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Payments for Maternal Care and Women's Experiences of Giving Birth: Evidence from Four Districts in Tanzania

Paper 3 from the Ethics, Payments, and Maternal Survival Project

Maureen Mackintosh, Tausi Kida, Paula Tibandebage, Joyce Ikingura and Cornel Jahari

Working Paper
13/3

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

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Ethics, Payments and Maternal Survival Project - Paper 3

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Abstract

Maternal mortality remains unacceptably high in Tanzania. While maternal health care is officially free in the public health care sector, the country's health system remains reliant on a great deal of out-of-pocket expenditure by patients. Payments are widely thought to remain a barrier to maternal health care. This paper presents new data on payments for maternal care. It is one of a series of papers providing access to the findings of the project.

The paper starts by summarising evidence from the four districts showing that a large majority of women interviewed had made some payments in order to access maternal care during pregnancy and birth. The payments are analysed by their purpose, their patterning by geographical location and sector where care was sought, and household circumstances of the informant.

The paper then explores in detail for the two urban districts, the perceived interaction between payments and experience of care at birth as recounted by the women interviewed. The report indicates that payments for maternal care are problematic, not only because many women struggle to afford them, but because payments influence the interactions between maternal health care staff and expectant mothers requiring care.

Furthermore, these payments appear to have become embedded in hard-to-change working cultures within facilities, which in turn shape different patterns of care or abuse. It follows that payments reform is not only a matter of influencing the level of payments but also their form and function within the process of care.

The charging-based culture needs to be replaced with a truly workable alternative. Achieving this would require a clear understanding of the causes of what is currently going on, and a firmer commitment to address the underlying causes at all levels, including health facility management.

Acronyms

ANC Antenatal Care
ESRF Economic and Social Research Foundation
FBO Faith-Based Organisation
NIMR National Institute for Medical Research
PNC Post-natal Care
TBA Traditional Birth Attendant

1 Introduction

This paper presents some results from a project supported by the Wellcome Trust on Ethics, Payments and Maternal Survival in Tanzania. The findings presented in this paper draw on a research project whose objectives and framework emerged from earlier work by the researchers on gendered health system failure and maternal mortality in Africa (Tibandebage and Mackintosh 2009; Mackintosh and Tibandebage 2006), and on payments and care in the Tanzanian health system (Kida 2009; Tibandebage and Mackintosh 2005, 2002). A central theme of the project enquiry is the interaction between payments for maternal health care, particularly delivery and post-natal care including obstetric emergencies, and ethical and unethical behaviour within maternal health care.

Maternal health care is officially free in the public sector in Tanzania. However, the Tanzanian health system is liberalised, and reliant on out-of-pocket expenditure by patients (Kida 2009). Non-government sectors charge formally for care, while expenses incurred by women for maternal care in the public sector are known anecdotally and from limited research evidence to be substantial (Perkins et al 2009; Kruk et al 2008).

Early interviews and advice from experienced midwifery and health sector managers and academics suggested that the government's high profile policy commitment to public sector provision free at point of care in Tanzania had had the effect of making it difficult to debate openly the extent and causes of current payments. It also may make it difficult for effective responses to be developed by health sector managers and policy makers towards the management and reform of established informal and formalised payments systems.

This paper presents results from four Tanzanian districts on the extent and pattern of payments and other expenses incurred in maternal health care by women interviewed who had had children in the previous five years. The paper then goes on to explore the interactions between payments and experience of care at the time of birth, as recounted by women in the two urban districts studied.

2 Methods and analytical framework

2.1 Fieldwork Methods

The sample and data collection instruments

The data in this paper are drawn from a mainly qualitative study. Fieldwork for the study 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 care facilities in the selected districts. The health care facilities in the survey were at different levels 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. This paper summarises data across the four districts studied, and then discusses evidence from the two urban districts in more depth.

Data analysis

Qualitative data on women's maternal health care experiences were coded and sorted into themes by using Nvivo software. Systematic analyses were carried out to identify patterns and commonalities and/or differences in experiences. Patton (2002) explains this method of qualitative data analysis in detail. Background data for health facilities and households, and data on payments, were analysed with Stata software using descriptive methods such as graphs and cross tabulations. We triangulated data sources, e.g. responses from women and responses from maternal health workers, so as to identify similarities or divergences in their responses regarding issues of payment and what is considered ethical maternal care. We also triangulated quantitative data, e.g. on payments, with qualitative data to assess whether issues emerging from the qualitative interviews were consistent with the quantitative findings.

Ethical considerations
This study was undertaken with the approval of the National Health Research Ethics Review Committee. In undertaking 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

2.2 Analysing Payments

Until recently there has been a dearth of systematic information on charging for maternal care in Tanzania and other sub-Saharan African countries. Earlier studies (Kowalewski et al 2002; Nanda 2002; Storeng et al 2008) had identified exclusionary and impoverishing impacts of payments for care. Recent publications (Perkins et al 2009, based on 2003 and 2006 data; Kruk et al 2008 based on 2007 data) confirm these findings. The focus of this fieldwork was to explore qualitatively the culture of charging, women's experiences of being charged, and to draw out some implications for maternal health care and maternal survival.

Analytically, this research drew on findings from earlier work on charging in Tanzanian health care. That research identified empirically, within the data on payments, different charging cultures that had become established. For example, distinctions were made by facility users between distinct types of informal charging at different facilities, contrasting 'bribes' to individuals, associated with unpredictability and abuse, and 'contributions' to facilities that were seen by patients as more acceptable (Tibandebage and Mackintosh 2005).Our findings echoed distinctions observed elsewhere between informal payments understood as 'donations' and those seen as 'fees-for-service' (Gaal and McKee 2005), distinctions with implications both for the motivation and behaviour of staff and patients.

In that earlier research (Tibandebage and Mackintosh 2005), the authors therefore developed a concept of 'charging', not as one-off payments, but as interactively and institutionally-shaped charging practices, influenced by norms, expectations, incentives, as well as previous experience and behaviour. We build on this approach here, identifying through our qualitative evidence, several different charging cultures that have become embedded in particular facilities or contexts. We argue in this paper that these charging cultures, once embedded, are hard to change: they become working cultures within facilities, which shape successful care and treatment or generate patterns of abuse. It follows that payments reform in maternal health care is not only a matter of influencing the level of payments but also their form and function within the process of care.

Findings: Payments levels and patterns in four districts

3.1 Levels of Payment

As noted previously, maternal health care in the public sector in Tanzania is officially free. However, evidence and opinion suggest that women who are able to pay support considerable costs. The data in this section summarise the payments made by women at the time of their most recent pregnancy and birth.

The data confirm that for most women interviewed, having a baby was far from free. Table 1 shows summary data, by district for total payments recorded. These are the sum of payments for ante-natal, birth and post-natal care, for all women who were not pregnant at the time of interview. The payments data include transport costs.

