ORIGINAL RESEARCH ARTICLE

‘She needs permission’: A qualitative study to examine barriers and enablers to accessing maternal and reproductive health services among women and their communities in rural Tanzania

DOI: 10.29063/ajrh2021/v25i3s.12

Karen Yeates[1], Sidonie Chard[2], Alexa Eberle[3], Alexandra Lucchese[4], Nicola West[5], Melinda Chelva[1], Prisca Dominic Marandu[5], Graeme Smith[6], Sanchit Kaushal[4], Zacharia Mtema[7], Erica Erwin[8], Anna Nswilla[9], Robert Philemon Tillya[10]*

Department of Medicine, Queen’s University, Kingston, Ontario, Canada[1]; Department of Public Health Sciences, Queen’s University, Kingston, Ontario, Canada[2]; Center for Clinical Epidemiology, Lady Davis Institute, McGill University, Montreal, QC, Canada; Faculty of Health Sciences, Queen’s University, Kingston, Ontario, Canada[4]; Pamoja Tunaweza Women’s Centre, Moshi, Tanzania[5]; Department of Obstetrics and Gynecology, Queen’s University, Kingston, Ontario, Canada[6]; Ifakara Health Institute, Tanzania[7]; BORN Ontario/Obstetrics and Maternal Newborn Investigations, Ottawa, Ontario, Canada[8], Ministry of Health, Department of Policy and Planning, Tanzania[9], Department of Health Systems, Impact Evaluation and Policy, Ifakara Health Institute, Tanzania[10]

***For Correspondence:** E-mail: *yeatesk@queensu.ca*

Abstract

The objective of this study was to examine the factors which serve as barriers and enablers to accessing maternal and reproductive health services among women in rural Tanzania. A qualitative study, utilizing focus group discussions (FGDs), was conducted in three districts. An interview guide was developed that focused on individual or community-based factors affecting women’s access to reproductive and maternal health services. Data was collected during December 2017 and May 2018, and analyzed using a thematic approach. The barriers included a lack of autonomy, lack of knowledge and education, travel and transportation barriers, lack of financial resources, lack of infrastructure, lack of confidentiality, lack of male involvement, cultural beliefs, and the use of traditional birth attendants. In contrast, the increased autonomy for women and the implementation of government policies were identified as enablers. Innovations need to be identified that address these barriers in order to increase access to maternal and reproductive health services in these districts. *(Afr J Reprod Health 2021; 25[3s]: 121-134).*

Keywords: Autonomy, qualitative, maternal health, reproductive health, focus group

Résumé

L'objectif de cette étude était d'examiner les facteurs qui servent d'obstacles et de facilitateurs à l'accès aux services de santé maternelle et reproductive chez les femmes en Tanzanie rurale. Une étude qualitative, utilisant des discussions de groupe (FGD), a été menée dans trois districts. Un guide d'entretien a été élaboré, axé sur les facteurs individuels ou communautaires affectant l'accès des femmes aux services de santé reproductive et maternelle. Les données ont été collectées en décembre 2017 et mai 2018 et analysées selon une approche thématique. Les obstacles comprenaient le manque d'autonomie, le manque de connaissances et d'éducation, les obstacles aux déplacements et au transport, le manque de ressources financières, le manque d'infrastructures, le manque de confidentialité, le manque d'implication des hommes, les croyances culturelles et le recours à des accoucheuses traditionnelles. En revanche, l'autonomie accrue des femmes et la mise en œuvre des politiques gouvernementales ont été identifiées comme des catalyseurs. Des innovations doivent être identifiées pour surmonter ces obstacles afin d'améliorer l'accès aux services de santé maternelle et reproductive dans ces districts. *(Afr J Reprod Health 2021; 25[3s]: xx-xx).*

Mots-clés: Autonomie, qualitatif, santé maternelle, santé reproductive, focus group

Introduction

Low and middle-income countries contribute to the burden of maternal deaths worldwide, with a maternal mortality ratio (MMR) in 2017 of 462 per 100 000 live births, compared to 11 per 100 000 live births in high income countries[1]. According to the World Health Organization (WHO), 94 percent of maternal deaths occur in low and lower middle-income countries[1]. Notably, in sub-Saharan

African countries, in 2017, the MMR estimate was 542 per 100 000 live births, with a life-time risk of maternal death estimated at 1 in 37[1].

According to a study in 2015 that aimed at understanding the insufficient progress made for newborn survival and maternal health in Tanzania, inequities in family planning, and gaps in coverage and quality of care at birth, especially in rural parts of the country were identified as limiting factors[2]. The lack of family planning and proper maternal care is attributed to many factors including high costs, limited resources, lack of knowledge, traditional gender roles, cultural beliefs and health system factors[3-4]. Most maternal deaths in Tanzania are due to obstetrical complications, particularly hemorrhage and hypertensive disorders of pregnancy including pre-eclampsia and eclampsia[4]. Thus, they are preventable with access to adequate maternal care.

In 2002, Tanzania's Ministry of Health and Social Welfare developed and implemented a programme based on the WHO- recommendations on Focused Antenatal Care model[6]. The implementation involved health workers' training sessions at the district, regional, and national levels on the new Focused Antenatal Care Guidelines and integrated approach to care[7]. In Tanzania, the recommended package includes an initial visit before 16 weeks, a second visit between 20 and 24 weeks, a third visit between 28 and 32 weeks, and a fourth visit at 36 weeks[8]. The reduced number of visits, focus on quality of care, and the integration of services were intended to address some of the barriers to utilisation of services, and to improve the continuity of care in low resource settings.

The WHO and the Tanzanian Ministry of Health's antenatal care guidelines recommend at least four antenatal care visits for uncomplicated pregnancies, with the first visit starting before 12 weeks of gestation[910]. However, studies have indicated that the vast majority of women in sub-Saharan Africa start antenatal care considerably late[9,11-14]. A comparative analysis of the use of maternal health services in sub-Saharan Africa showed that adolescent mothers initiated antenatal care attendance even later than adult mothers[11]. The findings of the recent Tanzania Demographic and Health Survey showed that though over 90% of pregnant women attend antenatal care at least once, only 51% make four or more visits during their entire pregnancy, and only 24% of women make their first antenatal care attendance before the fourth month of pregnancy[2].

