared to live births (ibid). The World Health Organization (WHO) rave review on PNC suggests that for each uncomplicated vaginal birth in a health facility, healthy neonates should be given care in the facility for at least 24 hours.

Whether or not, the birth take place at home, the first postnatal contact should be at least within 24 hours of birth (Bwalya, 2017). Nevertheless, of residence of delivery, at least three other postnatal contacts are commended for all mothers and babies, on day 3 (48-72 hours), amongst days 7 and 14, and 6 weeks after birth. On the other hand, less than a quarter of babies in less advanced countries are given PNC within 48 hours of delivery. The postpartum period starts about an hour after the delivery of the placenta and consist of the following six weeks. Several studies in both high- and low-income countries have identified the importance of the postpartum period for acute short-term, long-term, and chronic morbidity. Moreover, up to two thirds of maternal deaths occur after delivery (Dhaher, et al. 2008). Consequently, the World Health Organization suggests that health care should be a condition that occurs after 6 hours, 6 days, 6 weeks, and 6 months of post-delivery, in order to ensure women's physical and mental health wellbeing.

In Zambia, there is a shortage of studies associated to PNC between infants, this is because the data on PNC amongst infants had not ever been gathered up until recent times in the course of 2013-14. Regardless of this shortage in empirical literature in Zambia, studies in further countries have shown that, nevertheless of whether birth happened at home or in health facility, a number of aspects contribute to low levels of PNC, that is the age of mother at birth, observed size at birth, maternal health education, household income status, maternal occupation position, geographical distance, like the home distance to a health care facility, place of delivery, deficiency on antenatal care, and home place, amongst others (Bwalya, 2017).

In Malawi, the assessed maternal mortality is said to be high relating to the live births. In relation to that, PNC is seen to be the most abandoned part in the health care supply system regardless of being very significant time for the delivery of interventions that are vibrant to the health of both the mother and the newborn (Chimtembo, et al. 2013). As a result, serious difficulties which account for two thirds (2/3) of all maternal and newborn passing away; arise for the period of the postnatal period. Moreover, in Malawi, most of the maternal deaths happen in the course of the postpartum period, of which some happen for the period of the first week and others happen very soon within 2 weeks after delivery. Therefore, to decrease these deaths, the Malawi Government framed a guide for the lessening of maternal and neonatal mortality.

High rate of maternal mortality is among the major problems of public health importance. In sub-Saharan Africa, one in 16 women dies in pregnancy or childbirth

related causes (Filippi et al., 2006). This risk is 175 times higher than that in developed countries, i.e., one in 2800 (WHO, 2004). Tanzania is among the countries in sub-Saharan Africa with high rate of maternal mortality (Olsen et al., 2000; Mpembeni et al., 2007).

Estimates show that Tanzania ranks 6th among the 13 countries with highest levels of maternal mortality. These 13 countries account for 67% of all maternal deaths (WHO, 2004). The Maternal Mortality Ratio (MMR) for Tanzania is estimated to be 454 maternal deaths per 100,000 live births i.e., for every 1,000 live births; about four to five women die of pregnancy-related causes (URT, 2010).

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According to URT (2010), high level of maternal death is among the major difficulties of public health significance. In sub-Saharan Africa, the situation is worse whereas the number of women pass away during pregnancy is high compared to that of live births, this happened from childbirth associated grounds. In so doing, the situation is very high compared to that from the developed countries (WHO, 2004).

Likewise, as Tanzania is amongst the countries found in sub-Saharan Africa with high rate of maternal mortality, therefore, the approximations show that Tanzania position is 6th amongst the 13 countries with highest levels of maternal mortality (ibid). In Tanzania, likewise there is high level of maternal mortality compared to live births and under-five child mortality with 32 % of the latter mortality occurring in the first month of life (Mohan, et al. 2015).

Therefore, high rates in maternal passing away are mostly in line for limited access and use of maternal health care services. According to Lwelamira (2015), postnatal deaths caused by obstetric influences arise within few weeks post-delivery. Most of maternal deaths can be prevented by utilization of maternal health care services in health facilities among women.

2.7 Research Gap

Despite of the national and international health strategic plan in the Sustainable Development Goals (SDG) era 2016–2030, and also Tanzania making major

progress in reducing newborn and child mortality, childhood malnutrition and the battle against major communicable diseases including HIV, Tuberculosis (TB) and malaria, but still maternal deaths are common everywhere in the entire world and affects many people especially women (Tanzania-WHO, 2010). For that reason, numerous empirical literatures reviewed above revealed that most of studies conducted were mainly focused on general bio-medical maternal health care, ANC together with PNC. The aspect of demographic, social-cultural, norms, and socio-economic challenges encountered by pregnant women when accessing the ANC and PNC services was ignored. It is therefore the reason to have undertaken this study in order to fill in the identified gap.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter focused on describing the research design, research population, sampling procedures, and area where data were collected. Further, the chapter presented the research ethical considerations, and the way data were collected, analyzed, and later presented. Miller (1991) defines methodology as the guidelines which carry information on the way will be collected, analyzed and later on presented. Adding on, the section on methodology reveals the limitations of available resources needed during the whole process of research work; it further presents the assumptions involved in any research work and how each of the consequences or treats would be dealt with. Moreover, Nachimias (1996) noted that it is the scientific system which carries within it the procedures in which research draws its basis of arguments.

3.2 Research Methodology

Research methodology is a systematic way of dealing or solving any presented problem or the existing problem. Generally, it can be said that, is a science which shows how the research evolves while observing the scientific provisions (Kothari, 2004). It further includes the methods used for data gathering, processing and presentation of results. Subsequently this study has employed both qualitative and quantitative research designs which were used to collect relevant details of the topic under study. The questions regardless of whether qualitative or quantitative based

were formulated while observing their relevance to the study topic but also the composed research specific objectives.

Highlighting on qualitative research, Hartley (1994) noted that it is the information collected for the purpose of responding to specific identified problem while using rich collected details about the presented problem. The collected details are further analyzed in order to have a specific meaning from each of the category of information generated. It is worth noting that qualitative in nature allow the research to obtain information from the natural setting while allowing addition information to be obtained at the same time, observation is used to compliment the obtained details. On the other hand, Hartley (1994) stated that quantitative research is very useful method as it collects the details from the field using specific questions designed while observing the requirement of the current study or the specific objective of the study. Quantitative generally utilizes structured or same structured questionnaires.