Table 1: Total payments for care, most recent birth, by district (Tanzanian shillings[1])

District/ data	Urban 1	Rural 1	Urban 2	Rural 2	Total
Median	21,700	6,000	24,150	22,000	17,350
Mean	34,181	9,241	44,675	29,030	29,747
% zero	4.8%	12.2%	2.2%	8.9%	6.9%
Maximum	213,500	37,800	800,000	97,700	800,000
N	42	41	46	45	174

Only 6.9% of all the women interviewed said they had paid nothing, and the percentage was even lower in the urban areas. These interviews do not constitute a random sample of the population of the districts, and cannot therefore be generalised to district level. However, they show that this group of women, randomly selected along streets with widely divergent conditions and in very varied economic circumstances, experienced maternal health care as generally requiring out of pocket payment. As expected, the levels of payment on average were higher in urban areas.

Not all women interviewed received antenatal or postnatal care. However, as the available data for Tanzania led us to expect, access to antenatal care (ANC) was widespread. Almost all women interviewed (93%) had received some antenatal care; those who had not were mainly in the early stages of pregnancy and not yet ready to go to the clinic. A few women did not receive ANC for other reasons, including one woman in district Rural 2 who said her husband forbade her to go, and one-woman who said she had not attended because she was ill at the time.

Table 2 summarises the payments made for antenatal care by all those who had accessed it at the time of the interview (including women who were pregnant).

Table 2: Payments (in Tanzanian shillings) for antenatal care, by district, as recorded by those receiving some care only during their most recent pregnancy

District/ data	Urban 1	Rural 1	Urban 2	Rural 2	Total
Median	8,000	500	4,350	1,850	2700
Mean	14,137	2,323	15,084	3,501	8772
% zero	13.8%	41.1%	15.5%	33.3%	25.9%
Maximum	143,000	20,000	500,000	20,000	500,000
N	58	56	58	60	232

[1] One US dollar was worth around 1,600 Tanzanian shillings (TShs) at the time of the research.

In the two rural districts, a third and 41% of women respectively had paid nothing for antenatal care, while the percentages are smaller in urban areas. The mean payments were higher than the research team expected, for a service where transport costs are generally low. A subsequent working paper in this series explores the findings on antenatal care in more depth, including the links between levels of payment and access to tests and treatments in the two rural districts (Tibandebage et al., forthcoming). The major components of these antenatal care costs were found to be the costs of medication, supplies and tests. The latter were often paid for in pharmacies and shops rather than in facilities.

The largest payments were made at the time of birth. Table 3 summarises costs of their most recent birth, for all women who had had a delivery in in the previous five years[2].

Table 3: Payments (in Tanzanian shillings) for care at most recent birth by district, as recorded by all women

District/ data	Urban 1	Rural 1	Urban 2	Rural 2	Total
Median	10,000	2,000	14,500	20,800	10,000
Mean	17,057	5,424	24,557	23,587	17,987
% zero	14.3%	36.6%	10.9%	15.6%	19.0%
Maximum	95,000	25,000	300,000	97,700	300,000
N	42	41	46	45	174

Fewer than one in five women (19%) said that they had paid nothing for care during labour and birth. It is striking that the average payment in the second rural district (Rural 2) is comparable to average payment in Urban 2 (the urban district of the same region).

Table 4 shows the payments made by women who received some postnatal care. Only9% did not receive any postnatal care after their most recent pregnancy. About two thirds of women received some postnatal care in the first week; over 80% received some care between the second and fourth week; and around half received postnatal care at or after 6 weeks. The majority of women who received some postnatal care and follow up paid nothing for it.

Table 4: Payments (in Tanzanian shillings) for postnatal care at most recent birth, all women receiving some postnatal care, by district

District/ data	Urban 1	Rural 1	Urban 2	Rural 2	Total
Median	150	0	0	0	0
Mean	3,337	1,464	3,510	2,193	2,640
% zero	48.7%	72.2%	65.0%	77.3%	66.0%
Maximum	25,000	14,000	54,500	32,500	54,500
N	39	36	40	44	159

3.2 Payments by Type of Facility Attended

Most women interviewed had gone, or had sought to go, to a facility for the birth; only 11% had delivered at home or on the way to a facility. Of those who delivered in facilities, a large majority (72%) went to the public sector and 26% to the FBO sector. Only 2% went privately, supporting the impression from facility interviews that the private sector plays little role in maternal care at birth.

[2] Further work in process includes an analysis of these data by year of the recorded birth.

Of those who received ante-natal care, 66% went to public facilities, mainly dispensaries and health centres; 31% to FBO-owned facilities; and 3% to the private sector. The pattern of post-natal care is similar: 62% public sector; 35% FBO and 3% private. These figures do however underestimate the use of the private sector over all, since many women said that they obtained supplies and even tests from private shops.

Of those who delivered in the public sector, 20% went to public dispensaries, and 37% to health centres; 43% went to hospitals. Among those who went to the FBO sector however, 73% went to hospitals, reflecting the pattern of available facilities in the areas studied.

Giving birth at home was only sometimes free. Table 5 shows the pattern of payments for birth according to the sector in which a woman delivered, or home delivery. These data include both normal deliveries and emergencies. Median and mean payments in the public sector are lower than in the other sectors, but the sums still represent substantial financial commitments for many low income women.

Table 5: Payments(in Tanzanian shillings) for care at most recent birth by sector in which a woman gave birth

Sector/ data	At home	Public	FBO	Private	Total
Median	1,100	8,500	28,000	22,000	10,000
Mean	8,511	12,823	29,529	111,333	17,987
% zero	47%	14%	20%	0%	19.0%
Maximum	41,100	93,000	97,700	300,000	300,000
N	19	111	41	3	174

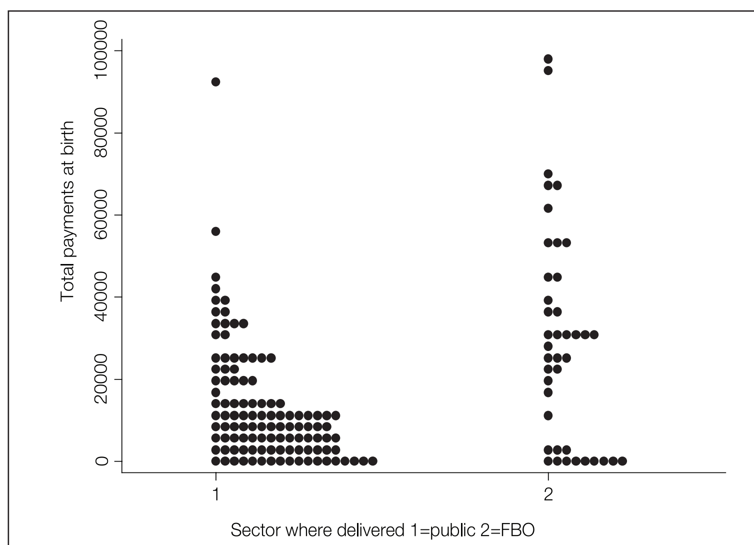
Table 6 shows the total birth payments for maternal care, according to the sector in which a woman delivered. Payments for home births were lowest, followed by payments for public facility births. Maximum payments were strikingly high in all sectors (although lower in the public sector on average).The FBO sector is shown to be quite an expensive option.

