Provision and Utilization of Maternal Health Services in Lalta Ward, Tanzania: Women's and Health Workers' Experiences

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Declaration

I hereby declare that this dissertation was written and prepared by me independently. Furthermore, no sources and aids other than those indicated have been used. Intellectual property of other authors has been marked accordingly. I also declare that I have not applied for an examination procedure at any other institution and that I have not submitted the dissertation in this or any other form to any other faculty as a dissertation.

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Abstract

Over the last decades, global and national health efforts to reduce maternal mortality in African countries have focused on increasing women's access to biomedical maternal healthcare services, which goes hand in hand with measures to motivate women to actually use these services. Since 2007 Tanzania has been expanding biomedical maternal healthcare services significantly in rural areas. However, evidence shows that the utilization of the same is still low and maternal mortality remains high. This dissertation explores the provision of biomedical maternal healthcare services in rural Tanzania, and the various ways pregnant women and mothers engage with the service in the context of increased availability and physical accessibility. Bringing together the experiences of women, healthcare providers, traditional birth attendants (TBAs) and community health workers (CHWs), the dissertation shows that women's experiences portray imbrications of agency and structure that challenge the simple correlation between increased availability and utilization of the service.

This dissertation is based on 10 months of ethnographic fieldwork conducted between February 2015 and March 2016 in Lalta Ward, located in Dodoma Region, Tanzania. I observed the provision of maternal health services in two village dispensaries and two referral hospitals. Besides doing observation, I interviewed women and their families, healthcare providers and administrators, NGOs' representatives, traditional birth attendants (TBAs), community health workers (CHWs), religious leaders, and a traditional healer. To gain a deeper understanding of women's maternity experiences, I used an extended case method and selected 12 pregnant women that I followed closely during pregnancy, childbirth and post childbirth. I also conducted focus group discussions with men, pregnant women and mothers in order to compare and contrast views on reported experiences. I obtained research permits from the University of Dar es Salaam and the National Institute for Medical Research.

Conceptually I build on Foucault's notions of "biopower" and "governmentality" which enables the analysis of the national and global efforts to subject pregnant women and mothers to use biomedical maternal healthcare services. I furthermore draw on the notion of transnational governmentality by James Ferguson and Akhil Gupta in order to understand the involvement of various global actors in the efforts to improve maternal health and wellbeing in Tanzania. Through Arthur Kleinman and Joan Kleinman's notion of "local moral worlds" I analyze how women understand maternal health, make sense of and use biomedical maternal healthcare services. In addition, I draw on the notions of authoritative knowledge by Brigitte Jordan, and "everyday forms of violence" by James Scott to investigate women's reactions to the efforts to subject them to use biomedical maternal healthcare services. Finally, I use the notion of "therapy management group" by John Janzen in order to make sense of the people involved in decision making about maternity care and the use of biomedical maternal healthcare services.

The findings of this study show that pregnant women and mothers used biomedical maternal healthcare services reflectively and pragmatically considering their world views, gender

relations, local conceptions of maternal health risk and economic capacities. The presence of multiple systems of knowledge about maternal wellbeing and care gave room for women to navigate between different forms of maternity care other than biomedicine according to their particular needs and concerns. Experiences from using the services in terms of mistreatments, unsatisfactory quality of the services and limitations posed by local conditions in the provision of biomedical maternal healthcare services prompted women to redefine their engagements with the services in ways that limited the utilization of the same. Moreover, poverty intensified by drought limited the capacity of women and their families to buy medical supplies and seek for childbirth services in referral hospitals. In other instances, the effects of poverty became manifest in severed family relationships that weakened the socio-moral support women needed to use the available biomedical services.

The study further shows that national guidelines for the maternal referral system which aim to enable women to access emergency obstetric care subjected healthcare providers to ethical and moral dilemmas. In referral hospitals, healthcare providers struggled with heavy workload and inadequate medical supplies that limited their ability to consistently provide good maternity care. Policy shifts away from the training of traditional birth attendants (TBAs), and the simultaneous introduction of community health workers (CHWs) who were expected to foster biomedical rationality beyond clinical settings by following up on women and encouraging them to use biomedical maternity services, affected women who still needed the services of TBAs. Community health workers themselves struggled to gain acceptance in women's lives. The study concludes that biomedical maternal healthcare services and interventions need to focus more on women's needs in particular contexts and that improving the quality of biomedical maternal healthcare services in both village dispensaries and referral hospitals is central to motivating women to use biomedical maternal healthcare services.

Zusammenfassung

In den letzten Jahrzehnten hatten globale und nationale Bemühungen im Bereich von Gesundheit das Ziel, die Sterberate von Müttern in afrikanischen Ländern zu senken und den Zugang für Frauen zu biomedizinischen Gesundheitsdienstleistungen für Mütter zu erhöhen. Diese Initiativen ging Hand in Hand mit Maßnahmen, die Frauen dazu motivieren sollten, diese Dienstleistungen tatsächlich zu nutzen. Seit 2007 hat Tansania seine biomedizinischen Gesundheitsdienstleistungen für Mütter in ländlichen Gebieten signifikant ausgeweitet. Allerdings belegt die Statistik, dass die Nutzung derselben noch immer gering ist und sich die Müttersterblichkeit auf einem hohen Niveau hält. Diese Dissertation untersucht die Versorgung durch biomedizinische Gesundheitsdienstleistungen für Mütter im ländlichen Tansania und die Art und Weise, in der schwangere Frauen und Mütter diese Dienstleistungen im Kontext einer gestiegenen Verfügbarkeit und eines erleichterten physischen Zugangs verhandeln. Die Dissertation umfasst die Erfahrungen von Frauen, Gesundheitsdienstleister*innen, traditionellen Geburtsbegleiterinnen und „Community Health Workers" und zeigt, dass die Erfahrungen von Frauen vielschichtige Verflechtungen von Agency und Struktur aufweisen und eine zu einfache Korrelation zwischen einer gestiegenen Verfügbarkeit und Nutzung der Dienstleistungen in Frage stellen.

Diese Dissertation basiert auf einer zehnmonatigen ethnographischen Feldforschung, durchgeführt zwischen Februar 2015 und März 2016 in Lalta Ward in der Region Dodoma in Tansania. Untersucht wurde die Bereitstellung von Gesundheitsdienstleistungen für Mütter in zwei Dorf-Dispensaries und zwei Referenzkrankenhäusern. Des Weiteren habe ich Interviews mit Frauen und ihren Familien, Gesundheitsdienstleister*innen und Administrator*innen, Vertreter*innen von Nichtregierungsorganisationen sowie traditionellen Geburtsbegleiterinnen, „Community Health Workers", den Leitungspersonen religiöser Organisationen und traditionellen Heiler*innen geführt. Um ein tieferes Verständnis der Erfahrungen von Frauen in Bezug auf ihre Mutterschaft zu erlangen, habe ich die *Extended Case Method* angewandt und 12 schwangere Frauen ausgewählt, die ich eng während ihrer Schwangerschaft, Geburt und der Zeit nach ihrer Geburt begleitet habe. Ebenso habe ich Fokusgruppeninterviews mit Männern, schwangeren Frauen und Müttern geführt, um deren Perspektiven mit den geschilderten Erfahrungen zu vergleichen und zu kontrastieren.

Konzeptuell gründe ich meine Arbeit auf Foucaults Begriffe von „biopower" und „governmentality", mit deren Hilfe ich die nationalen und globalen Bemühungen, schwangere Frauen und Müttern der Nutzung biomedizinischer Gesundheitsdienstleistungen für Mütter zu unterwerfen, analysiere. Darüber hinaus greife ich auf den Begriff der „transnational gouvernmentality" von James Ferguson und Akhil Gupta zurück, um die Beteiligung verschiedener globaler Akteur*innen in Bezug auf ihre Bemühungen, die Gesundheit und das Wohlbefunden von Müttern in Tansania zu verbessern, zu verstehen. Durch Arthur Kleinman und Joan Kleinmans Idee der „local moral worlds" analysiere ich, wie Frauen Gesundheit für Mütter verstehen sowie wie sie biomedizinische Gesundheitsdienstleistungen für Mütter verhandeln und anwenden. Ebenso beziehe ich mich auf Brigitte Jordans Konzept von

„authoritative knowledge“ und James Scotts Idee von „everyday forms of violence“, um die Reaktionen der Frauen auf die Bemühungen, sied en biomedizinischen Gesundheitsdienstleistungen für Mütter zu unterwerfen, zu untersuchen. Schließlich verwende ich das Konzept der „therapy management group“ nach John Janzen, um die Bedeutung von Personen, die in die Entscheidungsprozesse zur Mutterschaftsfürsorge und der Verwendung von biomedizinischen Gesundheitsdienstleistungen für Mütter involviert sind, zu erfassen.

Die Ergebnisse dieser Studie zeigen, dass schwangere Frauen und Mütter biomedizinische Gesundheitsdienstleistungen für Mütter in reflektierter und pragmatischer Art und Weise nutzen. Dabei verhandeln sie ihre eigenen Weltsichten, Gender-Beziehungen, lokale Konzeptionen von Gesundheitsrisiken für Mütter und ökonomische Möglichkeiten. Das Vorhandensein multipler Wissenssysteme in Bezug auf mütterliches Wohlbefinden und Fürsorge für Mütter bot einen Raum für Frauen, zwischen verschiedenen Formen der Fürsorge für Mütter jenseits von Biomedizin gemäß ihrer individuellen Bedürfnissen und Belange zu navigieren. Erfahrungen mit der Verwendung biomedizinischer Dienstleistungen in Hinblick auf Fehlbehandlung, die nichtzufriedenstellende Qualität der Dienstleistungen und Einschränkungen durch lokale Bedingungen für die Bereitstellung biomedizinischer Gesundheitsdienstleistungen für Mütter veranlassten Frauen dazu, ihr Verhältnis zu den Dienstleistungen neu auszuhandeln, was häufig die Nutzung derselben einschränkte. Darüber hinaus begrenzte die durch Dürreperioden verstärkte Armut die Möglichkeiten für Frauen und ihre Familien, medizinischen Sachbedarf zu kaufen und für die Geburtshilfe ein Referenzkrankenhaus aufzusuchen. In anderen Fällen manifestierten sich die Auswirkungen von Armut durch abgebrochene Familienbeziehungen, was die sozio-moralische Unterstützung, welche Frauen benötigten, um die verfügbaren biomedizinischen Dienstleistungen zu nutzen, schwächte.

Diese Studie zeigt, dass die nationalen Leitlinien für das Überweisungssystem für Mütter, welche darauf abzielen, Frauen den Zugang zur Notfall-Geburtshilfe zu garantieren, Gesundheitsdienstleister*innen vor ethische und moralische Dilemmata stellte. In Referenzkrankenhäusern haderten Gesundheitsdienstleister*innen mit einer großen Arbeitsbelastung und ungenügender materieller Ausstattung, was ihre Möglichkeiten, eine kontinuierliche gute Versorgung von Müttern zu bieten, einschränkte. Veränderte Politiken führten weg von einer Schulung traditioneller Geburtsbegleiterinnen hin zu einer gleichzeitigen Einführung von „Community Health Workers“, von denen erwartet wurde, eine biomedizinische Rationalität voranzutreiben, indem sie die Frauen über den Kontext der Klinik hinaus begleiteten und sie dazu animierten, biomedizinische Gesundheitsdienstleistungen für Mütter in Anspruch zu nehmen. Dies wirkte sich negative auf jene Frauen aus, die dennoch die Betretung traditioneller Geburtsbegleiterinnen benötigten. „Community Health Workers“ wiederum rangen darum, in den Leben der Frauen Akzeptanz zu finden. Die Studie schlussfolgert, dass biomedizinische Gesundheitsversorgung und -interventionen für Mütter in einem höheren Maße die Bedürfnisse von Frauen in spezifischen Kontexten in den Blick nehmen müssen und dass es zentral ist, die Qualität von biomedizinischer Gesundheitsversorgung für Mütter in Dorf-Dispensaries und Referenzkrankenhäusern zu verbessern, um Frauen dazu zu motivieren, biomedizinische Gesundheitsdienstleistungen für Mütter in Anspruch zu nehmen.

Dedication

To all mothers in Usandawe

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List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AMDD	Averting Maternal Death and Disability
AMREF	Africa Medical Research Foundation
ANC	Antenatal Care
ARVs	Anti Retroviral Drugs
BAKWATA	Baraza Kuu la Waislam wa Tanzania
BRN	Big Results Now
CBHP	Community Based Health Program
CBO	Community Based Organizations
CEmEOC	Comprehensive and Emergency Obstetric Care
CHF	Community Health Fund
CHW	Community Health Workers
DAS	District Administrative Officer
DED	District Executive Director
DMO	District Medical Officer
EPMM	Ending Preventable Maternal Mortality
FANC	Focused Antenatal Care
FGD	Focus Group Discussion
FOB	Faith Based Organization
HBF	Health Basket Fund
HIV	Human Immunoldeficiency Virus
HRSP	Human Resource Strategic Plan
HSSP	Health Sector Strategic Plan
IAG	Inter-Agency Group
ICPD	International Conference on Population and Development
IDI	In-depth Interview
ILO	International Labor Organization
IMF	International Monetary Fund
IPP	International Population Program
IUDI	Inter Uterine Device
LGAs	Local Government Authorities
MCH	Maternal and Child Health
MCHA	Maternal and Child Health Aides
MDGs	Millennium Development Goals
MIS	Malaria Indicator Survey
MMAM	Mpango wa Maendele ya Afya ya Msingi
MNCAH	Maternal, Newborn, Child and Adolescent Health
MoH	Ministry of Health

MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Childern
MoHSW	Ministry of Health and Social Welfare
MSD	Medical Store Department
NGO	Non Governmental Organization
NIMR	National Institute for Medical Research
NSGPR	National Strategy for Growth and Poverty Reduction
PHSDP	Primary Health Service Development Plan
PMTCT	Prevention from Mother to Child Transmission
PNC	Postnatal Care
POW	Plan of Work
PPP	Public Private Partnership
PSI	Population Service International
RAS	Regional Administrative Officer
RMNCAH	Reproductive Maternal, Newborn, Child and Adolescent Health
RMO	Regional Medical Officer
SAPs	Structural Adjustment Programs
SBA	Skilled Birth Attendant
SDGs	Sustainable Development Goals
SIDA	Swedish International Development Agency
SMI	Safe Motherhood Initiative
SWAp	Sector Wide Approach
TAMWA	Tanzania Media Women Association
TBA	Traditional Birth Attendant
TDHS	Tanzania Demographic and Health Survey
TMG	Therapy Management Group
TNA	Tanzania National Archive
TNMC	Tanzania Nursing and Midwifery Council
TTCL	Tanzania Telecommunication Company
UMATI	Chama cha Uzazi na Malezi Bora
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNPD	United Nations Development Program
URT	United Republic of Tanzania
USAID	United States Agency for International Development
UTI	Urinary Tract Infection
VEO	Village Executive Officer
WB	World Bank
WEO	Ward Executive Officer
WHO	World Health Organization
WRAT	White Ribbon Alliance Tanzania
WTO	World Trade Organization

Chapter 1

Introduction

1.1 Birth of Twins at Faraja Dispensary

When my mobile phone rang on the evening of April 28th 2015, I thought it was just a regular call. I had not gone to the dispensary that day and when I saw the name *Dada*[1] Juliana on my call register, one of the nurses at Faraja Dispensary, I thought she just wanted to know how I was doing. We became friends when I visited the dispensary for the first time. I answered the phone and after we exchanged greetings, she asked if I could go to the dispensary. It was around 7:00 pm. I wanted to know if there was any problem. She told me there was a woman at the dispensary with a twin pregnancy, "maybe you can talk to those who brought her if you come quickly," she told me. That was odd because if it was just a pregnant woman, why was it so urgent that I talked to those who brought her at that hour of the evening? I did not want to question Dada Juliana and told her I would be there in a short while.

I immediately took my notebook and the recorder and left for the dispensary. I walked hurriedly through open fields. From where I lived, it was approximately a ten minutes' walk to the dispensary. When I arrived, Dickson, the dispensary's laboratory technician was switching on a generator. I had already stayed in Magambua Village for more than two months, but I did not know that Faraja Dispensary had a generator. I only knew the dispensary had a solar system. Therefore, I asked Dickson why he was switching on the generator. He told me he wanted to assist a woman to give birth but was worried that the solar power might not be enough because other staffs had connected their houses to the dispensary's solar system.

After switching on the generator, we walked to the labour room. Outside, on the veranda, a man and an elderly woman were standing, wearing worried faces. I greeted them and proceeded to the

[1] *Dada* means sister, a form of address I was using for Nurse Juliana to show respect because she was older than I was.

labour room with Dickson. Inside, I found Dada Juliana and a heavily pregnant mother lying on the bed looking exhausted and in pain. I learnt that her name was Sara; she was 25 years old, married, and was pregnant with twins. “It is better you have come, let them (the man and the elderly woman standing outside) tell you why they delayed this much,” Dada Juliana told me with a somewhat angry tone after we exchanged greetings for the second time. I went outside but I did not know what to say to the man and the woman. I just told them I was sorry about the woman inside and that I wished she gave birth safely. At first, they thought I was a nurse. Thus, I explained to them that I was a student, researching about biomedical maternal healthcare services in their area. I learnt that the man was Sara’s husband and the elderly woman was her mother-in-law. It was not a good time for an interview and so, I just stood and waited outside with them.

After a short while, Dada Juliana walked out of the labour room and told me that “*njia haijafunguka”* (the cervix is not dilated). She said she was going to eat and she would be back. About thirty minutes passed and Dada Juliana was not back. Seeing the uneasiness of Sara’s husband and her mother-in-law, I thought of going to call Dada Juliana. I knocked at the labour room door and Dickson allowed me in. I told him I was thinking of going to check on Dada Juliana but Dickson asked me not to. What I did not know was that they already had an argument on whether to send Sara to Mshikamano Hospital[2] or help her right there. Dada Juliana was not ready to help. I knew Dickson had no specific training on midwifery because he was a laboratory technician. Dickson was positive that he could assist Sara. As I walked outside, he asked me to close the door partially so that if he would need me, I could hear when he would call.

While waiting outside on the veranda, many questions came to my mind. Why would Dickson assist with childbirth while there were two doctors and two midwives at the dispensary? Why was Dada Juliana not coming to help? To me, she seemed to be a very kind-hearted nurse. Why would she leave the woman in such pain to be assisted by someone without specific midwifery training? At that time, one doctor was on leave, another one had travelled but still there was another midwife apart from Dada Juliana living closer to the dispensary, but she had not shown

[2] Mshikamano Hospital was a Council designated hospital 80 kilometers from Magambua Village

up. Standing close to the door, I could hear Dickson encouraging Sara to push. I knew the time to give birth had come.

The thought of calling Dada Juliana was lingering in my head. Her house was approximately hundred meters from the dispensary but Dickson did not seem to count on her. After all, he told me to wait in case he needed my help. What could I help? I wondered while wishing all should go well. A moment later, I heard a sharp voice of a baby crying. I knew the first one was already born. However, I could still see the anxiety on the faces of Sara's husband and her mother-in-law as we waited silently. Dickson called me inside and asked if I could hold the baby who he had already wrapped in a *khanga*[3].

The labour room had a labour bed, a small table with a scale to measure babies' weights, a small wooden stool, and a rolling tray with medical supplies. Holding the baby, I had no choice but to wait for the second baby inside the room. I could clearly see the anxiety on Dickson's face. He complained to me that Sara lied about the labour pain. "She said the pain started in the afternoon, but she is very tired," Dickson explained to me. I sat silently around one corner of the room with the baby not knowing what to say until I heard Dickson encouraging Sara to push again and eventually, the second baby was born. I was happy and felt at ease. Sara seemed relieved. It was one of the most intense moments of my life and I did not wish to go through such an experience again.

Sara's mother-in-law who all this time was waiting outside was called in by Dickson. When the placentas came out, Dickson asked Sara's mother-in-law to clean Sara. Thereafter, we moved Sara and the babies to the women's ward. The mother-in-law was allowed to sleep over to look after Sara. Dickson told Sara's husband to go home and come back the next day with 20,000 Tanzanian Shillings[4] (equivalent to 8 Euros) as a fine for not going to a referral hospital. Without paying the fine the babies would not be registered or receive clinic cards. I wondered why the money was needed to register the babies because health services for pregnant women, mothers,

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[3] It is a colorful fabric mostly made from cotton wool. It is mainly worn by women around their waists. It is also used for carrying babies on the back, covering pregnant bellies and wrap-in the newborns.
[4] At the time of my research, 1 Euro was equivalent to 2,500 Tanzanian Shillings.

and children under five years were supposed to be free of charge (URT 2015a: 34). It was a private dispensary, but biomedical maternal healthcare services were provided in partnership with the government. I decided to hold on my questions until the next day.

We stayed in the women's ward for about forty minutes. At around 10:00 pm, Dickson switched off the generator and offered to walk me home. A moment after the generator was switched off; Dada Juliana walked in the ward and looked at the babies. She congratulated Sara and Dickson too, and offered to clean the labour room. She told me that, "Anitha have you seen now the way they delayed? She is lucky she has given birth safely here." Dada Juliana had called me to witness what she had been telling me earlier that many women delayed going to the dispensary and sometimes they could not assist them with childbirth because they were supposed to go to referral hospitals. As Dickson walked me home, I asked as to why Dada Juliana did not come back to help with the childbirth. He replied sarcastically but with a serious tone, *alikwenda kula bwana*! (She went to eat!). I just smiled, knowing I would talk to both of them on the following day.

In the following morning, I went to see Sara. I carried the newborn girls and congratulated her with 5,000 Tanzanian Shillings[5] (equivalent to 2 Euros). Sara's husband was there too and had already paid the fine. I asked if we could talk about the birth, they all agreed. I wanted to know why they delayed seeking birthing care and why they did not go to a referral hospital. I learnt that Sara was from Manantu, a village three kilometres away from the dispensary. She had given birth to her first child at Mshikamano Hospital almost two years back. With the twin pregnancy, she was advised to go to a referral hospital because it would be risky to give birth at the dispensary. However, Sara and her husband did not have enough money to go to the hospital. They explained that when Sara gave birth to their first child, the crop harvests were good and they had sold a lot of maize and thus, they had enough money.

However, since 2014, the rains were not good and the harvests were poor to the extent that they did not have enough to eat. Since it was made clear during antenatal clinic visits that Sara should

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[5] It is a custom in Tanzania to give money or any other present for the mother or the newborn. I saw the same being done in Lalta so I bought second hand clothes for newborns that I gave to mothers after childbirth. When I had no clothes I gave them money.

not go to the dispensary for childbirth, they decided she would give birth at home. One of her cousins married in another village had given birth to twins at home without any problems two years earlier, around the same time Sara had her first born. Sara hoped all would be well with her too and her mother-in-law was ready to assist her. The mother-in-law had experience in assisting with childbirth but she had never assisted a twin birth. During the interview, Sara admitted that the labour pain started early in the morning of the previous day and she tried to push since afternoon. As time passed, she got weak and worried. In the evening, she was afraid that she could get problems and asked her husband to look for a motorcycle to bring her to the dispensary. I asked them if they tried to consult a traditional birth attendant (TBA). The mother-in-law told me there was only one in their village but had travelled to Singida. However, Sara's intention was to come to the dispensary and was thankful that she was attended.

When I talked to Dada Juliana and Dickson, I learnt that Sara should have not been accepted for childbirth at the dispensary. With the twin pregnancy, according to the maternal referral system (WHO 1994), Sara was falling in the category of women with high-risk pregnancies who were supposed to give birth in referral hospitals that could handle obstetric emergencies. Attending such a woman at the dispensary carried the risk for maternal death, which could have severe consequences to the respective healthcare provider in terms of costing the healthcare provider's job. In addition, maternal death was a threat to Faraja Dispensary that was in the process of acquiring the status of a health centre. Dada Juliana complained that she and the other staff members told women to go early to referral hospitals but they delayed and went to the dispensary "to bring them trouble." I asked her what would have happened in Sara's case. It was obvious Sara could not make it to a referral hospital; even obtaining transport would have been a challenge because it was already dark. She insisted that they would find a way and that those who were supposed to go to referral hospitals should not be attended at the dispensary.