Generally, when qualitative and quantitative researches are used complimentary like in this study, they tend to fill in the gaps and take care of the weakness of each other. The complexity matters such as issues related to pre- and post-antenatal can be dealt with using the combination of the two. When the two research methods such as qualitative and quantitative are used in a single study are known as triangulation of mixed method (Kothali, 2008). The complexity issues related to the treatment of health personnel, social welfare officers, the family and community members of the pregnant women, the pregnant women themselves can be understood well, their

connection and relationship using mixed method as it is the case for the current study.

3.3 Research Design

Generally, Kothari (2004) defined the plan, or the procedures required for data collection and analysis as research design. Actually, it aims to provide the guidelines on the structure and framework on the collection, analysis, and presentation of data (Kothari, 2008). In nutshell, the research design helps in creating a foundation of the approach in which the data collection process finds its foundation.

Moreover, this research adopted a cross - sectional as its research design. When this design is used it allows data to be collected once from the research subjects, hence it is cost effective and allow the researcher to collect all required information for a specific period of time. The design adopted for this study allows the subset of the population to represent the whole population; it further allows the comparison and differences between numerous (Bailey, 1998). Adding on, the cross-sectional design is advantageous as it accepts collection of information (data) from various respondents in a specified period of time, usually very short with limited resources. It is for this reason; this study utilized the cross-sectional design around women access the pre- and post-natal services from Bugando Referral hospital in Mwanza

3.4 Area of the Study

This study was conducted at Bugando referral hospital in Mwanza. This area has been chosen by the researcher essentially because there have been a variety of program implemented by the government and other stakeholders to improve

accessibility and affordability of health services to pregnant women. These services include the pre- and post-HIV/AIDS counseling, various vaccination, reproductive health to young women and the pre-and post-natal services. Since issues related to pre- and post-natal involves aspects of human rights and this is one of health facility which also faces the maternal challenges and death of women and infants, it is therefore timely for this study to be conducted in order to find the determinants factors.

3.4.1 Geographical Characteristics of Bugando Referral Hospital

It worth noting that Bugando referral hospital which is located on the shore of Lake Victoria is one of the five referral hospitals in Tanzania. For many years, it has been providing its health services to all Tanzanians especially in Lake Zone. Bugando Referral Hospital (BRH) is located in Mwanza region, which covers the total area of 9,467 km²of land and water. It lies between latitudes -2° 44’ and 59.99” south of the Equator and longitudes 32° 44’ and 59.99" east of Greenwich. The geographical location of Mwanza is bordered from the north with Lake Victoria on the side of east Simiyu region, to the south it boarders with Shinyanga region (NBS, 2017).

According to the 2012 Tanzania National Census, the population of Mwanza region is 2.773 million. Moreover, NBS (20017) describes the dominant tribe in Mwanza region as Wasukuma tribe with other tribes migrating from the nearby regions such as Kagera and Mara. Furthermore, at least 80% of the populations of the region depend on agriculture, animal husbandry and fishing for their livelihood. However,

other economic activities take place in the region including small scale business activities.

3.5 Population of the Study

Population of the study is referred as a set of elements that is drawn from the general population so that it can be testable and can be generalizable (Bless et al., 2007). Hence, the population for this study involved health worker practitioners from BRH, social welfare officers working in BRH and women who have accessed health related services during pre- and post-natal.

3.6 Sampling Procedures and Techniques

3.6.1 Sample

Sample is referred to a set of research subjects selected from a general population (Salant and Dillman, 1994). The sample for this study therefore was drawn from the population of the service provider and recipient of health-related services from BRH. This population was selected due to the fact that it was homogeneous in nature.

3.6.2 Sampling Design

Kothari (2008) stated that a sampling design is a specific plan developed to obtain sample, which is usually done before data are collected from the natural setting. Due to the nature of this study, the information was collected and extracted from different research subjects while observing both simple random sampling and purposeful sampling. The simple random and purposive sampling were used to get the required sample.

Normally when the simple random sampling is undertaken it provides equal opportunities for all people to be selected (Thomson, 2012). The quantitative data were gathered using questionnaire where the short and precisely answers were sought from the research subjects. It is at this point the responses were collected, compared to find the similarities and differences among them.

Further, Bernard (2002) denotes that the purposeful sampling refers to the deliberate choice of an informant because of the qualities in terms of the rich information they have which is required for the current study. The purposeful sampling does not have a limitation of the participants; however, it allows people who are believes to be rich is the required information to be selected. Further, the voluntary participation is observed all the time and has to be willing to provide required information. The qualitative method utilized purposeful sampling for the key informants and focus group discussion.

3.6.3 Sample Size

Kothari (2008) stated that sample size is normally obtained or drawn from the general population to be research on. Depend on the purpose of the study or its nature, where these two factors may inform the decision of time to be used for the study and the number of people which the sample size needed to inform it in terms research subjects. However, the obtained sample size has to be generalizable. It is for the reasons identified above where this study employed the formulae developed by Krejcie and Morgan (1970) to determine sample size of the study research subjects.

The formula follows below:

Sample size = $\frac{\chi^2 NP(1-P)}{C^2(N-1)+\chi^2 P(1-P)}$ Where χ^2 is the chi-square value for 1 degree of freedom at some desired probability level (3.841), N is the population size which include a total of 18,910 population of women who visited Bugando Referral hospital for the past three years, P is the population parameter of a variable (0.5) and C^2 is the confidence interval (0.01) (Bernard, 1995: 77).

Therefore, from the above formula the calculated sample size is 95.54 which were approximated to 100 sample size.

Table 3.1: Bugando Referral Hospital maternal records from 2018 - 2020

Year	Number of Women Visitation at the Hospital
2018	6,110
2019	6,320
2020	6,480

3.7 Data Collection Methods

Given to the significance of both primary and secondary data, this study employed the two of them during the process of information collection. Walcott (2005) noted that the studies that uses both primary and secondary information normally avoids the pitfall that any other study which uses one of them is likely to encounter. Moreover, primary data are the information or details that are usually collected from the natural setting; sometimes referred as the original information. On the other hand, secondary data are the details or information which already exist as it was collected by another person, but another person have developed interest and would like to utilize or use them. The secondary data is applicable to both qualitative and quantitative details.

