REPOA
P.O. Box 33223, Dar es Salaam, Tanzania
157 Mgombani Street, Regent Estate
Tel: +255 (0) 22 2700083 / 2772556
Fax: +255 (0) 22 2775738
Email: repoa@repoa.or.tz

Website: www.repoa.or.tz

ISBN: 978 9987 615 44 5

Understandings of Ethics in Maternal Health Care: an Exploration of Evidence From Four Districts in Tanzania

Paper 2 from the Ethics, Payments, and Maternal Survival Project

Paula Tibandebage, Tausi Kida,
Maureen Mackintosh and Joyce Ikingura

Working Paper
13/2

Understandings of Ethics in Maternal Health Care: an Exploration of Evidence From Four Districts in Tanzania

Paper 2 from the Ethics, Payments and Maternal Survival Project

By Paula Tibandebage*, Tausi Kida** Maureen Mackintosh*** and Joyce Ikingura****

*REPOA), Tanzania
** Economic and Social Research Foundation (ESRF), Tanzania
***The Open University, United Kingdom
****National Institute for Medical Research (NIMR), Tanzania

Working Paper 13/2

Published for: REPOA
P.O. Box 33223, Dar es Salaam, Tanzania
157 Mgombani Street, Regent Estate
Tel: +255 (0) 22 2700083 / 2772556
Fax: +255 (0) 22 2775738
Email: repoa@repoa.or.tz
Website: www.repoa.or.tz

Design: FGD Tanzania Ltd

Suggested Citation:
Paula Tibandebage, Tausi Kida, Maureen Mackintosh and Joyce Ikingura '*Understandings of Ethics in Maternal Health Care: an Exploration of Evidence From Four Districts in Tanzania'.*

Working Paper 13/2, Dar es Salaam, REPOA

Suggested Keywords:
Maternal Health Care, Maternal Health Survival, Ethics, payments, Empowering nurses

ISBN: 978 9987 615 44 5

Ethics, Payments and Maternal Survival Project - Paper 2

Acknowledgements

We are grateful to our hard working interviewers, who also worked on translation: Samwel Ebenezeri, Magdalena Shirima, Tumaini Mashina, Onike Mcharo, Caritas Pesha and especially Cornel Jahari who also managed the fieldwork and assisted in supervising the data entry and cleaning. We are also very grateful to the women and men who gave their time to the household interviews, and to the nurses, midwives, doctors, clinical officers, traditional birth attendants and other professional staff who answered our questions, often under great time constraints. Our deep gratitude to the advisers of this project – Prof. Siriel Massawe, Mr Gustav Moyo, Dr. Sebalda Leshabari, Prof. Pam Smith and Ms Rachel Celia – for their invaluable advice at all stages of the project. Our thanks also for commentary and encouragement from participants in the Institute of Philosophy and ESRC-Innogen Workshop *Health innovation and social equity in the 21st century: A multidisciplinary focus on health injustices* held at the University of London in May 2012. This work was supported by the Wellcome Trust [WT094966MA], to whom we are most grateful. The content of this paper is the sole responsibility of the authors.

Table of Contents

Abstract

What is ethical maternal health care? This paper describes and reflects upon the unprompted responses to this question by women who were pregnant and/or had given birth, and by maternal health care staff, in four districts of Tanzania. The paper draws on data from a research project on *Ethics, Payments and Maternal Survival*.. This is the third of a series of papers providing the findings of the project. In analysing the qualitative data, we draw on literature from medical and nursing ethics, from the feminist and philosophical literature on relational ethics and the role of emotions in ethics. We find that the predominant conceptions of ethical care among both the women and maternal health care staff interviewed are relational, and that there is a strong shared view between the two groups of respondents that contextual issues such as acute shortages of medical supplies and skilled staff are of serious ethical concern.

Acronyms

ANC	Antenatal care
DHS	Demographic and Health Survey
EmOC	Emergency Obstetric Care
ESRC	Economic and Social Research Council
ESRF	Economic and Social Research Foundation
FBO	Faith Based Organisation
MMR	Maternal Mortality Ratio
NIMR	National Institute for Medical Research
PNC	Post-natal care
TDHS	Tanzania Demographic and Health Survey
TSPA	Tanzania Service Provision Assessment Survey
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organisation

1 Introduction

Among global health injustices, maternal mortality in Tanzania, as well as in many other low-income African countries, stands out. Estimates from Demographic and Health Surveys (DHS) in Tanzania (1996 &2005) indicate that the maternal mortality ratio (MMR) increased from 529 deaths per 100,000 live births in 1996 to 578 in 2004/05. More recent data suggest that the MMR may now be decreasing, with the most recent national data (NBS and ICH Macro, 2011) estimating the MMR at 454 deaths per 100,000 live births. WHO and others. (2012) have revised the estimate downwards to 460 deaths per 100,000 live births. Margins of error in MMR calculations, however, are wide, and some estimates are much higher. For example, WHO et al in 2007 estimated the MMR in Tanzania was1,500 per 100,000 live births.

Within Tanzania, striking inequalities in access to maternal health care during delivery by geographical and socio-economic characteristics, such as area of residence (rural vs. urban), education level, and wealth status (Tibandebage and Mackintosh 2009) imply that MMR is likely to be higher among poor, less educated women living in rural areas (Mbaruku et al 2003; Macleod and Rhode 1998). Gendered health system failures have helped to generate high MMR (Tibandebage and Mackintosh 2009).

Access to maternal health care is formally free in Tanzania. However, informal charging, and requirements to privately purchase supplies and tests, are widespread (Storeng et al 2008; Perkins et al 2009; Kruk et al 2008). This is worrying, given that charging is known to reduce access to maternal care especially among the poorest (McDonagh & Goodburn 2001).

Since haemorrhage has been identified as the leading cause of maternal death in sub-Saharan Africa (SSA) followed by eclampsia, sepsis and obstructed labour (Ronsmans et al 2006; Khan et al 2006), a central explanation of maternal death rates is women's lack of access to competent emergency obstetric and medical care (EmOC) in the days after giving birth. Facilities at all levels are known to lack essential medicines, other essential supplies, and trained staff (TSPA 2006) with lower level facilities being particularly weak (Urassa 1997; Nyamtema et al 2008). In Tanzania – as elsewhere in the sub-Saharan region – staffing levels and staff attitudes are particularly poor in maternal health care. There are severe shortages of trained midwives, poor pay and conditions of work, and recurrent attitudinal problems including a culture of poor – even abusive – attitudes to women (Tibandebage & Mackintosh 2002, 2005; Mamdani & Bangser 2004; Grossman-Kendall et al 2001; Kyomuhendo 2003; Murray & Pearson 2006; Jewkes et al 1998; Gerein et al 2006).

This paper draws on evidence from a research project *Ethics, payments, and maternal survival*[1]. The project explored the interactions between payment-based care and ethical/unethical behaviour. We draw here on the project findings concerning understandings of ethics by both women in need of maternal health care and the nurses and nurse midwives who attend them.

1 'Ethics, payments and maternal survival in Tanzania' project has been funded by a grant from the Wellcome Trust, which has been channelled through REPOA.

2 Theory and Methods

2.1 Medical and Nursing Ethics

We cannot here survey the huge literature of medical and nursing ethics. Instead, we focus on a distinction between principle-based and relational ethics which we then explore within our empirical data.

Principle-based frameworks

Many ethical frameworks within the field of medicine share the characteristic that they formulate abstract principles intended to be of general application. Texts on medical ethics generally proceed in this manner. They set out to provide a set of *principles* to guide behaviour, particularly of doctors, though there are references to a wider range of medical professionals. An influential formulation is a set of four principles (Beauchamp and Childress 2009: 13):

- Respect for autonomy;
- Non-maleficence ('do no harm');
- Beneficence ('seek to do good');
- Justice.

Beauchamp and Childress (2009) argue that these ideal principles are not absolute rules, rather they are 'general norms of obligation' (p.13) that guide the formulation of more specific rules of behaviour. Such rules may include, for example, confidentiality, privacy and informed consent, which are all associated with respect for autonomy. The principles or 'moral norms' may also *conflict*: 'Principles…are not absolute merely because they are universal' (p.15).

Therefore, this approach formulates ideal principles and associated rules that should guide individual clinicians' behaviour. The final principle, justice, however raises questions that include but also go beyond ethical individual behaviour to address issues concerning priorities in the allocation of resources and distribution of the benefits of health care.

Theories of justice in health care may derive from principles of human rights. The human right to the highest attainable standard of health is legally protected by international human rights treaties, and is also recognised in regional treaties and embedded in the constitutions and laws of many countries (Hunt & Bueno de Mesquita, n.d.). A report to the UN Human Rights Council from the then UN Special Rapporteur on the right to health (Paul Hunt) argued that the right to the highest attainable standard of health entitles women access to key reproductive health care services that can prevent mortality (UN General Assembly, 2006). States have an obligation to progressively realise this right.

Justice in health care may also derive from principles of equity such as 'to each according to need'. In this account, fee-for-service charging can therefore be judged unethical since it is exclusionary and hence contradicts that principle. Health systems have often been the site of political efforts towards greater social equality, drawing on discourses of social justice (Freedman, 2005; Mackintosh, 2001). The concept of capabilities, in the work of philosopher Martha Nussbaum, and the economist Amartya Sen, provides another approach to equity. Society is seen as having a moral duty to establish for all citizens a threshold level of capabilities (or opportunities) to function as members of society. Such capabilities include a life not prematurely ended, bodily health and integrity, and having the social basis for self-respect and non-humiliation – which in turn implies non-discrimination (Nussbaum, 2001, pp. 416-418). In this account, if charging is associated with humiliation, it is unethical even when it is not exclusionary.

Finally, a utilitarian set of principles aggregates benefits of care to individuals on the basis of their ability to benefit. The use of aggregate burden of disease calculations to direct resource allocation is an influential example of this approach.