1.2 Background to the Problem

Since the launching of the Safe Motherhood Initiative (SMI) in 1987, global efforts to improve maternal health have focused on the reduction of maternal mortality. Services provided before getting pregnant (family planning), during pregnancy and after childbirth, were all geared towards avoiding the risk to maternal death. As a result, availability, accessibility and utilization

of maternal health services were associated with the potential of reducing maternal mortality (Thaddeus and Maine 1994; Gabrysch et al. 2011; Mwaliko et al. 2014; Hanson et al. 2017). The urgency of availability and accessibility of biomedical maternalcare health services has been emphasized more with the SMI approach introduced in 2004 (WHO 2004a), that promotes giving birth with skilled birth attendants (SBAs), which is also set as an indicator of progress in the reduction of maternal mortality (WHO 2008a: 1-2).

To increase the utilization of biomedical maternal healthcare services, in 2007, Tanzania committed to expand primary health care facilities in rural areas. The government aimed to build one health centre in each ward, one dispensary in each village, and upgrade the existing health facilities, especially health centres, to enable them to provide emergency obstetric care (URT 2007a). In this respect, progress has been made in that, between 2007 and 2015, the number of dispensaries increased from 4, 676 to 6640, and health centres increased from 481 to 695 (Kapologwe et al. 2020: 5). Besides, biomedical maternal healthcare services are free since 2007, and since 2010, traditional birth attendants (TBAs) are no longer permitted to assist women during childbirth. Instead, community health workers (CHWs) were introduced in 2013 to follow-up on pregnant women and educate them on the importance of using biomedical maternal healthcare services (Tingira 2016; Geldsetzer 2019). However, half of the women in rural areas still give birth at home until today, with 54 percent using antenatal care as advised, and only 34 percent receiving at least one postnatal care checkup (URT 2016: 317). According to the Health and Demographic Indicator Survey conducted in 2015, the maternal mortality ratio was 556/100,000 live births, an increase from 454 per 100,000 live births in 2010[6] (ibid.). In this respect, the question arises; why is there no correlation between the increased availability, accessibility, utilization and the reduction of maternal mortality?

In attempts to understand the state of maternal health in developing countries, several anthropological studies have shown that there is a critical problem in framing of the problem of

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[6] According to the Tanzania demographic and health survey and Malaria Indicator Survey (TDHS-MIS) of 2015/2016 (URT 2016: 317), for over two decades maternal mortality ratio has remained persistently high. The MMR of 556/100,000 live birth is not significantly different from estimates reported in 2004/05 (578/100,000) and 2010 (454/100,000).

maternal health. Women's experiences in developing countries have been homogenized and solutions standardized without adequately considering the context in which women access and need biomedical maternal healthcare services (Allen 2004; Berry 2010; Obermeyer 2000; Arps 2009). These studies underscore the reality that, without considering differences in women's experiences and the understanding of what motherhood means in particular contexts, maternal mortality will continue being a problem. Others have pointed to the paradoxical role of the state as a promoter of both health and conditions that produce ill health (Chapman 2010; Pfeiffer and Chapman 2010; Storeng et al. 2013; Craig and Chuluundorj 2004; Gray 2005; Lugalla 1995). Particularly, these studies map out how neoliberal economic changes have affected maternal health in different societies. With the increased global and national push to use biomedical maternal healthcare services, more attention is called on the capacities and quality of maternity care provided in health facilities that women are advised, encouraged and sometimes compelled to go (Freedman 2016; Miller et al. 2016; Koblinsky 2016).

My study is a continuation of critical inquiries to maternal health interventions. I draw attention to the experiences of women and healthcare providers in rural areas of Tanzania at a time the utilization of biomedical maternal healthcare services is being emphasized more than ever. While it is undeniable that the distance to health facilities affects women's utilization of biomedical maternal health services, I ask: what do we know about women's experiences in rural areas of Tanzania in the context of availability, physical accessibility of biomedical maternal healthcare services and the increased push to use these services? What about the experiences of healthcare providers in these localities? Understanding the conditions under which biomedical maternal healthcare services are provided and the circumstances under which women use them or fail to use biomedical maternal healthcare services is my main focus. Lalta ward, the locality in Chemba District, Tanzania, where I did my fieldwork between February 2015 and March 2016 had three dispensaries, two of which were in Magambua Village, the headquarters of Lalta Ward. Until 1999, the closest health centre was at Kwamtoro Division, some 20 kilometres away from Magambua Village. Although women in Lalta appreciated the availability and physical accessibility of the services, most of my interlocutors had at least one home birth and many did not attend antenatal care as recommended. Nearly all my interlocutors did not receive or seek postnatal care and many seemed to avoid using modern family planning methods.

Sara's birthing experience is but one of several experiences I encountered during my study that shows limitations in the provision and uptake of maternal healthcare services at the village dispensaries. It draws attention to women's experiences and providers' dilemmas. Broadly, it shows the complexity of involved factors that shaped Sara's birthing experience. Whereas the immediate reason for Sara's decision to give birth at home may be construed as a result of poverty, looking closely at Sara's experience reveals the way in which the globally initiated maternal referral system interacted with local realities and shaped encounters of pregnant women *beyond* what was envisioned by the intervention. The availability of biomedical maternal healthcare services increased the possibility of getting birthing care, but the maternal referral system made Sara ineligible to receive birthing assistance at the village dispensary. Besides, the local implementation of the maternal referral system limited her chances of getting birthing care at the dispensary. Sara was fortunate to have received birthing assistance at the dispensary, some were not. In due regard, crucial questions arise. What do we know about their experiences? What about those who managed to go to the referral hospital as advised?

1.3 Seeing Things Differently: The Central Argument

The need for anthropological work is of paramount importance in ongoing policy changes and interventions of reducing maternal mortality in developing countries. While it is assumed that the increased availability, provision of free biomedical maternal healthcare services, and education programs will encourage women to use biomedical maternal healthcare services, anthropological scholarship has shown that there is no such a simple course. People do not simply accept or reject interventions but as active health agents, they use their own cultural logics and social relations to incorporate, revise, or resist the influence of interventions (Ginsburg and Rapp 1995; Dilger 2012; Lock and Kaufert 1998; Obermeyer 2000). Following this lead, I argue that the utilization of biomedical maternal healthcar services in rural areas of Tanzania depends on how the services are provided and how women make sense of them in relation to the manner in which they understand their local moral worlds as individuals, community members and members of a dynamic body politic.

Women become pregnant within particular contexts that shape how they make sense and engage with maternal services and interventions (Ginsburg and Rapp 1995; Rapp 1999; Lock and Kaufert 1998; Van Hollen 2010, 2003; Browner and Sargent 2011). Particular world views, gender relations, local conceptions of risk and the knowledge about maternity care in specific social as well as historical settings, shape how women make decisions about maternal health and the use the corresponding services. Equally important, larger historical, political, economic and social processes as well as environmental changes have impacts on women's lives, which, in turn, shape women's understandings of their world and the use of the available biomedical maternal healthcare services. (Craig and Chuluundorj 2004; Chapman 2010; Ginsburg and Rapp 1995; Rapp 1999).

Sara's birthing experience, for example, cannot be divorced from the globally initiated maternal referral system in Tanzania's healthcare services. In addition, economic instabilities faced by most families in Lalta limited their ability to seek for maternity services. Furthermore, while Sara's family lack of money to go to the referral hospital was severed by drought, it cannot be analyzed independently of the historical global neoliberal economic policies that shook national economies of developing countries from the mid-1980s, and affected the economic stability of individual families. In other instances, such effects manifested themselves in poor health services (expounded in Chapters 5 and 6) or severed family relationships, the very foundation upon which the use of the available services depended to thrive (Chapter 5).

Besides, it is important to recognize that, even when women develop 'a biomedical rationality,' their responses to the services and interventions are by no means permanent. Reflectively and pragmatically, women in Lalta re-imagined how to use the available services in ways that worked for them. Some reconsidered the use of the services after experiencing mistreatments during service provision or local conditions of the provision of the services discouraged them, while others adjusted their use of the services to suit their circumstances. To better capture these dynamics, in Chapter 5, I propose understanding of women's maternity experiences in terms of what I call "whole maternity experience." By this, I mean taking into account maternity experiences in the course of pregnancy to childbirth as well as the inclusion of past maternity experiences for the understanding of the present experiences.

A simple presentation of women's realities fitted in standardized interventions or particular understandings of maternal health, hinders more than it reveals, thereby, complicating the problem of maternal health even further. What safe motherhood means to women is not confined to the globally embedded definitions promoted in the provision of biomedical maternal healthcare services and interventions, but local realities of their lives.

1.4 Healthcare Providers, Traditional Birth Attendants and Community Health Workers

As much as this study is about women's experiences as they engage with biomedical maternal healthcare services, it is also about the involved actors in the provision of these services. Over the past decade, anthropological scholarship has called for more attention on experiences of healthcare providers in developing countries. Such studies discuss subjective experiences of healthcare providers working in conditions of scarcity as subjects and agents of the state, individuals and community members with particular aspirations as well as moral obligations. Experiences of healthcare providers allow us to understand how services are provided and how interventions take shape in local contexts. Besides, healthcare providers' experiences show how they interact and navigate within health institutions to meet patients' as well as their own individual needs (Wendland 2010; Street 2014; Sullivan 2011; Mattes 2016; Martin 2009; Whyte et al. 2010).

Responding to the call and adding to these studies, I pay attention to subjective experiences of healthcare providers, traditional birth attendants (TBAs) and community health workers (CHWs) as immediate providers of maternal health services and implementers of maternal health interventions. Most studies on maternal healthcare pay attention to how healthcare providers 'mistreat' women in the process of providing care, especially during childbirth. Also, poor salaries and difficult working environments have received considerable attention (see, for example, Allen 2004; McMohan et al. 2014; Bremnes et al. 2018; Martin 2009; Moyer et al. 2014). Some anthropological studies have also sought to understand why maternal healthcare providers resort to violent actions when providing birthing care (Van Hollen 2003; Brown 2010). The way providers (re)interpret interventions and guidelines to provide care in ways that are meaningful to them or the communities they serve is equally enlightening. In this aspect,

anthropological studies on the introduction of antiretroviral therapy (ART) provide a good lead (Mattes 2016; Whyte et al. 2010). In maternal health studies, concerns like that of Dada Juliana and Dickson are largely overlooked, but they touch on some of the core concerns of individual healthcare providers and shape women's experiences of the available services in rural areas. In referral hospitals, healthcare providers struggle to provide care under difficult working environments characterized by the overflow of patients and the lack of adequate human and medical resources, leading to re-conceptualizations of care to suit their circumstances (Chapter 6).

Similarly, TBAs and CHWs are important providers of maternal health services beyond health facilities. Like healthcare providers in rural Tanzania, they engage with maternal health interventions in their own meaningful ways. Understanding their struggles and aspirations shows what really works for them and for the women they serve. Debarring TBAs from assisting births as a way of increasing facility-based childbirth highlights the struggle of TBAs to secure their position as birth attendants, which is an important part of their social identity. Community health workers struggle to secure their position in women's lives too, and the national scaling up of CHWs leaves a lot to be desired.

1.5 Objectives of the Study

In telling the analytical narrative of women's and healthcare providers' experiences in the provision and uptake of biomedical maternal healthcare services in rural areas of Tanzania, my study was organized around four objectives. Recognizing that local realities are woven into wider historical, political and economic processes that link specific localities to distant places (Dilger and Hadolt 2015: 146), the first objective of my study sought to understand the historical development of maternal health as a global health problem and connect it to the local provision of biomedical maternal healthcare services and conceptualizations of maternal health. I asked: how did maternal health emerge as a global health concern? What does maternal health mean in the global context? Who defines maternal health and what are the associated interventions? I traced the historical conceptualization of the problem of maternal health, as well as the resulting policy formulations at the global level, and intervention designs including their adoption in Tanzania.

The second objective was to explore how biomedical maternal healthcare services were provided and the ways maternal health interventions were articulated in Lalta. I focused on how the interaction between healthcare providers and women unfolded in specific clinical settings. I asked: how are biomedical maternal healthcare services provided? How do healthcare providers' implement biomedical maternal healthcare interventions? What do the interventions mean to them? How do the interventions affect their working relationships? How do healthcare providers promote the use of biomedical maternal healthcare services? I account for healthcare providers' experiences as they are manifested in the articulation of different aspects of biomedical maternal healthcare interventions. As strong advocates of modern family planning methods (Chapter 4), and when providing antenatal, childbirth and postnatal care services, healthcare providers moulded the interventions and services according to dispensaries' medical capacities (Chapter 5). As individuals and moral beings, the implementation of the maternal referral system at the dispensary level and the provision of birthing services under conditions of scarcity in referral hospitals, challenged healthcare providers' moral grounds as well as working relationships (Chapter 6).

The third objective intended to assess how women conceptualized safe motherhood and used the available services. I explored what motherhood meant to women in Lalta and whether the meanings were the same or different from those of the safe motherhood initiative (SMI). I paid attention to local notions of (in)fertility and how pregnancy and childbirth were connected to how women understood their world. I asked: how do women make decisions about the use of modern family planning methods? What influence their decisions? What do women and men think about modern family planning methods as well as (in)fertility? To understand how women cared for pregnancy, childbirth experiences and postnatal care, I explored the manner in which decisions to use biomedical maternal healthcare services for pregnancy, childbirth and postnatal care were made, people involved in the decision process and the way women used the services. I explored what impinged on the use of the available services when women had decided to use them. In addition, I observed childbirth experiences in referral hospitals in order to understand what became of those who complied with the referral advice and sought birthing care from referral hospitals.

The fourth objective sought to explore various efforts to build a ‘biomedical rationality’ about maternal health and to encourage women to use the available services that went beyond the clinical settings. I focused on the use of CHWs for maternal health and debarring of TBAs from assisting births. I asked: what do CHWs undertake for maternal health? What challenges do they face? What does increase follow up and the push to use maternal health mean to women? How are TBAs affected by being barred from assisting births? How are women affected by these changes? Whom do women prefer between TBAs and CHWs?

The efforts of subjecting women to using biomedical maternal healthcare services simplify a complex situation. Paying attention to an interaction of different factors illuminates women’s complex experiences that are glossed over in globally initiated intervention designs. This calls for a different way of seeing the question of maternal health and the problem of maternal mortality, and what can be relevant solutions in particular contexts, not only for the reduction of maternal mortality but for the well-being of women (cf. Berry 2010; Allen 2004). This means paying attention to mundane details of the provision of biomedical maternal healthcare services and women’s lived experiences. It emerges that, without taking into account contextual specificities, pertinent intentioned services and interventions may affect women in unexpected and sometimes dangerous ways. This study contributes towards seeing things differently. I hope the provided information will not only add some new knowledge on anthropological studies on maternal health and stir-up further research but will also shade light on important information for actors in maternal health in designing viable interventions for specific rural contexts.

1.6 Theoretical Framework

1.6.1 The Novel Theory of Power Relations

In this section, I present the theoretical framework that guides my data analysis. An attempt to provide a unified argument about women, their families and healthcare providers in the provision and uptake of biomedical maternal healthcare services requires a theoretical framework that can capture power relations in the context of local/global convergence. A framework that can also show the ways in which power is manifested in intersubjective interactions in local moral worlds (Kleinman 1999b: 70). From the 1970s onward, anthropologists have demonstrated that medical

systems need to be examined within larger historical, political, and economic contexts (Dilger and Hadolt 2015; Feierman et al. 2010; Pfeiffer and Nichter 2008). In addition, Craig and Corbett (2009: 171) have called for anthropological investigations on emerging environmental changes to identify health vulnerability of local populations in the context of political economy. The call is particularly salient in my study because women's accounts of maternity experiences in Lalta were linked to drought that had hit the area a year preceding my fieldwork. Therefore, I situate women's experiences in the broader context within which they took place.

I find Michael Foucault's notions of biopower and governmentality suitable analytical lenses to account for the broader context and the efforts of subjecting women into using biomedical maternal healthcare services (Foucault; 1977; 1978; 1991; 2003). To attend to multiple levels of analysis in the context of globalization, I adopt the analytical framework from the Critical Medical Anthropology perspective by Singer and Baer (1995: 65-75). The perspective identifies four analysis levels. First, the macro level, which situates case studies in historical and political contexts. Next, the intermediate social level, which focuses on the relationship between providers and administrators in bureaucratic procedures, and third, the micro social level, which looks at interactions between healthcare providers and women in clinical settings. Finally, the individual level, which explores immediate experiences in relation to the three preceding levels (Ibid.). I am inspired by this framework because it allows me to theoretically and empirically navigate and link different analysis levels. I conducted interviews with people in international organizations and local administrators as well as observed and talked to healthcare providers in clinical settings, CHWs, TBAs, women and their families.

However, I do not take with me the conception of power as stated in the perspective. The authors make it clear that their approach draws attention to the importance of locating health studies relative to encompassing *capitalist-world-system* (Singer and Baer 1995: 64). In this sense, the context in which health issues are analyzed is envisioned in a hierarchically structured world community grounded on trade and economic relations where the flow of power is unidirectional, from the centre to the periphery (Dilger and Hardolt 2015: 142). This conception of power has been challenged by the rise of post-colonial theories from the 1970s onward. Attention was turned to the global circulation and interweaving of locally manifested occurrences, ideas, and practices

brought by the discussion of globalization and the call to dissolve dichotomies of 'centre' versus 'periphery' and 'local' versus 'global' (ibid: 141-142; see also Gupta and Ferguson 1992: 16). Tsing (2000: 346) uses an imaginary of the landscape to describe the pattern of globalization arguing that we can study the landscape of both flow and circulation to understand how people, culture, and things are being 'made'.

In this shift, Foucault's conception of power was salient. He developed a notion of power capable of comprehending the complex working of power in modern societies that I find very useful in understanding the framing of the problem of maternal health and the efforts of encouraging women to use biomedical maternal healthcare services. According to Foucault, power is not concentrated at the centre, unidirectional and negative; instead, power is branching and pervasive (Dilger and Hadolt 2015: 136-139).

1.6.2 Biopower

Foucault starts explaining about biopower by differentiating it from sovereign power of the classical ages. Sovereign power presented authority over life in which, according to the juridical Roman law, the sovereign had the right over death as well as power over life, things, and time of his subjects (Foucault 1991: 93). The privilege of the sovereign to decide about life and death was constrained to occasions when the sovereign himself was threatened by enemies from within and without (Foucault 1978: 135).

In the 17th century, sovereign power was gradually dominated by power situated and exercised at the level of life whose objective was to take charge of the subjects' lives and enhance life (ibid: 139). Foucault calls this form of power, "biopower," which is divided in two poles: "*Anatomo-politics of the human body* and *biopolitics of the population*" (Foucault 1978: 140). The first pole manifests itself in a host of disciplinary mechanisms and institutions such as schools, hospitals and prisons with the intension of producing docile bodies subjected to habits, rules, orders and authority. They are continually exercised around and upon an individual and s/he must allow them to function automatically in him/her (Foucault 1977: 128). This form of power, Foucault argues, derives its success by instilling individuals with norms and habits of self-surveillance as well as normalizing judgments, which inflict on homogeneity and make it possible to compare

oneself to others (ibid: 192). In this sense, power works not from above but from below, within individuals. The society is regulated through individual surveillance, what Foucault (1991: 107) calls, “technologies of power,” a more productive form of power than the sovereign power.

The second pole of biopower emerged in the second half of the 18th century following the population increase. Biopower sought to regulate the social body “by focusing on population processes namely, birth, morbidity, mortality, longevity and so on” (Foucault 1977: 140). Human sciences made possible the calculation of the overall health of the society in large scale (Csney and Morar 2015: 5). Knowledge about collective bodies was derived from statistical data of demography and epidemiology, which were collected and organized by experts. Human population processes could be quantified, rationalized and intervened (Foucault 1978: 144145). The exercise of power over living beings at that point no longer carried a threat of death by the sovereign power. The state could take charge of subjects and the welfare of collective bodies through control of vital processes (ibid: 141).

Foucault (1978) shows that the two poles of biopower functioned separately with the welfare state rationality until the 19th century when the population emerged as the political being that necessitated the review of the sovereign state model and government mechanisms. The question at this point was no longer the population as the object of power per se but a political being with a life of its own that potentially threatened the security of the population itself and the state (ibid: 141-142). A different art of government was needed to govern the population as the object and the subject, a far-reaching development that characterizes our understanding of biopower until today (Rabinow and Rose 2006).

1.6.3 Governmentality: Subjection of Free Individuals

Foucault delineated the notion of governmentality by tracing the genealogy of the modern state and the subject from the 16th century to the neoliberal era. He shows that until the 18th century, the term government was understood in a more general context than just political meaning of state administration that we use today. It was used in philosophical, pedagogic, religious and medical texts (Foucault 1991: 90). To govern meant self-control, directing of the family, souls, children, a household and other aspects of life (Ibid.). Deriving from this sense of the term

government, Foucault (2000: 341) proposes a broad meaning of government as the "conduct of conducts," a term that ranges from governing oneself to governing others. It refrains from the notion of the state as an overarching and repressive authority that seeks to maximize power as well as limit the autonomy of people (Lupton 1995: 9).

Accounting for this broader meaning of governmentality, Foucault shows that from the mid16th to the 18th century scholars were writing treatises as advice to the prince on how to govern his subjects best and ensure acceptance, obedience and respect (Foucault 1991: 87). Such treatises gave advices on the art of governance, "how to be ruled, how strictly, by whom, to what end, by what methods and so on" (Foucault 2003: 229). The adoption of a different mode of governance was prompted by population growth and economic changes. In the 17th century, the population as I have mentioned in subsection 1.6.2, emerged as a political being that called for a highly sophisticated form of governance. A different rationality was needed to manage the population and the market without disrupting their existence as well as individual autonomy. Liberalism emerged as the new form of rationality that sought to limit the extent of political authority and stressed individual autonomy (Foucault 2001: 219). It necessitated the formation of governmental techniques and complex of knowledge so as to know and govern the population for its own security and that of the state as well (Ibid: 220).

Drawing from Guillaume de la Perrière's definition of government, Foucault showed that to govern the population entailed the government of "things" (Foucault 1991: 91). Governmentality in this sense is defined as "the right disposition of things, arranged so as to lead to a convenient end" (ibid.). The government of "thing," Foucault points out is important because it differentiates government from sovereignty; the former operates on "things" and the latter on the territory as well as the subjects who inhibit it (Lemke 2015: 9). Rather than separating men and things, the government of things entails a kind of complex of men and things. Quoting Guillaume de la Perrière Foucault explains that:

> The things government must be concerned about, de la Perrière says, are men in their relationships, bonds, and complex involvement with things like wealth, resources, means of subsistence, and, of course, the territory with its borders, qualities, climate, dryness, fertility, and so on. 'Things' are men in their relationships with things like customs,

> habits, ways of acting and thinking. Finally, they are men in their relationships with things like accidents, misfortunes, famine, epidemics, and death (Foucault 2007: 96).

From this definition, Foucault identifies three aspects of government that are central in the understanding of biopower. First, the population becomes both the object and the subject of governmentality. The population, on the one hand, is a material body targeted by techniques of government for its own welfare and a subject because it calls for the conduct of oneself (Foucault 1991: 87). He shows further that the actions of individuals are shaped by milieu, "an intersection between a multiplicity of individuals working and coexisting with each other in a set of materialities that act on them and on which they act in return" (Lemke 2015: 9). This indicates that agency is not entirely a property of people, but the agential power relates with the milieu (Dean 1999: 99). It eschews any simple and unidirectional notion of causality or human agency. The milieu produces a "circular link between effects and causes since an effect from one point of view will be a cause from another" (Lemke 2015: 13).

Secondly, unlike the sovereignty that focuses on an individual's will and legal subjects, concerned with the population, government focuses on statistical quantities, geographical and biographical data. Experts produce knowledge and truths about the population and individuals (Foucault 1991: 99). The use of statistical data makes individuals calculable, comparable and predictable, making justification of biopolitical truths, policies and interventions possible (Lupton 1995: 10). The truth about maternal health, for example, is produced by experts and maternal mortality rates are used to justify interventions for the well-being of particular nations and the global at large. Maternal health is integrated with issues of development an aspect which further justifies interventions. Thus, the promotion of maternal health can be conceptualized as a biopower technique to enhance lives of pregnant women, mothers and newborns.