3.7.1 Primary Data Method

3.7.1.1 Focus Group Discussion

In a context of research, it is only focus group discussion according to Greenbaum (2000) which provides a platform for the study participants to share the views, perception, opinions, beliefs, attitudes, and frame of references that affect their lives around the topic under study. It is for these reasons as indicated that this study has adopted it as one of its data collection methods. Showing the flexibility and realistic when using FGD to collect data, Cresswel (2014) noted that depending on the need of the study, participants can be increased provided the sample size of the study is observed.

It is therefore for this reason; this study has employed it in order to understand the perceptions, attitude and views of women, social welfare officers and medical practitioners on issues related to pre- and post-natal at Bugando Referral Hospital.

3.7.1.2 Key Informant Interviews

Patton (2002) noted that the selection of key informant should be done very careful so that only those with firsthand hand information of the topic under study are the only one who is chosen. Further, it allows the data collector or research to clarify some information presented so that is sure of what has been shared related to the topic under study. It is the views of the participants in this context known as key informants which has be observed and respected all the times during data collection. However, the researcher has to be careful in collecting information, so that does not present his or her own views instead of those of the participants. In the context of this

work therefore, the key informants were women who accessed health related to pre- and post-natal, the social welfare officers and medical practitioners. They were exposed on the interview guide which sought their views, opinions, and attitudes of the topic under study.

3.7.1.3 Questionnaires and Surveys

Gillham (2008) stated that a questionnaire is a designed instrument consists of a series of questions which aims at collecting details from the respondents during survey. It is normally prepared to carter for a specific topic and area of study; this means that it cannot be used with a different study with different research objectives. In nutshell, the series of questions are developed while observing the set specific objectives of the study to be undertaken.

Additionally, questionnaires are very useful in collecting information related to demographic information such as age, marital status, education level, residential areas and sometimes the economic status of the respondents or their household during survey. Further, the specific objectives had some specific questions which helped this study to be rich in dealing with some issues as presented by the research subjects. In the context of this work, the questionnaires were self-administered to all research subjects such as women who accessed health related services during pre- and post-natal period at Bugando referral hospital.

Table 3.2: Category of research subjects and research tools

S/N	Categories	Number
01	Questionnaires	100
02	Interview Guide	6
03	Focus Group Discussion	14

3.7.2 Secondary Data Methods

Baker (2000) noted that secondary intends to collect, find out and organize all information related to the topic under study. Adding on, secondary data method refers to the constant review of literature which can inform the topic under study. The secondary therefore aims at collecting information related to the topic under study which enriching each segment of the study. It can be said therefore, the information collected and used for this study were intended to enrich the understanding of issues related to pre- and post-natal.

During the uses of secondary data, various libraries such as the Open University, the National library and Muhimbili Health Allied library were visited. Further, the search engine such as Google scholar was often used to get access to online or electronic journals and other related scholarly work. These scholarly works were very useful as it enriched the topic understudy with diverse information.

3.8 Data Processing and Analysis

Kothari (2008) opined that data process is the semifinal stage before producing final report. It involves editing, classify different information, coding and relating each piece of information and checking for its credibility to add value to the current study. On the other hand, data analysis is the interpretation of the findings through computer aided software such as SPSS for quantitative and Invivo or Atlas.ti for qualitative data.

In the context of this work, after the processing of data, analysis based on interpretation was done. In case of qualitative data, thematic analysis was done by

identifying common themes and grouped them in order to find the main themes. It is the main theme which was used for quotation to cement each argument.

On the other hand, the SPSS version 20.0 was used to generate tabulation and identify the relationships among variables. Descriptive analysis was done to the data obtained during survey to inform the specific objectives. Additionally, data presentation was done by using main thematic themes on the side of qualitative data while quantitative data were presented using pie charts, graphs and tables.

3.9 Reliability and Validity of Data

Reliability is always an essential part of any tool used for data collection. These tools before utilised to data collection have to be test so that the researcher is sure of them and their usefulness. According to Moskal, et al., (2000) therefore reliability is the degree to which tools used to data collection shows some degree of consistence. In order to ensure the usefulness of the tools used for data collection, the prepared tools such as questionnaires, interview guide and checklist were piloted before the actual work of data collection. After this exercise, the weakness identified was worked upon. After cross checking and re-assessing each tool for data collection, the final tools were prepared. The tool was subjected to pre testing in Arusha region.

On the other hand, validity is employed in any study for the purpose of decreasing the degree of error in the measurement used in any study (Creswell and Miller, 2000). Using questionnaires which was administer to all research subject it was possible to compare the degree of errors among responded questions and provided

answers. But also, reliability was ensured by using both probability and non-probability sampling so as to reduce biasness and supplementing information.

3.10 Ethical Consideration

Rubin and Babbie (2008) stated that ethical consideration refers to the guidelines and roles of what is ought to be done during the whole exercise of conducting research. Issues to consider as part of ethics during research may include confidentiality and anonymity, where the information collected from the research subjects were kept confidentially. Further, the research work was guided with the principle of voluntarism, where every person who was involved in this study had decision to continue or to end the participation in the study. Further still, the researcher was obliged to seek for consent from all research subjects before collecting information from them.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents the results and discussion of the collected data from the field. The results are presented and discussed while observing the specific objectives of the current study.

4.2 Demographic Factors Related to Maternal Care

Considering the sensitivity of the topic under study, the following demographic were treated as significant to inform this study, namely: age categories, education levels, marital status and location of districts where women visited Bugando referral hospital among research subjects.