Broad challenges in the implementation of maternal and child health programs in Tanzania can be broken down into health system factors and non-health system factors. Health system factors include shortage of skilled providers, weak referral systems, low utilisation of services, lack of equipment/supplies, and weak health infrastructure and management. Non-health system factors include inadequate community involvement, gender inequality, cultural beliefs and practices, and a weak educational sector[15].

This qualitative study was part of a mixed-methods study on the effectiveness of a smartphone-based intervention used by health providers and community health workers (CHWs) to improve recognition, diagnosis, and management of pre-eclampsia and eclampsia, while also strengthening guideline-based processes of antenatal and postnatal care in health centres and hospitals in 3 districts in Tanzania. When we were developing our intervention and implementation plan, limited published evidence existed on the knowledge, attitudes, and beliefs of women, community, and health providers regarding pre-eclampsia and eclampsia in Tanzania.

Therefore, to develop our mHealth intervention, we first sought to explore and examine the knowledge, attitudes, beliefs and practices, among women, men, lay/community health providers, and community leaders- regarding barriers and facilitators for health seeking for reproductive health services including family planning, ante-natal and postnatal care, especially with respect to pre-eclampsia and eclampsia in Tanzania.

Methods

Study setting and study design

The study was conducted in the Geita, Singida, and Singida DC districts of Tanzania. These study areas were purposely selected because they were the study areas for a mixed-methods implementation research program that was implementing a mobile health and health worker training and support intervention program to improve processes of antenatal care. They were also the study districts in a cluster-randomized controlled trial of health facilities and communities that were the study sites

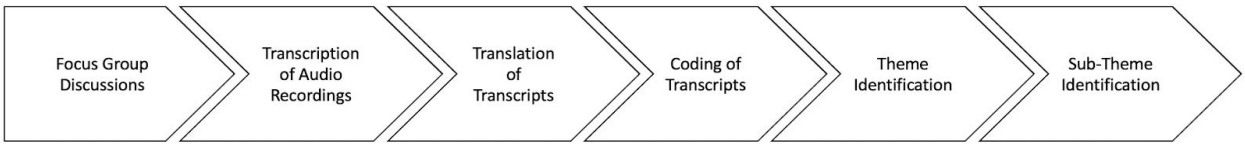

Figure 1: Description of study procedures and processes

Table 1: Provides a description of the participants that were recruited from the communities in the study areas

Community Based FGD Interview Participants					
Title	**Location**	**No. Interviewed**	**Median Age**	**No. Females**	**No. Males**
Unmarried Women	Geita	6	24	6	-
	Singida	7	23	7	-
Married Women	Geita	7	27	7	-
	Singida	7	31	7	-
Men (Single and Married)	Geita	8	38	-	8
	Singida	6	36	-	6
CHWs	Geita	2	33	-	2
	Singida	2	37	1	1
Traditional Healer	Geita	1	42	-	1
	Singida	0	-	-	-
Traditional Birth Attendant	Geita	1	38	1	-
	Singida	1	37	1	-

for a health provider targeted mobile health intervention, with a focus on improving detection and management of pre-eclampsia and eclampsia, and other processes of ante-natal and postnatal care. This was hoped to be achieved by strengthening linkages between pregnant women in rural communities with local health facilities, where antenatal care and obstetrical care by a skilled birth attendant was available. These districts were chosen because they were rural and had high maternal morbidity and mortality rates as well as other prominent indicators such as low use of modern contraception[2].

The research team developed a focus group discussion (FGD) interview guide that included questions set out to lead the discussion. The overall research objective focused on individual and community-based factors experienced by women that were considered barriers or enablers accessing reproductive and maternal health services (including contraception, antenatal care and postnatal services). A sample of some of the questions from the interview guide are listed below:

1. What do you know about maternal health?
2. What problems do women of this society have that affect fertility and care?
3. When women experience these challenges, what action do they take?
4. What beliefs do communities have in connection with family planning?
5. What diseases are common among pregnant women?
6. What are the strongest beliefs people have/understand about pregnancy?
7. Do women have a chance at decision–making, with respect to pregnancy and reproductive health care?
8. Are there any diseases of pregnancy that would take women to a traditional healer?

Participant sampling and recruitment

FGDs were conducted among women and men from health facilities and the communities in the areas of the study districts. The number of people involved in the FGDs was set in advance as 5-10 participants. Selection of participants was made in consultation with local health and village/community leaders who were affiliated with the community health management team, and who then identified and invited community members to participate based on participant criteria set by the researchers. Participants included unmarried women, married women, men, CHWs, traditional birth attendants, and other community leaders involved in community-based maternal health decision making (Table 1).

Data collection

First, a FGD interview guide was developed in English with a set of questions to lead the

discussions (Figure 1). It was then translated to the Kiswahili language and translated back to English (Figure 1). Data collection was done during the month of December 2017 and in May 2018 (Figure 1). FGDs were conducted in a quiet location and privacy was ensured to enable discussants to freely express their opinions. These FGDs were conducted for females and males separately in the community-based (no facility-based health providers) group sessions. In addition to taking field notes during the FGDs, all FGD sessions were audio taped (Figure 1). The sessions took about one and a half hours on average.

FGDs were chosen rather than other qualitative methods, as group dynamics and interaction was thought to create better anonymity and spontaneity. The combined effect of the group produced a wider range of information, insight, and ideas than the number of individuals' responses. The FGDs were conducted by skilled moderators who had training and experience in leading FGDs in similar contexts in rural Tanzania. A female team member of investigators and a female research assistant conducted the FGDs for women, and a male team member of investigators and a male research assistant conducted the FGDs for men.

Data analysis

Tape-recorded data were transcribed in Kiswahili and then transcribed to English for any outstanding questions, clarifications, and confirmation of findings from the initial transcription (Figure 1). Coding phases were discussed among the research team (SC, AL, AE) until consensus was reached (Figure 1). Thematic analysis based on initial coding was used to identify emergent themes and triangulate the information collected facilitated by NVivo for Mac v11.4.0 (QSR International, Melbourne, Australia) (Figure 1)[16,17]. This inductive approach allowed for establishing links between research objectives and findings from raw data, and developed a deeper understanding of the underlying experiences and processes evident in emergent themes[16,17]. Verbatim quotations were frequently used to illustrate the responses of the respondents on important issues and sub themes.