Relational ethics

Principle-based ethics can be contrasted with a second broad type of ethical reasoning that is relational, culturally embedded, and a matter of personal morality (Geisman et al., 2008; Kleinman & Benson, 2006). *Agent-relative* ethics allows that relationships and proximity may properly influence ethical judgements; that we should, for example, treat people to whom we are personally committed better than strangers. More generally, it is observed that norms of ethical behaviour vary locally and cross-culturally as well as responding to institutional and contextual change. Transactions respond to concrete and relational ethics and practice (Geisman et al., 2008).

The literature on feminist ethics is one source of thinking on relational ethics in health care (Baylis et al., 2008). The feminist literature on care emphasises relationships as a key aspect of ethical behaviour, noting the importance of attachment as a source of moral behaviour and identifying the limitations of detached impartiality as a guide to morality in practice. The role of working relationships is tackled in literature on emotions in health care. Nussbaum, a philosopher, and nurse-sociologists, such as Pam Smith, have argued that emotions and ethics are deeply intertwined. Nussbaum (2001) argues that emotions are central to the ability of a mature reasoning individual to make ethical judgements. Smith (1992) argues that nursing centrally involves *emotional labour,* i.e. the active use of emotion for the purpose of caring for others. Her work draws on Hochschild's (1983, p. 7) definition of emotional labour (in the context of air cabin crew) as the 'induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial safe place'. In other words, nurses must manage their emotions for others' needs. Emotional labour is not 'acting'; to care effectively involves the management of genuine feeling. Smith further argued that to care effectively nurses must themselves be supported, a condition that is unmet if nurses are working in under-resourced and/or hazardous conditions and without effective management support.

The application of the concept of relational ethics in studies of midwifery emphasises the importance of the relationship between midwives and women giving birth in promoting communication and safety (Hunter & Deery, 2009). Midwifery in the United Kingdom has seen a debate about the erosion of continuity of care for an individual by a named midwife, questioning whether this erosion has links to midwives 'turning nasty' (Robinson, 2000). This debate in the UK resonates with the data collected by the current study.

2.2 Methods

The sample and data collection instruments

Fieldwork for the project was undertaken in four districts located in two contrasting regions of Tanzania. In each region, the research included one urban and one rural district. Three wards in each district and then two streets or villages in each ward were chosen that displayed contrasting economic circumstances. Finally ten households were selected randomly along those streets or villages. Households where no woman was pregnant and/or no woman had given birth in the last five years were replaced. A total of 240 households were selected, sixty in each district.

Interviews with heads of households or their representatives in these 240 households collected basic data on the households' socio-economic conditions, while interviews with women collected data on payments and maternal care, including birth experiences. In the sampled households all eligible women were interviewed. In total, interviews were conducted with 248 women who had given birth in the last five years and/or were currently pregnant. The five-year cut-off point was applied to limit recall problems. The interviews captured information on the women's experiences of antenatal care, care at birth, and post-natal care, including payments made and their perceptions of the quality of care they received.

In addition, the fieldwork also included health-care facility interviews that were conducted with health workers in 59 health facilities in the selected districts. The health facilities in the survey were from different tiers of the health system and were drawn from three sectors – public, private, and those owned by faith-based organisations (FBOs). In total, 11 hospitals, 16 health centres, and 32 dispensaries were visited. Interviewees included medical directors and clinicians in-charge, managers responsible for maternal care, and midwives. Some traditional birth attendants were also interviewed.

Semi-structured questionnaires with provisions for in-depth probing were used in both household and health facility interviews. In addition, for household interviews a separate structured questionnaire was used to capture the households' socio-economic characteristics. Fieldwork was undertaken in September and October 2011.

As part of the interviews with women in household interviews and also with nurses, clinical officers and midwives in participating health facilities, we asked one question 'cold', that is without prompting, concerning the meaning of ethical maternal care. The interviews were almost all conducted in Kiswahili. For the women, the wording of the question in English and the instructions for the interviewers were as follows:

> What do you think is ethical maternity care? (Do not prompt, encourage ideas and suggestions, note all comments.)

For the nurses and clinical officers in charge of maternity care, the question was:

> What do you consider to be ethical maternal care Please explain and give examples (Allow an unprompted answer.)

The unprompted answers to these questions are the particular focus of this paper. The paper also explores some of the responses to follow up questions with probes. For the women, these follow-up questions were:

> Looking back over the experiences we have been discussing, do you think you received ethical care? If not, why not? If so, how and why? *(Do not prompt, encourage ideas and suggestions, note all comments.)*
>
> You have mentioned …….. *(refer to previous answers)***.** Do you think any of the following are also ethical issues as concerns maternal care? In what way, or why not? *(Prompt with those not mentioned, and record comments)*

- Competent treatment including emergency care
- Not suffering harm
- Respectful treatment, absence of humiliation/ abuse
- Access to services without payment
- Fairness, people being treated alike
- Good/better treatment by staff who know you
- Human rights / the right to maternal health care
- Receiving value for money when you pay for services

For the midwives, nurses in-charge and clinical officers, the follow up questions were:

What do you consider to be ethical maternal care? Please explain and give examples. (Allow an unprompted answer.)

In addition to the points you have just made, do you consider any of the following aspects of care to be matters of ethical concern? Please explain why?

- Competencies of facility staff
- Access to competent treatment including emergency care
- Human rights / the right to health
- Fairness, people being treated alike
- Good/better treatment for patients known to staff
- Supplying value for money services
- Supplying services without payment
- Respectful treatment of clients / patients
- Doing no harm

Is it possible to provide ethical and effective maternity care when resources are inadequate? What would have to change in order to make such care possible? (Prompts:)

- In resources available
- In the way the facility is managed
- In the way midwives and other maternal health care staff are treated?

Ethical considerations

This study was undertaken with the approval of the National Health Research Ethics Review Committee. In conducting primary data collection and analysing the findings, efforts were made to ensure anonymity and objectivity. Respondents were informed about the objectives of the study, and their informed consent was obtained. Participants were assured of anonymity during the data analysis and in the presentation of the findings. Accordingly, data were coded to protect identities and ensure privacy.

3 Understandings of ethical maternal care: Responses from interviews with women

The discussion in this section is based on an exhaustive analysis of the unprompted responses by women to the unprompted questions on ethical maternal care detailed in the methodology. We show that while some women did offer definitions of ethical care that draw on the kind of principles found in the medical ethics literature, this was not the dominant response. The dominant definitions offered were relational, relating particularly to the avoidance of abuse by health care staff. A further important set of responses were unclassifiable within the medical and nursing ethics literature: we refer to these as *contextual ethics* and defend this concept below.

3.1 Principles of Medical Ethics

Some women mentioned a set of expected behaviours by nurses and other medical personnel that corresponded to, or were attributes of, some basic principles characterised in the medical ethics literature. We outline these responses below[2].

Fairness and equity

Twenty interviewees spontaneously mentioned fairness in the way one is received and cared for by the facility staff. Unprompted answers on ethical care included::

> One [care] that is provided without discrimination. [148]
>
> Fair treatment for all, as well as equality. [128]
>
> Provide fair services without being biased to anyone even if is your relative. [19]
>
> Being helped with her problem without delay is the service with fair treatment. [111]
>
> Good services … which are fair and provided free for everyone, so everyone who goes to get services should be given services. [181]
>
> The nurse receives people of different calibre, educated and non-educated, but they still respect the patients. [9]

Thirty-four unprompted answers specified free services as an aspect of ethical care. Some referred to this as a right, since the government had mandated that care be provided for free, but most related it to fairness in access without reference to the ability to pay. Some linked it to the quality of care, arguing that free services should not be poor services. Strikingly, most of these responses were from women in one of the two regions only. Here are examples.

> Not to be discriminated against based on money. [12]
>
> Free delivery services including free supplies. [107]
>
> The service which even we who have low income can have access to without making any payments and still get good service. [180]
>
> It is the service which cares for clients/ patients first and if they need money it is after the care is provided. [28]
>
> Getting free services as per government directives. [39]
>
> *Be free as per the government directives. [39]*

2 The numbers in brackets at the end of each quotation are the unique reference numbers for each respondent

Professional responsibility and conduct
A second set of responses related to the principles of medical ethics concerned doing good, and doing no harm. These were cast in terms of professional and responsible behaviour by staff, including confidentiality. Respondents also placed particular emphasis on avoiding delays in order to treat patients effectively. Here are examples.

> Getting the right medicine. [1]
>
> Responsibility, for example, a laboratory attendant must be very careful … if he performs an HIV/AIDS test for a patient and gives improper results then he will be answerable. [9]
>
> Keeping patients' secrets. [18]
>
> Hard-working nurses. [31]
>
> It has to be good and right for the person. It should not cause any problems or dangers to the person seeking it. [202]
>
> Not waiting long for the service at clinic. [20]
>
> They should not be late to provide care, until a woman delivers on the floor. [38]
>
> Nurses should be on standby to receive patients' day and night, especially pregnant women who go there for delivery and should be attended on time to avoid torture to pregnant mothers. [56]
>
> It is good care as required according to your condition. For example, when you go to the hospital and have to be operated on, the doctors should be available and operate fast otherwise you can have problems or even lose your life. [7]

3.2 Relational or Caring Ethics

The ways in which nurses and other medical personnel relate to and treat or handle patients were mentioned unprompted by *almost all* the women interviewed as aspects of ethical maternity care. This was by far the dominant type of response. Women mentioned relational issues far more than any other set of issues.

Non-abuse
The great majority of these relational issues concerned the way patients are received and handled by health facility staff. A large number of women mentioned not being abused; others put it positively, mentioning respect, care, dignity, politeness and love for patients.