4.2.1 Age Categories among Research Subjects

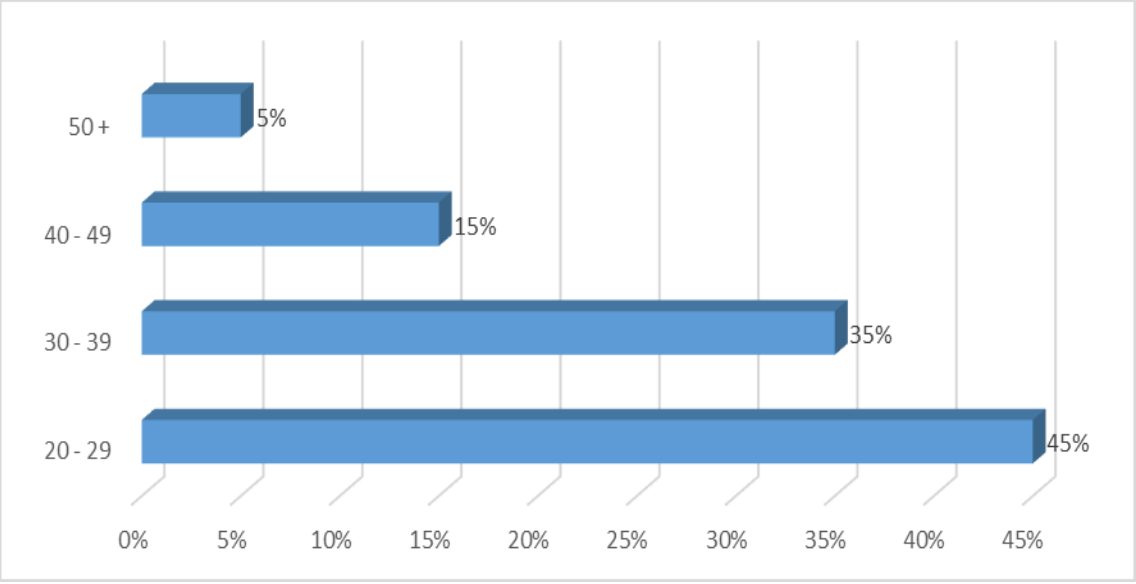

Figure 4.1: Age categories among research subjects

Figure 4.1 shows four categories of age responding with percent for each of them. Most of the respondents who accessed pre- and post-natal health services were in the age group of 20 – 29 with 45%. On the same note, the age group of 30 – 39 had the second majority with 35%. The least group was with 5% at the age of 50 and above.

The finding implies that most of the respondents from this study who accessed pre- and post-natal health related services were from the age category of 20 – 29 with 45%. Adding on, this age group shows that more women get pregnant at the same age category. It can also be argued that probably at this age category, most women get their first pregnancy, hence due to the complication related to it, they are forced to visit the hospital to access the health-related services while women in other categories, can ignore the services as it is not the first pregnancy.

The findings from this study were in agreement with the work of Mussa (2019) who proposed that at the age category of 19 – 30, most people show willingness in participating in issues related to social protection such as health. This is the case in this study were most of women participated as it was health related matters.

4.2.2 Education Levels among Research Subjects

Figure 4.2 indicates that most of the respondents had primary education (30%); 25% of respondents had completed secondary education; 18% were certificate holders; 15% were diploma holders; and the least were bachelor's holders with 12%.

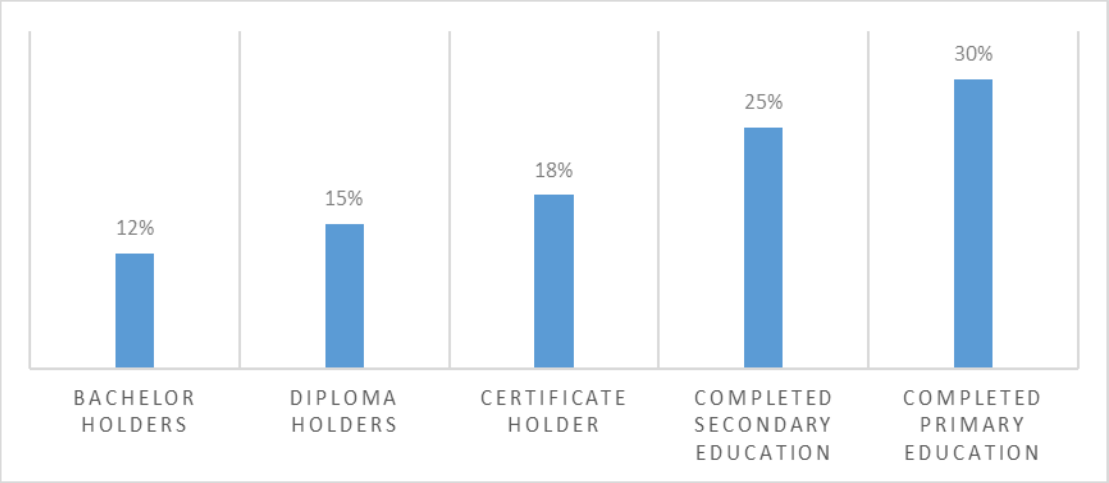

Figure 4.2: Education levels among research subjects

The finding implies that most of the respondents who access pre- and post-natal services at Bugando hospital were primary and secondary school levers. It further means that more education one achieves does not relate to seeking medical attention. These findings were echoing the work of Mbao (2019) who suggested that at relative tender age, women tend to access health services than when they become older.

4.2.3 Marital Status among Research Subjects

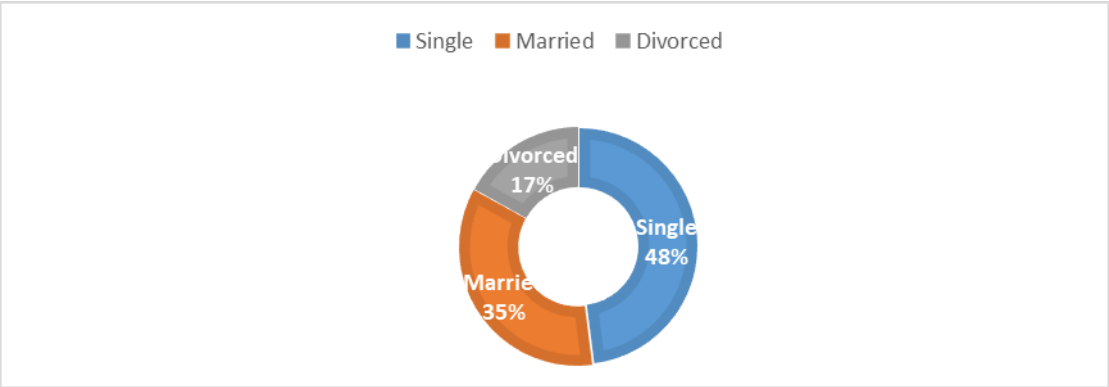

Figure 4.3: Marital status among research subjects

Figure 4.2 is represented with three variables of marital status, namely: single, married and divorced. It further shows that majority of women who access health

related to pre- and post-natal at Bugando referral hospital were singles with 48%; women who were married were only 35% while divorced were 17%.