Thirdly, governmentality enacts a distinct kind of power from sovereignty. It employs tactics to structure the possible field of action for others for particular finalities (Foucault 1991: 95). People are governed without their knowledge that they are being governed because things are arranged to determine the direction of one's actions according to one's will (Lemke 2015: 11). Increasing availability of biomedical maternal healthcare services in Tanzania is thus a way of encouraging women to use the services.

Furthermore, Foucault shows that a new form of governing collective bodies emerged. It was derived from the practice of Christian pastoral power exercised by knowing the inside of people's minds (Foucault 2003). Foucault calls it "technologies of the self" (Ibid: 147). With this government technique, individuals act on their bodies, souls, thoughts and conduct to transform themselves in order to attain a certain state of complete well-being (Lupton 1995: 12). Laws as well as biopolitical truths are internalized and people constrain themselves rather than being coerced and make rational choice(s) in accordance with biopolitical truths (Foucault 2003). Women in Tanzania, for example, are taught 'the truth' about maternal health that is expected to self-motivate them to make rational choices about maternal health and use biomedical maternal healthcare services. In this way, the state governs with individualizing power, but with totalizing effect for the benefit of the population (Dean 1999: 113).

Finally, Foucault (1991: 103) shows that governmentality entails the governmentalization of the state. Whereas the state is a crucial element in power relations, there are myriad of institutions and agencies as well as actors who are concerned with the regulation of bodies often by articulating common discourses and encouraging certain practices including the importance of rational choices and actions (Lupton 1995: 11). In the neoliberal era, "the political subject is born, an anatomic individual whose natural self-interest and tendency to compete must be fostered and enhanced" (Oksala 2015: 66). Moreover, the correlation of technologies of power and technologies of the self marks a distinct feature of neoliberal governmentality (Lemke 2002: 7).

Foucault is widely acknowledged for not only drawing attention on the multiplicity of power but also for showing that power is not always negative. His notions of biopower and governmentality clearly express the positive aspect of power and draw attention on how biological processes like reproduction are used to shape certain subjectivities and promote political goals. I find these two notions enabling in contextualizing complex workings of power in multiple levels. I use these notions to understand global endeavours of how maternal health is framed and promoted in the local moral worlds. Biomedical knowledge as it emerges is the main apparatus of biopower as far as maternal health is concerned.

Besides, anthropological scholars have shown the usefulness of these notions in understanding women's reproductive issues. For example, Sawicki (1991) was one of the earliest feminist scholars to show that Foucault's notion of power is useful in understanding how power that has no concentrated origin converges to subject and dominate the female body. Similarly, other scholars have shown that since the 18th century the professional and political power converges to subject the female body in the area of pregnancy and childbirth (Martin 1987; Davis-Floyd 1992; Inhorn 2006). Other studies show the relevance of the notions of biopower and governmentality to understand women' reproductive health and well-being in the context of globalization (see, for example, Berry 2010; Lock and Kaufert 1998; Van Hollen 2013; Browner and Sargent 2011; Lupton 1999a; Ivry 2010; Weir 2006).

However, there are two main shortcomings identified in Foucault's analysis of biopower and governmentality that can be limiting in comprehending the provision of biomedical maternal healthcare services and women's experiences. Foucault argues that individuals are not passive subjects of biopower. He makes it clear that people are neither totally free nor fully dominated by biopower (Foucault 1982). However, Foucault does not prioritize the complex responses of people to biopower (Lock and Kaufert 1998: 9). As a corollary, prioritization of experiences of those targeted by normalizing discourses and practices is called for (Berry 2010: 13). Lock and Kaufert (1998: 9), for example, point out that it is important to seek for understanding of the different ways in which those aimed to be governed take charge of their lives in different local moral worlds as they engage with health services and interventions.

The second shortcoming is directed to Foucault's theorization of governmentality which lacks consideration of the international, transnational and supranational organizations as well as transnational alliances of non-governmental organizations (NGOs) in the globalized context (Lemke 2013: 49). In developing countries, national states function along with NGOs and agencies, particularly in the provision of health services (see, for example, Mattes 2016; Dilger 2012). First, I will show how the second shortcoming has been addressed and then I will explain how I prioritize individual experiences.

1.6.4 Transnational Governmentality: Understanding the Landscape of Maternal Health Services and Interventions in Tanzania

Maternal health is one of the specific health areas that has caught global attention and attracted a multitude of actors including international, transnational and supranational organizations as well as philanthropic foundations. Also, there are many local community-based organizations (CBOs), faith-based organizations (FBOs), and non-governmental organizations (NGOs), which work along with national states of developing countries to improve maternal health. Until 2014, Tanzania had approximately 100 organizations and other agencies dealing with maternal health in different parts of the country (Lee et al. 2015: 2). In Lalta, between 2000 and 2010, World Vision International was involved in the training of TBAs and during the time of my fieldwork was actively involved in the training of CHWs for maternal health. Population Services International (PSI-Tanzania) and Marie Stopes Tanzania were involved in the provision of especially long-term family planning methods, which were a priority in the efforts to reduce maternal mortality and improve maternal health (see URT 2015a).

The proliferation of these actors who are not states but perform state-like functions in some areas of healthcare, challenges the scalar imagery of the state from the global to the local as vertical and encompassing (Ferguson and Gupta 2002: 990). Ferguson and Gupta show that the situation is far complex and point out that:

> In thinking about the relationship between states and a range of contemporary supranational and transnational organizations that significantly overlaps their traditional functions we found it useful to develop the idea of transnational governmentality borrowing and extending the idea of 'governmentality' first introduced by Foucault (...). We propose to extend the discussion of the notion of governmentality to modes of government that are being set up on a global scale. These include not only new strategies of discipline and regulation, exemplified by the WTO (World Trade Organization) and the structural adjustment programs (SAPs) implemented by the IMF (International Monetary Fund) but also transnational alliances forged by activists and grassroots organizations and the proliferation of voluntary organizations supported by complex networks of international and transnational funding and personnel. The outsourcing of the functions of the state to NGOs and other ostensibly non-state agencies, we argue, is a key feature, not only of the operation of the national states, but of an emerging system of transnational governmentality (Ibid.).

This modality of transnational governmentality eschews the simple scalar conception of global institutions as being “above” national states with unidirectional flow of power from the global to the local and reshapes the supposed association between national states, sovereignty, and territoriality (Gupta and Sharma 2006: 7). Instead, power is exercised by a multitude of actors. Nonetheless, Ferguson and Gupta (2002: 996) argue that it does not mean such modality of transnational organizational governmentality makes states weak or strong but “reconfigures their abilities to spatialize their authority and to stake their claims to superior generality and universality.” Despite the involvement of many actors in maternal health in Tanzania, the national government is the main director of all activities regarding maternal health in the country.

Full comprehension of the increase in transnational governmentality in developing countries requires looking back in history to see relations and power struggles that produced precarious conditions that most developing countries and especially the African continent face today (Ferguson 2006; Dilger 2012; Shipley 2010). Africa is described in terms of presentism with negative statements or statistical indices between what Africa was and what it is ought to be. This structures Africa as a pathological case, as a figure of lack, telling us what Africa was not, never telling us what Africa actually was (Shipley 2010: 656). Precolonial histories are erased, while colonial domination, exploitation and struggles for independence are muted, national state commitments to provide social services in the postcolonial period are undermined and the effects of neoliberal policies are glossed over (ibid.). In Chapter 3, I discuss the historical and political economy context within which maternal health interventions take shape in the presentday Tanzania. Now I turn to show how I account for women’s experiences in the local moral worlds.

1.6.5 Local Moral Worlds: Local Realities, Lived Experiences and Everyday Forms of Resistance

My attempt to prioritize how women respond to biopower and make sense of their lived experiences takes lead from the notion of local moral worlds, which was first developed by Arthur Kleinman and Joan Kleinman (1991), with later adjustments by Kleinman (1992, 1994; 1999a; 1999b; 2006). The notion of local moral worlds provides methodological and analytical guidance on how to understand lived experiences in particular settings and contexts. It enables us to make

sense of the lived experiences of women, healthcare providers, TBAs and CHWs in their social and institutional environments.

According to Kleinman and Kleinman (1991: 275-276), anthropologists criticize biomedical practitioners for delegimating the suffering in somatization by objectifying it as a disease. However, anthropologists too run the risk of committing the same mistake. Even with rich ethnographic data, the interpretation of a person or group's suffering as the "reproduction of oppressive relationships of production, or the symbolization of dynamic conflicts in the interior of the self, or as resistance to authority, is a transformation of everyday experience of the same order as those pathologizing reconstructions within biomedicine" (ibid: 276). The interpretation of illness as a social role or strategy misses the complexity, uncertainty and ordinariness of a person's unified world of experience (Kleinman and Kleinman 1991: 276).

To avoid delegimatization, ethnographers should look at lived experiences as serious moral undertakings, which entails a contextualized understanding of experience (ibid: 277). They define experience as an "outcome of cultural categories and social structures, interacting with psychophysiological processes such that the mediating world is constituted" (Kleinman and Kleinman 1991: 277). In local moral worlds, life is an intersubjective experience lived with others. It is the felt flow of our engagements. Moreover, what matters most in our daily engagements with others "centres on *what is locally at stake*" (Emphasis in the original) for ourselves, a network or community (Kleinman 1999b: 70).

What is at stake in local moral worlds is fundamentally different from ethical discourses, which are modelled as individual choices, standardized, secularized and seek universal application (Kleinman 1999b: 72). Mostly, when viewed from a comparative perspective with standardized ethics, what is locally at stake "may be unethical, may look corrupt, grotesque and even inhuman" (Kleinman, 1999a: 365). Although widely shared concerns of what matters such as material resources, religious commitments, family relationships and life itself are easily identifiable, what is at stake varies to specific actors across local moral worlds, and historical periods (ibid: 361). Even within local worlds, there can be differences due to class, political groups, gender and individuality such that heterogeneity as well as complexity characterizes most social spaces (Kleinman 1999a: 361-362).

For this reason, what is at stake is often contested, negotiated, compromised, and indeterminate. In the processes of contestations and negotiations, values for both individuals and collectives are actualized and continuously reworked. Here, the individual-collective dichotomy is dissolved. Kleinman uses a metaphor of a tidal stream to explain the nature of experience between intersubjective interactions and subjectivity as follows:

> Experience, like a tidal stream, washes in among the feelings of inner life and rushes out among values, norms, and relationships. Moreover, as fresh water and salt water intermingle but also maintain their own forms in a tidal stream, so too do subjective and collective processes create a mediating world of intersubjectivity while still at times possessing their own characteristics (Kleinman 1999a: 378).

Therefore, it is not an individual woman as an isolated being who makes decisions, for instance, about where to give birth, or whether to use family planning or not, but:

> (…) an individual as a part of a network of relations, memories, current pressures, and uncertain prospects, and constrained by interconnections and shared fate, who is the locus of experience. Hence, moral experience is about the local processes (collective, interpersonal, subjective) that realizes (enact) values in ordinary living. These processes cross the boundary of the body-self, connecting affect and cognition with cultural meanings, moral norms and collective identity with the sense of self. Thus, moral experience and personal experience are interfuse: values with emotions (Kleinman, 1999b: 71).

To understand a particular lived experience, an ethnographer must first identify and situate individuals within these local moral worlds. Critical reflexivity must be applied and ties that bind an ethnographer elsewhere in his/her local moral world must be suppressed (Kleinman 1992: 130-131). The ethnographer should also be aware that local moral worlds are not static but they are continuously shaped as values are reworked and local worlds are influenced by macro political, social, and economic processes (Ibid: 131). Certain policies "may protect some and expose others to social violence, actions may not be coherent; relationships may be besotted, exigency of situations may override choice, and infra-politics may create conformity or confusion" (Kleinman 1999a: 365). Here, Kleinman argues that ethnographers need to take a processual view of local moral worlds in which experience is emergent, changing, and unpredictable (ibid.). Local worlds transform and moral experiences just like locality possess a genealogy (ibid*:* 373). In due regard, the ethnographer can evoke "the irony, paradoxes,

uncertainty, and change which are the ultimate stuff of moral experience that are rarely taken up in standardized ethical framings" (Kleinman 1999a: 365).

Examining experiences as necessarily moral enables the ethnographers to value individuals' experiences and understand the broader reasons for people's behaviour, actions, or inactions. It takes such an understanding to comprehend the confrontation between Dada Juliana and Dickson about attending Sara (see Chapter 6) or even why Sara decided to give birth at home in the first place, and then took a chance to go to Faraja dispensary. Kaufert and Lock (1998: 2) remark that:

> Women are not passive, simply acting in culturally determined ways, or inherently resistant to medical interventions, but their actions are rooted in pragmatism. So, women's responses may range from selective resistance to selective compliance even though women can also be indifferent. But, 'ambivalence coupled with pragmatism may be the dominant mode of women's responses to medicalization'.

This was true for many women in Lalta. They made pragmatic and rational choices according to what worked for their situations. Therefore, my articulation of structural factors should not be taken to mean I am presenting women as mere victims of structural forces.

Foregrounding experiences of individuals entail paying attention to their agency. Foucault acknowledges the agency of individuals but he does not go into detail to show how individuals practice their agency. His discussion centres mainly on how biopower seeks to shape subjectivity. Scott (1989; 1990), on the other hand, shows how people react to power in mundane interactions in local moral worlds. Scott (1989: 34) calls people's reactions to power, "the everyday forms of resistance: the quiet, dispersed, disguised, or seemingly invisible actions in which one seeks tacit, de facto gains." Scott argues that individuals have original subjectivity that empowers them to resist power according to their own will. However, he does not say where such original subjectivity comes from and does not incorporate resistance into dynamic and interactive process with power (Vinthagen and Johansson 2013: 14).

Both power over the subject and resistance of the subject can be limiting but combining the two strikes a balance. Rather than classifying women's actions as resistance to biomedical maternal healthcare services and interventions, my intension of looking at women's agency in the light of everyday forms of resistance is to enable me to identify the everyday intentional or subconscious

acts which challenge biomedical knowledge and renders it powerless in the local moral worlds. That way, I show why it is important to take into account particular understandings of maternal health and safe motherhood.

1.6.5.1 Authoritative Knowledge and Therapy Management Group

Authoritative knowledge is one of the widely used notions in understanding pregnancy and childbirth experiences (see, for example, Davis-Floyd and Sargent 1997; Davis-Floyd 1992; Browner and Press 1996; Unnithan-Kumar 2004; Ivry 2010). It is an important notion in understanding women's reactions to biomedical knowledge as the main form of knowledge promoted for maternal health. This notion was developed by Brigitte Jordan in 1977 in a study on women's self-diagnosed pregnancy by using embodied experiences before medical confirmation. The notion of authoritative knowledge was developed further in Jordan's (1978) ground-breaking ethnographic account of birth in four different cultures. Additional developments of the notion are presented in other works (Irwing and Jordan 1987; Jordan 1992; 1997). Encountering different ways childbirth was handled in different societies and contexts, Jordan enlightens that:

> In many situations, equally legitimate parallel knowledge systems exist and people move easily between them, using them sequentially or in a parallel fashion for particular purposes. But frequently, one kind of knowledge gains ascendance and legitimacy. The legitimation of one way knowing as authoritative devalues, often totally dismisses, all other ways of knowing. Those who espouse alternative knowledge systems then tend to be seen as backward, ignorant, or naive trouble makers. Whatever they might think they have to say about the issue up for negotiation is judged irrelevant, unfounded, and not to the point. The constitution of authoritative knowledge is an ongoing process that both builds and reflects power relationships within a community of practice (Jordan 1992: 3).

Jordan points out further that, authoritative knowledge is persuasive and consequential:

> (...) authoritative knowledge is persuasive because it seems natural, reasonable, and consensually constructed. For the same reason it carries the possibility of powerful sanctions, ranging from exclusions from social group to physical coercion. Generally, people do not only accept authoritative knowledge, but they are actively and unselfconsciously involved in its routine production and reproduction. During pregnancy and childbirth, women willingly submit to the control of medical doctors and machines while suppressing their own experiential knowledge (Jordan 1997: 57).

With the existence of other knowledge systems and other ways of knowing that women draw from, Jordan suggests to focus less on authoritative knowledge of those endowed with power to define what counts as a legitimate way of knowing in a particular situation and more on how people in particular situations come to decide what counts as authoritative knowledge. She points out that:

> It is important to realize that to identify a body of knowledge as authoritative speaks, for us analysts, in no way to the correctness of that knowledge. Rather, the label "authoritative knowledge" is intended to draw attention to its status within a particular group and the work it does in maintaining the group's definition of morality and rationality. *The power of authoritative knowledge is not that it is correct but that it counts* (Emphasis in the original) (ibid.).

By this observation, Jordan underscores the importance of other knowledge systems that count in particular situations. In all social groups, Jordan (1997: 58) points out, "people provide justification for what they do and reasons for why they do what they do in this way and not the other." By authoritative knowledge then, Jordan does not mean knowledge of those in authority positions, but the knowledge that social actors come to an agreement that it counts in particular local moral worlds and give rationale for the action(s) taken. In this sense, Jordan's notion of authoritative knowledge augments Foucault's notion of biopower by showing that biomedical knowledge can be challenged in local moral worlds.

The collective practice of authoritative knowledge points to the importance of looking at the therapy management group (TMG). Janzen (1978) introduced the notion of the therapy management group to describe the process of seeking for healthcare and individuals who take charge of therapy management on behalf of the sufferer. The TMG negotiates choices and makes decisions according to what is thought to be the best form of care under particular circumstances, and what is at stake for the person including those around her/him (see also Dilger 2008; Nichter 2008) With the TMG in-charge, suffering is not an experience of the individual alone but all those around her who are explicitly or implicitly implied by his/her suffering in myriad ways (Kleinman 1992). In addition, the TMG is actively involved in organizing moral support and material resources for the sufferer (see Feierman 1979). This notion is important as I will show that pregnancy and childbirth were period where women counted on support from close family

members, lack of which significantly affected women's maternity experiences. Similarly, the TMG was affected by women's experiences.

1.7 Outline of Chapters

This dissertation is organized around eight chapters. In **Chapter 2**, I describe the research setting, the ethnic group and the study methodology. A history of Lalta is provided to situate the Sandawe ethic group in different historical periods, which have important implications on their livelihoods and the use of health services. Environmental and social processes in this specific context are brought into focus and the local healthcare system is described. The research process is explained on how I accessed the field, the sampling procedure, data collection methods, data organization and data analysis plan. The Chapter explains my evolving positionality; how I managed to establish rapport and build trust among women and moved between the local worlds of healthcare providers, women and their families. The experiences of doing ethnographic research in multiple settings from the village dispensaries to women's lives to referral hospitals and talking to government and international administrators is also delineated.

Chapter 3 looks at the emergence of maternal health as a problem that required intervention. I trace the efforts to intervene the maternal body that began during German colonial rule and show the evolvement of maternal health interventions during the colonial period. Then I focus on the efforts of improving maternal health in the post-independence period from 1961 to 1986. After that, attention is paid on the Safe Motherhood Initiative (SMI) as a global attempt to improve maternal health in developing countries from 1987 onward. I draw attention to policy formulations and intervention designs and trace progress towards the ultimate goal of reducing maternal mortality. As I give the historical account, I show differences and similarities in historical efforts to problematize and intervene the maternal body in order to establish lessons provided by history that are important in the reflection of the ongoing interventions and designs to reduce maternal mortality in Tanzania.

Chapter 4 builds from the preceding chapter. In this regard, the attempt is to situate what motherhood means to women and their families in Lalta by moving from the standardized global definition of safe motherhood to a particular local context. I use the provision of family planning

services as a starting point to understand how women and men made sense of safe motherhood. The discussion revolves around local conceptions of (in)fertility, marriage, gender relations, and the manner in which women and men use motherhood to make sense of their local world in ways that challenge the truth advocated by healthcare providers to influence the use of modern family planning methods for safe motherhood.

Chapter 5 focuses on the provision of maternal health for pregnancy, childbirth and postnatal care. I follow women through the course of pregnancy, childbirth and the postnatal period to understand how they take care of pregnancy, sought childbirth and postnatal care. I show that diverging knowledge systems of maternity care, particular women's needs, different perceptions of risk, local conditions in the provision of maternity health services, economic difficulties severed by drought and lack of family support, shaped the manner in which women used the available services. As Johnson (2016: 3) argues, "The transition to motherhood (*depending on the context*) can harbour multiple complex meanings or can reflect relatively simple realities." What I show are diverse maternity experiences. The main argument raised in this chapter is that women are neither passive users of the services nor self-consciously resisting the services but pragmatically use the services in ways that make sense to them. I show that in other circumstances, women failed to use the services in ways they could not foresee.

Chapter 6 turns attention to the implementation of the maternal referral system and childbirth experiences of women who were advised to go to referral hospitals for childbirth. I start the chapter with an account of a young woman who failed to comply with the referral advice but her mother desired biomedical care for her during childbirth. Then, I present reasons for women's failure to comply with the referral advice and the emotional suffering they experience having to give birth outside of health facilities. I further discuss healthcare providers' experiences in the implementation of the maternal referral system and the challenges the maternal referral system poses on the healthcare providers' clinical as well as social interactions. In addition, I follow women who went to the referral hospitals inorder to understand their childbirth experiences. I discuss healthcare providers' experiences in the referral hospitals to bring to the fore the reasons why they could not always provide the kind of birthing care women expected.

With particular emphasis on giving birth with the help of skilled birth attendants (SBAs), **Chapter 7** focuses on the abolition of TBAs and the introduction CHWs to educate women about the importance of using biomedical maternal healthcare services in order motivate them to use the services. I provide a historical account of the rise of both TBAs and CHWs including their role on maternal health. I then provide experiences of CHWs, TBAs and women to show the implications of these changes in the local context. The last part of the chapter provides a critical account on the relevance of abolishing TBAs and introducing CHWs for maternal health.

Chapter 8 provides a conclusion, contribution of the study to the anthropological scholarship and recommendations for action to policy makers and health administrators as well as suggestions for areas of further research.

Chapter 2

Context of the Study and Research Methodology

2.1 Introduction

This chapter provides a reflective account of the fieldwork process, data management and analysis. I start by giving an account of the field site, its geographical location, administration, health facilities, the people, and historical developments as well as contemporary socio-cultural and economic changes. In addition, I describe the local non-biomedical health services. I then explain how I conducted the ethnographic fieldwork; how I selected study participants, how I collected ethnographic information as a participant observer, and how I managed as well as processed the ethnographic materials. Finally, I will provide a reflection on my engagements in the field in terms of ethical considerations and my own positionality.

2.2 Geographical Location, Administration and Health Facilities

This study was conducted in Lalta Ward which is located in Chemba, one of the seven districts of Dodoma Region in central Tanzania. Chemba District is situated 140 kilometres north of Dodoma City, the regional headquarters, and 40 kilometres south of Kondoa District Headquarters. Formerly, it was part of Kondoa District. Chemba District was founded in 2012 under local government law Number 7 of 1982, and the district council became effective from July 2013. The district covers about 7,653 square kilometres consisting of four divisions, 26 wards, 114 villages, and 494 hamlets. According to the 2012 National Household and Population Census, the district had a population of 235,711 people (117,585 males and 118,126 females) with an average growth rate of 1.7 percent per annum (Chemba District Council 2015: 1). The district is semi-arid characterized with hills and forest reserves. The main economic activities include agriculture (maize, sesame, millet, sunflower, groundnuts, pigeon peas and rosella), bee

keeping, and livestock keeping such as cattle, goats, sheep, as well as poultry. In 2012, per capita income was estimated at 130,000[7] Tanzanian Shillings (ibid: 2).

Administratively, the district council is under jurisdiction of the District Executive Director (DED) assisted by heads of department and section. At the ward level, the District Council operates through Ward Executive Officers (WEOs) who represent the DED. The administration of the ward is vested in the Ward Development Committee (WDC). At the village level, the District operates through Village Executive Officers (VEOS). The highest decision-making body at the village level is the village assembly (Chemba District Council 2015: 3).

Lalta Ward is among 26 wards of Chemba District located in the north of the district. The ward comprises seven villages (Magambua, Manantu, Wairo, Ilasee, Kisande, Handa and Lahoda) and it is the biggest wards in the district with 11,832 people (URT 2012: 20). In 2015, each village had one primary school, and the ward had one secondary school located in Magambua Village (Chemba District Cuncil 2015: 2).