Some typical references on the issue of abuse include the following:

> They should listen to our problems carefully and should stop abusing us. [189]
>
> Not to say abusive words to patients. Some nurses humiliate patients. This is not allowed. [23]
>
> Not to be ignored when in pain or to be abused. [193]
>
> They should not humiliate us but respect us. [20]

> They should not be rude and they should respect patients and stop humiliating us because they are also women. [38]
>
> They should act like fellow women to us, instead of treating us rudely. [40]

Among the very many references to dignity, respect and caring behaviour were the following:

> Maternal care is about life on this earth because without women delivering babies there is no life on earth. So ethical maternal care should be about caring for pregnant women with due respect and treating them with dignity. [41]
>
> Respectful treatment. [196]
>
> A respectful and humble service of good quality. [212]
>
> Proper reception when attending any health facility. [11]
>
> Respect clients, be polite to them. [19]
>
> When someone receives you with a good heart, talks to you nicely. [29].
>
> They should care for us. [34]
>
> Maternal health care that really cares for the pregnant women. [242]
>
> Politely provided without any anger or fury. [130]
>
> It is to do good things for mother and child. This includes hospitality and humbleness. [4]
>
> They must love me as a patient. [40]
>
> For whole time when I went to receive services, the facility workers received me well and politely. Hence this was ethical maternal health care. [45]

No bribery

There were just ten unprompted references to avoidance of bribery and corruption, including:

> Not to ask for a bribe. [12]
>
> The service which is not associated with giving or receiving corruption. The service which follows the rules; pregnant mothers are listened to and no bribery. [156]
>
> Not asking for money by force. [17]
>
> They should talk to us nicely and prescribe medicine when we need it and not tell us there are no medicines while they are there. [20]

Being listened to / getting advice

It was also clear that women perceive their interaction with nurses and medical personnel in terms of being listened to and getting advice and training on maternal health issues as key aspects of ethical care. Participants' responses that illustrate this important aspect of care include:

> Ethical maternal care is the one whereby we are taught how to take care of our pregnancies, to take care of the newly born baby and to prepare a better meal for the newly born baby. [2]

The nurses should care for us and listen to us. [139]

To be given good treatment, that means to be listened to and to be given appropriate treatment. [21]

The nurses should listen to the pregnant women and give them good explanations. [3]

Good advice. [148]

I expect the healthcare provider, nurse or doctor to attend me gently, kindly because I am in pain, and therefore take good care, listen to me and attend me accordingly. [22]

A nurse should be close to the patient, listen to them, and not pretending to be busy and leave patient without any help. [160]

To be close to patients especially during delivery time so as to assist them. [23]

Making the mother understand things politely (the nurses). [34]

A facility worker should be humble, caring and listen to patients. [211]

The nurses should listen to my problem and be ready to help. [42]

3.3 Contextual Ethics

In addition, many of the participants' unprompted responses on what constituted ethical maternity care, did not fit into the two broad frameworks for assessing ethical care. Understanding what is ethical can be relative and context specific, varying according to socio-economic situations and prevailing cultural norms and values of a group of individuals. We thus consider the following aspects of ethical maternal care (as mentioned by the women interviewed) to constitute a third framework that we call 'contextual ethics'.

Competence

Our academic and professional adviser on midwifery for this project identified technical competence as a core ethical issue in midwifery in Tanzania. This theme tends to be taken for granted in the literature of high-income countries, but was mentioned by both women and staff in the current study. Women also emphasised the importance of knowing what was available and what was not.

Here are some examples:

Nurses and doctors must be … experts in their work. [232]

Reliable and experienced nurses and doctors. [163]

Nurses should have enough experience and knowledge. [233]

It is the service which has enough service providers to fulfil patients' needs. [38]

The facility must have all the services, to reduce disturbance for the pregnant women, and also they must inform the clients if the services are not available at the facility but it can be obtained elsewhere. [24]

Availability of services and supplies

Availability of services and supplies

There were also many references to the availability of beds, supplies and key services such as tests.

> The service which makes sure a pregnant woman receives all tests which are required. Medicine should be available at all health centres. [27]
>
> It's the service in which a pregnant woman is given all tests. [191]
>
> There should be enough supplies and all tests being conducted in the same facility. They should stop directing patients to other facilities only for getting tests. [56]
>
> Availability of all services at all times. [57]
>
> This will be when the patients are given due attention according to their needs. I want to give an example. When I delivered, the baby was put on bed together with three other babies. We mothers were sitting down. You can imagine after delivery to sit down with stitches is very painful. [33]

Value for money

Finally, there were a few unprompted remarks about the ethical importance of value for money:

> *Private facilities providing services equivalent to the money spent. [39]*
>
> *Service should be provided for free; staff should not tell us to make payments. If charged money you should get adequate services corresponding to the money paid. [8]*

4 Understandings of ethical maternal care: Responses from interviews with nurses IN-CHARGE, midwives and clinical officers

The health care professionals interviewed included midwives and the staff members in charge of maternal care in each facility, whether a nurse/midwife or clinical officer (two years of medical training). The same three ethical frameworks as in the analysis of women's responses are used for the analysis of staff perceptions of ethical maternal care. Unless otherwise stated, the data presented are the unprompted responses to the question: 'What do you consider to be ethical maternal care?'

4.1 Those in Charge of Maternal Care

4.1.1 Principles of medical ethics

A few of those in charge of maternal care indicated that they had received some education in the standard principles of medical ethics. Three respondents referred to the concept of doing no harm, including:

> Treating patients without doing harm. This is what ethical principles suggest. When a patient comes to the health facility, she is looking for rescue of the problem she faces, so if you add more problems to her (by harming) this is quite unethical. [2,17][3]
> Care that ensures both mother and new born are safe. [It] should ensure that no harm, e.g. infections, is done to mother and child. [4,55]

Most, however, did not couch discussion of ethical problems in this language.

Professional Responsibility

The themes of professional responsibility, and of fairness and non-discrimination, appeared strongly in the responses of nurses in charge. Some in-charge emphasised doing the job properly or providing good quality care. This category of responses included doing the job competently and completely in all its aspects, according to guidelines, for example:

> Proper nursing care (do all scientific procedures required). [1, 31]
>
> Ability to use her/ his knowledge to attend the patient. [1,8]
>
> One should prepare all the requirements, take all required tests ... and conduct delivery as required. [2,13]
>
> Try to identify her problem, take the history, tests, all the necessary … treat her for what she has to be treated for. [4,52]

A related aspect was early identification of problems:

> To report any complication immediately. [4,57]
>
> Try as much as you can to reduce maternal death, look/spot danger signs early and refer the patient as soon as possible. [2,34]
>
> Ask for assistance where the situation becomes complicated. [2,26]

3 Attributions: The first number is the identifier of the district, and the second number is the identifier of the respondent.

This linked to relevant staff attitudes, such as willingness and commitment to the task:

> Midwives to be willing to do the job properly as required. [1,11]
>
> Have qualified and skilled midwives who are also committed so that problems are identified in early stages of pregnancy. [1,22]

One respondent reflected on responsibility as follows:

> The service provider has to be … responsible ... and where you are not competent involve others who know, like other midwives and doctors ... as a service provider you should know and understand yourself and your limits. [2,28]

Three respondents linked ethical care to patients' safety. For example:

> The most important thing is to make sure that delivery is safe for both mother and child. [3,40]

Other respondents identified aspects of care that were associated with ensuring patients' safety:

> First, a woman should be kept in safety, privacy, cleanliness, quality and using sterilized equipment. [3,43]
>
> Privacy – woman would like to be served by someone who can keep their secrets. [3,44]

Seven respondents mentioned confidentiality, for example:

> Confidentiality is very important in this job and is a key aspect in providing ethical treatment. [2,29]

Just four respondents mentioned cleanliness e.g.:

> Cleanliness is also important. [4,49]
>
> Ensuring clean environment and equipment to prevent infection. [1,3]

Several respondents emphasised 'follow-through' to safe post-natal care (PNC):

> Right from ANC, a pregnant mother should get someone who will take good care of her; take (give) all the tests, treatment if any … When she comes for delivery, all the tests have to be done (history taken) and just in case she gets an emergency, some other things should be safe and observed, and the mother and baby have to be observed at least within the first 24 hours after birth. [3,41]

Finally, two in-charges mentioned as ethical issues the work burden of this professional commitment on the staff:

> Should be flexible to work long hours and day and night shifts [4, 46]
>
> Ability to work extra hours [4,53]

Fairness and equity

The second category of general ethical principles referred to by these interviewees was fairness or equity, and its link to rights. There were fewer of these responses: ten out of 49 respondents. Some of these interviewees made very general statements.

For example:

> Equality, all human beings are equal, so they should be treated equally without discriminating one group. [2,17]

Other respondents offered detail, such as:

> Must not display any favouritism to patient regardless of their income level. [2,24]
>
> There should be no discrimination, e.g., treating better those who you know or have better education or with more income. [3,34]
>
> Not to stigmatise the mother for whatever reason. [2,25]
>
> Treat everyone as an individual not [as part of] a group. [1,31]

Only one of these respondents spontaneously mentioned free services as an element of ethical maternal care, in the context of saving the life of mother and child:

> This includes serving them [women] freely as the government circular directs. [3,41].

4.1.2 Relational and caring ethics

As in the interviews with women, many of the unprompted responses of those in-charge of maternity focused on relational issues of politeness, non-abuse, communication and trust. A recurrent theme, which reflects the literature on the link between emotions and ethics was the need to love midwifery in order to do it well, e.g.

> You have to love your job and your patient. [1,12]
> The service provider should first love their work; use their knowledge and skills to serve clients. [2,26]

Non-abuse and respect

The women's responses in the previous section implied widespread expectations of abuse and disrespect. Some of the comments of the in-charges indicated an awareness of this. While the majority of women referred to this set of issues, a much smaller proportion of the in-charges did so. Comments that recognised the existence of abuse included:

> Do not use force, not to harm the client. [2,26]
> Don't shout at the mother. [2,13]
> The nurse should be kind, use the language that is not harsh and should respect the woman. [2,27]
> Not to be rude to patients. [1,11]

Over a quarter of all respondents expressed the issue of not abusing clients positively in terms of polite language. In some facilities, this was the sole unprompted response of the in-charge. For example:

Polite language when attending to patients. [4,48]

Language to patient should be good. [3,44]

Speak well to the clients. [2,26]

There is a need for polite communication to patients. [1,11].

Good customer care, show care to patient, treat them politely. [1,31]

Where women is received and attended to in a polite way. [2,23]

Just four responses recognised the underlying issue of respect, as raised by the women interviewees, e.g.