The findings implies that there is some transformation taking place around families in Tanzania where for people to status family or to have a child does not have to wait until is married. Further, since those who access services were in the age category of 20 – 29 with primary school qualification, it justifies the reasons for majority of them to be singles.

4.2.4 Women who Visited Bugando Referral Hospital by District

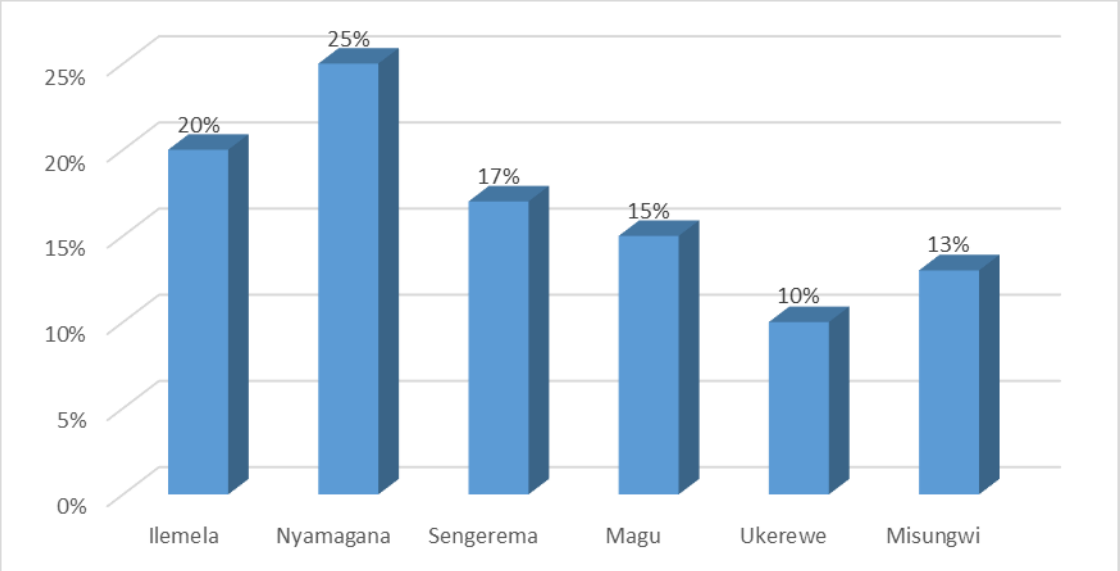

Figure 4.4: Women who visited Bugando Referral Hospital among Mwanza districts

Figure 4.4 presents the districts of Mwanza regional where some women visited Bugando referral hospital during their ANC and PNC. These districts include, Ilemela, Nyamagana, Sengerema, Magu, Ukerewe and Misungwi. As the figure

shows, Nyamagana had majority of women who visited the hospital by 25%; 20% were identified from Ilemela, 17% observed from Sengerema.

Magu, Ukerewe and Misungwi were marked between 15% and 10%. It is worth noting that the district of Kwimba and Buchosa though are part of Mwanza regional, were not represented during this study as no research subjects was sampled.

The findings implies that most of women who visited Bugando hospital were from Nyamagana and Ilemela, these districts actually form the large part of Mwanza city. It also shows that women who are in urban areas are very careful and informed of the importance to frequently check and take care of their health. On the other hand, it can be stated that women in urban area between the ages of 20 – 29 begin their family; and majority of them of the same age visits hospital for consultation related to ANC and PNC. These finding concedes with the work of Mbao (2019) who argued that women at young age begins to visit hospital for health-related matters consultation, which is the case with the current study.

4.3 Challenges during Antenatal Care

This sub section is presented using two parts, namely identified abuses and identified challenges encountered by women during antenatal care.

4.3.1 Identified Abuses during Antenatal Care

This study identified three main abuses during antenatal care among women access health services at Bugando referral hospital. The identified abuses include emotional, physical, and psychological abuses.

Most of the respondents identified emotional abuse with 40% as the leading affecting women during ANC. Other abuses were physical abuse with 32% and psychological abuse which was the least among others with 28%.

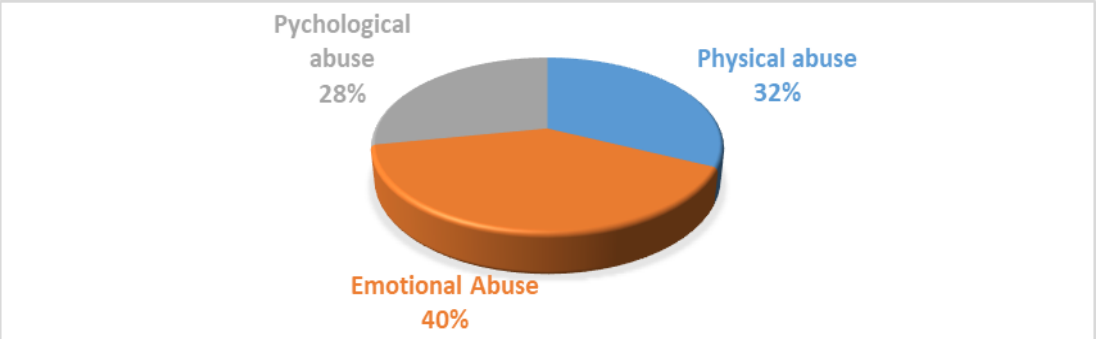

Figure 4.5: Abuses during ANC

The finding implies that most women during ANC encounter emotional abuses. However, the emotional abuse can be associated with questions asked by the medical practitioners or social welfare officers during pre- and post-testing of HIV/AIDS.

On the other hand, the findings from the qualitative data revealed the following as captured from women, social welfare, and medical practitioners. More details are provided below:

> *"It is a common practice to some pregnant women to begin the clinic while later, upon asking them for their delay, some of them may perceive it as an abuse. It is real very hard to work with people who do not like to cooperate while trying to provide health services to support their own health"*. (Focus Group Discussion with Medical practitioners at Bugando Referral Hospital).