Results

A total of 15 FGD sessions were conducted. A total of 48 men and women participated in the FGDs with 18 men and 30 women across the Geita and Singida districts. The participants identified multiple factors that affected access to reproductive health services, including family planning and antenatal care. These factors were then classified into 2 major themes and a variety of sub-themes that are represented below, with supporting quotations.

Theme 1: Barriers related to accessing maternal healthcare

Lack of autonomy in health seeking

The majority of statements that women made in the FGDs indicated their difficulty in accessing maternal health services at health facilities, as they lack the autonomy within their household or family to make independent decisions, even under circumstances where they want to seek health care services. One participant stated that:

"Women can't make decisions. Only a man makes decisions, I see in my grandmothers, my mother, for example when my grandfather wants to sell his farm and grandmother refuses, he will still sell it. Women do not have any authority." (Married Woman)

One CHW also said:

"She needs permission from her husband or family, sometimes men bring their wives to the hospital."

One participant in a male FGD in the community discussed that although a pregnant woman may know that she needs to access antenatal care, her husband or partner may not be educated about her treatment needs and this will impede her ability to access care:

"And even if the woman understands it enough she is waiting for permission from her husband to go to the clinic, so if a man does not have enough education about the treatment of a pregnant mother, you will find that he will not allow a woman to go to such services or delay in receiving services, later problems find that pregnant woman." (Man)

When the FGD was discussing access to reproductive health services more broadly, one married woman offered that one may want to access contraception and access it without telling her husband or partner as this can cause trouble in the marriage:

"You can tell a man you want to use contraception, but he doesn't want it, so you must be using it secretly. The issue of using contraceptives is until you have consulted a man otherwise you can break up the marriage." (Married Woman)

Lack of knowledge and education regarding healthy pregnancy and pregnancy complications

Lack of knowledge and education regarding a healthy pregnancy and the severity and detrimental effects pertaining to pregnancy complications is of great harm to women in these communities. There is an emphasis on knowing what tasks can be accomplished during a pregnancy without harm to the child, as well as the importance of attending the clinic:

"Maternal health is a consideration of what pregnancy means, what to learn about pregnancy, and about how to protect the baby in the womb. What tasks can make a pregnant woman do which can cause harm to her so she can avoid them. And what work she can do while pregnant and on which period of pregnancy, and she needs to go to the clinic regularly to check on her health and the baby." (Unmarried Woman)

One participant in the male FGD also stated that a lack of education regarding maternal health and pregnancy in general may result in a woman failing to realize she is pregnant altogether, which may lead to an eventual termination of the pregnancy:

"You find a pregnant woman, she does not have enough education about pregnancy so she may become pregnant without knowing if she is pregnant and eventually starts treating other illnesses later, she destroys the pregnancy." (Man)

Women may also delay their attendance at the clinic as a result of lacking education regarding the matter, and refuse to visit the health center to obtain information altogether:

"I think more deeply what is causing them not to attend clinic on time is too little education, because you can find me as a man not involved at a certain percentage in that pregnancy, because there are other women you can advise to go to the health center to get more information but they refuse." (Man)

Other women may be deterred from visiting the clinic, as they may see it as a waste of time, unaware of its importance:

"Some of you find they just don't know the importance, they see wasting time, they don't see anything that helps her when she comes to the clinic so she thinks it's best to just stay home." (Unmarried Woman)

Additionally, women that had previously given birth at home with good outcomes, may not see the importance of attending the clinic. However, resulting complications may require her to visit the clinic during following pregnancies:

"You find out that the mother was pregnant and all three pregnancies were born at home now that the fourth one sees work going to the clinic. Now all these I have given birth at home, for what is the problem, even if I go there what is there? Why not give birth here? Now often when she comes to give birth she has problems." (Unmarried Woman)

Lack of knowledge regarding a healthy pregnancy, such as adequate nutrition, can also cause great harm. As one traditional birth attendant stated, this may be due to the poor economic situation in many households of rural Tanzania. An inadequate food supply for the woman may result in additional health problems and complications that arise during pregnancy.

"Health problems include nutrition for pregnant women. It is a problem because if you do not have nutrition and you have a baby in the womb it is a problem. And if we look at women, the economic situation of the women is so depressing, sometimes a woman doesn't eat food she prioritizes her family and forgets she is pregnant and needs to eat enough. At the end of the day she suffers from anemia, even without blood transfusions she has poor health until she gives birth." (Traditional Birth Attendant)

Furthermore, large family sizes may also contribute to malnutrition, which further contributes to a compromise in the health of the pregnant woman:

"Also, nutritional factors because you find that women are the ones who are struggling with farming but who has decisions with the fruits is male, and you find a man has two or three families,

now the pregnant woman lacks good nutrition due to family size which this man owns until it results in the mother's health deteriorates and ultimately leading to death." (Man)

Some members of the community recognize the importance of a healthy pregnancy on improving health outcomes in pregnant women. As one woman stated, a healthy pregnancy includes regularly attending the clinic and adequate nutrition:

"The health of the expectant mother, I try, is the most important thing that a pregnant woman needs to get healthy to help her deliver safely, such as attending a clinic, getting a good diet. She should get a good diet as a complete diet and attend health facilities when she feels different from her pregnancy." (Unmarried Woman)

A lack of knowledge regarding a healthy pregnancy can take the form of overworking oneself while pregnant, which may give rise to complications during birth:

"Heavy bleeding during birth, and this is caused by heavy work during pregnancy, and if you work too hard in the last trimester leads to a lot of blood loss on the day of birth." (Unmarried Woman)

Difficulties with travel and transportation

Inadequate transport and distance to a health facility for antenatal care, or to deliver her baby, was also identified as a barrier to accessing maternal health services at a health facility. This was mainly related to poor road infrastructure and lack of ambulances for transportation. In some cases, the health facility with the antenatal clinic is a lengthy distance from the community. Many families in these rural communities do not own vehicles, and options for transport might include a 'boda' (motorcycle taxi), or a three-wheel drive vehicle locally called 'Bajaj'. Both are not comfortable for pregnant and laboring mothers, and may not be available when needed, or have a financial cost to use.