To pregnant and delivering women, show them the respect. [2, 30]

Respectful and not formal. [2,19]

Eleven others described ethical care as being kind or caring e.g.:

Service where one is kind to the patient. [4,47]

Should be caring and showing love to patient. [4,57]

Service where staff are welcoming. [3,33]

Should be flexible and kind person. [4,50]

Must be concerned with the well-being of the patient. [2,24]

Be a friend to a patient. [4,58]

One mentioned 'truthfulness'. [2,14]

Communication, listening and teaching

Some of the responses above refer explicitly to relationships with patients. About a quarter of respondents emphasised listening and communication as well as talking:

The most important thing is how you communicate with patients. Language matters in this job. This is our main challenge. [1,10]

Should listen to the patient attentively. [4,57]

Listen to client and understand them., give them chance to tell you what they feel. [2,26]

It is important to provide maximum attention to the patients. [1,1]

Where care giver is able to ask, seek information and learn. [3,35]

The service provider should greet the woman, give her explanations if she asks question, respond to them all and give her the right responses. [2,21]

Listen and to care for the client. Allow them (clients) to tell what they have, give them advice and provide help/assistance as required. [2,25].

To have good relationships with other members of the pregnant woman's family. [3,42]

Communication was particularly essential to the collaboration required for safe delivery:

> You have to have good communication with the patient so that you can collaborate during delivery. [1,12]

This in turn required close attention to the patient's condition and progress e.g.:

> Receiving well the pregnant mother, asking her questions relating to her labour, examining her to see the extent of her labour. From there you will see whether the labour has advanced enough to offer her place to rest waiting for delivery. [2,17]
>
> Give proper directions, keep close observation, monitor the labour [1,13]

This kind of communication could generate trust:

> A woman should be free to talk to the service provider, handle the woman with care and allow her to trust you and feel safe in your hands. [3,38]

Many in-charges emphasised appropriately teaching, informing and counselling their patients., e.g.

> If it involves testing, all tests should be conducted, and it should be explained well to her …Provide her with counselling and inform her of the importance of whatever services she gets, if there are any side effects she should expect, and the need for return visits if any. [2,27]
>
> Midwives who are capable of giving proper health education so that women are aware of risk factors. [1,22]
>
> It is where a woman is well advised and counselled/educated on how to bring up the child, on nutrition and watching the child's progress. Taking the weight [of the baby] and tests as required and explaining to the mother accordingly. [2,30]
>
> Do not force them to test for things you have not well explained to them and the benefits and reasons for that. [2,30]
>
> Give her proper explanation … give her proper and right advice. For example, if it's a pregnant woman complaining of stomach pains, as a nurse you have to test and check whether she is in labour and if she has to go back home. Advise her to return to the hospital or dispensary should she feel any pains or changes and that has to be immediately. [4,52]

Delay, bribery and emotional pressure

In the women's interviews, links were made in response to the question on ethics between being delayed and neglected, and being asked for bribes or to make unexpected payments. There was some recognition of these interconnected relational issues in the responses of those in charge of maternity.

There was recognition of the issue of delay, and that the delays did not arise solely from staff shortages:

> It [care] has to be provided at the right time. [2,21]

> Care should be attentive and prompt, e.g., do not keep woman waiting unnecessarily. [3,34]

The very few comments on bribery were linked by some to delays in care and abuse:

> You are not demanding bribes. In other places, a pregnant woman is not well-attended if she does not give something. [4,47]
>
> Should not be corrupt and ask for money from patients. [1,8]
>
> Not to charge the client when it's not part of the services. For example, even if the woman comes without requirements [that is, essential supplies] but she needs your service at that particular time, one should not hesitate to provide such services. [1,13]

Finally, a few comments recognised the pressure the staff were under, and the need to manage their own emotions and to cope:

> Be able to handle your emotions. [2,26].
>
> Also use polite language and control our temper even if patients are difficult. [4,58]
>
> Should respect oneself and the woman you are serving. [2,28]
>
> Not alcoholic [the staff] nor use alcohol during working hours. [4,46].

4.1.3 Contextual ethics

The discussion of abuse and bribery interlinks, as in the interviews with women, to contextual issues that were repeatedly referred to in the unprompted responses of those in charge. As in the interviews with women, the two major issues raised were technical competence of the staff and the availability of essential supplies.

Competence

Technical competence was emphasised by 15 of the interviewees as essential for ethical care. For example:

> The service provider should also be knowledgeable about the service they are providing because without that knowledge, the mother won't be served properly and it's not right for both the service provider and the person receiving services. [2,25]
>
> Attendants must also know the service they are providing. For instance, if the child is not in a good position, the service provider must be in a position to explain to the mother very well about such a condition. [2,30]
>
> It is important to be technically competent and check all the vital signs regularly. [4,49]
>
> Be able to identify the problems at an early stage. [3,44]
>
> Ability to spot and handle emergency cases. [1,8]
>
> Have staff with knowledge and skills. [3,33]
>
> The hospital and the service providers should be capable to help in case of emergencies. [3,44]

The frequency with which this issue was raised by in-charges reflects how often facilities do not

have enough competent staff.

> The staffing level needs to be adequate and especially a specialist in case of emergency should be within reach.[1,2]
>
> Should be able to learn new developments in the field. [1,8]
>
> She/he should be flexible to learn and work in a team i.e. team player. [1,8]

One respondent expressed anxiety about the recent decision to reduce the training of nurse midwives to two years:

Should be technically competent especially on the practical part. The two-year course is a disaster. When you employ them they are not competent. There is a need to resist this program. [4,59]

Availability of supplies and basic infrastructure

As in the interviews with women, the availability of essential supplies, such as gloves and medicines, was frequently raised by in-charges when asked about ethical care:

> All supplies and equipment should be in order. [1,2]
>
> Availability of supplies and equipment for delivery and EmOC [1,8]
>
> You have all essential supplies. [4,45]
>
> Has adequate supplies for maternal care. Government commitment on maternal health as priority should be seen in terms of having no shortages of supplies, e.g., government says one should have four pairs of bed sheets but in reality very little money is given for this. [1,22]

Other basic infrastructure, such as beds and water, were also identified as essential requirements for ethical care to be provided. Water is often a serious constraint. As a result, ethical care may not be achieved.

> The mother and baby have to be observed at least within the first 24 hours after birth, although here we do not keep them for 24 hours. We keep them for 6-12 hours because of the shortage of beds (small space and the women who come for the service are many). [3,41]
>
> Patient should be provided with all the required services when it is possible. [2,29]

4.2 Midwives

The quotations in the preceding section were all from staff members in charge of maternal services. We also interviewed working midwives at the facilities. In a few facilities, the only midwife available was also the person in charge; in some other facilities, no midwife was on staff.

In this section, we assemble, under the same three ethical frameworks, the responses of midwives to the unprompted question concerning the nature of ethical maternal care. In general, the midwives found it harder than those in charge to respond to the unprompted open question. They had more to say in response to the prompts by the interviewer.

4.2.1 Ethical principles

In these interviews there is a smaller proportion of statements of general principles. There was one general statement about doing no harm:

It should not cause negative impacts to the woman. [3,37]

Professional responsibility

Otherwise, over a quarter of the midwives interviewed emphasised doing the job properly. For example:

> It should be right depending on the age of the pregnancy, age of a mother and the number of deliveries she has had. [2,25]
>
> Following all procedures is most important. This involves examining her, giving her proper tests and necessary services. [3,40]
>
> Conduct all the necessary tests. [3,41]
>
> PNC [post-natal care] has to be as required. Observe her within 24 hours after delivery then at two weeks and six weeks after [birth] and be sure that she has gone back to normal. [3,39]
>
> Ethical services on maternal health starts from the first day a pregnant woman comes for ANC. You have to give her ethical health services because she needs good health care which includes medical tests, treatment and medicine. You have to look at her historical health status. [4,56]
>
> When she comes into labour, if she was well prepared during ANC, it will not be a problem. She will only need little reminders, the same will be with PNC. [3,41]

This required an attitude of dedication and concern for safety.

> The woman expects to be safe and have a child that is safe. The duty of a service provider is to help in order to achieve these goals. [3,34]
>
> You have to be keen and careful on how to conduct your work. [1,7]
>
> I have to like my job and be dedicated. [2,23]
>
> The service provider must love her job and this gives her chance to provide the right services, practice as you were taught, not to do as one feels like; follow the guidelines; and the provider to seek assistance whenever they are not. [3,35]

Midwives also identified some of the same aspects of professional conduct as the in-charges:

> Confidentiality, for instance, not to let a woman's problems be known to everyone, even those not concerned. [2,18]
>
> Privacy, not leaving woman in a crowd with others during delivery. [1,3] [this midwife was also in-charge]

Fairness and equity

Six midwives spontaneously mentioned aspects of fairness, including:

> Care that ensures fairness without saying this person is more able than someone else. [1,8]
>
> Segregating patients is not ethical. All patients are supposed to be served equally. [4,53]
>
> We have to respect our patients regardless of their income levels/or any other status. [2,23]
>
> Giving care without being fair or unfair to one client and not another ... also maternal health services are the right of every pregnant woman, so in any situation you have to provide good care. [4,56]

One midwife linked the issue of fairness to payment for care:

> Free service is ethical. [4,53]

4.2.2 Relational and caring ethics

Many midwives cited relational aspects of their work, especially politeness, listening, and teaching/education, and linked these aspects to patient safety.

Non-abuse and respect

Fifteen of the midwives interviewed mentioned issues of non-abuse and respect. Comments included:

> Use polite language to patient even if the patient is non-cooperative. Treat her with care and finally you get her to deliver safely. [2,29]
>
> To be polite to relatives who escort the expecting mother. [1,11]

> Do not be rude to patient and assist with all your heart and ability. [1,4]
>
> If you have given a patient a date/appointment to come back and if she does not show up do not be upset the day the patient shows up. [1,4]
>
> Good language throughout the time of service required. [4,43]
>
> It should be friendly, respectful of woman and safe for her. [3,32].