Table 6: Total payments (in Tanzanian shillings) for antenatal, natal, and postnatal care at most recent birth, by sector in which a woman gave birth

Sector/ data	At home	Public	FBO	Private	Total
Median	8,000	16,000	32,400	27,800	17,350
Mean	12,468	21,365	42,040	281,267	29,747
% zero	26%	4%	7%	0%	7%
Maximum	56,800	119,000	213,500	800,000	800,000
N	19	111	41	3	174

Figure 1 allows a closer look at the distribution of payments at the time of birth, and compares the public and FBO sectors. There is a larger proportion of the lower payments in the public sector, as against a wide spread of payments by those giving birth in FBO facilities.

Figure 1: Payments at birth by the sector where a woman gave birth



Finally, analysis of payments by level of facility shows (rather strikingly) that women who gave birth in public sector health centres did not pay less on average than women who gave birth in public hospitals. We discuss this point further below.

3.3 Breakdown of Payments by Type

Women made a wide variety of payments for maternal care. These included payments for transport; payments for supplies and medicines at a facility or bought in local shops; payments for treatments and for tests sometimes also bought outside the facility providing care; payments to facility staff; admission and in-patient charges; gifts to staff and helpers; and other miscellaneous payments.

Table 7 gives a summary breakdown of these elements of interviewees' total payments for their most recent birth. Not all interviewees could remember the detailed breakdown of their spending, so for a very few interviewees, total estimated spending exceeds the sum of elements. While transport is the largest item for median and mean payments, mean payments for other items were also substantial, particularly for supplies and tests purchased by women outside a facility. While a majority paid nothing for individual items, as noted above very few women incurred no expenses at all. Note that payments are recorded as zero in Table 7 when women received no care, as well as when care was received for free. We explore below the issue of the interaction between payments and experienced quality of care using the qualitative data for the urban districts.

Table 7: Breakdown of total payments (in Tanzanian shillings) for maternal care (antenatal, natal, and postnatal) at most recent birth.

Element of costs/ data	Median	Mean	% zero	Maximum	n
Transport	3,000	7,968	44%	74,000	174
Own supplies	1,000	5,732	45%	60,000	174
Facility supplies	0	3,026	69%	150,000	174
Tests /treatments	900	3,786	47%	99,000	174
Payments to staff	0	1,413	87%	100,000	174
Admission/in-patient	0	2,043	88%	60,500	174
Gifts to staff/ helpers	0	730	82%	12,000	174
Other payments	0	1,441	68%	20,500	174

3.4 Payments by Household Status

The women interviewed lived in households that owned very varied levels of household assets and resources. Table 8 shows the percentage of interviewees who lived in households with each listed characteristic, by district. 'Access to piped water' in this table includes a shared village or street tap. Only 4% of households had piped water inside the house, and another 38% outside the house e.g. in the courtyard; the large majority of those households were in the urban districts.

Table 8: Interviewees living in households with the listed characteristics, by district (percent of households)

District/ house characteristic	Urban 1	Rural 1	Urban 2	Rural 2	Total
Access to piped water	75	35	89	71	67
Flush toilet or improved latrine	71	21	82	37	53
Concrete house walls	63	26	64	11	41
Cement, tile, brick floor	76	42	84	21	56
Lighting by electricity including solar	43	13	51	11	29

A housing quality index has been constructed from these data that assigns each household '1' for very poor conditions and a scale of 2 or 3 for better conditions, and then adds the scores. Thus a score of 5, the minimum, indicates that a household has: no access to toilet facilities; no access to piped or well water, relying on ponds, streams or water vendors; walls constructed of wood, clay or corrugated iron; floor of mud or clay; and lighting by paraffin or candles. Conversely the maximum score of 13 implies that a household has a flush toilet; piped water; concrete walls; a hard cement, tile or brick floor; and electricity for lighting.

It is striking that 24% of interviewees in Rural 1 lived in households scoring 7 points or less (compared to 14.5% of all interviewees). Conversely 70% of interviewees in Urban 2 lived in households scoring 11 or more. The median score for the two urban areas was 11 as compared to and 8 or 9 for the two rural districts.

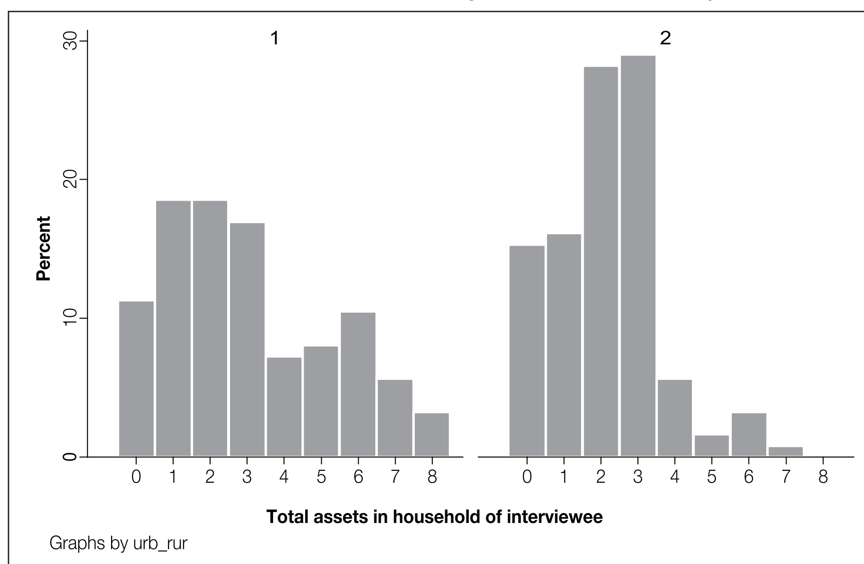
As expected, the housing scale correlates positively (though not strongly), with total payments recorded by women for maternal care.[3] Those in better housing conditions tended to spend more.

Households also varied widely in the assets they held. An asset scale was created by counting the number of the following assets owned in each household where one or more women were interviewed: radio, television, telephone, refrigerator, electric iron, other iron, bicycle, motorcycle or scooter, car or truck, bank account. Of all interviewees, 12% lived in households that owned none of these assets and a further 18% in households with only one: those percentages differed very little between urban and rural areas.

Disparities in asset ownership, however, were much greater in urban areas, as Figure 2 illustrates. In urban areas, 31% of interviewees lived in households with between 5 and 8 (the maximum) of these assets; in rural areas the percentage was 10% .

[3] The correlation coefficient between total payments for care and the housing quality scale = 0.1866.

Figure 2: Number of assets owned in the household, by urban/rural locations (1 Urban 2 Rural)



The asset scale correlates positively – and rather more strongly than the housing scale –with the levels of total payment for maternal care.[4] Women living in households with more assets tended to pay more for care.

Access to income is likely to influence payments. In general, women interviewed in urban households had spent larger sums on their most recent pregnancy than women in rural households. Households in which wages – private, parastatal or public sector – were an important source of household income were very predominantly (79%) in the two urban districts. Only 10% of rural households reported that wages were an important source of household income; most relied instead on income from farming. Furthermore, women from urban households relying on wage incomes (approximately one third of the urban total) had spent substantially more on their most recent pregnancy and birth than women from other urban households (Table 9). The same was not true for the small number of women living in rural wage-earning households.