One CHW suggested that a woman may delay her monthly visits to the antenatal clinic early on in the pregnancy, due to the long walking distance:

"Delay of starting a clinic, you find that one attends the clinic once or twice or is not going at all until she is about to give birth; and that is probably caused by the distance to the clinic."

A married woman also suggested that women start their antenatal visits late in their pregnancy, due to the length of time to travel to the clinic when she has chores waiting for her to do at home.

"Which challenges make women come late to the clinic? Other women hindered with house chores being plenty. If she starts the clinic early, she gets tired of walking every month to the clinic, so she has to jump some months."

Several men in the male FGDs highlighted road infrastructure and lack of adequate transportation as a definite barrier. One of the men in the FGDs said:

"Also, infrastructure like the road can cause problems for the pregnant woman, including the loss of her life and the baby too, the road gets worse so you find the birth date has arrived and then used bicycle, she will fail to get to the hospital and eventually give birth on the way and endanger her life and the baby."

Traditional birth attendants in the communities identified that road infrastructure and lack of transportation was also a barrier. This can lead to women choosing to receive their pregnancy care and delivery of their baby from a traditional birth attendant, and deliver at village health dispensaries where no skilled birth attendants are present. One traditional birth attendant said:

"But remoteness also contributes because there are some who are so far away, she can even give birth at a dispensary. Remoteness becomes a problem when you find yourself coming from a distant village, when she wants to give birth, that process of transport is there and she can give birth on the way, so some feel better to go to traditional midwives."

Lack of financial resources

Most FGD participants mentioned that women whose families do not have money for transportation and service cost (including cost of various treatments, such as facility-based delivery) prefer to stay at home during labor and delivery, and be attended by a traditional birth attendant. Even those who know the importance of institutional

delivery do not seek skilled attendant delivery at a health facility due to the lack of financial resources. Women also preferred to stay at home to save the money for their family, rather than using it for delivery at a health facility. This also leads to delays in seeking delivery by a skilled birth attendant (midwife) as early as possible.

"The challenges facing women in this community are poverty, I mean poverty means that a pregnant woman is about to give birth or while birth other problems occur, if an emergency happens she needs to undergo surgery now at our hospital their costs are different you are told two hundred, three hundred. Another was admitted two weeks ago, had eclampsia and underwent surgery, she paid six hundred thousand shillings. Such things are contributing to our society, especially pregnant women not getting qualified care." (Traditional Birth Attendant)

Lack of infrastructure, equipment and health provider resources in health facilities

Many participants described the lack of equipment and supplies as a barrier to women wanting to deliver at a health facility. This issue also causes financial strain on a family because the lack of basic supplies such as birth kits (pads, sutures, gloves) requires that a woman must purchase these items to bring with her when she is to deliver at a health facility. Lack of funds for this results in women choosing to deliver at home, as it will not cost the family any money.

"Another problem is the infrastructure, the challenges of pregnant women staying away from health centers, depends on her antenatal card telling her maybe she may have to give birth to a large hospital or health center, now the other pregnant women are reluctant, she get labor pain at home and goes to health facility and the facility is not adequately equipped, it becomes difficult to take her to a large hospital, it depends on whether the pregnant woman has complication can undergo risk, contributes to the negligence of following the instructions given at the clinic." (Traditional Birth Attendant)

Lack of confidentiality and stigmatization

As we have already presented earlier, we described the finding that men also control decision making about the use of contraception by their partners. Married women also identified that they felt they lacked privacy when seeking family planning counselling and treatment at health facilities, as other members of the community could see them and overhear conversations. This could lead them to assume that the woman was seeking contraception, since she was seen waiting near, or entering the room, where family planning services are delivered- this information could be provided back to her husband if she was seeking contraception without his consent.

"Is because of the arrangement of the facility we meet in one area for service, doctors' rooms, antenatal clinic, dressing room they are together. When I go to the contraception door, people are watching me and go tell my parents 'I have seen your daughter do one two three', or they will be going to tell my husband." (Married Woman)

Other participants also disclosed the lack of privacy they feel when seeking care at the local health facility where their neighbors and friends attend. This is often a barrier to them seeking antenatal care early on in their pregnancy, as even though a woman may not look pregnant yet, others will surmise that she is pregnant.

"And another thing in our society is that, when a woman gets pregnant it is something that makes her shy, she is embarrassed to start the clinic early, she sees everyone who already knows she is pregnant." (Married Woman)

Another prominent topic that arose when women were discussing lack of confidentiality and stigmatization, was the fear and experiences regarding testing for HIV infection that occurs during antenatal care, in order to prevent mother-to child-transmission of HIV.

"The lab is so small, and it is so crowded, you come in and find three or four people sitting there, how do you begin to express yourself?" (Married Woman)

The concern about lack of privacy and stigmatization if you are receiving treatment to prevent mother-to-child transmission of HIV, was also felt to be related to women not wanting to seek care early in their pregnancy (which they are frequently advised to do in order to be diagnosed

early with HIV and receive treatment to prevent transmission to their fetus).

"If you start clinic early and find that your health is weak, and neighbors seeing you going every month to the clinic say "this one is already infected with HIV, she has started taking medication" So you find many women are reluctant to start clinic early when the pregnancy is still young, but it is not advisable, pregnant women have to show early at the clinic to get their health checked." (Married Woman)

A Traditional Birth Attendant said:

"I see that the disease which can make a woman isolated or frighten her is HIV. This disease is not well received in our society and when a pregnant woman has it, it becomes more problematic." (Traditional Birth Attendant)

Use of traditional birth attendants

A driving force behind a woman choosing to give birth at home was due to a fear of leaving her other children unattended at home, while she delivers at the health facility. By giving birth at home, she would not have to travel to the hospital and leave her kids unsupervised:

"It is only during labor that the pregnant woman feels she has no need to go to the hospital, as she has no one to leave the children with which causes her to give birth at home." (CHW)

A traditional birth attendant stated that traditional midwives are trusted in the villages, regardless of the pregnant woman's education level. Additionally, it is the notion that if a midwife is unable to treat a woman, then a hospital will not be of much help either:

"There is a cultural concept, there are some women regardless of the education you provide to them, they have much trust in traditional midwives. You find traditional birth attendance charged her but no charges at the hospital; traditional midwives are trusted in villages. You find they tell you that, if a certain midwife has failed to help this woman, even going to the hospital cannot help, so, when complications rise, it becomes a problem." (Traditional Birth Attendant)

Additionally, pregnant women may have the understanding that certain complications can be managed and cured by traditional healers, rather than the hospital, and therefore be more inclined to seek treatment via natural remedies:

"There are sometimes pregnant women who have complications, those complications they associated with going to traditional healers. So even if a pregnant woman gets sick, even if they don't believe she is bewitched, they believe this problem can also be treated with natural remedies." (Traditional Birth Attendant)

Lack of male involvement

One unmarried woman highlighted that she has challenges attending the clinic as an unmarried woman, and particularly as an adolescent, as there is societal judgement regarding pre-marital sex and pregnancy.