One respondent recognised facility constraints:

> You must use good language to patients, but sometimes it is hard to be attached given our overcrowding situation. [1,22]

Communication, listening and teaching

Listening well and establishing communication were mentioned a number of times as key to ethical maternal practice.

> You have to listen to the patient attentively. [1,4]
>
> It has to involve listening to what the woman has to say, her problems and to assist her solve her problems. For example, if a woman comes late and in labour and the offices are closed. As a rule here, if a woman comes in such a state, you have to call the doctor (1,2, 3rd birth or has a scar [previous C-section] who will call in the theatre team And if as a nurse on duty you have not done the right thing, then it's a problem. [4,59]

The largest set of responses concerned informing and educating the women who come to the facility. They included:

> It requires the service provider to tell the woman and counsel the woman on safe pregnancy and delivery, and where the woman should get services and at what stage. [2,18]
>
> The women has to be tested first and confirm the pregnancy and get a full history, counsel her and prepare her well to understand what is necessary and required for her. [3,32]
>
> Tell her of all the dangers and treat her as required. [3,32]
>
> Giving women needed information, e.g., after delivery telling her the sex of the baby and congratulating her. [4,48]
>
> To examine pregnancy and advise clients on progress or problems if any. Guide a pregnant woman on how to take care of her pregnancy. Advise her on importance of vaccination. [3,44]
>
> Giving feedback to relatives who come with a pregnant mother and telling them what is expected if anything. [1,9]
>
> The mother who comes for delivery should know what she is coming to do and should cooperate with the nurse. [4,54]

It was recognised that effective communication required an attitude of care and attention so as to build a good relationship with the mother.

> A good reception is very important. This should be accompanied with allowing the mother to explain how she feels. [3,43]
>
> Advising how to lie on the bed, assisting her during delivery and being careful to avoid rupture. [3,40]
>
> The first thing is love to pregnant women. Educating them to be clean and to properly clean their babies. Attending PNC is another important thing that is needed. [4,53]
>
> Good relationship between those providing care and those seeking care. [1,10]
>
> It [service] has to be friendly and when it starts by being friendly, it will end up being the required one since you will have a chance to understand the person you are serving. [2,28]
>
> Advise her accordingly, e.g., on family planning and other services that she may need. [3,39]

Ethical care also demands proper attention to a woman's practical needs:

> To provide care for the baby after they provide a woman with a paper evidencing that the baby is born in our facility. This helps to get birth certificate. [3,40]

Delay, bribery and emotions

There was little recognition in the midwives' spontaneous responses of this set of relational issues that were of great concern to the women interviewed. Four midwives mentioned avoiding delay and inattention, including:

> Staff should be motivated to do the job well and not be thinking of other things. [4,58]

One respondent noted that this meant flexibility and being on call:

> I should be of help at any time in case of emergency. [2,23]

No one mentioned bribery explicitly, but one nurse midwife said:

> For instance, if she cannot afford to pay, do not deny her the services. [2,18]

One midwife mentioned the importance of controlling one's own emotions to provide good care:

> The person in pain will always say anything; be patient, understanding and provide the right care/treatment. [3,41]

4.2.3 Contextual ethics

The midwives commented even more often than the in-charges about the contextual issues already identified and discussed.

Competence and staffing

Competence, i.e. the importance of knowing what you are doing was a common concern among the midwives interviewed. Comments included:

> The midwife having the required skills and qualifications to do the right job. [2,29]
>
> Health workers should be well-trained/ equipped for the local level. [1,31]
>
> It is important for local TBAs (traditional birth attendants) to be given a modern training to avoid delays and unnecessary emergencies. [1,31]
>
> Need to have qualified midwifes and doctors. [1,5]
>
> Skilled staff who are able to diagnose and identify any complications. Where staff are able to make follow up. [4,55]
>
> During delivery, you must know whether the woman can push or if she will require a C-section, and refer them to some other tests and hospitals on time. [3,39]

Three respondents remarked that this required both skilled and adequate numbers of staff. It also required proper organisation: two mentioned team work and referral:

Availability of supplies

Lack of supplies was also a repeated ethical concern; eight midwives highlighted this issue. Responses included:

> There should be adequate supplies and drugs. The government has to ensure this. [1,8]
>
> Good preparation including having enough gloves, mackintosh, thread and enough clothes. [3,38]

Infrastructure and equipment were also a concern:

> Infrastructure should be adequate, e.g., big labour room. [4,58]
>
> It is important to have access to an ambulance just in case there are any emergencies. [4,54]

Finally, there was recognition that lack of supplies constrained what could be ethically provided:

> If supplies are available, allow her to get free service as per government directives without segregation. [3,43]
>
> Free service is ethical, but here, since it is public, most patients have to pay in order for the organisation to be able to run its activities. [4,53]
>
> Provide the services if they are available. [2,18]
>
> If you do not have all the services, refer her to where she will get services. [3,32]

5 Discussion

We consider here, with reference to some of the evidence from the follow up questions, the interconnections between certainn aspects of maternal health care that both pregnant women and health care staff identified as ethical. We examine three sets of interconnections: emotions and abuse; favouritism and bribery; and supplies and payments. We end with a reflection on the dangers of ethical vicious circles in maternal health care.

Emotions and abuse

Interviews with women, including the follow-up questions on ethics, confirmed the widespread experience of rudeness and abuse. Women strongly linked ethical care to not being abused or treated harshly/rudely and to being listened to, e.g.

> No, in government hospitals, I never got services ethically. The nurses are abusive/ insulting, they chase women away. [10]
>
> The nurses mistreat and abuse women. Student nurses are good and serve people well with smiling faces. The experienced nurses are bad and abusive. [24]
>
> Yes, it was ethical because I received all services including blood tests without being charged for them and even the nurses were not harsh to me … they listened to me carefully and nicely. [127].

Nurse midwives in their interview responses identified both the practical and emotional pressure they are under. Their comments included the importance of being able to "handle your emotions", and to "control your temper even if patients are difficult". Some indicated they were struggling to cope. In response to follow up questions, nurses said:

> If someone is overworked he or she can never provide good service. [1,2]
>
> We are overworked, paid low salaries and lack key equipment in our facility. [1,22].
>
> If there are no essential supplies you are worried because you could be at risk and also you do not have peace of mind. We as midwives should try to cope with the situation and do our job since this is a job that requires one to have a calling. However, we should push for improvements. [1,10]

In the second paper in the series from the project *Ethics, payments and maternal survival*[4] we explore these pressures on nurses in much more detail. As noted above, some women also noted, without excusing abuse, that nurses were struggling to cope.

Favouritism and bribery

There is extensive commentary in the women's interviews linking bribery to favouritism and discrimination. In response to the follow-up questions, women elaborated on this connection and many criticised it.

> It is not good to treat patients differently. We should stop the culture of favouritism. [146]
>
> If you dare to ask why some of us are taken to the doctor through the back door you will be abused to death. [209]
>
> In our dispensary…when a pregnant woman goes for delivery she will be forced to give

4 Tibandebage et al Empowering Nurses to Improve Maternal Health Outcomes, 2013

> money or gift to the nurse ... [or] ... the nurse will abuse her so much. [83]
>
> If someone is able to give the nurse some little money then she will get a better service although corruption is not ethical. [150]
>
> I never got free service. I wonder if on earth, especially in Tanzania, there is a free service. In fact corruption has taken root. When you do not have money to bribe like me, a pregnant woman will be given poor service. [30]
>
> For our nurses and doctors, money comes first then dignity. [152]

Many women, as cited above, argued that favouritism was not ethical even when it was about favouring people you know. One respondent to a follow-up question said:

> I do not think it is necessary to attend someone nicely simply because you're friends. What if we are not known to each other? Or what if we are not friends? It means I will die. That is not ethical. [91]

On the other hand, a few women disagreed. For these respondents, it was proper to treat those whom you know better.

> It is a good thing for a doctor to help his/her relative or friends. To me, I see it as a normal thing, and am used to it. That is why I see it as a normal thing. [210]
> If they know me why wouldn't they give good treatment to me? That is the meaning of knowing each other, so it is ethical. [74]
> It is ethical because this is the advantage of knowing people. It is a return on investment. [86]

Supplies and payments

Extreme supply shortages in some facilities and areas meant that women were paying for supplies and tests privately. Nurses were then accused (rightly or not) of selling supplies:

> The government has announced free services to pregnant mothers while we are facing shortages ..unfulfilled expectations cause conflicts between health workers and patients. [2,29]

In a woman's view therefore:

> The ANC services … were not ethical because [of the lack of equipment for] pregnancy-related tests and the facility was not ready to refund the payments for these tests in a private facility. [21]

Given chronic supply shortages in health facilities, the public commitment by the government to provide free maternal health care has thus set up conflicts between expectations and observed practices.

Ethical vicious circles

The level of stress in these interviews was striking. There were acute gaps between the aspirations for ethical care of both women patients and many maternal health care workers, and a quite widespread experience of rudeness, abuse and informal payments. Therefore it is possible to see how in some facilities an ethical vicious circle can occur (Figure 1).

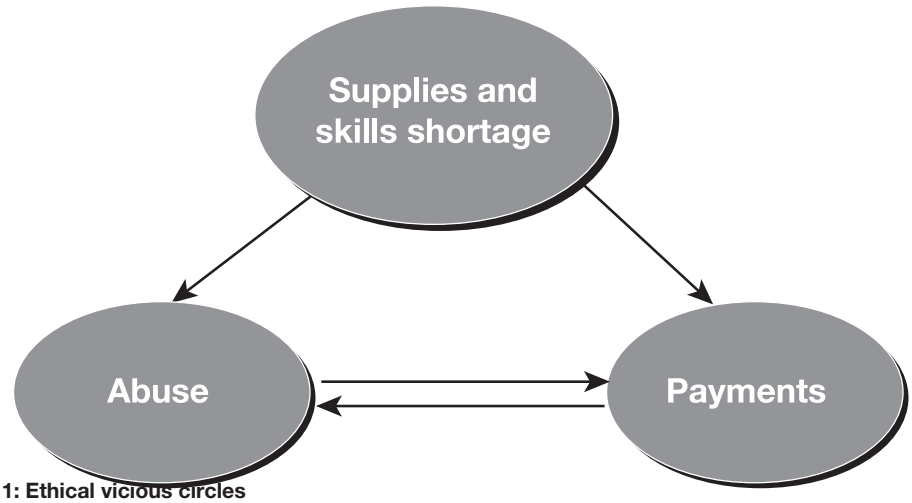

Figure 1: Ethical vicious circles

Shortages of supply and skills feed patterns of payment e.g. private payment for supplies. They also feed abuse, as people pay to jump queues and obtain scarce resources. Abuse and informal payments also then interact, as many of the responses illustrate.

