Tanzania: In their own words: Poor women and health services.

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Summary & Comment: "In Their Own Words: Poor Women And Health Services" highlights critical constraints that poor women experience in accessing health services, including the challenges they face and the strategies they use to overcome them. This summary report is meant to inform policy development and resource allocation in relation to basic services for the poor, and to mobilize the financial, human and material resources necessary to strengthen health services for women living in poverty. It is a 4 page companion piece to the longer "Poor peoples' experience of Health Services in Tanzania www.africafiles.org/article.asp?ID=7585 Women's Dignity specializes in treatment of and education on the problem of fistula in women when delivering a child.

In their own Words: Poor women and health services.

Access to health services

Health facilities are typically far away from where poor women live and are difficult to reach. Women reported having to walk as far as nine kilometers (km) away to reach a dispensary, and they sometimes walk much farther to reach a higher level health facility that can provide the services they need. In Korogwe district only 30 percent of the villages have a health facility. In Tunduru the nearest hospital may be 32 km away, and in Mpwapwa as far as 58 km.

Since emergency obstetric care is not available at dispensaries and health centres, women living in rural areas must travel long distances to a hospital in the event of a complication, or go without this care altogether. Women who reside in villages close to a main road may make use of public transportation – depending on available cash – but buses and other means of public transportation are neither reliable nor regularly available, and hiring a private vehicle is prohibitively expensive.

People most often walk by foot to seek services. Some may hire a bicycle, but many women reported not being able to afford the fee of Tshs 200 (US$0.20). In fact respondents reported that in cases of emergency – for example during a dangerously prolonged childbirth – women are often carried by stretcher the entire distance to a facility.

The situation is made even more problematic by the weak state of roads throughout much of the country, making travel extremely difficult by any means of transportation. This is particularly true during the rainy season where in some districts, for example Korogwe, the roads often become impassable.

Most poor women who are referred from lower to higher levels of health facilities fail to reach care because they lack either a means of transport or the money to pay for it. Ambulances are severely lacking in all three districts, although in Mpwapwa, district leaders are planning to buy three ambulances, plus bicycles and radio-calls for emergencies.

Cost and affordability of services

The cost of treatment is a serious barrier to care for poor women. Official charges, including the full service fee of Tshs 1,000 (US$1.00), can put treatment out of the reach of the poor. Furthermore, numerous participants reported having to pay bribes at health facilities in order to be treated. As a result of the cumulative costs, women seek care from traditional healers or in the words of one health worker, “they stay at home and wait for anything to happen to them, including death.”

Forced to find money for treatment, poor women resort to coping mechanisms that may drive them further into poverty. Many reported selling critical assets, including their crops, animals, land and their labour. Others borrow money, bond their assets, take their children out of school and cut back on food intake in order to pay for health care. If they fail to repay their debts, they lose their assets and become even more vulnerable. As the researchers found in Tunduru, “Borrowing is a problem. [Poor women] are the least trusted group as they are not capable of earning enough money to cater for their families and pay debts.”

Although government facilities have exemption and waiver mechanisms to provide free care to vulnerable social groups, they are not systematically implemented and therefore fail to protect the poorest of the poor. Health workers and health users alike have not been consistently informed about the criteria for exemptions and waivers, and there is confusion regarding the definitions of the two mechanisms. In some cases, people who are clearly eligible for one of the mechanisms are still denied treatment.

The *community health fund (*CHF*) scheme* is in place in Mpwapwa where pre-payment of an annual fee of Tshs 6,000 (US$6.00) covers unlimited primary care for a family of two parents and up to four children. Inability to pre-pay the annual fee, however, precludes most poor women from the scheme. Instead they opt for fee-for-service treatment where they pay Tshs 1,000 (US$1.00) for each visit to a health facility. In the long run the fee-for-service scheme may be a more costly alternative, but it is the only option available for people with scarce resources.

Quality of care

A range of service delivery problems decrease poor women's ability to access quality care. Women reported a frequent lack of medicines or inability to afford them, severe shortages of quality health care providers, disrespect from some health workers and cost as major barriers.

The availability and affordability of medicines is consistently cited as a serious problem by poor women. While government has recently increased resources going to drugs, poor women reported that they must purchase medicines outside of facilities, drug kits at facilities run out at mid-month, and it is not clear whether the cost of drugs is included in the mandatory fees that people pay for services.

Poor women and district officials alike reported the acute shortage of trained health care providers as a critical problem. In Tunduru there are only six doctors rather than the required 16; overall the district has a shortage of 158 providers. In Mpwapwa the shortage amounts to 228 health care providers.

While some research participants reported receiving good medical treatment regardless of being poor, many others described rude behavior among health workers. Some also talked about health workers' discrimination against the poor and their clear preference for paying clients. The very poor reported that they are forced to wait for care, because clients who are able to pay are taken first.

Government facilities are typically located closer to people living in rural and remote areas than are private facilities. Given the barriers posed by distance, the proximity of public facilities is a particular advantage for people living far from district headquarters. Government services were also seen to provide free services in certain cases – most likely due to exemptions and waivers (when granted). In some cases government facilities were reported to be more reliable than their private counterparts, except for the problems of medicines that are less available at government sites.