Table 9: Total payments(in Tanzanian shillings) for care at most recent birth, by urban/rural, and by household reliance on wages in urban areas

Location/ data	Urban, wages important	Urban, wages not important	Rural, all	Total
Median	28,000	16,900	11,800	17,350
Mean	60,579	26,499	19,596	29,746
% zero	0%	6%	10%	7%
Maximum	800,000	213,500	97,700	800,000
N	34	54	86	174

A pattern thus emerges. On average, women who live in rural areas, in poorer quality housing, in households with fewer assets, and who are without access to a household wage income pay less for maternal care. The qualitative evidence is used below to explore how these payments interact with experience of care at birth in two urban districts.

[4] The correlation coefficient between total payments for care and the asset scale = 0.2036.

4 Findings: Interactions between payments and experience of care at birth

This section explores the interaction between women's experience of the quality of care at delivery, and the pattern and level of payments. It draws on interviews with 63 women in the district Urban 1, and 61 women in Urban 2.

4.1 Payments and Place of Delivery

Giving birth in Urban 1

In Urban 1, the interviewees identify three major influences on decision to deliver at a particular facility, or at home: proximity (geography), resources (expected cost and ability to pay), and reputation and women's experience of particular facilities.

The district of Urban 1 is geographically dispersed, the outer areas of the district being quite rural. The households interviewed were randomly sampled along four very diverse streets in two inner urban wards: a relatively well-off inner urban street; two streets with moderate quality of housing and conditions; and one street of informal settlement. In addition, two outer area streets were sampled, considerably further from the urban centre and quite remote.

In total, interviewees described 52 experiences of delivery within the last five years. Among the women in the more remote ward, 80% of the deliveries were in a public health centre or dispensary, and 20% at home. In the two inner urban wards, 78% of the women gave birth in one of the two big hospitals (one public, one FBO-owned), 11% at home and 3% (1 person) in a private dispensary. None of the women in the inner urban wards had gone to a public health centre or dispensary[5].

Strikingly, only two of the women who had given birth at home said that this was by choice. For the others, the home birth had been as a result of an unexpected early birth or other emergency, assisted either by a family member or a traditional birth attendant (TBA).

> *It was an emergency - the labour pains progressed fast and I did not even have time to walk to the hospital. We had planned to go there the next morning.* [55 Urban 1]
>
> *It was an emergency: I delivered a premature baby of 7 months. So I delivered at home.* [43 Urban 1]

Charges did influence the response to emergency:

> *The delivery symptoms started at night and the health facility was not giving services in the night. There was a private hospital nearby but I could not go there because I had no money.*
>
> *Question: Who assisted you in delivery?*
>
> *There was one traditional birth attendant who was living near to me who is the one who assisted me*[32 urban 1]

Furthermore the two women who said they had chosen a home birth were living in the unplanned high density street, with poor housing a few household assets. One had gone to her grandmother who had a good friend who was a Traditional Birth Attendant –but the grandmother lived 2-3

[5] Three women had given birth in facilities outside the region.

hours on foot from a facility. The other had had a bad experience at a hospital after a still birth and had returned to support from a TBA:

> *I had had a still birth, I was using traditional medicines which I was given by a TBA and she told me that I should go to her for delivery when the time arrived. Also I live far from the health facility so it was not easy to go there.* [20 Urban 1]

Finally, and poignantly, one woman who had delivered a premature baby entirely alone at home and then gone to a public health centre with the child said:

> *If you deliver in a facility, it is very expensive, you need money to do so. So I thank God, I did it at home.* [43 Urban 1]

Most women in the more remote streets had delivered at the same local health centre. The reasons included proximity, cheapness and also familiarity and continuity of care, for example:.

> *I went to [the local public health centre] for delivery because it is the only health facility that provides delivery service. Also they know the history of my pregnancy since I was attending ANC at the same place. Another important reason is that they provide delivery service for free. On top of that I am familiar with one nurse (Mama Betty) and I felt comfortable going there because the nurse is very kind and talks nicely with patients.*[58 Urban 1]

Three women had been told to go to the hospital because of risks associated with their pregnancy. One left it too late to travel, and two could not afford it, so all three went to their local health centre*:*

> *I went to deliver at [the health centre] although they told me I should go to [the public hospital] but I did not have bus fare for transport*.[63Urban 1].

In the inner urban wards, two types of reasons dominated the decision by women to go to the public hospital. First, the dispensaries or health centres that they were attending, public or non-governmental, either did not admit women for delivery, or referred all first deliveries and those after the fifth delivery. Alternatively, they saw the hospital as a safer option because it provided a service that could deal with complications, and a service that was (at least in principle) free of charge. Some had received positive accounts or positive past experiences of those services, while some had a negative view but saw the hospital as the only option. The following quotation covers most reasons identified by other interviewees.

> *I went to [the public hospital] for delivery because I was advised so by the nurses at [the public health centre] during antenatal care. I was also encouraged by my neighbours because they knew all the services were available at [the public hospital] just in case I had an emergency. It was also near (a walking distance) and I was told the services are free and there are always many nurses on duty, not like health centres where in most cases there is only one nurse and there are many patients for her to attend.*[37 Urban 1]

One particular public health centre had twice referred women to the hospital on the grounds that the health centre lacked supplies; in one case this had been dangerous:

> *When I started labour I went to [a public health centre]. They told me they could not attend me because they were out of gloves. So they told me to hurry and go to [the public hospital,*

which is not close by]. My delivery was an emergency, the labour was progressing very fast … the time was 1 am. [16 Urban 1]

The other hospital in Urban 1was a referral hospital owned and managed by a FBO. It accepted women for delivery as emergencies (free of charge); for normal deliveries for a specified fee (in 2011 Tshs 15,000); and as private patients for a much higher fee. Women who delivered there gave three types of explanations for their decision.

Some women who knew their pregnancy was particularly risky had chosen that hospital because of its reputation for good quality care. Some had simply balanced the reputation against the cost, and believed it offered value for money as compared to the public hospital. Finally, a few who could afford private care were receiving it at that hospital.

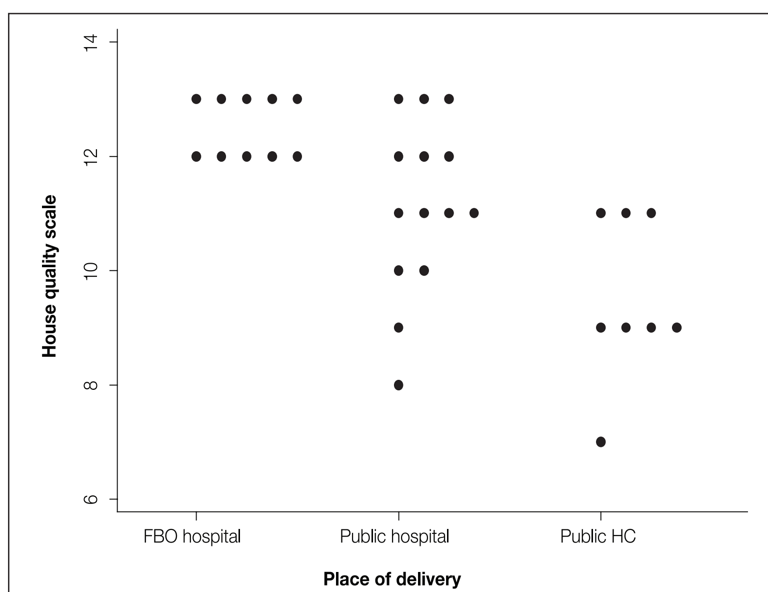
I went to [the FBO hospital] because it is a big hospital. It provides good services and it is not expensive. The cost of delivery was only 15000 shillings. [1 Urban 1]

I was referred to deliver at [the public hospital] but changed my mind and wanted to go to [the FBO hospital]… I am living with HIV … nurses are not careful enough at [the public hospital] and I feared that my child could get HIV if I had to deliver at that facility. It is better to pay in order to secure the life of my child. [12 Urban 1]

I went to deliver at [the FBO hospital by a private doctor. The service is good; I was scared of poor service at the general public clinic.[22 Urban 1]

The implication of these explanations is that women needed a certain level of assured ability to pay in order to go to the FBO hospital. This implication is reinforced by the finding that women who delivered there lived in higher quality housing as compared to those who delivered at the public facilities just discussed (Figure 3).