On the same notch, some pregnant women indicated,

> *"Some medical officers when attending the clinic, it is like they have been waiting for you. When we just arrived, they ask questions which are very personal. When you decide to remain silent, it's a case to them while you are trying to keep peace around. Some of the questions they ask do not relate to ANC, but you just ask to upset you".* (Focus Group Discussion with pregnant women at Bugando Referral Hospital).

Supporting the above views, others states,

> *"Medical practitioners and social welfare officers' use very abusive language to us. Sometimes they do insult us over minor issues like delaying to arrive at the clinic. It is these insults which impact negatively on our emotional and psychological wellbeing. Last time, there was a woman who was pushed by a medical practitioner for not attending the clinic as it is supposed to be. All these concerns impact negatively on our wellbeing".* (Focus Group Discussion with pregnant women at Bugando Referral Hospital).

Furthermore, social welfare officers indicated,

> *"It is a great requirement for instance when a pregnant woman begin her clinic to test for HIV status with her spouse. However, many women go for testing alone, upon asking for the where about of their spouses, it is like begins a war with them. The end of it, you will be told to be abusing them psychologically or emotionally*." (Focus Group Discussion with social welfare officer at Bugando Referral Hospital).

The findings above, both quantitative and qualitative; show some similarity of the abuses that pregnant women are exposed to during antenatal care at Bugando referral hospital. The abuses range from emotion to psychological and physical abuses. It is evident that with these kinds of abuses, it affects the quality of health-related services provided to pregnant women during ANC.

Additionally, both the qualitative and quantitative findings mirror with the work of Gross, et al (2012) who observed of the abuses taking place in medical setting when dealing with pregnant women. They listed some of them to include emotional, psychological and physical abuses. It is from this point where improvement around the provision of quality care has to be thought about so the pregnant women do not decide to stay in order for the fear of these unethical practices among practitioners (Social welfare officers and medical practitioners).

Commenting on the impact of the psychological, emotional, and physical abuse around pregnant women, Ali (2018) noted that it results on poor adherence to health services provisions among pregnant women. He therefore proposed to parts involved to fully their obligation while observing the rights of unborn and born child. This advice does not only recognize the right of unborn and born child, it also shares the same views on the rights of pregnant women.

4.3.2 Identified Challenges during Antenatal Care

Figure 4.6 identified the following challenges during ANC, namely: abuses among health practitioners, long queues at the clinic, transport problem, less family support and long walking distance from home to the hospital.

The figure indicates that most of the respondents encountered abuses from the health practitioners (24%); while 22% of respondent indicated of a distance from home to hospital as a challenge. Moreover, other challenges such as long queues at the clinic, transport problem and less family support were between 20% and 17% respectively.

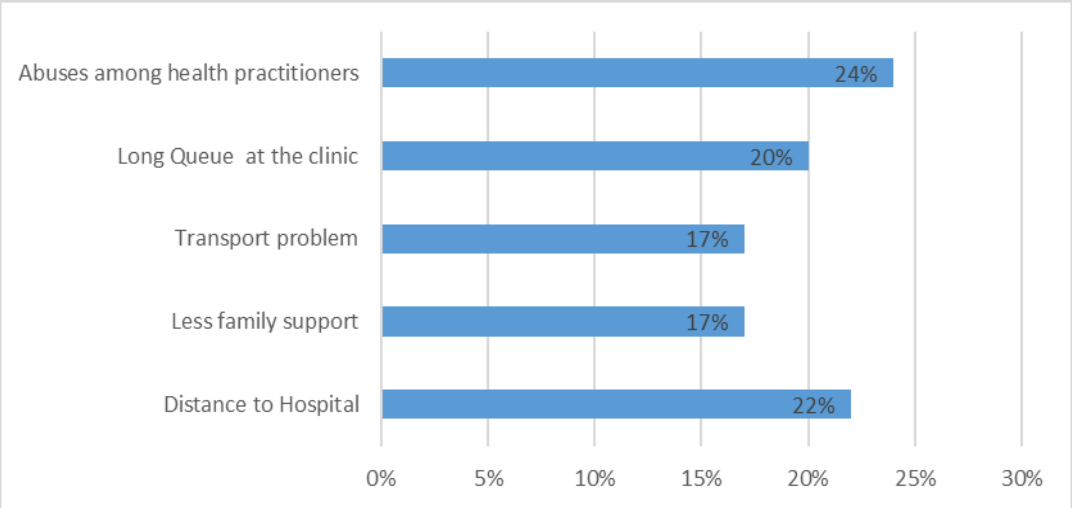

Figure 4.6: Challenges facing women during ANC

The findings imply that most women who visited the hospital during ANC and NPC encountered challenges related to abuses which were committed by medical practitioners. However, the abuses were not specifically identified.

In support of the quantitative finding, the qualitative data revealed the following,

> "*When attending the clinic, it is a common practice among medical practitioners to uses abusive language towards a pregnant mother. Sometimes, they may demand information which is not related to the* services they are providing. When refusing to respond or to share it to them, they begin to scold you heavily as if you have committed a crime". Focus group discussion with one of the women.

Commenting on the transport problem and less family support the following was reported,

> *"Normally the clinic is opened from 0800 hours in order to attend to the women who come from a distance. Since we have many women who come here, would like to begin saving them so can return early. However, due to transport problem, they arrive later, so of them around lunch time. While others due to less family support from their partners and family members may fail to attend the clinic accordingly*". In-depth interview with the medical practitioners and social welfare officers.

These findings above from the qualitative and quantitative shows the long way ahead of us towards realization of quality ANC and PNC services around women and children. These findings were in agreement with the work of Ali (2018) who recognized these challenges as may main setback towards alleviating increasing death among maternal care cases. He suggested of the family health education to be used so that members of the family can be aware of the support expected from them towards the child or the pregnant women.