Regarding biomedical healthcare facilities[8], Lalta Ward had three dispensaries; two of them were in Magambua Village. Thus, Magambua Village had Upendo Dispensary, a public health facility

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[7] Equivalent to 52 Euros.

[8] It is important to note that the provision of health services in Tanzania is hierarchically organized in six levels. The closet health facilities to the people especially in rural areas are village dispensaries followed by health centers. The difference between the two is that, dispensaries provide minor curative outpatient services to a maximum of 10,000 people while health centers provide inpatient services (to a maximum of 50,000 people), and therefore receives patients from village dispensaries who require inpatient care. Some of health centers provide surgical care including Cesarean section (Boex et al 2015: 4). District hospitals comprise the third level of health services. These include the (government) district hospitals under the district council and the council designated hospitals. These hospitals receive referral cases from village dispensaries and health centers; provide outpatient and inpatient service, X-ray and surgical services as well as emergency obstetric care. Administratively, village dispensaries, health centers, and district hospitals are under jurisdiction of the district medical officer (Ibid: 5). Following district hospitals (and council designated hospitals) are regional referral hospitals, which offer specialist services. There is one regional hospital in each of the 27 regions of the country. Regional hospitals are followed by the zonal referral hospitals, which provide services to patients in need of specialized care, referred from regional hospitals. Until 2015, there were three zonal hospitals: Bugando Hospital in Mwanza Region, Kilimanjaro Christian Medical Centre (KCMC) in Kilimanjaro Region and Mbeya Referral Hospital in Mbeya Region. On top is Muhimbili National Hospital which is divided into five highly specialized hospitals providing specialized care which include Muhimbili Orthopedic Institute, Ocean Road (Cancer Institute), Mirembe Psychiatric Hospital and Kibong'oto Infectious Disease Hospital (URT 2016: 1-7).

and Faraja Dispensary, a private health facility. Upendo Dispensary was opened in 1999. It was located close to the main road to Singida Town that passed across Lalta Ward. Upendo Dispensary provided acute medical care, reproductive, maternal and child health care, health education, childhood vaccinations and HIV counselling and testing. During the time of my fieldwork, the dispensary had two Grade B nurses.[9]

Faraja Dispensary was located approximately one kilometre from Upendo Dispensary. Officially, Faraja Dispensary started functioning in 2003. Prior to such full functioning operations at its premises, Faraja Dispensary provided mobile health services in the area. Since its official opening, Faraja Dispensary provided preventive and acute medical care, HIV counselling and testing as well as maternal and child healthcare services. In addition, it continued to provide maternal and child mobile clinic services in areas beyond Lalta Ward. Unlike other dispensaries, Faraja Dispensary functioned like a health centre. It provided inpatient services, and at the time of my research, the dispensary could take up to twenty inpatients. It had three wards, one for male patients, one for female patients and one for infants as well as children. It had a laboratory with one laboratory technician, two Medical Doctors[10] and two Grade B Nurses. In addition, the dispensary had one foreign volunteer midwife from Australia who started working at the dispensary in 2011, but during the time of fieldwork she was on a one-year leave. Besides, Faraja Dispensary received patients from outside Lalta Ward including from the neighbouring villages of Singida Region.

Lalta Ward was selected as a research site because of the availability of biomedical healthcare facilities. Before starting fieldwork, the plan was to conduct research at Magambua Village alone but the organizational structure of the provision of biomedical maternal healthcare services necessitated the inclusion of three other villages. Geographically, Wairo, Manantu and Ilasee villages are on average of three kilometres from Upendo and Faraja dispensaries, while Lahoda

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[9] Grade B nurses have completed four years of secondary education and two years of medical training in nursing and midwifery. However, it is common to find auxiliary nurses with only primary education and one year of nursing training performing the tasks of a fully trained grade B nurse (Hanson at al. 2012: 3). Grade A nurses with four years of secondary education and three years of professional training are found mainly in referral hospitals.
[10] One of the doctors was from the United Stated of America and had worked for the dispensary since 2007.

Dispensary is closer to Handa and Kisande villages. Upendo Dispensary served women from Ilasee and Magambua Villages. On the other hand, the government worked in partnership with Faraja Dispensary to provide free maternity health services to women from Wairo and Manantu villages. Women were restricted to adhere to the identified division of biomedical maternal healthcare service provision. To single out women from Magambua Village would have meant to exclude Faraja Dispensary, which did not provide maternity services to women from Magambua Village. Therefore, the study included the four villages served by the two dispensaries.

In addition, there was a health centre called Mbugani located twenty kilometres from Magambua Village at Kwamtoro Division, which provided antiretroviral drugs (ARVs) and HIV prevention from mother to child transmission (PMCTC) services that the village dispensaries did not provide. Women who tested HIV positive at both Upendo and Faraja dispensaries were referred to Mbugani Health Centre. However, the health centre did not provide emergency obstetric care. In Lalta, women with complicated pregnancies/births were often referred to Mshikamano Hospital in Singida Region, about 80 kilometres away from Magambua Village. Public transport to Mshikamano Hospital was available every morning. My anticipation before fieldwork was that pregnant women would be referred to Kondoa District Hospital, which was about 50 kilometres from the village using a shortcut road. However, many women with complicated pregnancies/births were more likely to go to Mshikamano Hospital or Umoja Regional Hospital (which was 120 kilometres from Magambua) instead of Kondoa District Hospital.[11] The shortcut road to Kondoa was not well maintained and impassable during the rainy season.

Kondoa District Hospital had a maternity waiting home built in 2008, but during my research, I found only two women who had gone to wait for childbirth at this maternity waiting home. Mshikamano Hospital had no maternity waiting home but provided a room for those waiting for childbirth. Umoja Regional Hospital had a maternity waiting home named Matazamio built in

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[11] Still in its infancy, in 2015 Chemba District still had no a district hospital of its own. A health centre in Hamai Ward, which was about 40 kilometers from Lalta, was expected to be upgraded into a district hospital. In general, the district had 4 health centers and 29 dispensaries (Chemba District Council 2015).

1991, which served women from villages across Dodoma Region. The idea of maternity waiting homes was adopted from the United States of America and Europe where they have been in existence since the early 20th century (Satti et al. 2013: 7). In the African countries, maternity waiting homes were introduced in the1960s. Since then, they have become an important part of the strategy of reducing maternal mortality especially under the safe motherhood initiative (ibid: 7-8).

Figure 2.1: The Map of Tanzania. Highlighted is Dodoma Region.

Source: Photographic copy from the National Bureau of Statistics (Used with permission)

2.3 The People

Chemba District although mainly occupied by the Rangi, Sandawe, Datoga and Gogo tribes[12] had people from other ethnic groups who migrated into the then Kondoa District. These included the Nyaturu from Singida Region, the Sukuma from Shinyanga, Mwanza and Geita Regions, and the Nyamwezi from Tabora Region (Kiondo 1995: 122). While the district had a diverse composition of ethnic groups, the majority of the people in Lalta Ward were of the Sandawe ethnic origin, and many of the study participants identified themselves as the Sandawe.

Originally, the Sandawe were hunter-gathers, constituting a stateless society (Iliffe 1979: 117). Their organization was based on clans without one overarching authority (Newman 1970; Raa 1969). Yatsuka (2015: 41) and Newman (1970: 25) indicate that between the 17th and the 18th centuries, the Sandawe had contact with their neighbours with whom they traded honey, meat, and hides for iron as well as grain. In the 19th century, the Sandawe learnt farming from the Nyaturu and the Gogo ethnic groups as well as livestock keeping from the Datoga ethnic group. Towards the end of the 19th century, agriculture formed the main source of their livelihood, but they did not establish big farms as their Nyaturu and Gogo neighbours did (Newman 1970: 56). Increasingly, hunting declined due to population growth and later on, colonial and post-colonial laws prohibiting hunting (Yatsuka 2015: 36). Today, the Sandawe are known as agriculturalists (ibid: 41).

Around 1850s, the Sandawe met the Nyamwezi and the Arab traders who traded along the central route of long-distance trade. The Nyamwezi and the Arabs went to Usandawe in search for ivory (Newman 1970: 21). Because of their involvement in the long-distance trade, the Nyamwezi had become colonizers of the region, and wanted to extend their domination to Usandawe (ibid.). They introduced Islam, but the Sandawe were reluctant to convert and did not like the domination of the Nyamwezi (ibid: 21). On the other hand, the Rangi eager about the changes brought by the Nyamwezi and the Arabs, converted to Islam in large numbers and intermarried with them

[12] Today, the term tribe (*kabila*) is used by people in Tanzania to refer to how they categorize or think of themselves, different from others. However, it is important to note that historically, the concept of tribe (and ethnicity) was used by colonialist to categorize groups on the assumption that people fit into neat groups. This categorization simplified complex identities and subjective reality of individuals (see Divalle 1990: 71).

(Newman 1970: 20). It is estimated that, today, 93 percent of the Rangi are Muslims of the Sunni sect (Cox 2008: 2). The Rangi looked down on the Sandawe as backward and avoided intermarriages with them (Newman 1970: 55). To date, intermarriages between the Rangi and the Sandawe are minimal. Religious differences play a significant role, as I will show further in subsection 2.4.2, whereby, during the German and British colonial rule, most of the Sandawe converted to Christianity.

Figure 2.2: *Tembe*, a traditional Sandawe house (Photo by Anitha Tingira, 2015)

2.4 Political, Economic and Socio-Cultural Changes During Colonialism

2.4.1: Colonization of the Sandawe

Upon the arrival of the German colonialists in the 1890s the Sandawe had long established contacts with their neighbors and had adopted farming and livestock keeping (Newman 1970: 65). However, they were still practicing hunting and gathering that involved constant shifting. The shifting was small scale between two to four kilometers and when they moved, they kept an eye on the empty homestead (*mahame*) that it did not grow into a total bush and after sometime, they returned to the homestead. The shifting was a matter of concern for the German colonialists

who were striving to establish their domination in Tanganyika (Iliffe 1979: 117). On top of their constant mobility, the Sandawe posed a challenge because as I mentioned above, they were a stateless society, which for the Germans, "were easy to defeat but hard to rule" (Ibid).

To ensure control of the Usandawe region, Iliffe (1979: 117-118) shows that in 1902 a German colonial officer appointed Mtoro, a Nyamwezi, as a chief of Usandawe but the Sandawe rebelled against Mtoro. In the same year, they waged a war, expelled the Nyamwezi from Usandawe and seized their cattle. The Germans interfered and in just three days, they killed around 800 Sandawe without suffering any causality. Mtoro was reinstated as a chief in the area and twenty other chiefs were appointed among the Sandawe who after experiencing the wrath of the Germans submitted to the German colonial domination.

The Germans were interested in Dodoma Region because of its central position in the then Tanganyika, and it became one of the important administrative areas. Later, after the First World War, Dodoma became one of the branches of the British headquarters (Schnider 2003: 449). However, the semi-arid climate condition attracted no significant economic investments in the region. The interior areas were further avoided because they were infested with tsetse flies (ibid.). During the time of my fieldwork, the northern part of Usandawe area was not occupied because it was heavily infested with tsetse flies.

The lack of colonial investment in the region did not stop the colonial government from introducing taxation. People in areas which had no significant colonial investments reacted with migration to other areas to look for hired labor especially in sisal plantations in Tanga, Morogoro and Arusha (Newman 1970: 65). The Sandawe did not like working as laborers and were known for being unreliable as hired labor. Only a few Sandawe men went to work in sisal plantations notably at the time following the great depression in 1929. Otherwise, the Sandawe obtained money to pay tax and buy other goods from trading honey and livestock. Later, when the British took over the colony, after the First World War, they introduced groundnuts which provided the Sandawe with another source of income to pay tax (Ibid: 58-60).

2.4.2 The Introduction of Christianity

Although Christian missionaries preceded the arrival of colonial rule and had converted people to Christianity in some areas of the country, the Sandawe were not influenced by these early missionaries who did not reach their areas. However, the reign of the Germany and later the British colonial rule marked the spread of Christianity in Usandawe. In 1909, the first Catholic mission under the Passionate Fathers from Italy was established at Kurio Village. Later, missions of the Passionate fathers were established in Farkwa Village in 1929, and Ovada Village in 1939 (Newman 1970: 59). Lalta ward was served by the Ovada mission. In March 2015 there was a big celebration of 75 years of Catholicism in Usandawe under the Ovada mission.

Both the German and the British colonial governments worked with the Catholic missions to modernize the Sandawe and force them to settle in one place. The missions provided social services; they built schools, health facilities, provided scholarships to students in middle school and encouraged the Sandawe to focus on tilling the land. Hunting and gathering were regarded as primitive and agriculture was representing a progressive future. Most of the Sandawe were converted to Catholicism, which aligned with their practice of monogamy and unlike Islam, did not prohibit alcohol consumption, which had important implications in the Sandawe diet (Raa 1983: 132).

Despite providing a room for some of the cultural practices of the Sandawe, Christianity prohibited the Sandawe rituals (Until today, the Sandawe are very rich in rituals for various occasions), hunting camps in which young boys were taught hunting skills (this contributed to the decline of hunting), female circumcision and the Sandawe religion which paid respect to the sun and the moon as supreme beings. The moon was associated with fertility and the night dance under the moon (*pheku'mo*) was believed to enhance fertility (Raa 1969: 38-39). While overtime hunting camps and *phek'umo* disappeared, the Sandawe were reluctant to give up *simbo*, a ritual performed to address different social and health problems, and *iyari*, performed to honor the birth of twins[13]. The Christian teachings on salvation and the supernatural power of God did not reflect

[13] For a detailed account of *simbo* and *iyari* rituals see Raa 1985 and Lim 2010.

anything supernatural in people's daily lives. The Christian priests denounced indigenous explanations of social, health and environment problems that provided the logical means for the people to understand their world and everyday lives. This left a void that Christianity could not completely fill (Cox 2008: 3). At the time of my research, *simbo* and *iyari* were the most practiced rituals in Usandawe. Many of my interlocutors identified themselves as Christians but reported to occasionally participate in *simbo* and *iyari* rituals. A similar situation is reported among the Rangi Christians who participate in certain rituals to address particular social problems (ibid: 7).

There were no accurate data on the number of Christians in the area but the majority of my interlocutors identified themselves as Christians. I found no estimates of the indigenous religion as well and all my study participants identified themselves as either Christians or Muslims. The Christian dominations were increasingly diverse. The Catholics were the majority and their churches were the biggest but some people were converting and joining the African Inland Church of Tanzania (AICT) and others were joining the growing evangelical churches (*makanisa ya kilokole*). In Magambua Village, for example, there were four churches of different dominations (Catholic, Lutheran, AICT and Assemblies of God). There was one small mosque which was also used by Muslims from Ilasee Village.

The spread of Christianity in Usandawe, unlike Islam, was attributed to the cooperation between the Catholic missions and the colonial governments in the provision of social services as well as famine relief (Newman 1970; Levtzion and Pouwels 2000; Iliffe 1987). After experiencing devastating effects of the 1919 famine, the British colonial government, in collaboration with the Catholic missions started providing famine relief in times of famine (Raa 1983: 127-128). Famine relief was a new experience which attracted many people to convert to Christianity in different parts of Africa (Iliffe 1987).

2.5 The Post-Colonial Period

2.5.1 Resettlement in Ujamaa Villages and the Impact of Structural Adjustment Programs

After independence in 1961, the government was geared to expand social services to rural areas, which for a large part the Germany and later the British colonial government had left to Christian

missionaries (see for example, Dilger 2014). The provision of social services to rural areas was facilitated by the Ujamaa policy[14] and villagization. The idea of Ujamaa villages was first introduced in 1967 by the then President Julius Nyerere to refer to villages that people live and work together for the good of all. From 1968, new villages began to be formed and the term Ujamaa villages was then applied to all newly formed villages (McHenry Jr. 1981: 1; Ludwig 1999: 127). However, by the 1970s, confusion ensued as to which villages should be classified as Ujamaa villages and which ones should not. Some villages were so different from others such that they were termed as "development villages" and others were termed as "permanent villages" instead of Ujamaa villages (McHenry Jr. 1981: 1). As a result, in 1975, the central government ended the confusion by passing the Ujamaa Villages Act that established formal procedures for classification of the villages, which was followed by forced reallocation of the rural population to Ujamaa villages (ibid.). That is why some scholars such as Eric Ten Raa (1979) who gives a detailed account of the establishment of Ujamaa villages in Usandawe refer Ujamaa villages to the villages established before and after 1975.

In establishing Ujamaa villages, the government worked in collaboration with the Christian missions. Talking to the *Sunday News* reported on 24th March 1974, Lauren Cardinal Rugambwa said, in Dodoma Diocese alone, the Catholic priests served the Christian community in 260 Ujamaa villages (Ludwig 1999: 128). Overall, with villagization, the government's aim was to control the people by settling them in Ujamaa villages where it could be easy to provide social services and initiate cooperative economic activites. In a period of three years since the passing of the Ujamaa Villages Act, 5,500,000 people were re-settled in Ujamaa villages (Hartmann 1983: 5). At first, it was expected that people would voluntarily move and settle in Ujamaa villages, but it was not always the case and when people were reluctant, force was used (ibid.).

Compared to other areas, the experience of establishing Ujamaa villages among the Sandawe as expressed by Raa (1979: 9), was positive. Ujamaa, to some extent, resonated with the Sandawe's way of life, which reflected ideas of cooperation and self-reliance. Although they lived in dispersed homesteads, they cooperated in hunting, cultivation of fields and harvesting, based on

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[14] For a reflective account about Ujamaa policy see Chachage and Chachage (2005).

clan lines. The Ujamaa policy required these qualities with some modifications for cooperation to function as economic units. Force was used in rare occasions when some of the people moved back to their old homesteads. In such cases, the old houses were burnt down. Some of my interlocutors like Nyemo who was 80 years old at the time of my research, recalled vividly how she (positively) experienced relocation to the Ujamaa village. She said:

> You see now, when we moved here, that tree (pointing to a very big tree in front of her house) was very small. I was a young woman with four children. We were living in the hills where the Barbaig (also known as the Mang'ati) are now staying but Nyerere brought us here. We were told to build houses, we were given food and they asked us to stay. Life was good but now no one is giving food even to an old person like me (IDI, Nyemo, Magambua Village).

Villages were established along the Dodoma-Kwamtoro-Singida road and their number increased from 40 in 1969 to 354 in 1974 (Prime Minister's Office 1974 cited in Raa 1979: 3). By 1975, when the Ujamaa Villages Act was passed, most of the Sandawe were already resettled in the villages (ibid: 1).

The establishment of the villages was mainly defined by easy accessibility explaining why most of them were located along the main road (Raa 1979: 3). The government avoided establishing Ujamaa villages in the interior even when such areas had fertile soil because of the cost of building roads to access them. Consequently, some of the villages were overpopulated while others had soil erosion and bad soil for agricultural activities, aspects which resulted into manmade famine that compelled the government to provide food as famine relief (ibid: 10-13). The government wanted close control of people and easy access in the provision of social services irrespective of whether or not the areas were conducive for people to settle and undertake agricultural production (Hyden 1980: 144-145).

A cooperative state farm was opened near Kwamtoro and was provided with tractors, farm equipment and veterinary services. Traders were restricted from trading activities, which were taken over by cooperative shops (*maduka ya ushirika*) and women shops. Milling machines were brought by the government and were operated by the villages. Health facilities and schools were expanded and water pumps were provided to help with the acute water shortage in the area. The main road was maintained and the government provided a bus that operated between Kwamtoro,

Singida, Dodoma and Kondoa (Raa 1979: 8). These were rapid changes but they did not last for a long time. Towards the end of the 1970s, most of the farm equipment, milling machines as well as water pumps had broken down and the shops lacked necessary goods (ibid: 9). The Tanzanian government was facing critical economic difficulties resulting from the Ugandan war, collapse of the East African Community and the global oil crisis, which crippled her ability to serve the Ujamaa villages (Dunlop 1984: 4). Projects in Ujamaa villages also faced challenges due to people's little knowledge and skills to implement them (Ergas 1980: 390). People's living standards declined significantly and villages began to collapse. Health services, for example, shifted from curing to prevention due to unavailability of medicine (Raa 1979: 8).

During the years of Ujamaa, the monthly cattle markets (*minada*), which were accompanied by traders selling different goods, provided relief to the people in the villages. They could obtain goods which were otherwise unavailable in the collapsing cooperative shops (ibid.). Such markets still existed during the time of my fieldwork using the same route from Kwamtoro, Farkwa, Sanzawa, Lalta, Babayo and Tumbakosa. The *mnada* day in Lalta (Magambua Village) was on the 20th of every month and it was the main place for buying and selling goods. Most of the things pregnant women were required to prepare for childbirth were bought on the *mnada* day. The people from the villages also sold grain, eggs, and livestock. The few available shops in the villages sold basic goods such as cooking oil, salt, dried fish, kerosene, soap, matches, body lotion, maize flour and cereals. Anything extra had to be obtained on the *mnada* day or one had to go to Kwamtoro, Singida, Kondoa, or Dodoma.

After the devastating effects of the failure of the Ujamaa villages, the country was yet to experience a critical period of structural adjustment programs (SAPs) that reversed most of the achievements attained in the first two decades of independence (Kiondo 1995: 111). I could not find literature with detailed accounts of the lived experiences of the Sandawe during the structural adjustment period but learning from my interlocutors, it was evident that like in the rest of the country, they too experienced socio-economic crises. People I talked to recalled the economic difficulties, especially between 1983 and 1989 when they could hardly get even soap to wash their clothes. Some recalled decreased government support on agricultural subsidies (i.e. fertilizers and pesticides) and the decline in veterinary extension services. Ujamaa villages such

as Ilasee had acute problem with soil erosion, which was rehabilitated during the implementation of the Ujamaa policy (Raa 1979).

Following the adoption of free trade conditions in 1986 as required by the SAPs, dealers resumed trading activities that led to the closure of cooperative shops. At that time, some of the Sandawe started moving to the urban areas, notably, Dodoma and Arusha where they engaged in petty trading and casual labour to support themselves and those left behind in the villages. In Dodoma City, an area called Chang'ombe (a squatter settlement) gained popularity as the Sandawe's place since the early 1990s. Many people in the villages mentioned having relatives living in urban areas such as Dodoma, Kondoa, Singida, Arusha and Dar es Salaam.

Towards the mid-1990s, recovering from the economic crises of the 1980s and the adoption of neoliberal economic policies, socio-economic development was no longer a matter of the national state alone. The Tanzanian government started working with international, multinational bilateral organizations and national NGOs. In Kondoa District, some of these organizations included the International Labour Organization (ILO), United Nations Development Fund (UNDP), World Vision International, Oxfam and Swedish International Cooperation Agency (SIDA). Faith-based organizations (FBOs) were also active in development projects in the district. The Catholic, Anglican, Lutheran and the African Inland Church as well as the state sponsored Muslim organization[15], became involved in health and development projects (Kiondo 1995: 153). The Islamic and Christian based organisations shaped the politics of social services provision in the district. The Rangi, the majority of people in Kondoa District who were Muslims dominated decisions about development and the distribution of resources leading to the concentration of development projects in the northern part of the district where the majority Muslims resided (ibid: 122). The southern part depended mainly on development projects under Christian faith-based organizations. For instance, I was told by one of the village leaders that in 1993, the African Inland Church of Tanzania (AICT) requested a piece of land to build a dispensary at one of the villages at Kwamtoro Division but they were denied for what was alleged to be the fear of

[15] Called in Swahili, Baraza la Waislam Tanzania (BAKWATA).

spreading Christianity. However, they were given a piece of land in Magambua Village where they started building Faraja Dispensary in 1999.

In 1996, Usandawe received the attention of the World Vision International which worked to improve health services, schools, and provided support during drought seasons. However, at the time of my research, Lalta Ward was facing an acute shortage of water attributed to the failure of their Member of Parliament to help them to solve the problem even after being in power for ten years. Being a Muslim, the member of parliament was alleged by my interlocutors to neglect the Christian dominated area of his constituency.