"For example, most of us girls get pregnant, now when it is the first time she comes to the health facility, everyone is surprised they say "this little girl is pregnant" then when a pregnant woman hears that, she feels bad then it becomes a challenge for them to attend the clinic."

Women and men also identified that men's lack of involvement in supporting their partners to seek antenatal care and also in attending the antenatal visits with them was a strong barrier to women seeking facility-based antenatal clinic services. In Tanzania, the Antenatal Care Guidelines encourage male involvement by asking couples to attend ANC clinics together. There appears to be a perception among women and men that they are required to attend together. It is possible that women are scolded when they do not bring a male partner with them when they attend clinic, or that they will be turned away when they attend clinic. One male participant stated:

"In short, when a woman comes without a husband, she does not get the service, that is why you find other women giving birth at home or to traditional birth attendance. When a man is told to go to the clinic, he refuses, he has no idea what his responsibility is, seeing he is very disturbed he tells his wife to relax at home she will give birth at home or to a traditional midwife."

The lack of male involvement was frequently seen as a barrier to accessing maternal health care. Many CHWs said they frequently saw one of their roles as encouraging men and women to attend antenatal clinic visits together.

"The father of the family does not understand that pregnant women should attend the clinic early, until pregnancy reaches delivery, sometimes women come alone to the health facilities to give birth." (CHW)

Men and women also identified that the requirement for pregnant women to attend the antenatal clinic with their male partner directly resulted in a woman not knowing about the health of her fetus and how the pregnancy was progressing (including knowing her estimated delivery date or other guideline-based antenatal testing, such as testing for anemia and HIV).

Both male and female participants highlighted that not all women have a male partner, especially young women and adolescent girls, and therefore, this requirement poses a significant barrier to receiving care throughout a woman's pregnancy.

"Not all pregnant women are married (not all live with their husbands), and hospitals often require a woman to go with her husband, so most women are desperate to go to the clinic. Many are unaware that they will go for other tests, after which the pregnancy becomes greater and have never been to a clinic." (Man)

Women also noted that if a woman could not attend antenatal care because her husband would not attend with her, the woman could be subject to a fine. The community chairman may also negatively look upon the woman, her husband, and her family, for not receiving facility-based antenatal care.

"Most men refuse, that's why a pregnant woman comes to the clinic without a man and is sent back to bring a man." (Man)

Cultural beliefs

Cultural beliefs also presented as barriers to women accessing reproductive and maternal health services. An argument against the use of clinics for care and delivery was that such accommodations were absent in the past, yet pregnancies were still able to be conducted in a safe manner:

"Maybe by adding a little bit to this, if you look our environment and myths that we have, let's say a little less there are other women she can just say, or why in the past our elders had no clinics and they gave birth, there was no clinic and they gave birth safely, even I will give birth without problems." (Man)

In some cases, these cultural beliefs give rise to myths and misinformation that can negatively affect the community's perception of health, and lead to stigmatization related to a woman's role in the family to have children. As stated by a male participant in the FGDs, if a woman uses contraception, she may not be able to have children when she may choose to, and that her days will be 'invisible in time'; this refers to her perception in the community as a woman without a child. Specifically, her days would be 'invisible', as she would not be able to fill them with the necessary activities of child-rearing:

"It is also believed that if you take birth control pills you will not be able to have children. Also, other reasons for people not taking contraceptives are about a woman's days starting without a specific schedule or her days being invisible in time." (Man)

Theme 2: Factors that enable access to maternal and reproductive healthcare

Perceptions of increased women autonomy

An increase in autonomy was strongly associated with improved reproductive health and maternal care. Additionally, there has been a gradual increase in the decision-making abilities of women in rural districts in Tanzania, which has resulted in improved health outcomes. One unmarried woman in the FGDs stated:

"Now there is involvement, right now you can ask and be answered, and make decisions but in the beginning, there was none."

Additionally, one married woman stated that the aid and resources provided by programs such as Action Aid, a non-political, non-religious global justice organization, have provided women with a voice.

This has led to an increased sense of autonomy and involvement in decision-making:

"In decision-making, there are more differences than in the past. This has come after the Action Aid organization came to us and has continued to empower women to speak out wherever they are. This has helped women to identify themselves, so even though they are in a family meeting, they ask to speak, though it has not been all over the place, but it has helped so many women to get involved in various things."

Government policies on incentivization of health facilities utilization

In order to de-incentivize home births in Tanzania, the governments of the rural districts from which participants were interviewed have enacted various policies. For example, one CHW from the FGDs stated that women that require care at the hospital following a delivery at home are required to be identified and fined when they are brought to the health facility for care after delivery:

"They are delivering at home, which is why they are now forced not to deliver at home. Once they arrive at the clinic if she has delivered at home, she will have to give a letter of identification from the village chairman that she has delivered home, along with a receipt she paid ten thousand as fine to be received at the hospital." (CWH)

One male participant emphasized this policy and the potential for financial penalties for a woman delivering her baby at home, instead of in a health facility with a skilled birth attendant:

"But right now, if you give birth at home and if you are not brought in by the midwife, they must fine you fifty thousand shillings, because they are in control."

Another way in which the district leadership and health facilities are involved in incentivizing health facility attendance for antenatal care and/or facility-based deliveries is through distribution of free consumables such as flour, to pregnant women and their families. This is seen as a method of raising awareness and gaining interest regarding the benefits of attending the clinic for care:

"Then the clinic gives flour to pregnant women and children, so they announce in the village that flour is given for pregnant women and children. So, when the village turns up, they come flooding until nine o'clock, 10 o'clock leaving with a package of flour, that has also greatly contributed to drawing women to the clinic." (Man).