4.4 Challenges Facing Women during PNC Period

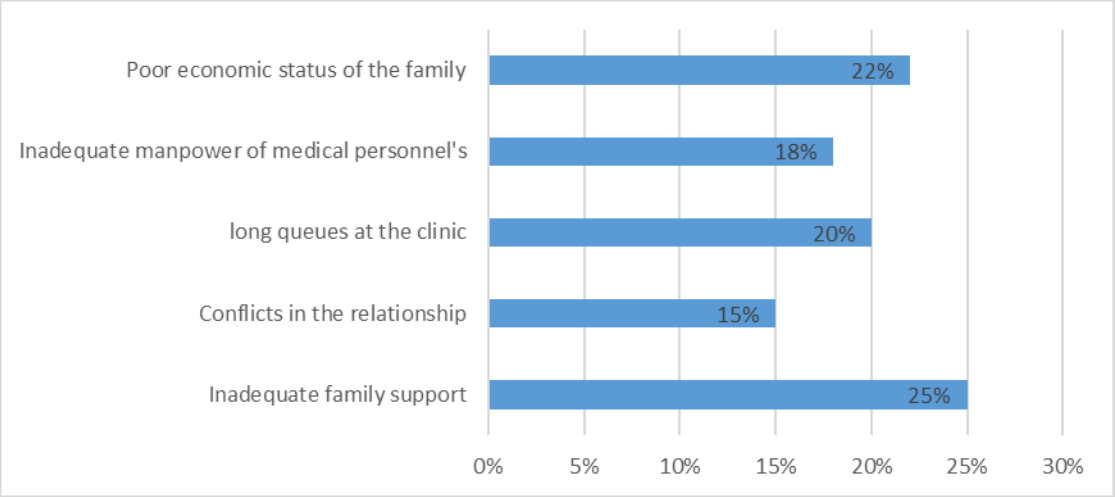

Figure 4.7: Identified Challenges facing women during PNC Period

Figure 4.7 presents the identified challenges during post-natal care among women accessing their health services from Bugando Referral hospital.

Some of the identified challenges with this study include poor economic status of the family, inadequate manpower of medical personnel's, long queues at the clinic, conflict in the relationship and inadequate family support.

Further, figure 4.6 shows that most of the respondents indicated to be challenged with two leading challenges, namely, the inadequate family support with 25%; and 22% was observed with poor economic status of the family. Other identified challenges were long queues at the clinic with 20%; inadequate manpower of medical personnel with 18%; and conflicts among partners or families.

The findings as indicated above implies that most of women who accessed PNC at Bugando hospital were challenged with inadequate family support and poor

economic status of the family where the basic necessities of the mother and the child cannot be met or provided. Many families due to limited knowledge of their primary role around PNC, they end up not considering the health and nutrition needs of the mother and the child.

The quantitative findings were further supported with the qualitative voices as presented below:

> *"…Children have their special specific needs that the family has to be aware of and provided them. However due to poor economic status, some of them do not prioritize these needs; instead, the child's needs are compromise which affects their growth…".* In-depth interview with women from Misungwi.

Showing the position of the conflicts among partner's one of the social welfare officers noted,

> *"In some circumstance the partner may live well during ANC, however after this period instead of remaining together for the interest of the child, they begin fights which force the partner to separate".* (In-depth interview with a social welfare officer).

Commenting on limited family support, one of the medical personnel revealed,

> *"It has been a practice here that during ANC women have to come with their partners. Key issues related to health and preparation of delivery is tabled and discussed one after the other. To some extent, the role of each partner is as well discussed. However, when they go back, they stop to support each other. Further, when the partners reside with others, they do not tell them of what role they have to play during PNC. This come a challenge to the mother and a child".* (In-depth interview with a medical practitioner).

The findings for quantitative and qualitative as indicated have shown that the common challenges identified among women accessing health services related to

PNC at Bungando Referral Hospital includes poor economic status of the family, inadequate manpower of medical personnel's, long queues at the clinic, conflict in the relationship and inadequate family support. With these challenges it can postulated that women and children cannot access quality PNC services as it is supposed to be. It is therefore proposed for responsible authority to work on the identified challenges so that women and children can access the services without delays. On the other hand, the family members have to be sensitized on the importance of supporting women and children to access their basic necessities such as balance diet and nutrition food that carters for the health needs.

Adding on, it seems many families in the study area do not intervene early with the family disputes; partners are left alone to deal with their situation. It is therefore a high time for families to support these newly families to deal with their marital conflicts for the interest of children.

The findings as presented on the challenges during PNC were in agreement with the study conducted by Niguss (2011) who proposed on the importance of supporting new families on the health needs of women and children during PNC period. Adding on, the family has to prioritize on the health-related demands of the children and women so that their body can regain important nutrients in their body. This can be achieved when there is a clear understanding of these needs and what each family member is supposed to do when providing support to children and women during PNC.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This study on ANC and PNC summaries the findings, presents the conclusion and recommendations for further actions to be taken in order to improve the health status among pregnant women, mothers, and children.

5.2 Summary

It was through the consulted research work around the topic where the researcher managed to come up with the title of the current study. The study was therefore entitled "***Examination of Challenges Facing Maternal Care among Women: A Case of Bugando Referral Hospital".*** The study was guided with three specific objectives, namely: (i) to identify demographic factors related to maternal care (ii) to assess the challenges facing women during antenatal care period and (iii) to assess the challenges facing women during PNC period. With these three specific objectives and due to various identified issues related to ANC and PNC, the study opted to be guided by Social Learning Theory. Moreover, the study had one hundred respondents who were women in their fertility time. These women were from seven districts of Mwanza region; twenty participants who were medical practitioners and social welfare officers at Bugando Referral Hospital.

Due to the nature of this study, cross sectional research design which utilizes qualitative and quantitative approaches, was applied was applied. It was employed in

order to yield quality information from the research subjects. Further, data for qualitative were collected using check list from medical practitioners, social welfare officers and women, while the quantitative information was collected using questionnaires. Lastly, data analysis was done using SPSS version 20.0 for quantitative data and thematic analysis for qualitative data.

The first objective: To identify demographic factors related to maternal care:
Four variables such as age categories, education levels, marital status and location of districts where women are analysed and discussed. The following were the findings; most women who access services were in the age category of 20 – 29 with primary school qualification, it justifies the reasons for majority of them to be singles. Adding on, women who visited Bugando hospital were from Nyamagana and Ilemela, these districts form the large part of Mwanza city.

The second objective: To assess the challenges facing women during antenatal care period. The following were the identified challenges facing women during antenatal care period, namely: abuses among health practitioners, long queues at the clinic, transport problem, less family support and long walking distance from home to the hospital.

The third objective: To assess the challenges facing women during PNC period. The following were challenges facing women during PNC period, namely: poor economic status of the family, inadequate manpower of medical personnel's, long queues at the clinic, conflict in the relationship and inadequate family support.