Figure 3: Household quality index by facility where a woman gave birth, district Urban 1 (scale 5= minimum; 13= maximum)



Giving birth in Urban 2
In the Urban 2 district, three wards were purposively selected with varied geographical and economic characteristics: one outer ward that is mixed urban-rural in character; one well-off inner urban ward; and one squatter ward. The households interviewed were randomly sampled along six streets, two in each ward, ranging in characteristics from well off to very poor.

In Urban 2, 87% of women interviewed had delivered their last child either at the regional public hospital in town (41%) or at a large urban public health centre. Only two women had gone to the private sector, both to private hospitals outside the region of the interviews. None had delivered at home. The concentration of births in these two facilities is striking, and contrasts with a much wider range of public and FBO dispensaries and public health centres that had provided the ante-natal care.

Most of the women who had delivered at the public health centre explained that they had been directed there by the FBO or public lower level facilities that had provided ANC but not delivery services: this included another local public health centre which provided only ANC and PNC. Several women said that the public health centre to which they went specialised in delivery care, and some described themselves as having been 'directed' there. These examples are quite typical:

> *All pregnant women go to [the public health centre] for delivery and even on our ANC cards they wrote that we have to go to deliver at [the public health centre].That is why I went to [the public health centre]. When you go to [the public health centre] and they find that you will have complications they refer you to the regional hospital* [180 Urban 2]
>
> *I delivered my baby at [the public health centre] because it was the centre for delivery and at that time [an FBO dispensary] was not offering delivery services. The Regional Hospital is near to my home as compared to [the public health centre] but they only accept you if you have been referred or it is an emergency so because I had no problem with my pregnancy I had to go to [the public health centre] for delivery.*[155 Urban 2]

However, women were also very conscious of charging and costs, and also of the reputation of the local facilities. There was a consensus among the interviewees that charges and costs to patients at the public health centre were moderate and that generally nurses were not abusive. Again, these comments are typical, as part of the explanation for delivering at this public health centre; the first two women had first explained the type of reason given above, then added:

> *Also [the public health centre] provides free service although we pay for medical supplies and drugs during delivery. [the public health centre] workers have a good attitude, they are not harsh or angry . They are respectful.*[130 Urban 2]
>
> *Also I did not get any problem that is why I went there. And at [the public health centre] they provide good service and services are provided for free although you are required to take with you supplies like mackintosh [plastic sheet] and gloves.* [131 Urban 2]
>
> *This health centre is far from any home. Charges for health services are free though I was forced to buy some medical supplies. Facility workers' attitude is good, they do not abuse.* [129 Urban 2]

There had thus clearly been a successful local campaign in both public and FBO sectors to direct women to this public health centre. In addition, women said that for a while the labour ward in the regional hospital had been closed for renovation. The emphasis on directing women to the public health centre was confirmed in an interview with the person in charge of maternity at the regional hospital, who said that the public health centre was effectively acting as a district hospital to ease the burden on the regional hospital. However the health centre had no theatre, and hence could not deal with emergencies requiring surgery. The lack of alternative non-hospital delivery options for women in the area is also notable.

Despite pressure to go to the health centre, some women interviewed had nevertheless delivered at the regional hospital. A number of women had been referred there, either before birth or at on arrival at the public health centre because of immediate or anticipated complications. For example:

> *I delivered my baby at the regional hospital because I was advised and also it was written on my ANC card that I have to go to big health facility for my delivery because it took me a very long time to conceive.*[164: Urban 2]

> *The labour pain started early while the pregnancy was seven months. So I was taken to the regional hospital for treatment and advanced services.*[171 Urban 2]

Others had gone to the hospital on their own initiative, both in 2011 and earlier, and some explained that this was not as advised, but a facility they preferred. Women needed a certain amount of determination to access services there:

> *It is close to my home place; it is relatively bigger and offers better services with the best doctors and nurses who are trusted and ethical. I went there purposely, not by chance, their nurses are not rude like the ones at [the public health centre].* [146 Urban 2]

> *I did deliver at the Regional Hospital because it is a big health facility and has equipment and a big number of experienced health providers compared to all other hospitals in this town. It is a normal practice that all women at this household use this facility for delivery.* [183 Urban 2]

> *Because it was my first pregnancy I decided to go to the regional hospital because they have good services. But usually we are supposed to go to [the public health centre]. But for me I do not trust their services because most of them* [the attendants] *are students.* [133 Urban 2]

> *I chose to go to [the regional hospital] because it is near compared to [the public health centre]. Once I reached [the regional hospital] the nurses wanted to send me back because I was supposed to go to [the public health centre] for delivery services*[140 Urban 2]

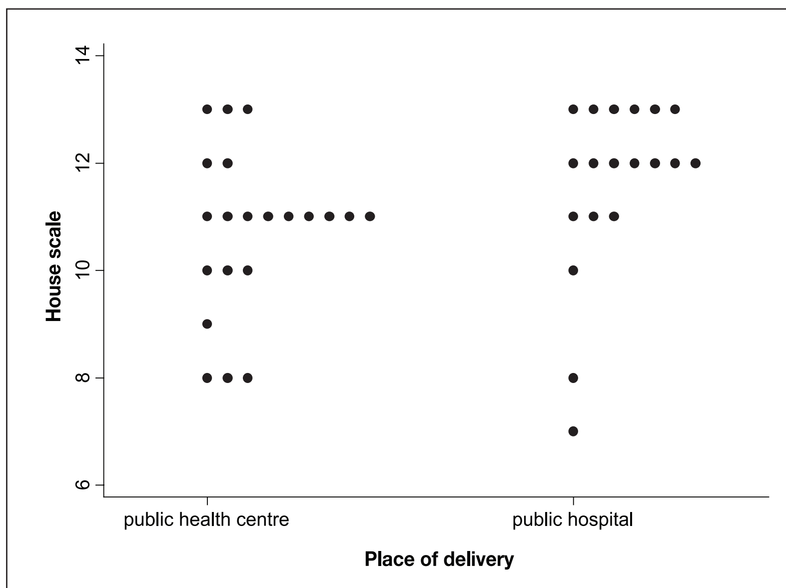
The last woman quoted also argued that the services at the regional hospital had been poor in 2008 but had improved recently; and she had delivered there in 2011.