Discussion

This study gives in-depth insight into a range of factors that women, men and community members involved in maternal health care and decision making, perceive as barriers and enablers to healthy pregnancy, including access and utilization of facility-based reproductive health and maternal health services (antenatal care, delivery and post-natal care). Based on our thematic results, we've developed a pictorial summary of the barriers and enablers to accessing or seeking reproductive and maternal health services in rural Tanzania (Figure 2).

As evident in the pictorial summary above, in the 3 rural districts involved in the study, there were more barriers to women accessing or seeking reproductive and maternal health services, than enablers. Barriers included: 1) lack of autonomy in a patriarchal society, 2) lack of knowledge and education regarding healthy pregnancy and pregnancy complications, 3) travel and transportation, 4) lack of financial resources, 5) lack of infrastructure, equipment, and health provider resources at health facilities, 6) lack of confidentiality and stigmatization, 7) lack of male involvement, 9) cultural beliefs, and 10) use of traditional birth attendants. Enablers included: 1) increased autonomy and 2) implementation of government policies to increase and incentivize health facility utilization.

According to the FGD participants, the decision to seek antenatal care and delivery care at a health facility is mainly impacted by the control and decision of the male head of household. This is similar to the findings of a study done in Nepal, where men were stated to be the primary decision makers for their pregnant partners[18]. Similarly, a qualitative study conducted in Ethiopia identified that a woman's husband is given primary authority to decide where his wife will give birth, further highlighting the lack of independence and involvement women in Africa have in regards to their pregnancy decisions[19-20]. Interestingly, this study also highlighted that pregnant women who have more autonomy in making decisions pertaining to household expenses, are more likely to deliver at a health facility[20].

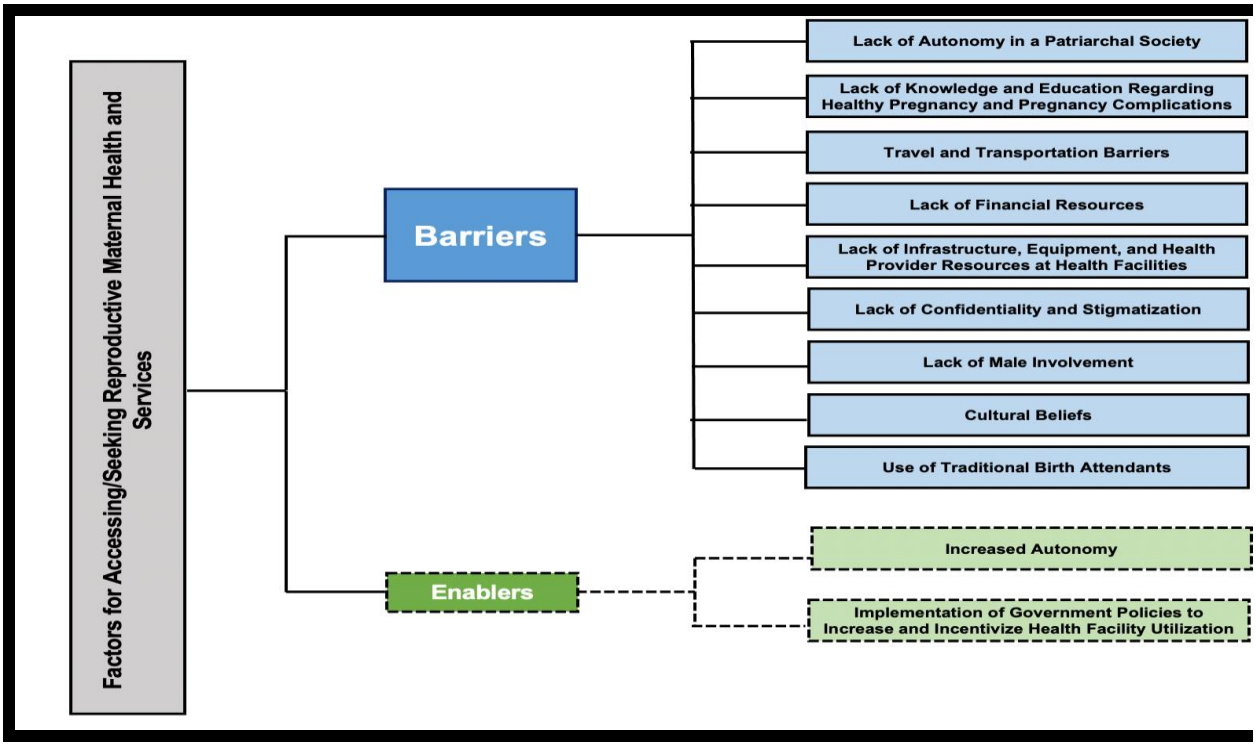

Figure 2: Summary of the barriers and enablers to accessing or seeking reproductive and maternal health services in rural Tanzania

The lack of knowledge and education regarding a healthy pregnancy and pregnancy complications was addressed as one of the primary barriers to a woman's access to maternal and reproductive health services. Members of the community stated that a lack of knowledge regarding the importance of antenatal care may deter women from attending the clinic altogether, or result in delayed antenatal care visits. These findings are similar to another study conducted in Tanzania, which stated that a pregnant woman's lack of awareness and belief in misconceptions, particularly in their first pregnancy, resulted in delayed antenatal care attendance[21]. Women were unaware as to when to attend an antenatal care clinic, and the number of visits recommended[21]. Additionally, women that previously gave birth at home with positive outcomes may lack the knowledge, nor, feel the need to attend the clinic during following pregnancies[22].

Economic factors, including transportation and health service costs, served as additional barriers to the FGD participants. This led to a lack of health seeking behavior for antenatal care and facility-based delivery, and women preferring care and home delivery by a traditional birth attendant. In a similar study conducted in Southern Ethiopia, women were interviewed in order to understand the popularity of home deliveries[19]. During these in-depth interviews, about 22% of the women identified that high cost was the most important barrier to inhibit them from seeking institutional delivery[19].