2.6 Contemporary Social Changes

2.6.1 The Sukuma Immigration and the Emergent Land Crisis

When I arrived in Lalta to begin my fieldwork in February 2015, the atmosphere was tense due to a fight between a Sukuma man and Sandawe man in Babutole Village that had resulted in the death of a Sukuma man. It was the second fight following another one in 2013, in which two Sandawe men were killed. The fights were over farm boundaries and the Sukuma were alleged to insult the Sandawe by calling them "lazy" and "incapable of cultivating big farms." The people expressed their concerns and bitterness about the Sukuma who were immigrating into Usandawe in large numbers and taking land (see also, Yatsuka 2016: 99). Immigration of the Sukuma to Usandawe which gained momentum from the early 2000s, was a continuation of the movement of pastoralists in search for land as well as pasture, which resulted into conflicts with agricultural communities. Areas most affected by conflict between the pastoralists and agriculturalists with reported deaths after the fights were Kilosa and Kilombero districts in Morogoro region; Handeni and Kilindi districts in Tanga Region; and Mbarali District in Mbeya Region (Mwamfupe 2015).

Apart from the recent immigration, the Sukuma had a long history in Usandawe. They had moved to Usandawe mostly in the 1970s, cultivating paddy in swampy areas, which made Kondoa District popular for paddy production in the Region (Newman 1970; Yatsuka 2016). By then, there were no major tensions and the Sukuma were not a concern to the Sandawe until when they began immigrating in large numbers to the extent of outnumbering the Sandawe in some villages

like Polomanguma. Dealing with the land conflicts was challenging for village leaders because the Sukuma could bribe district officials as one of them explained:

> The problem is that some of them have permits (*vibali*) from the land section at the district level. When they come here, the one with the permit shows you and then he starts calling others and you find it is only one with the permit, but many are coming. Even when you go to the district council, the Sukuma have money and they can get around (the district council). They are a big challenge to us (IDI, a village leader).

According to Newman (1970), the Sandawe had no elaborated land tenure. People could move freely and frequently as long as there was land available to accommodate the non-Sandawe. Newman (1970: 39) explains further that during the time of his research in the 1960s:

> The concept of clan ownership as practiced by Turu, Gogo, Rangi and many African groups, where formal permission to land acquisition must be obtained from clan elders who are responsible for a specific segment of territory is unheard of. The only rights are those vested in the individual once he takes up cultivation. He cannot be dispossessed of his land, as is possible under the system of clan ownership (...), and his rights to claim lapses only when the land is no longer put to use (...). Another feature of the Sandawe's rudimentary system of land tenure is lack of readily visible markers bounding adjacent fields (...). The ditches, sisal hedges and thorn brush employed by the Rangi, Turu and Gogo are rarely encountered. Sometimes paths are used as markers, but fields often merge into one another; only the respective owners know where one man's property leaves off and someone else begins.

The extract is an old expression of the Sandawe's land tenure system but the Sandawe's attitude towards land has not changed much until recently (Yatsuka 2016: 43). During the time of my fieldwork, thorn brushes marking farm boundaries were a common feature in many fields located far from households and empty deserted homesteads were very few. Claims over land ownership and rights were increasing. One of the village leaders told that the ward council had about 30 cases related to land disputes between the Sandawe and the Sukuma.

2.6.2 The Plight of Alcoholism, Drought and Male Migration

The problem of alcoholism became evident from the very early days of my fieldwork. Several women to whom I talked complained about the lack of support from their spouses due to excessive drinking. Alcohol consumption among the Sandawe has a long history and has never been a concern, rather, it had been and still is cherished. Long before they adopted farming and

livestock keeping, millet was obtained from neighbours and was used together with honey to brew alcohol which was used in special occasions (celebrations and rituals), and for relaxation. Raa (1983) reports that alcohol formed an important part of the Sandawe diet and during the famine outbreaks, hunger also meant lack of grains for alcohol brewing:

> The Sandawe not only consider beer an essential element in their ritual life, but also a desirable adjunct to their ordinary intake of food (…). During famines, the Sandawe complain as much about shortages of beer as food (…) and the British complained bitterly of the Sandawe squandering of relief grain on beer making (ibid: 127-132).

The local beer (*choya*) was brewed and consumed at home or sold at the local bars. Children were allowed to drink the early morning brew which had not fully fermented. One of my interlocutors explained that teachers in the primary school at Magambua Village smelled pupils before starting classes to make sure that they had not taken alcohol. Those found to have taken alcohol were punished and sent back home. Realizing the drinking habit of the Sandawe, the British colonial government imposed alcohol tax and close control of alcohol consumption in 1950 (Raa 1983: 127). During the time of my research the sale and consumption of alcohol on working hours (from 8:00 am to 4:00 pm) was restricted (Halmashauri Wilaya ya Kondoa 2014: 1). However, the restriction was not observed and it was common to find people drinking during working hours.

Moreover, today alcohol is an important cash generation activity for women and for 3 three of my interlocutors it was the main economic activity. Most of the women I interviewed knew how to brew alcohol and did so whenever the need arose. Alcohol was brewed for the purpose of relaxation, celebration, rituals, or to generate cash for a particular need. Local brew made for the purpose obtaining cash for a particular need (not as a regular economic activity), was consumed at home and people could go to drink from morning to evening. On average of three times a week, there was a household in the villages which had alcohol ready for drinking. One noticeable thing in the drinking gatherings was the presence of women and children, especially in the morning hours. In cultivating, weeding and harvesting, neighbours helped each other and alcohol was used as a token of thanks.

Thus, alcohol formed an important part of the Sandawe's way of life, but the situation was changing rapidly. Availability of industrial made alcohol posed a threat to many families.

Alcoholism was a growing problem especially among men because they drank not only *choya* but also *viroba* (gin packed in small packets of 50 ml) sold at 500 Tanzanian Shillings (equivalent to 20 Cents-Euro). Some women complained that drinking (especially *viroba*) made their husbands violent and some had allegedly stopped taking care of their families. One of my interlocutors, a 25-year-old married woman and a mother of two said:

> I tell you my sister; alcohol drinking is a big problem now. Ask anyone, she/he will tell you that even children sometimes go to class drunk. Alcohol is brewed in many houses. My husband drinks a lot and sometimes he beats me. He does not care. I go to the farm alone and when I gave birth to this child, he was not at home (IDI, Mwanaisha, Ilasee Village).

Alcoholism, which seemed to be a growing problem among men, was mostly attributed to *viroba*[16], which most women did not drink.[17] Frequent drought periods limited the availability of *choya*, but *viroba* were always available.[18] Since 2014 was a year of drought, many households did not have enough to eat but alcohol was brewed in some of the households. Some of my interlocutors told me that if I had gone during a good year or soon after harvesting, alcohol would have been brewed in many more households than what I was seeing then. Unfortunately, 2015 was not a good year as well. By April, most of the crops in the fields were dry before they were ready for harvesting.

The devastating effects of droughts were particularly evident during the home visits. Most families I visited had two meals per day. The main food eaten in the two meals comprised *Ugali* (stiff porridge made from maize flour) with *mlenda* (a dried type of local vegetable). For the households with cattle, sour milk provided additional part to eat with *ugali*. Migration of men to towns for casual labour was a means of supporting families back in the villages. However, it meant leaving the family under the care of the wife until the man secured some job to do and being able to send money home as remittances. Some women complained of men using the

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[16] In February 2017, the government of Tanzania banned the production, importation and sale of *viroba* but traders found a way of going around the ban by selling the bottled gin at 1000 Tanzania Shillings (equivalent to 40 CentsEuro).
[17] For those women I asked as to why they did not drink *viroba*, they said *viroba* were too strong for them to handle. They termed *viroba* as "men's alcohol" (*pombe ya wanaume*).
[18] In periods of food shortage, the government prohibits production of local beer. See for example, Mtanzania newspaper 22nd November 2016.

excuse of going in search of casual labour as a way of abandoning their families in the times of famine. To deal with drought and economic difficulties, some men were also involved in illegal timber harvesting and hunting.

Figure 2.3: A bus unloading viroba boxes at Magambua village. (Photo by Anitha Tingira, 2015)

2.6.3 Transport and Communication

Served with a relatively well-maintained road passable throughout the year, Lalta Ward is directly connected to Singida and Kondoa towns as well as Dodoma City and the three major centres in Usandawe: Kwamtoro, Ovada and Farkwa. Transport to Dodoma and Singida was available every morning, easing people's movement to towns. A land rover going to Kondoa was available every other day from Kwamtoro through a shortcut road. Otherwise, a bus going to Kondoa from Singida via Ovada, Lalta and Kwamtoro took a long route (about 90 kilometres from Lalta) was available on Tuesdays and Fridays. Had I gone around the early 2000s, as people in the villages said, I would have experienced transport problems as the only bus available had limited trips between Dodoma City and Singida Town. During the time of my fieldwork, there were two reliable buses that operated between Singida and Kwamtoro and from Dodoma to Ovada Village. In addition, I observed people moving between villages using motorcycles (mostly referred to as *bodaboda*). Several times, patients were taken to the dispensaries with *bodaboda,* a mode of transport that has recently gained popularity in both urban and rural Tanzania. Besides, it has

become one of the main economic activities for young men. In Magambua Village, there were four *bodaboda* riders and I hired one of them to facilitate my movements between the villages.

Another aspect of communication I noted in Usandawe was the use of mobile phones. Some of my interlocutors had mobile phones or line (a mobile phone chip), which could be used on a borrowed phone. Some young men, like my *bodaboda* rider, had a smart phone connected to WhatsApp and Facebook. The network connection was not strong in 2015, but Tanzania Telecommunications Company Limited (TTCL) was building a tower at Manantu Village, which was expected to strengthen the network for mobile phone communications. Some few households I visited had television sets and several had radios.

The availability of solar panels sold on the *minada* days made it easier for people to use electronic devices. For example, several women mentioned to have heard information on maternity care from radios. In addition, solar power has become an important source of light. Most households were using solar lights and both dispensaries had solar panels. Women reported to have been relieved of carrying kerosene whenever they went for birthing services at night. Print media (magazines and newspapers) were not readily available but radios provided instant information and connected people to the outside world. The year 2015 was a general election year and thus, the demand for access to information was particularly high.

2.7 Non-Biomedical Healthcare Services

Regardless of the availability of biomedical maternal healthcare services, the use of 'traditional medicines' during pregnancy and childbirth was reported by most of my interlocutors. Some reported to have consulted traditional healers for protection of pregnancy, some used herbs to accelerate labour or ease menstrual pain, and others attended ritual performances for healing infertility. Bruchhausen (2018: 26-27) cautions, applying European terms is problematic and poses a major challenge in understanding social phenomena, particularly in African contexts; thus, it is important for me to clarify what I exactly mean by the term 'traditional medicine.' In so doing, first, I briefly explain how traditional medicine has been defined, an aspect which shows the problem inherent in the term.

In the preface of the book, *Plural Medicine, Traditional and Modernity*, Ernst (2002: i) observes, the term 'traditional medicine' connotes historical and political developments in which different medical systems are imagined and represented as "rational and scientific" or "irrational and unscientific" within broader homogenized categories. In the early 19th century, European countries experienced major developments socially, economically and scientifically. As a result, non-European (particularly African and Asian) ways of life were associated with a variety of negative terms such as 'backward,' 'barbaric,' 'uncivilized' and 'primitive' (ibid: 7). Such cultural representation had direct bearing on how particular ways of healing and medicine were perceived and defined. Non-European healing practices were "homogenously defined as 'traditional medicine' portrayed as irrational, static, and unscientific compared to 'Western biomedicine,' which was portrayed as scientific, rational and dynamic" (Ernst 2002: 7-8). For the identification of the presumed homogenous healing practices, "healers were categorized in groups of herbalists, born setters, ritualists and spiritualists and each of them was alleged to have a clear domain of expertise" (ibid: 7).

However, critical ethnographic accounts of healing practices in Africa show that healers "demonstrated rationality, progress, and adaption to change" (Bruchhausen 2010: 106). Feierman (1990: 102) for example, shows that during the pre-colonial period, healers in Ushambaa in north-eastern Tanzania specialized in different healing practices and travelled to different regions to learn about various healing practices. During the German colonial rule in Tanganyika, healers in Uhehe in southern highlands of Tanzania rationally attributed transmission of certain diseases to particular insects, and particular methods were used for disease prevention (Bruchhausen and Roelcke 2002: 83). A slight shift of perception on certain aspects of indigenous healing, particularly the use of medicinal plants was noted during colonialism. For instance, Bruchhausen and Roelcke (2002: 87) show how linguistic and epidemiological studies enabled German colonialists to gain a wider understanding of terms expressing particular ailments and medicinal plants to treat them. Specimens of medicinal plants were obtained for scientific examination (Bruchhausen 2018: 39). However, the Germans' interest in medicinal plants did not change the general perception on traditional healing as irrational and unscientific. Ritual and spiritual healing were expressed as 'beliefs in the supernatural,' which through time, would disappear and in other cases, witchcraft, for instance, was criminalized (Langwick 2011: 56). In Tanzania today,

spiritual and ritual healing practices are treated as less of medical practices and they are managed by the Ministry of Information, Culture, and Sports (Bruchhausen 2018: 40). Similarly, the focus by the WHO and the national governments is inclined on medicinal plants which mirror efforts to reformulate traditional medicine in terms of herbalism (ibid: 41-44).

Furthermore, categorization and separation of healing practices overlooked the entwined engagements of healers as herbalists, ritualists as well as spiritualists, and different explanations of ailment causation (Meier zu Bisen and Dilger 2012: 22). While biomedicine associates ailment to natural causes and attend to the physiological body as a separate entity, traditional healing practices attribute ailment to natural, spiritual, or social causes (Feieman 2000: 320; Bruchhausen 2018: 31). A closer look at traditional healing practices reveals the effectiveness of herbs to heal is not separated from rituals performed by a healer (Feierman 2000: 325). Also, people do not always associate particular ailment symptoms to specific causation but often get to know about causation of ailment(s) after trying different healing options (Feieman and Janzen 1992: 2-3). Narrowing ailment to natural causes leaves a void about social and spiritual causes of ailments. Even today, as traditional healing continues to adapt to change; understanding of ailment causation as natural, social *and* spiritual as well as the interfusion of ritual and spiritual healing practices persists (see, for example, Marsland 2007: 753; Meier zu Bisen and Dilger 2012: 22).

Analytically, the term 'traditional medicine' is thus problematic. To avoid the challenge it poses, the use of the terms that carry as broad meanings as possible has been suggested (Feierman 1985: 110-114; Bruchhausen 2018: 27). However, in the daily interactions, the term 'traditional medicine' is still highly used. My interlocutors used the term 'traditional medicine' to express a range of healing practices from self-administered herbs to the use of medicine provided by traditional healers (*waganga wa kienyeji*) and attending ritual performances. My interlocutors said traditional healers did not only heal but could also cause harm. Therefore, my use of the term 'traditional medicine' takes a contextualized meaning as expressed by my interlocutors who differentiated it from biomedicine but did not make a clear-cut distinction between the 'natural' and the 'supernatural' realms. The use of the term 'traditional medicine' (*dawa za kienyeji*) thus, indicated different ways women understood maternal health and maternity risks according to the resonance of ideas about health and healing other than biomedicine.

The traditional healer to whom I talked and that most women reported to have consulted, identified herself as neither a herbalist, ritualist nor spiritualist but as *mganga*[19]*wa kienyeji* (traditional healer). She provided herbs for physiological treatment as directed by ancestors, medicine for protecting pregnancy from malicious forces, and in some other cases, organized *simbo*, a ritual performance that called in the ancestral powers for combating witchcraft and healing, especially chronic ailments. In addition, the emergence of evangelical churches (*makanisa ya kilokole*) attracted the attention of women who were looking for ailment solutions including infertility. Christian religious leaders too, emphasized on the entwinement of spirituality and materiality. For example, the Evangelical religious leader in Magambua Village said in order to be healed from a particular ailment, pills must be taken with faith. Similar conceptualization is reported by Krause (2014: 225) about pharmaceuticals and Pentecostal healing in Ghana.

2.8 Study Methodology

2.8.1 An Overview of the Ethnographic Practice

Ever since ethnography was beset by the crisis of representation in the early 1980s challenging its moral and epistemological basis, anthropologists took a critical turn. Since then, discussions have revolved around how to do fieldwork, analyze and present ethnographic materials in an ethical, critical and reflexive manner. Issues of contextualization of lived experiences in a complex globalized world, conceptualization of place and culture, inequalities and power relations have received considerable attention (see, for example, Marcus and Fischer,1999; Gupta and Ferguson 1992; Ferguson and Gupta 1997, 2002; Ferguson 2011; Marcus 1995; 1998). Knowledge production is no longer a matter of anthropologists describing others fitted in meta-narratives but an intersubjective engagement in which the researcher's involvement is made visible and people are understood as well as represented without being denied of their personhood (Hartsock 1987: 189). Currently, there is a consensus within anthropology that the researcher's

[19] The word *Mganga* is also used to refer to a biomedical doctor. Depending on the context, to show the difference on what type of *mganga* is referred to my interlocutors used the term *mgaga wa kienyeji* (a traditional healer).

reflexivity, positionality and identity are integral in ethnography and that fieldwork, analysis together with writing constitute a continuous praxis (Denzin 2002: 483).

Ethnographic research like mine that involved engagements in different research settings and encounters with suffering as well as structural violence within dynamic local moral worlds, poses moral and ethical dilemmas that require vigorous reflexivity and negotiation of positionality (see Von Unger, Dilger and Schönhuth 2016; Dilger, Huschke and Mattes 2015; Dilger 2011). However, standardized ethical guidelines enforced by institutional review boards that are expected to provide guidance to conduct research in an ethical manner often fail to account for the unforeseen, and emerging ethical concerns that characterize ethnographic research (Dilger 2017; Dilger, Huschke and Mattes 2015; Sultana 2007; Guillemin and Gillam 2004). This adds pressure to the encountered ethical and moral dilemmas. Reflecting on his long-term ethnographic research on HIV/AIDS in Tanzania, Hansjörg Dilger shows that ethical guidelines provided by ethical review boards are inclined to medical research undertakings that use universal models about health and disease. He critically underscores that:

> (…) theoretical and methodological basis of social-anthropological research (...) can hardly be grounded on a universally valid model of disease, health and ethics but that the epistemologies of illness and disease, and the methodological and ethical implications that derive from them, vary with research settings and the way in which anthropologists are involved in the shifting research sites (Dilger 2011: 103).

Therefore, researchers are encouraged to be open about their engagements in the field and about the manner in which they deal with moral and ethical dilemmas. Rather than:

> (…) referring to abstract ethics code in research (...) critical reflection on our engagements and positionality in (and beyond) the field requires cultivation of ethical and moral selves, a process that mirrors the ways in which we explore ethical selffashioning and moral personhood among our research participants (...). From this point of view, it is crucial that we understand ourselves as moral persons who exist, act, feel, and think in relation to others and their ways of being (Dilger, Huschke and Mattes 2015: 4-5).

Also, there are some concerns about long periods of fieldwork and the use of participant observation as a starting point of understanding complex connections including social relations in the globalized world (see Marcus 1995; 1999; 2002). However, the two remain central in ethnography. In anthropological studies, extended periods of fieldwork and participant

observation are still very much relevant and invaluable in understanding the lived experiences from the people's point of view (see, for example, Mattes 2016; Allen 2004; Van Hollen 2003). Nonetheless, this does not negate the fact that other methods can also be used along with participant observation in obtaining ethnographic information (Ferguson 2011: 201).

With these observations in mind, in the remaining part of this chapter, I provide a detailed account of how I conducted fieldwork, the sampling procedures, and data analysis plan. I explain my engagements in the field and the way my participation in the lives of others contributed to knowledge production that I present in this study. My engagements show emotional involvements, struggles with ethical dilemmas and the negotiation of positionality, identity and practices of reflexivity in local moral worlds (Sultana 2007: 375; Dilger et al. 2015: 4).

2.8.2. Sampling Procedures and Data Collection

The fieldwork was conducted in two phases. The first phase, which was between February and September 2015, focused on the provision and uptake of biomedical maternal healthcare services at the village dispensaries with a few visits to the referral hospitals following up women who were given referrals for birthing care. The second phase of fieldwork, which was conducted between January 2015 and March 2016, paid attention on biomedical maternity care in referral hospitals. For three months, I observed interactions and provision of birthing care in maternity wards in Mshikamano Hospital and Umoja Regional Hospital including Matazamiao maternity waiting home.

As the ethnographic research underlying this study was necessarily multisited (Marcus 1995), I moved between different local moral worlds and reflected on diverging (inter)subjective experiences of the provision and uptake of maternity services. I followed women from homes to the village dispensaries and referral hospitals. Participant observation helped in acquiring knowledge and building rapport with women and their families as well as healthcare providers, TBAs and CHWs. I observed interactions and service provision in the village dispensaries and the referral hospitals. Additionally, I observed interactions outside clinical settings among women, healthcare providers, traditional birth attendants (TBAs) and community health workers (CHWs).

Following the contextualization method (Kempny 2005; Dilger and Hadolt 2015), I paid attention to the connections and relations that I considered helpful to better understand the existential dilemmas (and solutions) in the provision and uptake of biomedical maternal healthcare services in the village dispensaries and referral hospitals. Apart from women, their families and healthcare providers, I talked to health administrators, NGOs' representatives, traditional birth attendants, community health workers, religious leaders and a traditional healer. In the village dispensaries and referral hospitals, I observed the implementation of globally initiated interventions in specific local settings.

Sixty-seven (67) women were selected and interviewed. Initially, through convenience sampling procedure, informants were selected depending on childbirth incidences and the readiness of the women to participate in the study. I mainly met women at the dispensaries during clinic visits where I was able to ask them to participate in the study. My first clinic visit was on Thursday the 5th of March 2015 at Upendo Dispensary. I alternated in observing clinic sessions between the two dispensaries as they were both carried out on Thursday mornings. While the healthcare providers introduced me to women as a researcher, they addressed me as a nurse. However, as I will show shortly, the form of address changed over time.

In accessing informants through purposive sampling procedure, I involved CHWs who had information about women and their places of residence. Through snowball sampling procedure, some women I talked to identified other women they knew and who experienced similar scenarios. Moreover, CHWs were a good source of information about women who had given birth at home because they were, in most cases, the first to know before the healthcare providers. The *bodaboda* rider I hired was also quick to tell me of home or on the way to the dispensary births whenever he heard of them. I talked to women who had given birth right at the dispensary, and I also followed women into their homes whenever I heard incidences of childbirth at home or on the way to the dispensary.

Later, to include the diversity of different categories of care, the selection of women became highly systematic. For example, as I interviewed women who had recently given birth, postnatal care was rarely mentioned. The same was also noted when women who had given birth at home brought their newborns for checkup. Attention was exclusively on the newborns; mothers were

rarely checkedup or asked anything concerning their postnatal conditions. I had to make deliberate efforts to find those who received postnatal care to explore in more detail circumstances under which they received postnatal care that the majority of women did not seem to be aware about. Additionally, I probed more about postnatal care when I talked to the healthcare providers.

Age was also considered; while majority of women (35 out of 67) were between 20 and 30 years (the most active reproductive ages), nine were teenagers,[20] and 23 were above 30 years. The main economic activity for many was farming supplemented with casual labour and brewing of local beer. Only one of the informants was employed as a primary school teacher and was the only informant with college education. Three other informants had secondary education, 10 had never been to school and the rest had primary education. With regard to marital status, 56 of the informants were married[21], 4 were separated and 7 were single.

At the beginning of fieldwork, when I started observing clinic interactions, I identified three women in early stages of pregnancy and followed them closely to gain a deeper understanding of their maternity and childbirth experiences. One among the three women dropped out after just two visits in the first two months. She did not make it explicit but after missing three appointments in a row and avoiding me during a clinic visit, I decided to stop following up on her. I followed the remaining two women and as I continued with fieldwork, some of the research participants became more willing to letting me into their lives and I selected ten other women and followed them closely.

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[20] Tanzania is one of the countries with high rate of teenage pregnancies in Sub Saharan Africa; a problem associated with school dropout among girls in the country and induced (illegal) abortion. According to the (TDHS 2016: 111) 27 percent of girls aged 15-19 have begun childbearing an increase from 23 percent in 2010, and 30 percent of girls are married before the age of 18. Thirty-nine percent of girls in Dodoma region begin childbearing before the age of 18, which makes it the third region with high teen pregnancies following Tabora (43 percent) and Katavi (45 percent).