Though many women mentioned qualified staff with good attitudes, and good equipment including surgical capacity, no-one, in explaining why they had delivered at the regional hospital, mentioned charges. This can perhaps be partly explained by the fact that women delivering at the hospital had

paid much the same on average at the hospital as compared to the health centre, while the median payment was substantially lower at the hospital.

However, the women from the better off households in Urban 2, as measured by the housing quality asset scale, were more likely than those in poorer housing to have delivered at the regional hospital (Figure 4). The decision about where to deliver was thus strongly patterned by place of residence and resources.

Figure 4: Household quality index by facility where a woman gave birth, district Urban 2 (scale 5= minimum; 13= maximum)



4.2 Payments and Experience of Care at Birth

Women whom we interviewed were highly conscious of the difficult interconnection between payments and quality of care. The very few women who paid to deliver in the private sector – all among the better off – took the view that they could rely on receiving decent care in response to their payments. Here is one example:

> *The facility private dispensary is closer to my home and their services are good they are places I attended before…*

She stated that she trusted the dispensary, emphasising that:

> *The trust I have in them is because it is a private organisation I have to pay for the service, and by paying I will receive a kind of care and treatment that I want from them.* [6 Urban 1]

And here is another: a woman from Urban 2 who had gone to a private hospital in a neighbouring city:

Their services were good, they keep you under good supervision, a doctor is available all the time of delivery so he/she can help you when there is a problem; supplies and medicine are sufficient. It is a private hospital so the service provided is of high quality. [151 Urban 2]

The first speaker had paid Tshs 22000 for delivery in a local private dispensary run by an elderly medical doctor; the second had paid Tshs 300,000 to deliver in a private hospital.

This theme, of the search for value for money, ran through many of the women's discussions of their experiences of care and payment, at all levels of ability to pay. As the data in earlier sections show, few women delivered without making some payments, and their concerns were not only for finding the money, but ensuring value for money.

Types of payment for delivery

Generally, the women interviewed in these two districts expected to have to pay something at delivery, and they prepared beforehand, ensuring they had some cash and often purchasing supplies to take to a facility for delivery, or to use during home delivery. One woman in Urban 1, for example, had had been helped during labour by a neighbour and had then given her Tshs2000. This money, she said, had been raised from selling cassava and sweet potato, in the expectation of having to pay at the public health centre.

Table 10 shows the payments at birth in the public facilities, and one FBO hospital, reported by women interviewed in the two urban districts. As discussed above, these are payments mainly for delivery in a regional hospital in each district; a single public health centre in each district; and an FBO referral hospital in Urban 1. Payments for supplies in Table 10 include supplies bought at shops and taken to facilities for use at delivery; and payments described as supplies paid for at the facility. The latter purchases are often payments to nurses for supplies: we return below to the interaction between such payments, other informal payments to staff, and experiences of abuse.

Table 10: Mean payments (in Tanzanian shillings) reported by women for most recent birth in urban districts, by type of facility.

Payment for:	Urban 1			Urban 2	
	FBO hospital	Public hospital	Public health centres	Public hospital	Public health centres
Supplies	3,000	2,400	2,850	10,474	6,043
All non- transport	30,500	4,180	4,750	11,158	7,471
Transport	12,900	7,300	1,270	8,095	11,210
Total payments	43,400	11,480	6,020	19,252	18,681

In the public hospital in Urban 1, some women had gone for delivery taking supplies with them:

I bought syringes and plastic birth gloves for the nurse at the time of delivery from the pharmacy… because they are not available in the hospital. If the pregnant woman goes into the hospital for delivery services without such equipment they get abused by the nurses, and the nurses become angry [13 Urban 1]

Women reported sometimes buying supplies from the ward:

I was also supposed to pay Tsh 2500 to the nurses in order to buy blood clotting injection for me. [21 Urban 1]

They prescribed many medicines for me but they said the medicines were not available so I have to buy them. [28 Urban 1]

A number of other women, however, had not paid for supplies, and stated that the supplies they had required had been provided free of charge. In particular, several women who had been admitted to hospital as emergencies had paid nothing for supplies; for example:

I did not buy supplies everything was available at the hospital….I appreciated the service I received …. nurses and doctors did not demand anything from me. [16 Urban 1]

While the requirement to pay for supplies was erratic in the public hospital in Urban 1, in the remote public health centre, payments for supplies had become routine. All the women interviewed had made such payments, and they were clearly regarded as normal, if not necessarily acceptable.

My husband was instructed to go and buy gloves for my delivery, so he paid instead, a total of 2000shillings and the nurses bought the gloves. [50 Urban 1]

After I had delivered, the Nurse told me I had used four pairs of gloves whereby each pair cost 1000 shillings [for which the interviewee paid]. [48 Urban 1]

I only bought gloves from "Mama Helena" who has a shop near the facility. She sells them to the patients for 2000 shillings a pair. [44 Urban 1]

I think there is shortage of supplies because everyone who goes for delivery is requested to buy supplies especially gloves. [50 Urban 1]

It is a very difficult time when one wants to go for delivery because everything, all supplies and medicines, you need to buy and for me, I really could not afford it until I borrowed some cash from my friends. [45 Urban 1]

The other hospital in Urban 1 where many women had delivered was the FBO-owned referral hospital. Here it was possible to go for a normal delivery for Tshs 15,000. Women who went to the hospital as private patients paid substantially more. Women who went to this hospital had generally made their payments at the cashier, and had not usually been asked for other payments. The Tshs 3000 average payments for supplies registered in Table 10 was a single large payment by a private patient.

In the regional public hospital in Urban 2, payment for supplies was reported, but as in the Urban 1 public hospital, the payments were erratic. Some of the women who had paid said:

I gave 5,000 shillings to nurses, in order to buy mackintosh, gloves, blade, scissors and thread; you normally don't buy yourself, but nurses buy for you [135 Urban 2].

The nurse who attended me demanded 5000 shillings for supplies, which means that I had to buy supplies from them. [137 Urban 2]

I spent Tshs 45000 for buying various supplies and medicine from the pharmacy near the hospital. Among other thing I bought four catheters, three pair of gloves, twelve syringes, forceps for pulling the baby, liquid medicine and a drip for facilitating labour pains. [147: Urban 2]

For my previous delivery [2007] *I spent 3000 Tshs for supplies like gloves and other things, which is completely different from current* [2011] *costs of Tshs 20000.* [157 Urban 2]

One woman who had had an emergency caesarean said:

We were told to buy supplies for the operation. My husband had no money by that time, so they told him to go and look for money and buy those supplies. My husband went to look for money, my situation changed and things were worse. The doctor decided to use the supplies of fellow patient for my operation and I was operated. The supplies were replaced with the supplies brought by my husband. The cost of the supplies bought was 90,000 shillings. [164 Urban 2]

Though the majority of women had made payments for supplies – some of them very high– some women had not:

I received very good care. All the supplies I got at the hospital, and I did not pay for anything. [179 Urban 2]

I did not pay for anything and all supplies were provided at the hospital. [132 Urban 2].