The lack of privacy at health facilities was also mentioned as another reason for not attending antenatal care, and for the preference of home delivery. In a study conducted in Tanzania, it was identified that the degree to which health facilities are sensitive to a pregnant woman's condition and medical status remains unknown[19]. Discrimination continues to serve as a significant barrier to pregnant women, suggesting the need to re-organize the structure of these health facilities, in order to alleviate feelings of insecurity[23,24].

Male and female participants both cited a lack of confidence in the capability of health facility staff to be able to provide the necessary care, especially when a woman was in labor, due to inadequate resources (including shortage of staff, equipment, and resources) at health facilities. The inaccessibility and unacceptability of health resources and infrastructure continues to present as a large gap in being able to achieve quality delivery of maternal health services in Africa[25]. In a

Tanzanian study aiming to understand the barriers to accessing maternal health services, it was revealed that a lack in health facility resources often results in health workers becoming frustrated, and often causes women to feel as though they don't have the right to adequate care[25].

The lack of male involvement was also mentioned to serve as a barrier to women accessing maternal health services. In many cases, the importance of a man was felt most by unmarried women, who stated that attending the clinic in the absence of a man led to societal judgement. Additionally, several participants stated that women who did not come to the clinic with a male partner were likely to be scolded or sent away. In another qualitative study conducted in Tanzania, health providers were aware of this limitation for pregnant women; however, shared the opinion that the policy was beneficial for the health of the pregnant mother and baby- in an effort to educate, counsel and test the man and woman together when possible[21,26,27]. Focused antenatal care (FANC) guidelines in Tanzania encourage couples to attend ANC clinics together[26-27]. Similarly, PMTCT guidelines also encourage participation of men in voluntary counselling and testing (VCT)[27-30].

Existing cultural beliefs were also identified as having a negative impact on the ability of women in rural districts to seek maternal healthcare services. Cultural beliefs gave rise to myths and misinformation related to reproductive health, including the belief that contraception (birth control pills) may cause infertility. Additionally, since healthy pregnancies in the past occurred in the absence of health facilities and clinics, many community members believed that antenatal care won't further improve delivery, or maternal health. However, this remains only as a cultural myth, as studies in West Africa have shown that about 25% of maternal deaths occur during the prenatal period, caused mainly by pre-eclampsia and antepartum haemorrhage- both likely to be prevented if pregnant women attend antenatal care, as recommended[31].

Many of the participants also indicated the use of traditional birth attendants to be a significant barrier to accessing or seeking maternal health services. In a study undertaken in rural Tanzania, it was determined that the health care system doesn't formally acknowledge the role of traditional birth attendants in maternal health[32]. Unfortunately, their contributions are also not well described in policy documents[32]. Implementing more initiatives to further train and include traditional birth attendants in the process of seeking maternal health services will increase the knowledge of traditional birth attendants, and help them establish a very trusting bond with women[32].

Interestingly, during our FGDs, two enablers were discovered in increasing access to maternal health services in these 3 rural districts in Tanzania; these included increasing autonomy (compared to historical levels) among women as decision makers regarding their own health and finances, and implementation of government policies to increase and incentivize health facility utilization for antenatal and facility births at facilities with skilled birth attendants. However, more effort needs to be taken in order to understand their significance as enablers, and the degree to which they increase the uptake of maternal health services for women.

Ethical considerations

Ethical clearance was obtained from Institutional Review Boards of Ifakara Health Institute, Queen's University, and the National Institute for Medical Research in Tanzania (NIMR) Institutional Review Board. The FGD participants had to be a resident in the local community and all participants had to provide informed consent to participate in the research, including recording of the FGDs. They were also told during the informed consent process that they should feel comfortable in openly discussing their experiences, beliefs, and opinions in a confidential group discussion. Additionally, they were told that their inputs would be completely confidential and that no identifying information about them would be recorded beyond the information collected in the informed consent process. Each participant was given a copy of the transcriptions. Consent at the community and individual levels was obtained in both verbal and written formats. Information regarding age, sex, marital and occupational status was collected by the research assistant, and remained with the data.

Strengths and Limitations

One strength of our study is that our analysis was based on data that was collected from multiple types of respondents, including married and unmarried women, men, CHWs, and traditional

birth attendants. Another strength of this study is the systematic way that themes were identified. All FGDs were qualitatively coded by three trained research team members. Discussions had to reach a consensus on the most important themes and subthemes to include in the paper. This process ensured maximal accuracy and reliability of our results, providing our study with optimal internal validity. A limitation of our study is that we obtained qualitative data from three districts of Tanzania, all of which are very rural and not representative of semi-urban or urban dwelling communities. Therefore, it is unclear if these results can be generalized to the country as a whole, or even to other low-income countries.

Conclusion

In Tanzania, individual autonomy, lack of financial resources, cultural beliefs, stigma and lack of male involvement remain significant barriers for women in seeking and accessing reproductive and antenatal care. Increasing autonomy and decision making power among women regarding seeking and accessing care is occurring and government policies and incentives are reported as having an impact on reducing barriers to reproductive and antenatal care. Further research to identify educational and health system interventions to reduce barriers further could improve uptake and access to reproductive health services and lead to improved maternal and child outcomes in Tanzania.

Acknowledgment

This work was carried out with the aid of a grant from the Innovating for Maternal and Child Health in Africa initiative - a partnership of Global Affairs Canada (GAC), the Canadian Institutes of Health Research (CIHR) and Canada's International Development Research Centre (IDRC).