[21] In asking about marital status, two different sets of questions were used to get a precise answer, *umeolewa?* (are you married) and *umefunga ndoa?* (are you formerly married). The use of the term *umeolewa* to them also meant living with a male partner regardless of whether they were in a formal marriage. The formal marriage did not seem to be a matter of great concern so long as the woman was living with a partner. I therefore combined those married and cohabiting under the married category.

In addition, I interviewed other involved individuals in the lives of women, during pregnancy, childbirth and after childbirth comprising 21 relatives, and 17 husbands. I interviewed 18 healthcare providers from the two village dispensaries and the two referral hospitals. Outside the medical facilities, actors involved in maternal health interventions were approached. I interviewed 4 TBAs who had attended more than ten births, one from each village. Some of the TBAs received training but assisted one or two births and decided to stop while others never assisted births despite receiving training (Chapter 7). Therefore, I decided to involve those who were active after training and those who did not receive training but were recognized as TBAs. Four CHWs who had been active for at least one year were also selected. I talked to one traditional healer who women mentioned to consult for maternity and fertility problems. Two Christian religious leaders (Catholic Church and Assemblies of God Church) were interviewed as some women reported to have consulted them for social and health problems. Moreover, I talked to 2 village leaders and one 80-year-old elderly woman. I refer to this woman as Nyemo. She was involved in treating infertility but did not identify herself as a traditional healer. Furthermore, I talked to the Dodoma Region Medical Officer (RMO) who was responsible for the administration of health services in Dodoma region and the District Medical Officer (DMO) of Chemba District who was responsible for the administration of health services at the district level.

During the second phase of fieldwork, in February 2016, I had the opportunity of talking to the Deputy Secretary of the Ministry of Health, an appointment which I sought from June 2015. Access and interviews with representatives from international agencies involved in maternal health interventions in Dodoma Region were facilitated by my prior experience working as a research assistant in two research projects under the United Nation Population Fund (UNFPA) in 2010 and 2011. I talked to the UNFPA and WHO representatives as well as one representative of World Vision International which was actively involved in training and giving support to CHWs since 2013. Prior to training CHWs, the World Vision International was involved in training and provision of birthing supplies to TBAs from 2000 until 2010.

While participant observation went along with interviews, I arranged to conduct focus group discussions in order to make a quick comparison and contrast on reported experiences. I

conducted 4 focus group discussions with women and 2 focus group discussions with men. Gathering men for focus group discussions was somewhat challenging because I did not have regular encounters with them as I did with women. With the help of CHWs, I managed to conduct two FGDs with men in Magambua and Manantu villages. During FDGs with men, I was interested in knowing their role in maternity care as well as their views on family planning. I was able to get various views especially on how men perceived family planning, pregnancy and childbirth. In addition, I collected reports and documents from the hospitals, the Ministry of Health as well as NGOs and newspapers that reported on maternal health issues in the country, especially during the fieldwork time. I also visited various websites providing information about maternal health in developing countries.

2.8.3 Thick Participation and Intersubjective Engagements

Understanding the lived experiences in local moral worlds involves what Spittler (2001) calls thick participation (*dichte Teilnahme*)[22] in which he emphasizes on the importance of active participation and the experience gained in social situations involving all of the senses. Thick participation in health facilities and the lives of women as well as healthcare providers opened up the door to a nuanced understanding of the contextual and complex maternal experiences.

In the two village dispensaries, I observed how services were provided and how women were treated. Power relations, which are constructive of the ethnographic facts we seek to understand, were evident. In the health facilities, women interacted with the national state, international organizations and global maternal health policies as the healthcare providers expressed the embodied power of the state (see Ferguson and Gupta 2002; Sullivan 2011). While observation formed the main part of my participant observation in the village dispensaries and referral hospitals, participation was highly pronounced in the lives of women and their families, which gave rise to the close relationship with study participants.

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[22] I learnt about Spittler's article on *dichte Teilnahme* from a friend doing a PhD in Bergen University, Norway. Although the abstract is in English, the rest of the article is written in German. Given my limited ability to understand German, I had a German friend read it for me.

In the dispensaries, I spent most of the times observing interactions in the provision of biomedical maternal healthcare services. My participation was confined in helping with small tasks, especially in Faraja Dispensary, which had more patients than Upendo Dispensary. At times, I was requested to help in collecting maternity clinic cards, listing the names of women in the register book, or setting the tables for antenatal care sessions. During mobile clinic services, I helped in filling the received vaccinations on children's clinic cards. Participation in the mobile clinic services, which often involved going to the remote areas beyond Lalta showed me how people in the interior areas of the country struggled in accessing biomedical maternal healthcare services. Provided only once on every second Tuesday of a month, mobile clinic services were the most tiring for the healthcare providers who worked from morning hours until sunset. Due to the workload, at one point, one of the nurses asked if she could teach me how to inject vaccinations to children. She pointed out to the driver (for Faraja Dispensary) she said she taught him how to do it and he was helping in injecting vaccinations to children. However, I was adamant that I could not even try. I had no medical training whatsoever, instead, I agreed to help in giving children vitamin A drops.

In addition, I observed children clinic services which were provided on every Tuesday. Therefore, I spent every Thursday and every Tuesday at either of the two dispensaries. It was necessary to attend the children clinic services in order to meet women who were still in the postnatal period as they brought their newborns for medical checkups and vaccinations. I was interested in observing how they were treated and whether they were asked anything about their health related to the postnatal period. Since childbirths could not be predicted, I spent about one month alternating between the two dispensaries during the working hours and missed births which happened at night or during the early morning hours. Therefore, I asked the healthcare providers to call me (via mobile phone) whenever women arrived for childbirth, a pathway that allowed me to be present for most of the births that happened at the dispensaries even at night times.

Observation at the village dispensaries helped me to decipher administrative challenges and power relations among the healthcare providers. Upendo Dispensary had two healthcare providers (one being in-charge). Aspects of power relations were evident, but I hardly observed any confrontations between them. The situation was different at Faraja Dispensary which had

more healthcare providers. I felt and observed tensions and confrontations on matters related to the welfare of the dispensary and healthcare providers (Chapter 6). The tension between the healthcare providers at Faraja Dispensary did not affect my relationship with them. Thus, even at times when they had direct confrontations, they were ready to talk to me, and I made sure not to meddle into their conflicts. After conducting fieldwork at the two referral hospitals, comparing my relationship with the healthcare providers at the referral hospitals and those at the village dispensaries, I could term my relationship with the healthcare providers at the latter as more friendly. They invited me into their homes, talked to me about issues beyond work and sometimes they called me on the phone to greet me after had I left.

Apart from observing clinic interactions and going for mobile clinic services, I spent most days of the week with women at their homes. This gave me a sense of their daily activities, challenges (especially financial difficulties) and family problems, things I would not have experienced had I relied on interviews or observation in the clinical settings alone. In addition, during interviews, I asked women to take me through their typical day activities in order to get a sense of their everyday lives before getting pregnant as well as during and after childbirth. With participation, I made deliberate efforts to integrate into the lives of women, something which was also facilitated by my prior research experience. I had been working as a research assistant for qualitative and quantitative research on reproductive health between 2007 and 2012.

As I followed women in their homes for interviews and follow up visits, I helped with some tasks which gave me a sense of women's daily activities. Sometimes for those I was following closely, I accompanied them to fetch water and to milling machines. These were important places that took me into women's spaces where I was incorporated in gossips about what was going on in the villages. I also participated in weddings and funerals, attended village meetings, church services, political campaign meetings, alcohol drinking gatherings and ritual performances. I also had an opportunity to accompany CHWs during home visits when they followed up on pregnant women and mothers.

Through thick participation, I was able to enter into life settings and situations of the research participants sighting maternity experience whose intensity could not be fully deciphered through interviews and observation. In some few instances, women and their families involved me in the

birth plans and preparations. I accompanied two of the study participants I was following closely to Mshikamano Hospital for childbirth and met another one waiting for childbirth at her relative's home in Chang'ombe, Dodoma. I shared not only their experiences, challenges, concerns and uncertainties about maternity care but also the joy of the arrival of new lives into their families. In daily interactions for some, my identity became *dada.*[23] Such form of address was important for me to maintain as it carried an important meaning in the intersubjective engagements and understanding of women's maternity experiences.

In the referral hospitals, my role was more of an observer than that of a participant. I made it clear I had neither a medical background nor birthing experience. I met and chatted with women before childbirth in the labour wards and after childbirth, in the postnatal wards. To the healthcare providers in referral hospitals, I was a researcher with limited participation and I was not asked to assist with anything. However, I offered to accompany some women who needed to take some tests and do ultrasound, which took me into different sections in the hospitals. I experienced long waiting queues in the laboratory and ultrasound as well as the inconveniences of free biomedical maternal healthcare services when certain tests had to be taken outside the hospitals or birth supplies needed to be bought. In the maternity and postnatal wards, I observed the manner in which healthcare providers interacted with women, their workload, how medical records as well as maternal/infant death reports were written, how medical supplies were procured, and the healthcare providers' efforts to ensure that they had enough medical supplies whenever they took over the shifts.

2. 8.4 Data Analysis Plan

Throughout the ethnographic fieldwork, data collection and data analysis went simultaneously. I took notes on aspects I observed and activities I participated in and reviewed them on a daily basis. I paid particular attention on taking notes in order to avoid taking things for granted and reflect on my positionality in understanding the lives of both women and healthcare providers. Researchers studying familiar contexts and those who have been in the field for a long time are

[23] Meaning sister, a form of address meant to show respect but also indicates a level of close relationship as of a relative.

identified as taking poor field notes, often taking things for granted (see DeWalt and DeWalt 2011: 88). I wrote down and reflected on things I could recall but did not get time to write them down instantly. The daily reflection on the generated data enabled me to follow up on things that needed clarification and revised the questions in the semi-structured interview guides. Every day, I immersed myself in the lives of others and by the end of the day I took a step back to reflect and put into perspective what I participated, observed, experienced, or heard in the semi-structured interview and conversations. Immersing into and detaching from the worlds of others is a delicate and the most challenging task for ethnographers that need to be observed in order to avoid jeopardizing the intersubjective space in the emergent experiences (Kleinman 1994).

A highly systematic form of data analysis followed after the completion of my fieldwork. At the end of the first phase of field work, I returned to Berlin for a period of ten weeks (between October and December 2015) to reflect on the fieldwork process and the generated information. I went through the data and began the transcription of the conducted interviews and focus group discussions. After completing the second phase of fieldwork and the transcription of all the recorded data, NVivo, a qualitative data analysis software was used to sort and organize the data in order make them manageable. I read the transcribed texts and open coded the data following the logic of grounded theory. Here, common patterns of lived experiences were identified. To proceed from common patterns of lived experiences and get to a reflective analysis, the next step was informed by hermeneutic phenomenology technique of data analysis, whose concern is on the underlying structure of experiences rather than the common pattern of the same. It involves intensive reading of individual cases, reflective writing and interpretation to explicate the essence of the lived experiences (Kafle 2011). I paid attention to individual cases by noting essential themes of particular experiences, which made clear the differences and diversities of similar experiences.

In the analysis, selected individual cases are described in detail in the sense of thick description (Geertz 1973), which includes the contexts (situations) of experiences, histories, emotions, and webs of social relationships. Thick description emphasizes on the importance of contextualization, which brings the reader closer to the context of the lived experiences of people

under study. I combine thick description with theoretical analysis to elucidate meaningfully the varied and multifaceted of experiences women and the healthcare providers.

2.8.5 Ethical Considerations, Positionality, Emotional Engagements and Reflexivity

2.8.5.1 Ethical Considerations and Emerging Concerns

To begin fieldwork, I needed an ethical clearance. Being a health-related study, obtaining an ethical clearance from the National Institute for Medical Research (NIMR) was necessary. I had learnt from experiences of other researchers I knew that obtaining the ethical clearance from NIMR takes a relatively long time. To save time, I applied for the ethical clearance at the University of Dar es Salaam[24] and NIMR as soon as I arrived in Tanzania in January 2015. Within one month, I obtained the ethical clearance from the University of Dar es Salaam, which allowed me to begin fieldwork while waiting for the ethical clearance from NIMR. The entry point for my fieldwork, in this case, encompassed the people in the village rather than the health centres/providers. However, I was able to go to the village dispensaries to meet informants and observe clinical interactions but not (formally) talk to the healthcare providers or obtain any medical data.

After I obtained the ethical clearance from the University of Dar es Salaam, I proceeded to seek for a permit from the Dodoma Region Administrative Secretary (RAS) and Chemba District Administrative Secretary (DAS). By 19th February 2015, I was in Magambua Village to start my fieldwork. I presented the research permit to the Ward Executive Officer who, as per administrative procedures, instructed village chairmen to assist me whenever I needed support. Magambua Village Chairman introduced me to the healthcare providers at the two dispensaries. I knew a letter from the District Medical Officer (DMO) would be demanded in order to talk to the healthcare providers. Thus, I explained to them that I was still waiting for a research permit from NIMR through which the DMO would grant me permission to talk to them. I received the

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[24] In accordance with the government circular in a letter (ref. no. MPEC/R/10/1, dated July 1980), the ViceChancellor of the University of Dar es Salaam (UDSM) was empowered to issue research clearance to the University's staff on behalf of the government and the Tanzania Commission for Science and Technology (COSTECH). I am affiliated with the University of Dar es Salaam since September 2009.

research permit from NIMR on the 13th April 2015, whose copy was presented to the Dodoma Regional Medical Officer (RMO) and the Chemba District Medical Officer (DMO) and access to health facilities was granted. For access to Mshikamano Hospital, which was in Singida Region, Ikugi District, the permit was presented to the RMO of Singida Region and DMO of Ikugi District.[25]

I also prepared informed consent forms which I read to the research participants before the beginning of an interview. The consent form stated the purpose of my study and their right to either agree or refuse to participate in the study. After reading the informed consent form, I gave the forms to the participants for signing. However, for some study participants, signing the forms raised many questions; I tried as much as possible to explain to them the importance of the forms. This was more of the case with women and their families than it was with healthcare providers and health administrators. Once the consent forms were signed, I kept one copy and left the other with the participants. Likewise, there was also the issue of informed consent from participants under 18 years. Five adolescents involved in my study were under 18 years. Consent was sought from both, the adolescents and their parents/guardians/spouses.

While the signing of the informed consent forms was observed, the matter of informed consent in ethnography has been argued to be a continuous process rather than a onetime event (Mueller and Instone 2008: 382). Wendler and Rackoff (2002: 1) observe that "neither the (governmental) regulation nor the researcher's ethics literature explain how to implement informed consent as a process than as an event." The way in which informed consent is a continuous process depends on how situations emerge and events unfold during fieldwork (ibid.). The challenge is that there are no uniform fieldwork experiences and in this case, I explain what I considered emergent challenging situations that required critical reflection as I carried on with fieldwork.

One of the earliest challenges apart from the scepticism of signing the consent forms was encountered during the semi-structured interviews as I followed and interviewed women in their

[25] I did not talk the RMO of Singida and DMO of Ikugi because my primary research site was in Dodoma Region and I considered enough talking to the RMO of Dodoma Region and DMO of Chemba District.

homes. Whilst I enjoyed talking to women alone when they attended ANC, home interviews always had the potential of involving more than just the intended interviewee. In many instances, husbands, mothers or relatives joined the conversations and I ended up talking to two or three people. This had both advantages and limitations. Whereas I got the accounts of pregnancy and childbirth experiences from other people involved, the women became less conversant and I had to rephrase the guiding questions in order to accommodate others who joined the conversations. Most importantly, I had to explain to them about the informed consent and, in most cases, verbal consents were obtained.

Another thing worth noting during the in-depth interviews is that some of the research participants were uncomfortable about being recorded. I made it clear every time before we began the interviews that I would be recording the conversations and put the recording gadget in a plain site. When they expressed their uneasiness with the recording, I switched it off and resorted to note taking. I encountered this situation mostly with the healthcare providers, some of whom would not ask me to switch off the recorder but would talk in a very low tone, especially when expressing their grievances about the administration and administrative procedures. To maintain a sense of trust, I continually assured them that their identities would be protected and that the information provided would be used only for the purpose of the study and not otherwise. While I use actual names of places in the thesis, the names of interlocutors and health facilities are pseudonyms and whenever a title of a particular person is used, an informed consent was obtained. I have also changed the gender of some of the healthcare providers.

While I could easily ask for informed consent during interviews, the situation was a bit different for observation especially among women who came to the health facilities for childbirth. When Sara learnt that I was a researcher, she commented, “I thought you were a nurse.” The way she said, did not indicate a complaint or a concern but the important thing to me was that she had thought of me as someone I was not. I had no time to introduce myself and I was there in the labour room when she was giving birth. Although I had not planned to enter the labour room on that day, the thought of observing women giving birth especially when no prior consent was obtained became a matter of concern. In evaluating the situation, I also thought it was inappropriate to ask for consent from women in labour pain. Combined with the devastating

effects of seeing Sara giving birth to the twins, I decided not to enter the labour wards and talked to women after they had given birth. For most of the times, I talked to the relatives who brought the woman and avoided to enter in the labour wards even when the healthcare providers suggested I could.

3.8.5.2 Between Local Moral Worlds: From A Nurse to *Mama Maendeleo*

Dilger (2011) shows how the involvement of an ethnographer in different research setting requires the ethnographer to position himself/herself according to particular understandings of social reality which may not always align with official ethical guidelines as promoted by interdisciplinary committees. Furthermore, the position and identity assigned to the researcher by the research participants play a significant role in acquiring knowledge (Dilger, Huschke and Mattes 2015). My fieldwork involved talking to a wide range of informants with different views about maternal health. I had to navigate and position myself between different local moral worlds. My positionality in the lives of women and their families evolved through time as I interacted with them and experienced the provision of biomedical maternal healthcare services. My engagements as a participant observer certainly played an important role. I noted the difference on how women and their families positioned me including the amount of information they were ready to share with me.

As I already mentioned, this fieldwork was not my first, therefore, I somehow felt confident about my ability to relate with people. My connection to the research site was further influenced by being a Tanzanian, sharing the same national language (Swahili) and the national (Tanzania) history. Therefore, to the people in the study area, I was not a total stranger, though still a stranger because I came from a different part of the country. At the same time, I started facing challenges from the very beginning. I arrived in Magambua on the 19th February 2015, around the same time that new secondary and primary school teachers were reporting to their working stations. I was received by Victoria Mashana, a secondary school teacher whom I had met in October 2012 when I visited Magambua for the first time after two months of developing my research proposal in Berlin. A stayed with her for two weeks then I found the host family of Mr. and Mrs. Francis Ng'atwa.

When I started going around the villages meeting people and introducing myself, many people thought I was a teacher. During such village walks, I met some pregnant women and their families. Walking around the villages was meant to have a quick glance of the geography of the villages and make my presence known instead of waiting to meet women at the dispensaries. I spent the first two weeks observing movements and interactions in the villages where, among other things, maternity issues were discussed. It was very enlightening, especially with regard to spaces for women outside homes and the dispensaries. I noticed women meeting at milling machines (*mashineni*), water wells (*visimani*), and some women reported later during interviews that they had learnt about biomedical maternal healthcare when meeting with other women in these places.

The people received me with a mixture of expectations and imaginations. While many people thought I was a teacher, others spread the word that I was a government investigator such that I was received with so much scepticism in some homes even after I explained to them that I was a student and a researcher. After I explained about my study, some thought I was a new nurse. I faced and answered many questions regarding my identity and many times, I had to explain what I was doing and why I was doing certain things. There were times I got worried that women and their families would not take me simply as a researcher. However, with time and as events unfolded, my identity changed from a teacher, an investigator and a nurse to that of *Mama Maendeleo*[26] and sometimes they referred to me as "that woman who talks about women and children." Such identity helped me to maintain a close relationship with women as I navigated in different spaces of power relations. In the section that follows, I explain the encounter that triggered the evolvement of my identity and positionality in the lives of women and their families.

[26] *Mama Maendeleo* literally means mother development. I learnt later that, people in the villages used the term to refer to female administrative officials who worked closely with the people. Particularly they used the term for a community development officer who worked for Tanzania Social Action Fund (TASAF) to reach and help poor families.

2.8.5.3 An encounter at Upendo Dispensary

Thursday of April 23rd 2015, started like any other day of my research. I prepared myself early in the morning and around 8:45 am; I was already at Upendo Dispensary waiting to observe an antenatal clinic session. When I arrived at the dispensary, I found one pregnant woman lying on the floor at the veranda. As I approached her, I realized I had already met her three weeks before when she came for antenatal clinic visit. She was six months pregnant. As I greeted her, she tried to sit up to return the greeting but she appeared to be in pain. When I asked her what the matter was, she looked at me hesitantly and then said she was sick. I sat beside her and said I was sorry that she was not feeling well, and she came so early and alone. She appreciated my concern and told me she had to come that early and alone because her husband had beaten her the previous night. Thus, throughout the night, she had terrible pain around her waist and she could not feel the baby playing. She was 21 years old and that was her first pregnancy. She told me she was scared that she was going to lose the baby. As we continued chatting, other women arrived and the discussion changed to what was happening in the campaign rallies for the upcoming general election.

At around 9:00 am, the nurse arrived. I helped her get the benches and the table out to the veranda to start the clinic session. After everything was set, she collected the clinic cards from the 6 women who had come for antenatal care on that Thursday. The woman I saw lying on the veranda was the first to be called as the cards were collected in terms of first come first served. She tried hard to stand and it took some time before she was able to start walking to the other end of the veranda where the nurse was impatiently waiting. She shouted to the woman not to waste time and be fast. Since I sat closer to the nurse, I whispered to her that the woman was in much pain such that she was unable to walk fast. My intention was to ease the agitation and the shouting; little did I know that I made a mistake. She turned to me and told me she knew and she saw the woman was in pain; “Do you want to teach me my job?” She asked me. She continued shouting at me not to interfere with her job. I just stood silently, not knowing what to do or say as she continued saying that she knew her job and I should not teach her what to do. At last, I managed to say, “I am sorry” and moved to the other side where the women were sitting.

I waited and observed as the nurse attended the woman and instructed her to make sure she went to a referral hospital on that very same day. I tried to follow the woman after she was attended but just a few meters from the dispensary we found her husband waiting for her. I later learnt that she went to Mshikamano Hospital and as was worried, she had lost the baby. I never met her again as she moved back to her parents in Singida and the husband avoided talking to me.

Later that day, I was surprised about how the news of my encounter at the dispensary spread very fast. It seemed like everyone in Magambua Village knew what happened at the dispensary that morning. Many people felt sorry for me and told me not to mind the nurse because that is how she was. One pregnant woman who was at the clinic that morning commented; "*Umeuonja moto wake*" (You have tasted her fire). Some women had already mentioned that the nurse was harassing them verbally. I had not experienced what women were telling me until that day. The nurse shouting at me, made me taste their world as the woman said. This brought not only the sense of intersubjective experience but also strengthened rapport and trust between me and the women. Some who were not sure that I was not a nurse became certain that I was not a nurse.

As I met women who had not been at the dispensary that day, the first thing they asked was what happened and I explained to them. Slowly I started being incorporated in the gossiping cycles and sooner than later I realized the number of women addressing me as a nurse decreased significantly. I then acquired a new identity of *Mama Maendeleo*. The new label did not interfere with my relationship with healthcare providers but rather, strengthened rapport and trust with women. Other healthcare providers felt sorry that I went through such an encounter. The Magambua Village chairman interfered and as the Swahili saying goes, *mkubwa hakosei* (An elderly person never err), I approached the nurse and said I was sorry once again. Although it mended our working relationship, compared to other healthcare providers, our interaction level outside the dispensary setting was rather limited.

In fieldwork, there is often the breaking through moment that can be pinned to one particular event or moment (see Dewalt and DeWalt 2011). For me, this would have been one of the bad moments of the fieldwork experiences to remember had it not helped to strengthen the bond of trust between the women and me. In a way, it was a blessing in disguise. Although at first, I was worried on how I would proceed with fieldwork at Upendo Dispensary, the incidence made me

realize that I was excluded from some spaces of women's lives that were important in generating information about their experiences of biomedical maternal healthcare services.