Medical equipment and medicines are available without any problem although I bought my own medical supplies I never used those supplies at the hospital. [140 Urban 2]

Women were accustomed to pay for supplies at the public health centre in Urban 2, just as described for the public health centre in the remote area of Urban 1. Just two women said they had not paid at the Urban 2 public health centre. All the other women had paid for supplies; these are just a few examples:

I paid 10000 shillings at the health centre for buying gloves, razor blades, syringe and medicine. [129 Urban 2]

I also bought supplies at the health centre - that is gloves, mackintosh, thread and razor blade for 10,000 shillings. [134 Urban 2]

Money to buy medical supplies such as gloves, thread, syringes, plastic tubes for drip and razor blades, cost a total of 10,000 shillings. [141 Urban 2]

I took gloves with me… I bought them for 3500 shillings at the pharmacy. [143 Urban 2].

I paid for the supplies e.g. needle, gloves, medicine, mackintosh, total Tshs 18500. [169 Urban 2]

I bought gloves, mackintosh, thread and blade for 5000 shillings and I bought clotting injection for 2000 shillings as well as thread for minor surgery for 4000 shillings. [175 Urban 2]

These payments had become the norm at this health centre:

We know that those gloves and mackintosh are sold that is why we prepare ourselves early and it is not possible to go there [to the health centre] *without taking them* [supplies] *or having money to buy them.* [131 Urban 2]

4.3 Payments, Care and Abuse

We asked our interviewees how they perceived the quality of care during their most recent delivery. Women's responses clearly illustrate how failure to pay is associated with abuse, a point also emphasised in our working paper on the interaction of payments, ethics and abuse. Payments interact with unethical behaviour, including neglect and abuse, in complex ways.

In Urban 2, more than two thirds of the women interviewed, when asked about quality of care, linked their response to the issue of payments. Payments themselves can be seen as an abusive exercise of power in a context where most women interviewed were aware that maternal care in the public sector was supposed to be free.

One of the most frightening situations for women could occur when payments were unpredictable, personalised and linked directly to access to care in the process of delivery. In the public hospital in Urban 1, one woman described the fear as follows;

When I went to [the public hospital] for delivery after having labour pains for a long time, the nurse asked for a gift (4000 shillings) so that she could attend me.She completely refused to help me in the morning; and I decided to give 4000 shillings to the attendant on duty so as to get service. After I gave her the money, she told me to keep it a secret and I should not let anybody know about the gift, so I did not tell anyone except my mother and my husband who were at the hospital at that time of the morning. I felt like dying because if my relatives were not there I would have died for sure….My mother and my husband paid the money (4000 shillings) to the nurse, without a receipt…if I had nothing, it means I would not be attended. [40 Urban 1]

Other women described similar experiences:

I gave 5000 shillings to the nurse who assisted me during delivery. I gave it to her before the baby was born because I was scared and I was confused by the labour pains and the women in the labour ward kept saying that, "If you give something to the nurse, at least you get someone to pay attention to you". So I did give money and I was given the services..… it was much better than before I had given something or compared to the women who did not have anything to give. [37 Urban 1]

Arriving without supplies could also result in abuse:

If the pregnant woman goes to the hospital for delivery services without such equipment [supplies] then they get abused by the nurses, and the nurses become angry. [31 Urban 1]

Facility staffs have abusive language especially if one did not go with money or supplies for delivery. [13 Urban 1]

Strikingly, some women who related better experiences went on to comment that this had happened *despite* the fact that they had not paid. The juxtaposition of ideas made clear that they had in their minds the view that they might well need to pay to be treated decently, so the lack of payment merited comment or explanation:

I was never abused or shouted at … All medical supplies and medicines were available … the whole delivery service was provided for free.

I received very good care, midwives and nurses … helped me to deliver safely ….they talked nicely and comforted me. At the time … one of my sisters was a midwife at the labour ward, so she helped me a lot. [19 Urban 1]

On the whole, women saw the care available at this hospital as *potentially* good – with qualified staff and equipment. Those who had given money thought it had resulted in better attention:

It [the service] *was much better than before I had given something or compared to the women who did not have anything to give.*

If you do not have money at hand you can wait a long time without service. But if you give even 1000 shillings only, you receive good service, they will test if you are ready for delivery, even call for the doctor to check on you if you have a problem. [27 Urban 1]

If you do not have money they do not give any care for you for example one patient delivered on the floor because she did not have money to bribe the nurse. [28 Urban 1]

Some had given gifts, such as a woman who had had twins. She commented that the service was not very competent – the second twin had initially been missed. But the nurse had worked hard to help her, so:

I thanked the nurse and when my husband came I got some money to give as gratitude for the kindness … I felt better to have given money because my conscience was forcing me to give, even though it was little but I was quite happy I did it. [41 Urban 1]

Others withheld gifts, though aware they might be expected, and some regretted the money expended:

I did not give any gift to the nurse who assisted in delivering because that is part and parcel of her duty; she is not supposed to be given any gift. [2 Urban 1]

I did not give any gift because I felt like the nurse did not attend me nicely as I was expecting. [29 Urban 1]

It was the first time I delivered at the hospital. I regretted that I did not stay and deliver at home. This was my fourth child, and the first three times I delivered at home. [3: Urban 1]

At the public health centre, while payments for gloves and medicines were routine, payment to the staff varied, but most women had paid something to nurses. Sometimes this was characterised as a gift:

> *I gave a gift of 2,000 shillings willingly. I was not forced to give it to her.* [47 Urban 1]

Most however saw the payments as an obligation, and the amounts reported varied substantially.

> *I was also forced to give her (the nurse) 2000 shillings as a gift because when you do not give her she complains. Complaining when you do not give them anything is the habit of all the nurses at [this public health centre).* [48 Urban 1]

> *The nurse also told me to give her 5000 shillings, the amount was said to be for kerosene. I offered this after delivery. Each woman who delivers there has to contribute 5000 shillings though they say it is for kerosene but we know it is like a gift.* [56 Urban 1]

Again, unpredictable demands caused particular distress:

> *After delivery the nurse told me that I was supposed to pay 10000 shillings as facility charges and I had no alternative but to pay. I had 2000 shillings when I went there for delivery for buying gloves. This money was from my savings. The other 10000 shillings I paid after delivery, and I went back home because I was not prepared for it… I decided to sell two ducks for 12000 shillings.* [51 Urban 1]

Women who were not asked to make this kind of payment attributed this generally to personal relationships within the facility. One woman who had struggled to find 700/= for a bicycle lift to the facility made no payment other than gloves and medicines, and had walked home; she said she had got to know the nurse at ante-natal care and was treated kindly and without payment for delivery. Another who had not paid commented that she knew the staff well, discussing them by name. One simply said that she had no money so could not pay.

Women who delivered at this public health centre recounted, however, few experiences of abuse. There were a number of positive accounts of kind behaviour, careful treatment (of both women and babies), and positive relationships built up with staff. One woman said:

> *I have never come across someone who was abused or humiliated by nurses at [this public health centre].* [56 Urban 1]

The assumption that delivery at the public health centre required payment applied also to other local health centres. The woman (above) who was sent away in advanced labour from a different public health centre in the middle of the night, on the excuse of lack of supplies, commented:

> *I was not asked to pay anything, but this might have contributed to the refusal.* [16 Urban 1]

In contrast, the payments at the FBO hospital in Urban 1 could be substantial, and although there were some complaints of abusive behaviour there by nurses and doctors, the two issues were not linked in women's account of their experiences at birth. In this hospital, there appeared to have been a genuine clamp-down on requests for payments, and supplies were available.