However, these circles are not inevitable. There was a set of perceptions shared by both women and maternal staff that these conflicts were partly rooted in the contextual failings of lack of competent staff and essential supplies, and some sympathy among women for the conditions under which nurses were working. Facilities that received better reviews from women had generally simultaneously tackled the supply management problem and interaction between bribery and abuse.

In summary, the key findings of this paper are two. First, that 'ethics' in maternal health care in Tanzania is widely understood in a relational sense, that is, to concern proper professional and equitable relationships between health care staff and pregnant women. And, second, that the contextual issues of staff and supply shortages and their implications, are strongly perceived by both staff and women to be matters of serious ethical concern.

References

Baylis, F. Kenny M., & Sherwin, S. (2008). A relational account of public health ethics. *Public Health Ethics, 1*(3), 196-209.

Beauchamp & Childress. (2009). *Principles of biomedical ethics* (5th Ed.). New York: Oxford University Press.

Bureau of Statistics [Tanzania] and Macro International Inc. (1997). *Tanzania Demographic and Health Survey 1996*. Calverton, Maryland: Bureau of Statistics and Macro International.

Freedman, L. (2005). Achieving the MDGs: Health systems as core social institutions. *Development*, *48*, 19-24.

Geissler, P., Wenzel, A.K., Imoukhuede, B., & Pool, R. (2008). "He is now like a brother, I can even give him some blood" – Relational ethics and material exchanges in a malaria vaccine 'trial community' in The Gambia. *Social Science and Medicine, 67*(5), 696-707.

Gerein, N., Green, A., & Pearson, S. (2006). The implications of shortages of health professionals for maternal health in Sub-Saharan Africa. *Reproductive Health Matters, 14*(27), 40–50.

Grossmann-Kendall, F., Filippi, V., De Koninck, M., & Kanhonou, L. (2001). Giving birth in maternity hospitals in Benin: Testimonies of women. *Reproductive Health Matters*, *9*(18), 90-98.

Hochschild, A. (1983). *The managed heart: The commercialization of human feeling.* Berkeley: University of California Press.

Hunt, P., Bueno de Mesquita, J. (n.d.). *Reducing maternal mortality: The contribution of the right to the highest attainable standard of health.* Human Rights Centre, University of Essex http://www.essex.ac.uk/human_rights_centre/research/rth/docs/ReducingMaternalMortality.pdf

Hunter B. & Deery D. (2009). *Emotions in midwifery and reproduction.* Basingstoke: Macmillan.

Jewkes, R., Abrahams, N., & Mvo, Z. (1998). Why do nurses abuse patients? Reflections from South African obstetric services. *Social Science and Medicine, 47*(11), 1781-1795.

Khan, K.S., Wojdyla, D., Say, L., Gülmezoglu, A., & Van Look, P. (2006). WHO analysis of causes of maternal death: A systematic review. *The Lancet, 367*(9516), 1066-74.

Kleinman, A., & Benson, P. (2006). Culture, moral experience and medicine. *Mount Sinai Journal of Medicine*, *73*(6), 834-839.

Kruk, M. E., Mbaruku, G., Rockers, P.C., & Galea, S. (2008). User fee exemptions are not enough: Out-of-pocket payments for 'free' delivery services in rural Tanzania. *Tropical Medicine and International Health,* 13*(12)*, 1442-1451.

Kyomuhendo, G.B. (2003). Low use of rural maternity services in Uganda: Impact of Women's status, traditional beliefs and limited resources. *Reproductive Health Matters*, *11*(21), 16-26.

Mackintosh, M. (2001). Do health care systems contribute to inequality? in D. Leon & G. Walt (Eds.), *Poverty, inequality and health.* Oxford: Oxford University Press.

Macleod, J., & Rhode, R. (1998). Retrospective follow-up of maternal deaths and their associated risk factors in a rural district in Tanzania. *Tropical Medicine and International Health, 3*(2), 130-137.

Mamdani, M., & Bangser, M. (2004). Poor people's experiences of health services in Tanzania: A literature review. *Reproductive Health Matters, 12*(24),138-153.

Mbaruku, G., Vork, F., Vyagusa, D., Mwakipiti, R., & van Roosmalen, J. (2003). Estimates of maternal mortality in Western Tanzania by the Sisterhood Method. *African Journal of Reproductive Health, 7*(3), 84-91.

McDonagh, M., & Goodburn, E. (2001). A global picture of poor-rich differences in the utilisation of delivery care. In V. De Brouwere & W. Van Lerberghe (Eds.), *Safe motherhood strategies: A review of the evidence*. Antwerp: ITG Press.

Murray, S.F. & Pearson, S.C. (2008). Maternity referral systems in developing countries: Current knowledge and future research needs. *Social Science and Medicine, 62*(9), 2205-2215.

National Bureau of Statistics (NBS) [Tanzania] & ICF Macro. (2011). *Tanzania Demographic and Health Survey 2010*. Dar es Salaam: NBS and ICF Macro.

National Bureau of Statistics (NBS) [Tanzania] & Macro International. (2000). *Tanzania Reproductive and Child Health Survey 1999*. Dar es Salaam: NBS and Macro International.

National Bureau of Statistics (NBS) [Tanzania] & Macro International Inc. (2007). *Tanzania Service Provision Assessment Survey 2006.* Dar es Salaam: NBS and Macro International Inc.

National Bureau of Statistics (NBS) [Tanzania] & ORC Macro. (2005).*Tanzania Demographic and Health Survey 2004/05*. Dar es Salaam: NBS and ORC Macro.

Nussbaum, M. (2001). *Upheavals of thought: The intelligence of emotions.* Cambridge: Cambridge University Press.

Nyamtema, A.S., Urassa, D.P., Massawe, S., Massawe, A., Mtasiwa, D., Lindmark, G., & van Roosmalen, J. (2008). Dar es Salaam perinatal care study: Needs assessment for quality of care. *East African Journal of Public Health, 5*(1), 17-21.

Perkins, M., Brazier, E., Themmen, E., Bassane, B., Diallo, D., Mutunga, A., Mwakajonga, T., & Ngobola, O. (2009). Out-of-pocket costs for facility-based maternity care in three African countries. *Health Policy and Planning, 24*(4), 289–300.

Robinson, J. (2000). Why are midwives turning nasty? *British Journal of Midwifery, 8*(3), 143.

Ronsmans, C., & Graham, W.J., Lancet Maternal Survival Series steering group. (2006). Maternal mortality: who, when, where, and why. *The Lancet, 368*(9542), 1189-1200.

Smith, P. (1992). *The emotional labour of nursing: How nurses care*. London: Macmillan.

Storeng, K.T., Baggaley, R.F., Ganaba, R., Ouattarac, F., Akoum, M.S., & Filippi, V. (2008). Paying the price: The cost and consequences of emergency obstetric care in Burkina Faso. *Social Science & Medicine, 66*(3), 545–557.

Tibandebage, P., & Mackintosh, M. (2009). Maternal mortality in Africa: A gendered lens on health system failure. In L. Ranitch & C. Leys (Eds.) *Socialist Register 2009*. London: The Merlin Press.

Tibandebage, P., & Mackintosh, M. (2005). The market shaping of charges, trust and abuse: Health care transactions in Senegal. *Social Science and Medicine, 61*(7), 1385-1395

Tibandebage, P., & Mackintosh, M. (2002). Institutional reform and regulatory relationships in a liberalising health care system: A Tanzanian case study'. In J. Heyer, R. Thorp & F. Stewart (Eds.) *Group behaviour and development.* Oxford : Oxford University Press.

United Nations General Assembly. (2006). *The right of everyone to the enjoyment of the highest attainable standard of health.* Report by the Special Rapporteur. New York A/61/338

Urassa, E., Massawe S., Landmark, G., & Nystrom, L. (1997). Operational factors affecting maternal mortality in Tanzania. *Health Policy and Planning, 12*(1), 50-57.

World Health Organisation (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), & World Bank. (2012). *Trends in Maternal Mortality 1990-2010.* Geneva: WHO.