To the women, dispensaries were places of care as well as spaces of violence and power. After one and half months of being in Lalta, I felt like I was incorporated into women's lives. The encounter made me realize I had yet to gain their trust. Being labelled as a nurse somewhat attached me to the dispensary as a space of violence and power, and excluded me from the spaces where what was happening in the dispensaries was discussed and gossiped. With this breakthrough moment, I was able to navigate into the worlds and spaces of women and the healthcare providers without compromising the information I got. My relationship with women improved and I did not notice any deteriorating relationship with other healthcare providers. On the other hand, I became extra careful on the comments I made to healthcare providers about how they treated women something that took an emotional toll on me in situations that I thought I could do more than what I did.

The role of an ethnographer as a passive observer has been challenged by scholars (see Singer1989; Farmer, 1992; Schepher-Huges 1995). These scholars call for active participation of the researcher when the situation calls for it. However, my experiences taught me that immediate active participation is not easy and it can sometimes have negative consequences to the research participants. Several times, especially in the referral hospitals I encountered cases of women being shouted at or neglected when they called for the attention of the healthcare providers. Based on the experience I had with the nurse at Upendo Dispensary, I was cautious with interfering in such situations. It was not easy to foresee how my interference might affect women. Rather than confronting the healthcare providers, I assisted women in walking along with them to the labour wards or talking to them kindly (see Chapter 6). As I talked to the healthcare providers, I also understood as to why they behaved the way they did but throughout, I avoided direct confrontations.

For the administrators and representatives of international agencies and World Vision International, I was simply a researcher and a student. I had single encounters with them during the scheduled interviews. However, I noticed the difference on how the healthcare providers in village dispensaries and referral hospitals addressed and included me in their daily work and lives

outside the clinical settings. My contact with the healthcare providers in the village extended beyond the clinical settings, while in the referral hospitals, I was more of a researcher with limited participation in the lives of the healthcare providers outside the hospitals. With the exception of the 6 healthcare providers with whom I conducted in-depth interviews outside the hospitals, interactions with others were solely in the hospitals. Furthermore, I was rarely asked to assist in anything. I attributed this to the point I made earlier during the introductory meetings that I had no medical training. The same declaration, however, did not prevent the healthcare providers at Faraja Dispensary from asking me to assist during mobile clinic services. Despite the differences in the two settings, I had no problems relating with the healthcare providers and I could see this during the informal conversations and when I interacted with them during in-depth interviews.

2.9 Conclusion

This chapter provided a detailed reflective account of the fieldwork work process. I have described the geographical, social, political, and economic context of Lalta, which was the primary field site for this study. I have also delineated the sampling procedure and data analysis. I have explained in detail my engagements in the field and the challenges I faced with regard to ethical guidelines. While I tried as much as possible to observe the ethical guidelines, I also made reflective ethical decisions whenever I encountered situations not accounted for in the ethical guidelines. I have also shown that my positionality and identity changed overtime, which placed me in a better position to understand women’s experiences.

Chapter 3

Problematizing and Intervening the Maternal Body: A Historical Overview

3.1 Introduction

The ongoing efforts of reducing maternal mortality in developing countries mirror a history of defining and intervening the maternal body for economic, cultural and political reasons that began during colonialism. For colonialists intervening the maternal body was geared to ensure constant supply of labour, modernizing indigenous populations and gaining acceptance (Vaughan 1991; Jolly 1998). For the missionaries, the maternal body was a site of Christianization of mothers and securing new Christian members (Hunt 1999; Comaroff and Comaroff 1986; Vaughan 1991). Whereas the intension of maternal health interventions in the postcolonial period have shifted primarily towards the welfare of women and children with the involvement of NGOs, philanthropists, multi and transnational organizations, the manner in which the problem of maternal health is defined, the proposed solutions and limitations of the interventions echo some important similarities across different historical periods. Grasping the historical developments is crucial for researchers, health planners and policy makers in understanding where we are and what can be done to improve maternal health and reduce maternal mortality.

In order to understand what maternal health entails, conditions and factors shaping maternal health interventions as well as the present state of maternal health in Tanzania, this chapter examines the historical context in which maternal health emerged as a concern since the introduction of the German colonial rule in Tanganyika in the late 1880s. I argue that, since then, interventions on the maternal body have framed maternal health as a medical problem whose improvement depends on changing practices surrounding pregnancy and the use of healthcare services for both pregnancy and birth care. However, at no point have healthcare services been able to meet fully the maternal health needs. Budgetary deficiencies, shortage of healthcare providers, limited availability of health services and supplies have been common features across

all historical periods with rural areas being the most affected by these deficiencies (Renggli et al. 2019).

Besides, health services, and interventions were not introduced in a vacuum. People in particular place had their own healing systems that were suppressed and even regarded as obstacles to the improvement of maternal health (Vaughan 1991; Hunt 1999; Watts 1997). Certain kinds of truths about women were and are still produced in order to justify interventions on maternal health (Pigg 1992; Vaughan 1991; Hunt 1999; Allen 2004; Berry 2010). Nevertheless, the process of defining of intervening the maternal body has never been unilinear. Involving different cultural perspectives on pregnancy and childbirth, historical endeavours to intervene the maternal body show the process of resistance from indigenous people[27], and negotiations with colonial and postcolonial actors (Nguyen 2016; Berry 2010; Allen 2004; Masebo 2010; Van Tol 2007).

The discussion in this Chapter is divided into three sections. In the first section, I examine the interventions on the maternal body in Tanganyika during the Germany and British colonial rule. I will start by describing the broader political economy context in which colonial health services were established and the way maternal health emerged as a concern. The second section focuses on the postcolonial period. I delineate the context in which health services were provided, the state of maternal health after independence, and the impact of structural adjustment programs on the health sector and maternal health in particular. The last section focuses on the introduction of the Safe Motherhood Initiative ‑ which informs and shapes the ongoing global interventions on maternal health, and its adoption in Tanzania.

[27] I use the term indigenous to refer to black Tanganyikan men and women who apart from the European population were the main target of health interventions. I opted for the use of term indigenous rather than black Africans because the latter creates a dichotomy and racial connotation that legitimizes the assumed superiority of those labeled whites and inferiority of those labeled black (see Tsri 2016).

3.2 Introduction of Colonial Health Services

3.2.1 Health Services during Germany Colonial Rule

After years of Germany's contact with East Africa through traders and missionaries, Tanganyika formally became a German colony in 1884. In the initial years of colonial occupation, the European population was small comprising of military men (who fought to stop slave trade and halt resistance to the imposition of colonial rule), colonial administrators and their families. Medical facilities were established to serve mainly this population and a few indigenous people, Arabs and Afro-Asiatic individuals who worked for the colonial government (Turshen 1984: 140). The German colonial administration divided the colony into provinces, which were administered by the Germans and districts which were administered by *Akidas*, mostly Arabs and Afro-Asiatic. Their main duties were to collect tax and maintain law and order (Schulpen 1975: 15; Iliffe 1969: 13).

The first hospital under the colonial government was opened in 1889 in Bagamoyo in a building that was seized from the Arabs. This hospital had 50 beds, 2 Medical Officers, and 4 orderlies. Other hospitals were built along the coast in Pangani, Dar es Salaam, Tanga, Kilwa, Lindi and Mikindani to serve military men (Schulpen 1975: 22; Iliffe 1998: 29). More small hospitals were built in Tabora, Ifakara, Moshi, Mwanza, Bukoba, Iringa and Mbeya (Nsekela and Nhonoli 1976: 14).

Health services to the rest of the indigenous population were provided by missionaries who had been to Tanganyika before the establishment of German colonial rule and had more medical facilities (Iliffe 1969: 10). The Francophone White Fathers under the Catholic Church opened the first hospital in 1885 in Usagara Mountains, followed by Magila in 1877, and Karema in 1888. Other missionaries, notably Protestants, expanded health services to the rural areas. These included The University Mission to Central Africa (UMCA) and The Church Missionary Society (CMS). Their main aim was to reach more indigenous people and convert them into Christianity. This resulted into rivalry between the Catholic and Protestant missionaries (Sullivan 2011: 72). However, when it came to combating the spread of Islam which was spreading fast in rural areas, the missionaries worked together (Schulpen 1975: 15).

The colonial government expressed the need to serve the indigenous population but lack of funds and medical personnel were the major obstacles (Beck 1977: 31). The first public hospital that tended to indigenous people was built by the support of Sewa Haji, a wealthy Asian merchant who agreed to provide funds in return of commercial privileges but with the condition that the hospital should bear his name and provide health services to all the people without racial segregation. The German and later the British colonial government had a policy that excluded Asians from the provision of social services, and during the British colonial rule, they started building their own health facilities (Dilger 2014: 57). In 1983, Sewa Haji Hospital was opened. It was the only public hospital in Dar es Salaam serving the indigenous people until 1961 (Beck 1977: 11). In 1956, the name of the hospital was changed to Princess Margaret and after independence it was once again renamed Muhimbili National Hospital (Schulpen 1975: 41).

Major organizations in the provision of health services to the indigenous population came after the breakout of the Maji Maji war (1905-1906), which was a reaction against brutal treatment in the establishment of colonial administration and its economy (Iliffe 1969: 7). Uprisings against the colonial administration were also observed in other colonies and the international debates called upon the colonial administration to reduce brutality and improve the treatment of the indigenous people in order to gain support and acceptance. One way of doing that was to provide health services (Beck 1977).

More medical staffs from Germany were sent to Tanganyika. By 1910, there were 66 doctors and 39 sanitation officers, a significant increase from 16 doctors and 20 sanitation officers in 1895 (ibid: 11). To reach more of the indigenous population, the German colonial government started supporting missionaries in the provision of health services. Missions were also regarded as being important for the introduction of European concepts of civilization and health (Bruchhausen 2003: 101). In the efforts of easing the tension between the missionaries and work smoothly with them, the German colonial government divided missionaries into spheres of influence in 1911 (Ibid: 15).

Even when working together, the provision of health services was hardly enough for the indigenous people most of who still depended on 'traditional medicine' to deal with ailments (Clyde 1962: 2). In attempts of reaching more people, the colonial government and the

missionaries grappled with shortage of medical personnel and funds (Clyde 1962; Beck 1977). The German colonial government trained indigenous as medical auxiliaries but they mainly worked during health campaigns against diseases such as sleeping sickness (Webel 2013).

The inadequacy of colonial health services for the indigenous population was more evident when they responded to using them especially when they realized the services were effective in treating particular ailments. For example, in 1914, a nurse at Luata dispensary in Masasi District in southern Tanganyika documented the overwhelming task of providing health services for treating yaws:

> The patients increase daily, and the medicine does the opposite. They are a problem, and I feel completely overwhelmed. We talk of sending the Makonde Chiefs to tell them to prevent people from coming. However, can one open a dispensary and then tell people to stay away? They come in droves! (...). On Thursday evening, fifteen patients came in from Makonde. They cannot go straight back when they have come from so far, and they all have brought food for three or four days. There were ninety patients sleeping on the station last night. They were everywhere; whenever you go, you meet patients. I feel so helpless (Ranger 1981: 266).

The German colonial government strove to provide not only curative services but also preventive medicine. Vaccines were provided to curtail the spread of particular diseases such as smallpox and sleeping sickness which were some of the major threats in the colony (Schulpen 1975: 41-42). Some other preventive measures demanded changes in peoples' ways of life, sometimes coercive means were used to compel people to abide by the preventive measures. For instance, in promoting hygiene it was mandatory to build latrines failure to do so was punishable (Bruchhausen 2003: 100). The colonial government made it clear rather than meeting the health needs of the indigenous population the main intention of providing health services was to safeguard the colonial economy by keeping the indigenous labourers in good condition (Iliffe 1998: 27; Turshen 1984: 141). The German colonial endeavours of providing health services to the indigenous population were cut short by the breakout of the First World War in 1914. Until 1918 when the war ended, health services in Tanganyika were still in the infancy stage with urban areas served better than was the case with the rural areas.

3.2.2 Colonial Health Services after the First World War

After the War, it took about two years before the Mandate over Tanganyika was transferred by the League of Nations to the British in 1920. When the British took over, the health system was on the verge of collapsing because of the lack of medical personnel (Clyde 1962). During the war, medical doctors under the German administration were enrolled for the military service. The provision of health services in the colony was exclusively left in the hands of few missionary doctors and nurses (Schulpen 1975: 44).

Thus, the British colonial government had the difficult task of reviving health services for the European population and the indigenous people. To increase the medical workforce, from 1920 a campaign of recruiting doctors from Britain was initiated (Croizer 2005). By the end of the year, 24 doctors had arrived in Tanganyika (Schulpen 1975: 44). The government had no medical infrastructure particularly in rural areas, so they counted on the help of missionaries and thus, subsidized their services (Dilger 2014: 57). Plans to provide medical services to the indigenous population began to take shape in 1924 when the then Director of Medical Services of Tanganyika Dr. John Owen Shircore considered the establishment of the dispensary system, a basic health unit that provided basic medical care (Croizer 2005: 173).

Understanding the British efforts to provide health services through the dispensary system requires situating such efforts within the British system of indirect rule. The administration of medical services followed a hierarchical organization. At the top was the central government, which was concerned with health policies and preventive medicine. Province and district administration units dealt with the provision of curative medicine (Turshen 1984; Croizer 2005). The British intended to differentiate their administration from that of the Germans but the introduction of indirect rule did not change the local administrative structures that were set by the Germans. The districts, which were formally under *Akidas*, remained the same but this time they were placed under native authorities headed by indegenous chiefs who acted as intermediaries between the people and the colonial government (Spear 2005). The dispensary

system was introduced in 1926 and native authorities were assigned to collect tax, establish dispensaries and select young men[28] to be trained as tribal dressers (Croizer 2005: 32-33).

Trained for three months in either government or mission hospitals, tribal dressers were a new category of healthcare providers who would work in the established dispensaries under the supervision of District Medical Officers[29]. They were trained "to treat minor medical cases, including hookworm and intestinal parasites, rendering first aid in surgical conditions and promoting the elementary principles of hygiene" (TNA 61/29 Vol. 1 cited in Dreier 2015: 71; see also Iliffe 1998: 40). The better-qualified staffs were kept in urban areas where there were several hospitals. Tribal dressers were a huge relief for the colonial government in terms of covering large areas and the reduction of cost. The starting salary of a tribal dresser was less than 15 shillings a month against 400 shillings a month for a European nurse (Schlupen 1975: 46).

Despite the promising potential of the dispensary system to service the indigenous population in rural areas, some Medical Officers were sceptical about training tribal dressers without thorough investments in the provision of medical services as expressed by one of the medical doctors in the Parliamentary proceeding of the Royal Society of Medicine in 1928:

> Tanganyika territory has concentrated on the scantly trained tribal dressers with the idea of completely covering the area before doing anything more thorough. The association of these boys[30] with tribal authorities is in keeping with the policy of indirect government. It remains to be seen whether such boys will continue to do good service with such meagre training and scope (Chesterman 1932: 1074).

[28] Most of tribal dressers were young men mainly because they were the ones sent to school compared to young women. However, from 1930s, some young women also began to be trained as tribal dressers (See Schulpen 1975).
[29] The post of a medical officer was exclusive for European doctors. There were also Indian doctors, but they worked assistant surgeons along with European doctors. The medical posts took a racialized pattern with Europeans being on the top of the ladder, followed by Indians and at the bottom were low cadre black health workers. For more information, see Croizer 2005 and Turshen 1984.
[30] "Boy" is a colonial term was used to refer to especially male domestic servant. Domestic servants were compelled to appear and operate according to European beliefs and norms. The "boy" was the locus of the denaturalization of the indigenous identities that were denied by the colonialists (Menke 1991). In this regard, expect for direct quotes, I use the term young men instead.

In later years, even some of the colonial administrators grew critical of the building and functioning of the dispensaries. In one of his evaluations of dispensaries in 1940, Dr. Sneath who was the Director of Medical and Sanitary Services remarked:

> There is an-ever present tendency on the part of eager local authorities supported by administration, to put more and more small dispensaries made of mud and wattle, whether or not the dressers staffing them could be properly supervised. It seemed a simple answer to public demand to erect an inexpensive building and employ a Tribal Dresser, whose salary as a learner was only twenty shillings a month, increasing by stages to sixty shillings after nine years' service. But without regular and frequent inspection by the few qualified medical officers, many of these dressers soon lost interest and forgot their methods of treatment. One example of what could happen was reported by Dr. H.G Calwell, who visited a dispensary in Singida District. The building appeared clean; the man in charge intelligent and neatly dressed, and the confidence local people had on him was obvious from large numbers awaiting treatment. But when asked to produce his records, he explained that none had been kept since the dresser had gone sick two months before; he himself was only untrained sweeper who could neither read nor write (Clyde 1962: 121).

Yet establishing this cadre of health workers was by no means an easy task. Getting young men who would volunteer for the training for the post of tribal dressers was challenging because they were not many educated indigenous young men who could meet the qualifications of being able to read and write (van Etten 1976: 28). This means there was lack of enough tribal dressers and the dispensary system could hardly cover the vast interiors of Tanganyika. Dispensaries were concentrated in some areas than others depending on the ability of native authorities to recruit, train and support tribal dressers (Dreier 2015). Until 1929, only 147 tribal dressers were trained and deployed to work in rural areas (Schulpen 1975: 47).

The documented experiences of tribal dressers and even missionary medical personnel who championed the provision of medical services in rural areas reflected lack of proper physical infrastructures, medical supplies and supervision from Medical Officers (Clyde 1962; Masebo 2011; Dreier 2015). For example, the district commissioner of Ulanga noted the lack of enough medical supplies and supervision in remote dispensaries in the district:

> The supply of drugs and medical equipment were pathetically small, two or three bottles (...). I should like to (...) try to improve supply and may be the efficiency of the dressers, who seemed to be of good character. The dressers told me how long they had been trained, (most of them 2 years or more). As these dressers were mostly ex-standard IV boys, the

> periods do not seem very long in which to become proficient in the use of microscope. I could not help wondering if these dressers could handle the profusion of drugs and equipment to the best advantage especially as they are unsupervised and untaught by medical officers and have no books of reference. I did glance through several outpatient registers and I could find hardly a case in which a patient had more than one injection in the course of Bilharzia treatment, which is, I believe rather a waste of drug (TNA 461 16/8 Vol. 1 as cited in Dreier 2015: 96).

Some missionaries expressed the difficulties of working in rural areas without adequate physical infrastructures:

> I had a small hospital, the door of which was too narrow to take a stretcher. When a patient died during the night, we couldn't put the body into a mortuary as there was none, nor could we put it outside because hyenas would eat it. And, of course other patients could not sleep with it. So, they used to leave the body in the state until morning and move their own beds out into the night: an excellent system until the night pride of a lion strolled through the compound (Clyde 1962: 144).

The colonial government recognized the importance of missionaries in providing medical services in rural areas but following the establishment of government and native authorities' dispensaries, the health services support to missions diminished (Jennings 2015). However, the contribution of missionaries in the provision of health services could not be underestimated. To the time of independence, missionaries had more medical facilities than the British colonial government (Dilger 2014: 57, Jennings 2015: 153). In 1928, the Director of Medical Services in Tanganyika made it clear that they would no longer use missionaries in the provision of health services because they wanted the people to recognize the government's efforts and commitment in serving them (Masebo 2010: 111-112). This came along with strict measures in controlling the expansion of missionary medical services (see, for example, White 1941). Nonetheless, the government continued to provide support in training the indigenous workforce (tribal dressers trained in government hospitals could work in mission dispensaries as well), collaborated with missionaries during epidemics and in the provision of maternal and child health services that missionaries were doing better (Masebo 2010: 112).

The Great Depression of 1929 followed by the Second World War (1939-1945) affected the government's ability to finance health services (Jennings 2006: 236). The quality of health services in dispensaries which were expected to improve overtime, remained low throughout the

1930s to the mid-1940s, and the expansion of both hospitals and dispensaries slowed down considerably (van Etten 1976: 28). The provision of health services picked up again from 1946 when Dr. Sneath introduced a 10-Year Plan that provided for the expansion of curative health services, epidemiological research, introduction of fees for hospital treatment and decentralization of medical services. This plan was adopted by the government in 1950. As a result, there was an increase in curative services; however, dispensaries continued providing limited health services (Schulpen 1975).

There were many variations on how tribal dressers provided medical services, but generally, dispensaries addressed a limited number of ailments and did not reach many of the interior areas. For more advanced medical services, people had to go to either district or mission hospitals (Dreier 2015). As a result, indigenous knowledge about colonial medicine was shaped not by the power proclaimed upon colonial medicine but by how people experienced it. It was viewed to be able to treat some ailments but not others. People sought services from traditional healers for diseases the colonial medicine could not treat as expressed by one indigenous young man in Masasi District in 1926:

> European medicine is very good if a man gets yaws (but) we have some very big diseases Europeans cannot cure them. They cannot cure elephantiasis and cannot cure snakebites, but African doctors can. If you have been bewitched by evil spirits, Europeans cannot cure you, but African medicine can cure you these diseases at once. European medicine can cure them and us, but African medicine can cure ourselves only (Ranger 1981: 267).

In practice, colonial medicine competed with traditional medicine. Although the British colonial government suppressed traditional medicine, it could not meet people’s medical demands and this contributed to medical pluralism (Tilley 2016: 748; Sullivan 2011: 87).

3.3 The Establishment of Colonial Maternal and Child Health Services

3.3.1 Maternal and Child health Services During the German Colonial Rule

Along with the general provision of health services, both German and British colonial government became increasingly concerned with the question of population growth and reproduction. From around 1910, the German colonial government noted that the reproduction

rate of the indigenous population was significantly low and infant mortality was high. This situation threatened population growth and colonial officials were worried about population decline (Bendix 2012). This concern can be understood in the context of demand of population growth in Germany and other European countries that were expressed at the time (Lindner 2014). The German government was specifically concerned about the declining birth rates that were feared to slowdown the progress of the nation. Medical and hygienic measures were proposed to ensure maternal health and infant survival for population growth (ibid: 212-213).

Some observers and medical personnel saw population decline, high infant mortality and low birth rate as resulting from the colonial invasion and the introduction of the colonial economy that led to the breakdown of families, poor living conditions and the spread of diseases (Turshen 1984; McCurdy 2010). However, factors that influenced the course of action on infant mortality were attributed to the widespread of venereal diseases, 'harmful' cultural practices during pregnancy, childbirth and infant raising, inadequate skills of indigenous midwives, lack of hygiene, low status of women and early marriage, abortion and prostitution (Bendix 2012: 117-120; McCurdy 2010: 176).

The emphasis that was given to cultural rather than structural factors inherent in the colonial economy shows that the blame was put on indigenous men and women themselves. Measures leading to infant and child survival were channelled through the mother who became the main focus of interventions. These interventions ranged from preventive approaches that were intended to change the mindset and practices about maternal and child health to curative interventions that moved childbirth from home to the health facility. Expressing the importance of focusing on the mother the staff surgeon Otto Peiper said:

> Here in East Africa (...) the welfare of the infant has to begin with the welfare of the pregnant woman; care for the infant has to encompass that of the mother as well (Peiper 1912: 256 quoted in Bendix 2012: 99).

Policies to control abortion and prostitution were formulated and enlisting women to work in colonial plantations was banned in 1913. Education about hygiene, maternity, and infant care was provided to women through village leaders and the sticks used for abortion were confiscated (MacCurdy 2001: 448; Bendix 2012: 123). Birth services provided by indigenous midwives were

regarded as problematic and were said to contribute to infant and maternal deaths due to the lack of proper hygienic care and inability to handle complicated pregnancies (McCurdy 2001: 447; Bendix 2012: 152-153). However, there were hardly any infrastructural facilities for birth services except those provided by missionaries. Therefore, as it was with other health services the German colonial government collaborated and subsidized missionary maternity services especially in rural areas. In urban areas, birth services were mainly meant for European women. In Dar es Salaam for example, only a few indigenous women (between 30 and 40 per year) were assisted by European midwives during childbirth (Lindner 2014: 218).