5.3 Recommendations

Addressing challenges facing women during ANC and PNC using Bugando hospital as a case study, it allowed the researcher to come up with the following recommendations which are basically focused to women, family members, community, medical practitioners, and social welfare officers.

5.3.1 Recommendations For Women at Fertility Time

It was observed from the findings that women at the age group of 20 – 29 were the majority among others who visited the hospital; it is therefore recommended that women should seek for proper information related to ANC and PNC before deciding to have a child. This information would help them to make an informed decision of what is expected of them.

5.3.2 Recommendations for the Family

Family members bear the blame for not taking charges of their responsibility to protect the interest of the child. It was also observed that they provide less support to the partners and sometimes less support to address their disputes. It is therefore recommended that the family members should be aware of the rights of children and the impact of conflicts to the development of the child. Children have a right to be raised by both of their parents; hence parents have to be supported to remain together for the interest of the child.

5.3.3 Recommendations for the Community

The community at large has limited knowledge of ANC and PNC, hence it is

recommended for the responsible government organ to create this awareness so that children's and women's rights are not compromised.

5.3.4 Recommendations for the Medical Practitioners and Social Welfare Officers

The study has pinpointed on some abuses committed by the medical practitioners around women when access ANC and PNC services. It is therefore recommended that the responsible bodies have to work towards making sure the practitioners adhere with the ethical codes of their practices.

5.4 Conclusion

Social learning theory has shown that during the first pregnancy; at the age of 20 – 19 categories women tend to seek for health services. Some measures have to be taken among other age categories so that they do not stay away from accessing the health services as stay indoor would lead to some complications and sometimes death. But also, some women are complaining about bad treatment of health workers this is not new to most hospitals in the country, the study urges the concerned stakeholders to give serious attention to this issue and provide customer service education and monitoring especially to old health worker who could be a great group to set good example to young generation health workers.

On the other end health workers are complaining about HIV testing especially for spouses of women who attend maternal health services. This group of men who refuse to take such an important test should also be given awareness education on

importance of such tests to themselves, their women and children and whole family. The study also observed that there were no women who visited the hospital from the districts of Kwimba and Buchosa. This situation cannot go on unattended to; it is upon the hospital and social welfare officer to create awareness in these districts so that can as well visit the hospital to access the same services.

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APPENDICES

Appendix 1: Clearance Letter

THE OPEN UNIVERSITY OF TANZANIA

DIRECTORATE OF RESEARCH, PUBLICATIONS, AND POSTGRADUATE STUDIES

P.O. Box 23409 Fax: 255-22-2668759Dar es Salaam, Tanzania,
http://www.out.ac.tz

Tel: 255-22-2666752/2668445 ext.2101
Fax: 255-22-2668759,
E-mail: drpc@out.ac.tz

10/01/2018,

To The Regional Commissioner;

Mwanza.

RE: RESEARCH CLEARANCE

The Open University of Tanzania was established by an act of Parliament no. 17 of 1992. The act became operational on the 1st March 1993 by public notes No. 55 in the official Gazette. Act number 7 of 1992 has now been replaced by the Open University of Tanzania charter which is in line the university act of 2005. The charter became operational on 1st January 2007. One of the mission objectives of the university is to generate and apply knowledge through research. For this reason staff and students undertake research activities from time to time.

To facilitate the research function, the vice chancellor of the Open University of Tanzania was empowered to issue a research clearance to both staff and students of the university on behalf of the government of Tanzania and the Tanzania Commission of Science and Technology. The purpose of this letter is to introduce to you **Mr. John P. Fulli; PG 201703000,** who is a Master student at the Open University of Tanzania. By this letter, **Mr. John P. Fulli** has been granted clearance to conduct research in the country. The title of her research is **"An Examination of Challenges Facing Maternal Care among Women: A Case of Bugando Referral Hospital".** The research will be conducted in Mwanzat.

In case you need any further information, please contact:
The Deputy Vice Chancellor (Academic); The Open University of Tanzania; P.O. Box 23409; Dar es Salaam. Tel: 022-2-2668820

We thank you in advance for your cooperation and facilitation of this research activity.
Yours sincerely,

Prof Hossea Rwegoshora

For: VICE CHANCELLOR

OPEN UNIVERSITY OF TANZANIA

Appendix 2: Questionnaire

Questionnaire for Women Accessing Maternal Care Services at Bungando Referral Hospital

1. Age Category among Research Subjects
    a. 20 – 29
    b. 30 – 39
    c. 40 – 49
    d. 50 +
2. Education levels among Research Subjects
    a. Completed Primary Education
    b. Completed Secondary Education
    c. Certificate Holder
    d. Diploma Holder
    e. Bachelor holder
3. Marital Status among research subjects
    a. Single
    b. Married
    c. Divorced
4. When visited Buganda referral hospital where were you from?
    a. Ilemela
    b. Ukerewe
    c. Magu
    d. Sengerema
    e. Nyamagana
    f. Misungwi
    g. Kwimba
    h. Buchosa
5. After falling pregnant did you get any support from the family members?
    a. Yes
    b. No
6. What challenges among the following have you encountered during antenatal care?

a. Physical abuse
b. Psychological abuse
c. Emotional abuse

7. Who do you live with?
    a. My husband
    b. My fierce
    c. My parents
    d. Alone
    e. Relative
8. Why are you not staying at home?
    a. After falling pregnant wanted freedom
    b. The family pressure for me to leave home
    c. My partner wants
9. What are the common challenges that you encountered during Antenatal Care?
    a. Abuse among health practitioners
    b. Long queue at the clinic
    c. Transport problem
    d. Less family supports
    e. Distance to hospital
10. What are challenges that faced women during postnatal care period?
    a. Poor economic status of the family
    b. Inadequate medical manpower at the health facility
    c. Long queues at the clinic
    d. Conflict in the relationship
    e. Inadequate family support

Appendix 3: Interview Guide

1. After falling pregnant why were you not supported by the family members? (Probe for more details)
2. What challenges did you encounter during antenatal care? (Probe for more details)
3. Explain, why are you not staying at home? (Probe for more details)
4. What are the common challenges that you encountered during Antenatal Care? (Probe for more details)
5. What are challenges that faced women during postnatal care period? (Probe for more details)
6. What do you think can be done to deal with the identified challenges during ACP and PCP? (Probe for more details)