Publications by REPOA

Books

"Researching Poverty in Tanzania: problems, policies and perspectives"
Edited by Idris Kikula, Jonas Kipokola, Issa Shivji, Joseph Semboja and Ben Tarimo

"Local Perspectives on Globalisation: The African Case"
Edited by Joseph Semboja, Juma Mwapachu and Eduard Jansen

"Poverty Alleviation in Tanzania: Recent Research Issues" Edited by M.S.D. Bagachwa

Research Reports

12/4 *Factors Affecting Participation in a Civil Society Network (Nangonet) in Ngara District*
Raphael N.L. Mome

12/3 *"The Instrumental versus the Symbolic: Investigating Members' Participation in Civil Society Networks in Tanzania"*
Kenny Manara

12/2 *"The Effect of Boards on the Performance of Microfinance Institutions: Evidence from Tanzania and Kenya"*
By Neema Mori and Donath Olomi

12/1 *'The Growth of Micro and Small, Cluster Based Furniture Manufacturing Firms and their Implications for Poverty Reduction in Tanzania'*
Edwin Paul Maede

11/2 *'Affordability and Expenditure Patterns for Electricity and Kerosene in Urban Households in Tanzania'*
Emmanuel Maliti and Raymond Mnenwa

11/1 *"Creating Space for Child Participation in Local Governmence in Tanzania: Save the Children and Children's Councils*
Meda Couzens and Koshuma Mtengeti

10/5 *"Widowhood and Vulnerability to HIV and AIDS-related Shocks: Exploring Resilience Avenues"*
Flora Kessy, Iddy Mayumana and Yoswe Msongwe

10/4 *"Determinants of Rural Income in Tanzania: An Empirical Approach"*
Jehovaness Aikaeli

10/3 *"Poverty and the Rights of Children at Household Level: Findings from Same and Kisarawe Districts, Tanzania"*
Ophelia Mascarenhas and Huruma Sigalla

10/2 *"Children's Involvement in Small Business: Does if Build youth Entrepreneurship?"*
Raymond Mnenwa and Emmanuel Maliti

10/1 *"Coping Strategies Used by Street Children in the Event of Illness"*
Zena Amury and Aneth Komba

08.6 *"Assessing the Institutional Framework for Promoting the Growth of MSEs in Tanzania; The Case of Dar es Salaam"*
Raymond Mnenwa and Emmanuel Maliti

08.5 *"Negotiating Safe Sex among Young Women: the Fight against HIV/AIDS in Tanzania"*
John R.M. Philemon and Severine S.A. Kessy

08.4 *"Establishing Indicators for Urban Poverty-Environment Interaction in Tanzania: The Case of Bonde la Mpunga, Kinondoni, Dar es Salaam"*
Matern A.M. Victor, Albinus M.P. Makalle and Neema Ngware

08.3 *"Bamboo Trade and Poverty Alleviation in Ileje District, Tanzania"*
Milline Jethro Mbonile

08.2 *"The Role of Small Businesses in Poverty Alleviation: The Case of Dar es Salaam, Tanzania"*
Raymond Mnenwa and Emmanuel Maliti

08.1 *"Improving the Quality of Human Resources for Growth and Poverty Reduction: The Case of Primary Education in Tanzania"*
Amon V.Y. Mbelle

07.2 *"Financing Public Heath Care: Insurance, User Fees or Taxes? Welfare Comparisons in Tanzania"*
Deograsias P. Mushi

07.1 *"Rice Production in the Maswa District, Tanzania and its Contribution to Poverty Alleviation"*
Jerry A. Ngailo, Abiud L. Kaswamila and Catherine J. Senkoro

06.3 *"The Contribution of Microfinance Institutions to Poverty Reduction in Tanzania"*
Severine S.A. Kessy and Fratern M Urio
Publications by REPOA

06.2 *"The Role of Indigenous Knowledge in Combating Soil Infertility and Poverty in the Usambara Mountains, Tanzania"*
Juma M. Wickama and Stephen T. Mwihomeke

06.1 *"Assessing Market Distortions Affecting Poverty Reduction Efforts on Smallholder Tobacco Production in Tanzania"*
Dennis Rweyemamu and Monica Kimaro

05.1 *"Changes in the Upland Irrigation System and Implications for Rural Poverty Alleviation. A Case of the Ndiwa Irrigation System, Wes Usambara Mountains, Tanzania"*
Cosmas H. Sokoni and Tamilwai C. Shechambo

04.3 *"The Role of Traditional Irrigation Systems in Poverty Alleviation in Semi-Arid Areas: The Case of Chamazi in Lushoto District, Tanzania"*
Abiud L. Kaswamila and Baker M. Masuruli

04.2 *"Assessing the Relative Poverty of Clients and Non-clients of Non-bank Micro-finance Institutions. The case of the Dar es Salaam and Coast Regions"*
Hugh K. Fraser and Vivian Kazi

04.1 *"The Use of Sustainable Irrigation for Poverty Alleviation in Tanzania. The Case of Smallholder Irrigation Schemes in Igurusi, Mbarali District"*
Shadrack Mwakalila and Christine Noe

03.7 *"Poverty and Environment: Impact analysis of Sustainable Dar es Salaam Project on "Sustainable Livelihoods" of Urban Poor"*
M.A.M. Victor and A.M.P. Makalle

03.6 *"Access to Formal and Quasi-Formal Credit by Smallholder Farmers and Artisanal Fishermen: A Case of Zanzibar"*
Khalid Mohamed

03.5 *"Poverty and Changing Livelihoods of Migrant Maasai Pastoralists in Morogoro and Kilosa Districts"*
C. Mung'ong'o and D. Mwamfupe

03.4 *"The Role of Tourism in Poverty Alleviation in Tanzania"*
Nathanael Luvanga and Joseph Shitundu

03.3 *"Natural Resources Use Patterns and Poverty Alleviation Strategies in the Highlands and Lowlands of Karatu and Monduli Districts – A Study on Linkages and Environmental Implications"*
Pius Zebbe Yanda and Ndalahwa Faustin Madulu

03.2 *"Shortcomings of Linkages Between Environmental Conservation and Poverty Alleviation in Tanzania"*
Idris S. Kikula, E.Z. Mnzava and Claude Mung'ong'o

03.1 *"School Enrolment, Performance, Gender and Poverty (Access to Education) in Mainland Tanzania"*
A.V.Y. Mbelle and J. Katabaro

02.3 *"Poverty and Deforestation around the Gazetted Forests of the Coastal Belt of Tanzania"*
Godius Kahyarara, Wilfred Mbowe and Omari Kimweri

02.2 *"The Role of Privatisation in Providing the Urban Poor Access to Social Services: the Case of Solid Waste Collection Services in Dar es Salaam"* Suma Kaare

02.1 *"Economic Policy and Rural Poverty in Tanzania: A Survey of Three Regions"*
Longinus Rutasitara

01.5 *"Demographic Factors, Household Composition, Employment and Household Welfare"*
S.T. Mwisomba and B.H.R. Kiilu

01.4 *"Assessment of Village Level Sugar Processing Technology in Tanzania"*
A.S. Chungu, C.Z.M. Kimambo and T.A.L. Bali

01.3 *"Poverty and Family Size Patterns: Comparison Across African Countries"*
C. Lwechungura Kamuzora

01.2 *"The Role of Traditional Irrigation Systems (Vinyungu) in Alleviating Poverty in Iringa Rural District"*

Tenge Mkavidanda and Abiud Kaswamila

01.1 *"Improving Farm Management Skills for Poverty Alleviation: The Case of Njombe District"*
Aida Isinika and Ntengua Mdoe

00.5 *"Conservation and Poverty: The Case of Amani Nature Reserve"*
George Jambiya and Hussein Sosovele

00.4 *"Poverty and Family Size in Tanzania: Multiple Responses to Population Pressure?"*
C.L. Kamuzora and W. Mkanta

00.3 *"Survival and Accumulation Strategies at the Rural-Urban Interface: A Study of Ifakara Town, Tanzania"*
Anthony Chamwali

00.2 *"Poverty, Environment and Livelihood along the Gradients of the Usambaras on Tanzania"*
Adolfo Mascarenhas

00.1 *"Foreign Aid, Grassroots Participation and Poverty Alleviation in Tanzania:*
The HESAWA
Fiasco" S. Rugumamu

99.1 *"Credit Schemes and Women's Empowerment for Poverty Alleviation: The Case of Tanga Region, Tanzania"*
I.A.M. Makombe, E.I. Temba and A.R.M. Kihombo

98.5 *"Youth Migration and Poverty Alleviation: A Case Study of Petty Traders (Wamachinga) in Dar es Salaam"*
A.J. Liviga and R.D.K Mekacha

98.4 *"Labour Constraints, Population Dynamics and the AIDS Epidemic: The Case of Rural Bukoba District, Tanzania"*
C.L. Kamuzora and S. Gwalema

98.3 *"The Use of Labour-Intensive Irrigation Technologies in Alleviating Poverty in Majengo, Mbeya Rural District"*
J. Shitundu and N. Luvanga

98.2 *"Poverty and Diffusion of Technological Innovations to Rural Women: The Role of Entrepreneurship"*
B.D. Diyamett, R.S. Mabala and R. Mandara

98.1 *"The Role of Informal and Semi-Formal Finance in Poverty Alleviation in Tanzania: Results of a Field Study in Two Regions"*
A.K. Kashuliza, J.P. Hella, F.T. Magayane and Z.S.K. Mvena

97.3 *"Educational Background, Training and Their Influence on Female-Operated Informal Sector Enterprises"*
J. O'Riordan. F. Swai and A. Rugumyamheto

97.2 *"The Impact of Technology on Poverty Alleviation: The Case of Artisanal Mining in Tanzania"*
B W. Mutagwaba, R. Mwaipopo Ako and A. Mlaki

97.1 *"Poverty and the Environment: The Case of Informal Sandmining, Quarrying and Lime-Making Activities in Dar es Salaam, Tanzania"*
George Jambiya, Kassim Kulindwa and Hussein Sosovele

Working Papers

13/2 *Understandings of Ethics in Maternal Health Care: an Exploration of Evidence From Four Districts in Tanzania*
Paper 2 from the Ethics, Payments, and Maternal Survival project
Paula Tibandebage, Tausi Kida, Maureen Mackintosh and Joyce Ikingura

13/1 *Empowering Nurses to Improve Maternal Health Outcomes*
Paper 1 from the Ethics, Payments, and Maternal Survival project
Paula Tibandebage, Tausi Kida, Maureen Mackintosh and Joyce Ikingura

Special Papers

12/4 *Growth with Equity – High Economic Growth and Rapid Poverty Reduction: The Case of Vietnam*
Do Duc Dinh

12/3 *"Why Poverty remains high in Tanzania: And what to do about it?"*
Lars Osberg and Amarakoon Bandara1

12/2 *The Instrumental versus the Symbolic: Investigating Members' Participation in Civil Society Networks in Tanzania*
By Kenny Manara

12/1 *The Governance of the Capitation Grant in Primary Education in Tanzania: Why Civic Engagement and School Autonomy Matter*
By Kenny Manara and Stephen Mwombela

11/1 *"Tracer Study on two Repoa Training Courses: Budget Analysis and Public Expenditure Tracking System"*
Ophelia Mascarenhas

10/5 *"Social Protection of the Elderly in Tanzania: Current Status and Future Possibilities"*
Thadeus Mboghoina and Lars Osberg