References

1. Shabani J, Todd G, Nswilla A and Mbaruku G. Maternal mortality in urban and rural Tanzania Social determinants and health system efficiency. Policy brief 40424 | October 2018 International Growth Centre (www.theigc.org)
2. Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) [Tanzania Mainland], Ministry of Health (MoH) [Zanzibar], National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF. Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015-16. Dar es Salaam, Tanzania, and Rockville: MoHCDGEC, MoH, NBS, OCGS, and ICF; 2016.
3. Shija A, Msovela J and Mboera L. Maternal health in fifty years of Tanzania independence: Challenges and opportunities of reducing maternal mortality. Tanzania Journal of Health Research. 2012;13(5):352-64.
4. Maluka S, Joseph C, Fitzgerald S, Salim R and Kamuzora P. Why do pregnant women in Iringa region in Tanzania start antenatal care late? A qualitative analysis. BMC Pregnancy and Childbirth. 2020;20(1).
5. Savage A and Hoho L. Knowledge of pre-eclampsia in women living in Makole Ward, Dodoma, Tanzania. African Health Sciences. 2016;16(2):412.
6. von Both C, Flebetaa S, Makuwani A, Mpembeni R and Jahn A. How much time do health services spend on antenatal care? Implications for the introduction of the focused antenatal care model in Tanzania. BMC pregnancy and childbirth. 2006;6(1):6-22.
7. Nyamtema AS, Bartsch-de Jong A, Urassa DP, Hagen JP and van Roosmalen J. The quality of antenatal care in rural Tanzania: what is behind the number of visits? BMC pregnancy and childbirth. 2012; 12:70.
8. Magoma M, Requejo J, Merialdi M, Campbell OM, Cousens S and Filippi V. How much time is available for antenatal care consultations? Assessment of the quality of care in rural Tanzania. BMC pregnancy and childbirth. 2011; 11:64.
9. Villar J and Bergsjo P. WHO Antenatal Care Randomized Trial: Manual for the Implementation of the New Model Geneva: WHO; 2002.
10. Ndidi EP and Oseremen IG. Reasons given by pregnant women for late initiation of antenatal care in the Niger delta, Nigeria. Ghana Med J. 2010; 44:47–51.
11. Magadi MA, Agwanda AO and Obare FO. A comparative analysis of the use of maternal health services between teenagers and older mothers in sub-Saharan Africa: evidence from Demographic and Health Surveys (DHS). Soc Sci Med. 2007; 64:1311–25.
12. Kiwuwa MS and Mufubenga P. Use of antenatal care, maternity services, intermittent presumptive treatment and insecticide treated bed nets by pregnant women in Luwero district, Uganda. Malaria J. 2008; 7:44.
13. Ndidi EP and Oseremen IG. Reasons given by pregnant women for late initiation of antenatal care in the Niger delta, Nigeria. Ghana Med J. 2010; 44:47–51.
14. Bbaale E. Factors influencing the utilisation of antenatal care in Uganda. AMJ. 2011;4(9):516–26.
15. https://cdn2.sph.harvard.edu/wp-content/uploads/sites/32/2014/09/HSPH Tanzania5.pdf
16. Oppermannt M. Triangulation-A Methodological Discussion. Int J Tour res. 2000; 2:141-6.
17. Cresswell JW and Plano Clark VL. Designing and Conducting Mixed Methods Research. Third Edition. SAGE Publications, Inc. ISBN: 9781483344379. 2018.
18. Baral YR, Lyons K, Skinner J and van Teijlingen ER. Determinants of skilled birth attendants for delivery in Nepal. Kathmandu University. Med J. 2010; 8(No. 3|Issue 31):325–332.

19. Shiferaw S, Spigt M, Godefrooij M, Melkamu Y and Tekie M. Why do women prefer home births in Ethiopia? BMC Pregnancy Childbirth. 2013; 13:5
20. Margaret E, Kruk MP, Mbaruku G, de Pinho H and Galea S. Women's preferences for place of delivery in rural Tanzania: a population-based discrete choice experiment. Am J Public Health. 2009; 99:1666–1672.
21. Mgata S and Maluka SO. Factors for late initiation of antenatal care in Dar es Salaam, Tanzania: A qualitative study. BMC Pregnancy and Childbirth. 2019 Nov 12;19(1).
22. Maluka SO, Joseph C, Fitzgerald S, Salim R and Kamuzora P. Why do pregnant women in Iringa region in Tanzania start antenatal care late? A qualitative analysis. BMC Pregnancy and Childbirth. 2020 Feb 24;20(1).
23. Tancred T, Marchant T, Hanson C, Schellenberg J and Manzi F. Birth preparedness and place of birth in Tandahimba district, Tanzania: what women prepare for birth, where they go to deliver, and why. BMC Pregnancy Childbirth. 2016;16(65).
24. Kowalewski M, Jahn A and Kimatta SS. Why do at-risk mothers fail to reach referral level? Barriers beyond distance and cost. Afr J Reprod Health. 2000 Apr 4(1):100-9.
25. John T, Mkoka DA, Frumence G and Goicolea I. An account for barriers and strategies in fulfilling women's right to quality maternal health care: a qualitative study from rural Tanzania. BMC Pregnancy Childbirth. 2018;18(352).
26. Guidance on provider-initiated HIV testing and counselling in health facilities. 1.AIDS serodiagnosis. 2.HIV infections - diagnosis. 3.Counselling. 4.Guidelines. I.World Health Organization. II.UNAIDS. ISBN 978 92 4 159556 8 (NLM classification: WC 503.1)
27. Nyamtema AS, Bartsch-de Jong A, Urassa DP, Hagen JP, van Roosmalen J. The quality of antenatal care in rural Tanzania: what is behind the number of visits? BMC pregnancy and childbirth 2012; 12: 70
28. Maluka SO and Peneza AK. Perceptions on male involvement in pregnancy and childbirth in Masasi District, Tanzania: a qualitative study. Reprod Health. 2018;15(68).
29. Ganle JK and Dery I. 'What men don't know can hurt women's health': a qualitative study of the barriers to and opportunities for men's involvement in maternal healthcare in Ghana. Reprod Health. 2015 Oct 10; 12:93.
30. Moshi FV, Kibusi SM and Fabian F. The Effectiveness of Community-Based Continuous Training on Promoting Positive Behaviors towards Birth Preparedness, Male Involvement, and Maternal Services Utilization among Expecting Couples in Rukwa, Tanzania: A Theory of Planned Behavior Quasi-Experimental Study. J Environ Public Health. 2018 Sep 27;1293760.
31. Scott S, Kendall L, Gomez P, Howie SRC, Zaman SMA, Ceesay S, D'Alessandro U and Jasseh M. Effect of maternal death on child survival in rural West Africa: 25 years of prospective surveillance data in The Gambia. PLOS ONE. 2017 Feb 22;12(2): e0172286.
32. Shimpuku Y, Madeni FE, Shimoda K, Miura S and Mwilike B. Perceived differences on the role of traditional birth attendants in rural Tanzania: a qualitative study. BMC Pregnancy Childbirth. 2021; 21:137.