In the public hospital in Urban 2, however, women who perceived their care as bad did generally link their complaints to issues of payment. These are some of the comments of women dissatisfied with their treatment at the public hospital. A woman who had been asked by a nurse for Tshs 5000 for supplies and also other payments said:

> *I was very disappointed, because we are told that the maternal services are free but in actual fact they are not because we are charged. When it comes a time to go for service, you must pay. I did not like their service for sure. They like money too much.* [137 Urban 2]

As in the Urban 1 public hospital, women in Urban 2 felt that payments in the hospital could be a matter of life and death:

> *The services were not good because if you don't have money you can die while in hospital. Though I was in critical labour pain, I was told to call my husband to bring money otherwise I will continue suffering. This was very tough for me.* [164 Urban 2]

Women in this district also recounted that they faced neglect, abuse, and even a possibility of death when they are unable to pay for supplies or bring them having bought them elsewhere. Some of the women said quality of care was good but they indicated this was because they had paid or brought supplies. In other words, they thought services would have been bad if they had not paid or brought their own essential supplies.

One woman who delivered in the public hospital argued:

> *"The problems I got, together with my baby, in delivery were due to carelessness of nurses because they kept quiet for a long time while I was in labour pain and the passage could not open up to enable the baby to come out. My suggestion is that mothers should be helped to deliver especially when they are not able to pay for supplies. On top of that nurses should also respect the pregnant mothers or should respect maternal care".* [153 Urban 2]

As regards the public health centre in Urban 2, women made similar arguments. One woman went on to question the notion that there were truly supply shortages at the health centre:

> *They gave me good care but it's because I gave them some money; if I hadn't they wouldn't have given me good care. Supplies are not sufficient, since we pay for them. But what I wonder is, if the supplies are not available at the hospital* [health centre] *where do they get them when we pay for them? They take them from the facility and bring them to provide service.* [174: Urban 2]

Women who had had good experiences at the health centres similarly attributed this to their payments:

> *In short, their service from reception to the service provision was good, but if you do not have supplies, you will die, because, nobody will look at you to help you must have cash and pay for the supplies so that you can receive a service.* [169 Urban 2]

Given these findings, it is not surprising that women perceived getting good care without being asked to pay as the main criterion of good quality care during delivery. Here are foursuch comments, the first two referring to the health centre in Urban 2, and the second two to the hospital in Urban 2

The service was actually good. I did not pay for it, I did not buy the supplies and even the attendants [nurses and midwives] *did not force me to pay them. [*127 Urban 2]

The service that I got when I delivered was good, the delivery services were given for free. The midwife helped me to deliver safely. [130 Urban 2]

The service was so good, since I did not pay for it. [170 Urban 2]

Actually the service was good, I did not pay for it and yet I did not suffer of it. I was well received by the nurses because they were afraid of being labelled negatively. I think the staff on the shift of that day were so kind to me. [146 Urban 2]

Paying for delivery services and supplies has thus become common and normal. The result is that some women, having been told that they would be given the service and their spouses could pay later, or who regarded the payments as not too high, thought of these payment demands as favours to them, and saw this as good quality care. Here are two examples:

Services during delivery were good because that night when I went for delivery service I had no money to buy medical supplies and medicine, but they used theirs, and told me that once my husband came tomorrow morning, he will make all payments needed, because I had no money to buy such medical supplies. [129 Urban 2]

The services during my delivery were generally good. The nurses were good to me, and the expenditure was not all that big rather it was moderate. [134 Urban 2]

Having been surprised by this response, the interviewer asked: "Are services not supposed to be free?" to which the woman responded:

Yes, I know that all maternal care services are supposed to be free of charge-but we are advised to buy these supplies because we do not know whether the supplies will be available at the time of delivery or not. Also it is easy because all supplies are sold at [the] health centre. [134 Urban 2]

Some women who said that they had not paid anything for delivery and that the quality of care was good had relatives among the members of staff:

"Actually they are trying and their services are good because they listen to me. But I think it is because my sister is a nurse there although she was not there when I went for delivery. [delivered at the public hospital]. [156Urban 2]

The delivery services at the health centre are good and I do have my relative who is a midwife, she helped me a lot and gave me good care. I did not get any problem even if she finished her shift, her colleague who took over her shift when I started to deliver she helped me, and gave me some instructions until I delivered safely. The midwife was so kind. [181 Urban 2]

5 Concluding discussion: Cultures of charging, cultures of care or abuse

The findings presented in Section 4 show that all the facilities to which most of the interviewees went for delivery were charging for care. In the FBO hospital in Urban 1, the practice was formalised, and payments were generally made to a cashier. The practices of informal charging in wards or asking women to bring supplies had been largely suppressed in that facility. As a result, the hospital had largely detached the issue of charging from the problem of abuse. Their charge for normal delivery was substantially above the charges in health centres, but not substantially above the average non-transport charges paid by women who delivered at the public regional hospital in district Urban 2 (Table 10).

The majority of the women interviewed who had not delivered at home, delivered in four public facilities. In all four, charging was widespread. The charging cultures had become particularly routinized and embedded in the two public health centres. These health centres were actively selling supplies to patients, so that patients who did not bring their own supplies could often buy them at the facility. Payments 'for supplies' to nurses had become quite standardised around sums such as Tshs 5000 or Tshs 10,000. In some cases the facility staff apparently would buy supplies on behalf of patients from local shops. There was a 'grey area' around payments to staff, payments at the facility for supplies, and payments to shops for supplies: some payments might fall into all three categories, and women were not necessarily clear what it was that they had paid for and how.

In both public regional hospitals, charging appeared to be widespread but more erratic than in the health centres. Emergencies could mean large unexpected demands for cash for supplies, requiring distress sales of assets. It was also in the pressured labour wards of the public hospitals that individual payments to nurses were most closely associated with abuse and attempts to avoid abuse.

In the two public health centres, it seems clear that delivery care at its current standard relied on a flow of funds and supplies from women that was normalised and embedded. Women were generally well aware that this was not supposed to be the situation, that maternal case was supposed to be free of charge, but there was widespread acceptance that currently this was how the facilities functioned. For those who found the funds and conformed, the level of reported abuse was not high.

These various charging cultures have become part of women's expectations, and those of staff members, and will not be easy to change. The greater 'visibility' of the hospitals – noted by one of the women quoted above, who thought the nurses were anxious to avoid negative commentary – appeared to be associated in these cases with more uneven and unpredictable, but not lower, payments than in the health centres.

One of our professional advisers commented at the start of this project that any birth is 'a kind of emergency', that is, sudden, unpredictable in its course, needing to be well managed, and with the potential to turn into a severe emergency. Charging is causing problems for effective management of this process, but the charging-based culture needs to be replaced with care, with attention to what is currently happening, and with a truly workable alternative. An alternative to the charging-based culture can only be workable if it is informed by a clear understanding of the underlying causes of this culture, and a more firm commitment to address them is made at all levels, including health facility management.

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