10/4 *"A Comparative Analysis of Poverty Incidence in Farming Systems of Tanzania"*
Raymond Mnenwa and Emmanuel Maliti

10/3 *"The Tanzania Energy Sector: The Potential for Job Creation and Productivity Gains Through Expanded Electrification"*
Arthur Mwakapugi, Waheeda Samji and Sean Smith

10/2 *"Local Government Finances and Financial Management in Tanzania: Empirical Evidence of Trends 2000 - 2007'*
Reforms in Tanzania"
Odd-Helge Fjeldstad, Lucas Katera, Jamai sami and Erasto Ngalewa

10/1 *"The Impact of Local Government Reforms in Tanzania"*
Per Tidemand and Jamal Msami

09.32 *"Energy Sector: Supply and Demand for Labour in Mtwara Region"*
Waheeda Samji, K.Nsa-Kaisi and Alana Albee

09.31 *"Institutional Analysis of Nutrition in Tanzania"*
Valerie Leach and Blandina Kilama

09.30 *"Influencing Policy for Children in Tanzania: Lessons from Education, Legislation and Social Protection"*
Masuma Mamdani, Rakesh Rajani and Valerie Leach with Zubeida Tumbo-Masabo and Francis Omondi

09.29 *"Maybe We Should Pay Tax After All? Citizens' Views of Taxation in Tanzania"*
Odd-Helge Fjeldstad, Lucas Katera and Erasto Ngalewa

09.28 *"Outsourcing Revenue Collection to Private Agents: Experiences from Local Authorities in Tanzania"*
Odd-Helge Fjeldstad, Lucas Katera and Erasto Ngalewa

08.27 *"The Growth – Poverty Nexus in Tanzania: From a Developmental Perspective"*
Marc Wuyts

08.26 *"Local Autonomy and Citizen Participation In Tanzania - From a Local Government Reform Perspective."*
Amon Chaligha

07.25 *"Children and Vulnerability In Tanzania: A Brief Synthesis"*
Valerie Leach

07.24 *"Common Mistakes and Problems in Research Proposal Writing: An Assessment of Proposals for Research Grants Submitted to Research on Poverty Alleviation REPOA (Tanzania)."*
Idris S. Kikula and Martha A. S. Qorro

07.23 *"Guidelines on Preparing Concept Notes and Proposals for Research on Pro-Poor Growth and Poverty in Tanzania"*

07.22 *"Local Governance in Tanzania: Observations From Six Councils 2002-2003"*
Amon Chaligha, Florida Henjewele, Ambrose Kessy and Geoffrey Mwambe

07.21 *"Tanzanian Non-Governmental Organisations – Their Perceptions of Their Relationship with the Government of Tanzania and Donors, and Their Role and Impact on Poverty Reduction and Development"*

06.20 *"Service Delivery in Tanzania: Findings from Six Councils 2002-2003"*
Einar Braathen and Geoffrey Mwambe

06.19 *"Developing Social Protection in Tanzania Within a Context of Generalised Insecurity"*
Marc Wuyts

06.18 *"To Pay or Not to Pay? Citizens' Views on Taxation by Local Authorities in Tanzania"*
Odd-Helge Fjeldstad

17 *"When Bottom-Up Meets Top-Down: The Limits of Local Participation in Local Government Planning in Tanzania"*
Brian Cooksey and Idris Kikula

16 *"Local Government Finances and Financial Management in Tanzania: Observations from Six Councils 2002 – 2003"*
Odd-Helge Fjeldstad, Florida Henjewele, Geoffrey Mwambe, Erasto Ngalewa and Knut Nygaard

15 *"Poverty Research in Tanzania: Guidelines for Preparing Research Proposals"*
Brian Cooksey and Servacius Likwelile

14 *"Guidelines for Monitoring and Evaluation of REPOA Activities"*
A. Chungu and S. Muller-Maige

13 *"Capacity Building for Research"*
M.S.D. Bagachwa

12 *"Some Practical Research Guidelines"*
Brian Cooksey and Alfred Lokuji

11 *"A Bibliography on Poverty in Tanzania"*
B. Mutagwaba

10 *"An Inventory of Potential Researchers and Institutions of Relevance to Research on Poverty in Tanzania"*
A.F. Lwaitama

9 *"Guidelines for Preparing and Assessing REPOA Research Proposals"*
REPOA Secretariat and Brian Cooksey

8 *"Social and Cultural Factors Influencing Poverty in Tanzania"*
C.K. Omari

7 *"Gender and Poverty Alleviation in Tanzania: Issues from and for Research"*
Patricia Mbughuni

6 *"The Use of Technology in Alleviating Poverty in Tanzania"*
A.S. Chungu and G.R.R. Mandara

5 *"Environmental Issues and Poverty Alleviation in Tanzania"*
Adolfo Mascarenhas

4 *"Implications of Public Policies on Poverty and Poverty Alleviation: The Case of Tanzania"*
Fidelis Mtatifikolo

3 *"Who's Poor in Tanzania? A Review of Recent Poverty Research"*
Brian Cooksey

2 *"Poverty Assessment in Tanzania: Theoretical, Conceptual and Methodological Issues"*
J. Semboja

1 *"Changing Perceptions of Poverty and the Emerging Research Issues"*
M.S.D. Bagachwa

Project Briefs

Brief 39 *Examining the Institutional Framework for Investment in Tanzania: A perspective from the Executive Opinion Survey, 2012-13*
Johansein Rutaihwa

Brief 38 *"Achieving High Economic Growth with Rapid Poverty Reduction: The Case of Vietnam"*
Do Duc Dinh

Brief 37 *"Social-Economic Transformation for Poverty Reduction: Eight Key Messages for Unlocking Tanzania's Potential"* Philip Mpango

Brief 36 *"Tracer Study for Research Users: The case of TGN Media Training"* Ophelia Mascarenhas

Brief 35 Understanding Rural Transformation in Tanzania

Brief 34 Affordability and Expenditure Patterns for Electricity and Kerosene in Urban Households in Tanzania

Brief 33 Biofuel Investment in Tanzania: Awareness and Participation of the Local Communities

Brief 32 Supporting Tanzania's Cocoa Farmers

Brief 31 The Instrumental versus the Symbolic: Investigating Members' Participation in Civil Society Networks in Tanzania

Brief 30 Competitiveness of Tanzanian Coffee Growers amid Bifurcated Coffee Markets

Brief 29 Using Annual Performance Reports to Manage Public Resources in Tanzania

Brief 28 Growth of Micro and Small, Cluster-Based Furniture-Manufacturing Firms and their Implications for Poverty Reduction in Tanzania

Brief 27 Creating Space for Child Participation in Local Governance in Tanzania: Save the Children and Children's Councils

Brief 26 Tracer Study on REPOA Training Courses for Research Users: Budget Analysis and Public Expenditure Tracking System

Brief 25 Transparency in Local Finances in Tanzania. 2003-2009

Brief 24 Social Protection of the Elderly in Tanzania: Current Status and Future Possibilities

Brief 23 Children's Involvement in Small Business: Does it Build Youth Entrepreneurship?

Brief 22 Challenges in data collection, consolidation and reporting for local government authorities in Tanzania

Brief 21 Children's Involvement in Small Business: Does it Build Youth Entrepreneurship?

Brief 20 Widowhood and Vulnerability to HIV and AIDS Related Shocks: Exploring Resilience Avenues

Brief 19 Energy, Jobs and Skills: A Rapid Assessment in Mtwara, Tanzania

Brief 18 Planning in Local Government Authorities in Tanzania: Bottom-up Meets Top-down

Brief 17 The Investment Climate in Tanzania: Views of Business Executives

Brief 16 Assessing the Institutional Framework for Promoting the Growth of Micro and Small Enterprises (MSEs) in Tanzania: The Case of Dar es Salaam

Brief 15 Preventing Malnutrition in Tanzania: A Focused Strategy to Improve Nutrition in Young Children

Brief 14 Influencing Policy for Children in Tanzania: Lessons from Education, Legislation and Social Protection

Brief 13 Disparities Exist in Citizens' Perceptions of Service Delivery by Local Government Authorities in Tanzania

Brief 12 Changes in Citizens' Perceptions of the Local Taxation System in Tanzania

Brief 11 Citizens Demand Tougher Action on Corruption in Tanzania

Brief 10 Outsourcing Revenue Collection: Experiences from Local Government Authorities in Tanzania

Brief 9 Children and Vulnerability in Tanzania: A Brief Overview

Brief 8 Mawazo ya AZISE za Tanzania Kuhusu Uhusiano Wao na Wafadhili

Brief 7 Mawazo ya AZISE za Tanzania Kuhusu Uhusiano Wao na Serikali

Brief 6 Local Government Reform in Tanzania 2002 - 2005: Summary of Research Findings on Governance, Finance and Service Delivery

Brief 5 Children Participating in Research

Brief 4 Changes in Household Non-Income Welfare Indicators - Can poverty mapping be used to predict a change in per capita consumption over time?

Brief 3 Participatory Approaches to Local Government Planning in Tanzania, the Limits to Local Participation

Brief 2 Improving Transparency of Financial Affairs at the Local Government Level in Tanzania

Brief 1 Governance Indicators on the Tanzania Governance Noticeboard Website
TGN1 What is the Tanzania Governance Noticeboard?

LGR 12 Trust in Public Finance: Citizens' Views on taxation by Local Authorities in Tanzania

LGR 11 Domestic Water Supply: The Need for a Big Push

LGR10 Is the community health fund better than user fees for financing public health care?

LGR 9 Are fees the major barrier to accessing public health care?

LGR 8 Primary education since the introduction of the Primary Education Development Plan

LGR 7 Citizens' access to information on local government finances

LGR 6 Low awareness amongst citizens of local government reforms

LGR 5 Fees at the dispensary level: Is universal access being compromised?

LGR 4 TASAF – a support or an obstacle to local government reform

LGR 3 Councillors and community leaders – partnership or conflict of interest? Lessons from the Sustainable Mwanza Project

LGR 2 New challenges for local government revenue enhancement

LGR 1 About the Local Government Reform Project