Overall, poor women reported that although private facilities are more costly, they give care more quickly, the staff are friendlier, and drugs and equipment are more available. An important advantage of private facilities in the views of poor women is that patients who cannot afford the fees can work (provide labour) in lieu of payment if necessary.

Quotations:

"Many [poor women] cannot afford transport costs [to health facilities], so they sell their food, borrow, use herbs or just wait to die."
Health worker, Mpwapwa

"I was sick but I did not go to hospital because I had no money.... I could not walk all those kilometers as a sick person."
35-year-old woman, Mpwapwa

"I fetched water to make bricks so that I could get money to take my child to the hospital."
Woman from Korogwe

"When a pregnant mother goes to the healthcare centre for delivery she has to carry things like gloves, razor blades, etc. If you have no money to buy them you will not be attended. They will harass you and ask you to deliver on your own."

37-year-old woman, Mpwapwa

“If a poor woman is admitted to the health centre and has no money to pay for her medicine, she will not get treatment.”
70-year-old woman, Mpwapwa

Why was this study done?

In Their Own Words: Poor Women And Health Services highlights critical constraints that poor women experience in accessing health services, including the challenges they face and the strategies they use to overcome them. This summary report is meant to inform policy development and resource allocation in relation to basic services for the poor, and to mobilize the financial, human and material resources necessary to strengthen health services for women living in poverty.

The study intentionally brings forward the voices of poor women. While their experiences are often representative of the challenges faced by poor people overall, their needs are also distinct. Women are typically the care-takers of entire families, especially children and family members who are themselves ill.
Women experience, uniquely, the successes and failures of maternal health services – often with tragic results. Women’s voices are generally less heard and certainly less heeded. Their insights and recommendations have the potential to create fundamental changes for marginalized people.

The *four main issues* raised by the women participating in this study point to key considerations for improving health services for the poor:
• Access to health services
• Cost and affordability of services
• Quality of care
• Governance and accountability

Data collection for this study was carried out in September and October 2003 by GRAFCA (*Grassroots Female Communicators Association*) in conjunction with *Women’s Dignity Project*.

Researchers visited three villages in each of three districts of Tanzania (Tunduru in the far south, Korogwe in the north, and Mpwapwa in the centre of the country). Despite the different locations, the three districts have similar problems. Most
notable is the poverty, which is pervasive. Each district also has both government and non-governmental and/or faith based organizations providing medical services.

Data collection included interviews and focus group discussions, informal household visits, and a mapping of facilities. In total, interviewers met with over 130 poor women. They also met with 35 village leaders, six senior district officials, 18 health workers and personnel in 16 religious institutions (e.g. churches and mosques). The data was analyzed by the GRAFCA researchers and the *Women’s Dignity Project* to draw out conclusions and recommendations.

Women’s Dignity Project has also published an extensive literature review on *Poor People’s Experiences of Health Services in Tanzania*. The report confirms the findings from this study on poor women and enables a further analysis of these critical issues.

Lastly, *Women’s Dignity Project* and *GRAFCA* would like to thank the women, government officials, community members and health workers who shared their time and concerns, making this report possible.

Governance and accountability

Study participants reported numerous instances of village and district officials assisting poor people to access care and manage health problems. There were also cases in which officials held health workers accountable for deficiencies in care or outright negligence. Health Service Boards are both wanted and needed to provide this support on an official basis.

Overall, however, reliable mechanisms are not in place for people to air grievances or lodge appeals. Poor women expressed their fears of “being avenged” by health workers if they were to raise concerns. Furthermore, health service fees and costs are not consistently published or communicated to the general population. Information is not

regularly available on official health charges. Similarly, people are not fully informed about exemptions and waivers and as such, these mechanisms to protect vulnerable groups are not reliably implemented.

WOMEN'S DIGNITY PROJECT

The *Women's Dignity Project* (WDP) was established to prevent and manage obstetric fistula,* enhance the dignity and rights of those living with the condition, and promote gender and health equity. We base our work on the understanding that health conditions affecting poor people result from social, economic and political factors that underlie poverty.

WDP seeks to:
• Better understand girls' and women's vulnerability to fistula
• Strengthen communities and organizations to take action on fistula and the inequities impacting the poor
• Stimulate public debate and action to address these inequities
• Influence programs and policies to promote the dignity and rights of the poor
WDP also assists girls and women to get fistula treatment and begin their lives anew.

If you would like to find out more about our work, or to support a girl or woman with fistula, please contact us:
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Tel: 255.22.2152577 or 8 • Fax: 255.22.2152986 • Email: **wdp@cats-net.com**

**Obstetric fistula is caused by prolonged and obstructed labour. The constant pressure of the baby's head in the birth canal causes a hole to form between the bladder and vagina (vesico-vaginal fistula or "VVF") or between the rectum*
and the vagina (recto-vaginal fistula or "RVF"). As a result, urine and/or feces leak continuously and uncontrollably from the mother's vagina. In nearly every case of fistula, the baby dies.

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