There was a need of increasing the number of midwives to cater for indigenous women. Initially the colonial government and missionaries hired European midwives. However, later the training of indigenous women for midwifery positions was considered as a more viable and sustainable solution. Women who were ‘powerful’ in the sense of being able to influence other women were preferred for the training. The then Governor of German East Africa requested the colonial office in Berlin to have a few indigenous women trained as midwives in Germany; but, the request was declined for what the colonial administrator in Berlin thought it would be inappropriate to train ‘African’ women in German hospitals. It was instead, agreed that, indigenous women would be trained in Tanganyika. However, the trainings did not take place because of the breakout of the First World War in 1914 (Ibid: 218).

There are hardly any recorded accounts of women’s views of infant and maternity services; but accounts of medical personnel, missionaries and administrators provide a clue that in the early years of the introduction of colonial maternal health services, women resisted the services. Medical personnel both in rural and urban areas had significant problems attracting women to give birth in health facilities. Missionary midwives in particular put much efforts to attract women to their facilities. For example, it took Dr. Maynard (a missionary midwife who established health services in Shinyanga in 1913) more than 10 years to gain significant trust from indigenous women to come to give birth in her clinic (Allen 2004: 26). This was not the case in Tanganyika alone but also in other European colonies (Van Tol 2007). Convincing and attracting women took a long time of learning and understanding women’s needs (Nguyen 2016).

This means giving birth in health facilities or maternity clinics did not take place immediately after the introduction of the services.

Indigenous norms and values surrounding childbirth were accused of being responsible for the reluctance. A German observer wrote in 1911; “Young women would have none of the help of the midwife sisters. They rather stick to the *desturi* of their elders” (Bendix 2012: 174). Others suggested that the indigenous women were not used to the idea of confinement for childbirth in another place other than the home where they were supported by family and friends (Allen 2004: 26; Clyde 1962: 127).

Throughout the colonial period, maternal health interventions constructed bodies of indigenous women, pregnancy and childbirth practices as problematic. Above that, racial hierarchy and segregation was clear. The government provided better maternal health services in urban areas where most of the European population lived. Most indigenous women living in urban areas lacked maternal health services (Lindner 2014: 214). Arabs and Asians were not targeted by these interventions, which intended to secure indigenous labour, and thus, they established their own health services (Dilger 2014; Greewood 2019). Until 1924, Sewa Hadji was the only public hospital in Dar es Salaam that provided maternity and childbirth services for indigenous women under European midwives (Campbell 2004).

3.3.2 Maternal and Child health Services During the British Colonial Rule

As it was with the Germans, the British interest in maternal health began with concerns on infant mortality, low birth rate and population decline. When they took over Tanganyika, it did not take long before they identified poor infant survival as a problem. Surveys conducted between 1921 and 1922 presented a gloomy picture. The District Officer of Ufipa District found out that only 48.2 percent of infants survived past one year and about half of them died before reaching their second birthday. Medical Officers of Kondoa, Moshi and Tabora Districts reached similar conclusions (Tanganyika Territory 1921: 100).

These findings prompted the British colonial government to take action. High infant mortality was attributed mainly to the prevalence of diseases particularly syphilis and smallpox, cultural superstitions and practices surrounding childbirth including poor childcare after birth particularly

with regard to bad infant feeding practices (Jennings 2006: 232). Solutions were thus to control the spread of diseases, discourage cultural practices that were said to harm mothers and children, and educate mothers about pregnancy and childcare. In 1921, the Chief Medical Officer declared that:

> A campaign against venereal disease would probably result in a marked increase in the number of births, but the percentage of deaths can only be reduced by the spread of education, especially in the female population. Suitable diet, clothing and in case of serious illness a visit to a Government or Missionary Hospital before the resources of witchdoctors have been exhausted, would have the great influence in reducing the present high infant mortality rate throughout the Territory (Ibid.).

The efforts of curtailing infant mortality focused on welfare services because, for increasing infant and child survival, preventive interventions were considered as better than the provision of curative services (Masebo 2010). In welfare clinics, women were taught about housekeeping, hygiene, infant and childcare. Scholars argue that welfare clinics instilled women with ideas of modernity that intended to suppress traditional practices of infant and childcare that were considered harmful (Masebo 2010: 111; Allman 1994: 29).

The first government maternal and child clinic was built in Dar es Salaam in 1924 and a European nursing sister was employed to take charge (Jennings 2006: 233). The clinic provided vaccinations for women and children, and the nurses paid home visits to supervise and educate indigenous women about pregnancy and childcare, and encourage them to do away with prejudice against treatment of maternity cases in hospital. In the attempt to attract women to use these services, the clinic was modelled as indigenous houses with examples of European ideas of hygiene and cleanness. The report stated:

> This Nursing Sister has already attended several maternity cases at their own homes. A number of other cases have been attended at the Native Hospital, at which the Nursing Sister, who is well qualified both professionally and by her knowledge of Swahili, is in charge of the Maternity Ward. A small Maternity Ward has been commenced in Dar es Salaam and will shortly be completed: should it prove popular with native women; similar institutions will be provided in other parts of the Territory (Britannic Majesty's Government 1925: 18).

In the following years, more clinics of similar model were opened in Kahama, Tabora, Tanga, Lindi, Machame and Mwanza provinces (Clyde 1962: 127).

However, the colonial government did not make major investments on birthing services. This aspect of maternity care for almost the entire colonial period was in the hands of missionaries who considered it as an important aspect of healthcare; it provided them with the opportunity of accessing women and gaining new Christian members. Maternal health services were intended to transform women from pagan maternal and childcare practices to new styles, particularly, delivering babies under hygienic conditions as well as liberating them from polygamous marriages (Dreier 2015: 154). The main objective of missionaries was to convert women and their families to Christianity. Missionaries had learnt that the provision especially of maternal health services brought them closer to the people. They focused on indigenous maternal body with a racialized lens as "a discrete site to producing an individual and a Christian" (Jennings 2008: 32).

Some scholars report that mission hospitals served more females than male patients (Jennings 2006; Dreier 2015). For example, Doyal and Pennel claim that:

> With regard to maternal and child health, the missions were especially zealous. Their hospitals tended to favour female patients, making ample provision of childbirth so as to deliver as many new candidates as possible for baptism. Given the existing labour shortages, high infant mortality rates were of particular concerns, and small grants-inaid were therefore made to medical missions to encourage their work in the field (Doyal and Pennel 1979: 251).

Missionaries were more patient in convincing women and sometimes used incentives such as provision of food for lay-ins during childbirth in order to attract women to give birth in their clinics (Dreier 2015: 163; Jennings 2006: 245). Sometimes they first had to assist home births so as to gain the confidence of the men and women as noted by Sister Arnolda of Ifakara mission who attended several home births:

> I explained to the people, that we do not want to save babies only, but mothers too. (...) when I was called to assist, the mother was often already dying with terrible pain, and high fever (...). Some I could help, but not all. When I failed I used the opportunity to explain to those present - often 60-80 people (...) why it happened the way it did (PADSM, Ifakara Mission and Parish 4; cited in Dreier 2015: 159).

In some areas, missionary maternity services were more accepted than those of the government. For example, in Kahama District, women avoided giving birth at the government clinic because

medical personnel were impatient and harsh (Jennings 2006: 245). By 1926, the number of women using birthing services was increasing gradually but steadily. For instance, at Dr. Maynard's clinic, 146 births took place in the first half of 1926 and the number increased to 1,937 in 1933 (Ibid: 238).

3.3.3 Differing and Shifting Perspectives in Intervening the Maternal Body

British colonies had a unified medical system across all her colonies, which showed similarity in many aspects (Croizer 2005). However, with maternal health there were different perspectives stemming from the way maternal health interventions were conceived by the involved actors. One of the areas that showed conflicting views in the establishment of maternal and child health services was on the training of indigenous women as professional midwives. In 1927 when the government noted a sharp increase in the use of services for childbirth, it prepared a proposal of training indigenous women for midwifery positions, who were anticipated to help later with the increasing workload (Allen 2004: 27). The proposal was also intended to address the problem that the government faced with European midwives it had hired. Most of them were less patient with women and did not know local languages (Jennings 2006). Potential candidates identified for training were elderly women, most preferably widows, who had born children, respected members of their communities and already serving the community as birth attendants; and young women who had some form of schooling, who were able to read, write and follow instructions (Bruchhausen 2003: 105).

The discussions that followed thereafter between the British colonial government, medical officers, and missionaries revealed major differences, and influences. When the Director of Medical and Sanitary Services consulted Dr. Maynard,[31] she suggested that young women (15 to 18 years) were the best choice as opposed to older women (Allen 2004: 28). She argued that although the young women might stop working after getting married, they would become useful mothers and the community would have some intelligent mothers (presumably able to influence

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[31] This is because she had one of the most successful clinics in the colony and had already started training some young women who after training continued practicing in their communities without supervision. The colonial government did not like the idea of midwives working without supervision (Jennings 2003: 237).

other mothers). Older women she contended, were deeply contaminated by indigenous customs and using them would be unproductive. This stance was supported by some other colonial administrators who argued that training elderly women even in the future should not be considered because they would hinder total acceptance of maternity services (Ibid.).

Nonetheless, others preferred the training of elderly women. Sister Thecla of Ndanda mission who worked among the Makonde sought the support of and cooperated with indigenous midwives to promote notions of cleanness and hygiene without compelling women to go to the clinic, not a common practice among missionary midwives who described indigenous midwives as obstacles to breaking 'harmful customs' (Bruchhausen 2003: 105). Despite such views, Sister Thecla believed that young women would not be accepted by mothers during childbirth (Jennings 2006: 245). The argument proposed by Sister Thecla resonated with ethnographic descriptions of the Makonde, which showed that those who assisted childbirth were older women and respected members of the community (Mackenzie 1925). Assigning such a task to young women meant undressing the respect of older women, which would lead to resistance. Thus, ideas of who to train emerged from how different individuals perceived the people they worked for and lived with.

It was finally agreed that women of between 25 to 30 years of age would be trained because it was difficult to find younger women who met the education qualifications and when they had the qualifications, parents were not always ready to let them go for the training and preferred them to get married instead (Bruchhausen 2003: 108). Formal nursing trainings began in 1936 when missionaries established the first nursing training school at Lulindi then Ndanda followed by Sumve in 1937. Native authorities also established training centres in Musoma, Bukoba, Mwanza and Tukuyu (van Etten 1976: 31). Trained for 4 years, indigenous nurses were referred to as auxiliary nurses until 1943 when the government issued them certificates. They were then referred to as medical/hospital assistants and they worked in hospitals (Schulpen 1975: 50). Meanwhile from 1930, missionaries informally trained indigenous women, some of whom continued working with them and others left to work in their communities (Jennings 2006).

Despite the endorsement of training young women, the question of who should be trained continued to be a matter of discussion until the 1950s. Some still emphasized the training of older

women believing that given the number of years that had passed; the influence of customs had diminished. In 1951, Mary Craig who had been working as a health visitor for the government since 1928 preferred the training of elderly women who were literate arguing, "Young girls did not inspire the confidence of African women who had obstetric tribal customs that must be respected and gradually won over" (Bruchhausen 2003: 107).

By the 1940s, women had become so accustomed to giving birth in the clinics that some of these clinics became overloaded and overcrowded. Even increasing the number of midwives by training indigenous women seemed not to have kept pace with the growing need of birthing services. Some of the chiefs started demanding the expansion of these services and questioned the lack of enough government funded maternity clinics. Native authorities wanted to expand the services by building more clinics. Candidly unwilling to expand the services, the Medical Officer made it clear that the government had no financial means of expanding birthing services. Instead, the Medical Officer asked the welfare services to focus on prenatal and postnatal services as preventive measures that could improve the health of mothers. He made it clear the goal of the government was serving the child through the mother (Allen 2004: 30). He challenged native authorities further that the most important thing was not to expand the buildings but to provide better services (Masebo 2010: 214). The mere expansion of buildings, he argued, would be a waste of resources. His argument was important as the Second World War had caused a big shortage of medical supplies due to lack of shipping (Schulpen 1975: 54).

Some concerned Medical Officers suggested measures to be taken to deal with the situation. The Medical Officer of Tabora Province recommended that women without any pregnancy complications should be encouraged to give birth at home and maternity clinics should be reserved for women experiencing pregnancy and birth complications (Allen 2004: 31). This idea was supported by other Medical Officers. However, the idea was criticised by those whose areas were not experiencing the overcrowding problem. For instance, the Medical Officer of Arusha Province argued that getting women to give birth in the clinics was not an easy task. He was worried that asking women to give birth at home would raise resistance from women. Instead, he suggested that women should be encouraged to give birth at home only in places that were experiencing the overcrowding problem (Ibid: 32).

The idea of home birth was taken up by the government and the argument shifted to how to help women giving birth at home. Fresher courses (provided by European midwives) of 6 months for literate elderly women (those able to read and write in Swahili) was proposed. Still obtaining elderly women who were literate was a challenge but they managed to begin trainings in 1951. These women were called village midwives and were trained on pregnancy and childcare, and hygiene during childbirth and worked under the supervision of the clinic midwives (Schulpen 1975). They were also provided with birth baskets/kits and were required to keep clean records of the labour and childbirths. The training of elderly women was however, taken as an interim measure; these were later to be replaced by qualified midwives (ibid: 72).

Considering opinions of other medical officers as well, in 1953, five changes in the provision of maternal health services were proposed. First, the development of maternity services emphasized on the establishment of antenatal and postnatal services with in-patient services for complicated cases only; second, the control of expansion of institutional midwifery; third, home birth to be encouraged for urban and peri-urban areas whose clinics were experiencing overcrowding; fourth, the establishment of home services should consider the topography and density of the population; and where home services were unfavourable, institutional services should be established. Fifth, the development of home maternity services should depend on the availability of supervisory staff (Allen 2004: 32).

3.4 Health Services after Independence: Continuing the Colonial Legacy

Right after independence in 1961, there was no particular attention on maternal health. The government developed a three years plan to guide social and economic development. In this plan, medical services received a small part of the budget allocation (4 percent)[32] most of which was directed to curative services in the urban areas. The low budgetary allocation was due to the lack of comprehensive information on the status of the health sector. The government needed to do a thorough assessment of the health sector to design a plan for health services. This task was assigned to Dr. Richard Titmuss, a British sociologist and researcher, who together with other

[32] The lion share of the budget went to education and economic development (van Etten 1976: 38).

five committee members reviewed the organization and provision of health services in Tanganyika in order to recommend future actions. The committee started working in 1961 and produced a report in 1964 (Titmuss et al. 1964).

While waiting for the report, in view of the shortage of the citizen doctors, in 1962 a medical school was established in Dar es Salaam. The training of medical tribal dressers was stopped, and they were required to undergo training to upgrade to the status of Assistant Medical Officers in the course that was offered in the new medical school (van Etten 1976: 34).

The Titmuss committee's report produced in 1964, served as the main guideline in the planning of the health sector in the first 5 Year Development Plan (1964-1969). Among other things, the report called for the expansion of medical services into the rural areas, building of rural dispensaries, introduction and building of rural health centres, and training of health staff (Titmuss 1964). The central government left the task of building health facilities in rural areas to local authorities, which replaced native authorities[33] and provided funds (a maximum of 50 percent of the total capital cost) for building health centres (Bech 2013: 66). Due to limited funds in local authorities, most health facilities in the rural areas were of poor quality and lacked qualified staff, supervision and medical supplies[34] (van Etten 1976: 40; Bech 2013: 6667).

At the end of the fifth year, there were no substantial improvements in the health sector. Although the Arusha Declaration of 1967 declared the pursue of a socialist policy and emphasized on the 5 Year Plan, the government had limited financial and human resources to meet all social service needs in the country which in a way resulted into the neglect of the health sector. The focus was first on agriculture, which was considered the backbone of the country's economy, small industries and education (Nyerere 1967). The lack of planning machinery and staff in the health

[33] In 1962, the government abolished native authorities and the chiefs and introduced local government authorities also known as district councils (URT 2011).

[34] Later in 1972 following the focus of central planning under Ujamaa policy, local government authorities were dissolved and re-introduced again in 1982. The government experimented taking power to the people by decentralizing the central government (Act No. 12/1982), but the experiment failed (Beck 2013: 73). Reestablished local authorities continued facing problems notably shortage of resources and poor performance. For more information, see URT. 2011. "History of Local Government in Tanzania."

sector was an additional impediment. Despite all the shortcomings however, medical services were free except for voluntary agencies[35], which were charging small fees (Bech et al. 2013: 76).

The Arusha declaration also prohibited private medical practice. Most of the private doctors left the country leaving a big void in the health sector (Bech at al. 2013; Young 1986). The support to cover for the shortage of medical personnel was obtained from volunteers who came from other socialist countries such as China and Cuba. Some of these volunteers were posted to work in the rural areas (Young 1986: 132). On the other hand, scholars were increasingly critical of the provision of medical services by the government. They inquired about the lack of preventive medicine and poor medical services in rural areas (see, for example, Segall 1973).

In the second 5 Year development Plan (1969-1974), realizing that it could not do without financial support, the government started accepting external support from donors, which president Nyerere was initially afraid that it would compromise the country's independence (Turshen 1984: 180). This plan also stipulated and carried out the expansion of health services in rural areas particularly those which were mostly underserviced such as Kigoma, Singida and Dodoma (van Etten 1976: 53). By 1976, there was promising progress towards extending services into rural areas as noted by President Nyerere:

> We were slow in changing the direction of our health towards meeting the needs of the people in rural areas. But the new emphasis began in 1972 and has gathered speed since then. Thus, for example, in 1967, there were only 42 rural health centres in operation; in 1976, there were 152 with many more under construction. And there were 610 more maternal and childcare clinics in 1976 than were operating ten years before. There was also a 200% increase in the number of Medical Assistants at work in the country. These provide medical services in the villages where the majority of the people live (Nyerere 1977: 14).

Preventive services were also promoted and more medical aides for rural areas were trained and employed. Mass education campaigns, notably *Mtu ni Afya* (Man is Health) and *Chakula ni Uhai* (food is life), were launched to promote preventive health measures notably, hygiene, sanitation, and nutrition (Chagula and Tarimo 1975). However, extension of health services in rural areas

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[35] After independence all missionary services were referred to as voluntary agencies (Nyerere 1977: 3)

came at the expense of stagnation of health services in the urban areas (Sullivan 2011: 101). It seems to have been difficult for the government to sustain the improvement of health services in the rural and urban areas simultaneously. Up to 1980, the government's priority was on the development of health services in the rural areas. However, big hospitals and highly trained medical staff were still in the urban areas (Iliffe 1979: 207).

3.4.1 Maternal Health Service after Independence

The need for biomedical maternal and child healthcare services was mentioned in the second 5 Year Plan as an area of concern but was not addressed until 1971 because of the lack of financial resources (Dunlop 1984: 1). Maternal and child health committee combined with family planning services was established in the Ministry of Health (MoH) with the help of external aid from the USAID (ibid: 42). The MoH together with the USAID and UNICEF designed a curriculum for training maternal and child health aides (MCHA) in a one year and six months course that focused on midwifery services, simple preventive and curative paediatric measures, as well as family planning (Dunlop 1984: 4). Prior to that, midwives were trained by the voluntary sector which had 16 training centres. The government intended to start 19 training centres and by 1975, ten centres were already operating and others were under construction. Maternal and child health aides were intended to work in the rural areas replacing village midwives (Schulpen 1975: 72).

Maternal and child health services were also infused with the wider goal of improving the health of the population and modernizing the people (Hart 1977). During clinic visits, women were taught about hygiene, sanitation and nutrition. Maternal and child aides who were recruited from and posted in their respective rural areas showed understanding of local etiology, manoeuvred the explanations about maternal and child health, hygiene, sanitation and nutrition in ways that resonated with local realities. Such approaches attracted women to attend in the health facilities (Feierman 1981: 400). The use of mobile clinics, which were introduced in 1972, also enabled the reaching of more women for antenatal and childcare services (Schulpen 1975: 158). By 1978, eighty percent of all pregnant women in Tanzania were estimated to have received biomedical maternal healthcare services. A study conducted by the WHO in the same year indicated that 53 percent of births took place in health facilities, the number increased to 60 percent in 1984 (Jonsson 1986: 749).

However, the success depicted in maternal and child health services was not reflective of the general healthcare system. Most of the health facilities lacked necessary support to improve the provision of medical services. Healthcare providers complained of the lack of supervision and drugs as well as low salaries (Jonsson 1986; Sullivan 2011; Bech 2013). There were also serious setbacks resulting from poor distribution of tasks and coordination of activities in the MoH. The Medical District Officer (DMO) for example, who was supposed to coordinate primary healthcare services was at the same time the Chief Doctor of the district hospital and a member of the District Executive Director's team, which made it hard for him to cope with all the tasks and be able to supervise health workers (Jonsson 1986: 752). Different units in the MoH functioned independently, which created confusion. Donor support that targeted specific areas compounded the problem with some units like the MCH receiving more support than others (Ibid: 753).

Despite the shortcomings, Tanzania[36] had made noticeable progress in the provision of health services, which was however, arrested by economic instability that began from the early 1970s (Bech 2013: 69). Tanzania had been struggling with economic crisis that began building up in 1973 when the first oil crisis hit the globe. Recurring droughts especially those of 1973 and 1974 took a toll on agricultural production and the export of agricultural produce declined (ibid.). Villagization was also not well received in some areas and its implementation required huge funds thus costing the government enormously (Turshen 1984). The country's involvement in supporting independence struggles of other countries added to the financial burden. The war with Uganda (1978-1979), the decline of the East African Community and the second oil crisis of 1979, aggravated the crisis crippling the government ability to provide public services even more (Dunlop 1984: 4).

3.4.2 Structural Adjustment Programs (SAPs) and Health Sector Reforms

The last stroke in the failure of the government to sustain the provision of social services was the result of structural adjustment programs (SAPs) that were introduced to allow liberalization of trade, investments and finances. Donor countries and international organizations withheld

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[36] Following the Union of Tanganyika and Zanzibar in 1964, Tanzania was born.

financial support to pressurize developing countries to adopt the policies. However, the then President, Julius Kambarage Nyerere was reluctant (Edwards 2012: 3). He tried to revive the economy by cutting down public expenditure, loosening trading restrictions and devaluing the shilling, but his efforts were futile. Donors were still not ready to provide support unless the country adopted the programs (Tripp 1997). There was a critical shortage of foreign exchange, which resulted into extreme shortage of basic commodities, lowering the prices for agricultural products to the extremes (Ibid: 26). By 1985, the government gave in to the demands of SAPs in order to rescue the economy at large and the provision of social services in particular (Bech et al. 2013).

In the early years of the implementation of the conditions of SAPs, some improvements were observed in the provision of social services but were short lived. By the end of the 1980s, there was mounting evidence of the negative effects of the policies on the declining of the living standards across developing countries (Lugalla 1995; 1997; Dilger 2010; Kaiser 1996). The situation of civil servants deteriorated, salaries were low, and cases of patient mistreatment and corruption increased (Sullivan 2011: 154; Bech 2013: 102-103). The quality of medical services and availability of drugs in government hospitals were poor leading to many avoidable deaths. Lugalla (1995: 249) quoting a *Daily News* report of the 5th of June 1988, shows that 71 women who were in labour at Muhimbili Medical Centre died due to the shortage of blood and the lack of essential obstetric medicines. Given the deterioration, the health sector was in the urgent need of improvement.

From the early 1990s, the government committed to address the problem of inadequate funding in the health sector and improve efficiency in the provision of health services. In 1993, the provision of health services by private hospitals, which was banned in 1977 was re-introduced leading to the booming of private practices including those supported by NGOs and FBOs (Dilger 2012: 64-65; Tibandebage et al. 2001: 1-2).

Between 1994 and 1995, the government proposed health sector reforms through the decentralization of health services to enable district councils to plan and provide health services in their respective areas. User charges and community health fund (CHF) were established as a means of creating revenue for the health sector to improve the provision of health services (WB

1999a: 117-118). Public Private Partnerships (PPP) was emphasized to compliment the public sector. These reforms, which were mainly financed by the World Bank resulted in a health sector Program of Work (POW) that identified particular goals in accordance with the reforms and strategies of implementing them (Sullivan 2011). From then donors would contribute to the implementation through the health sector wide approach (SWAp), which the government had designed to facilitate collaboration among stakeholders, coordinate planning, and monitoring. Following the SWAp, in the same year, a health basket fund (HBF) was established to enable different funders to bring together their finances to support the implementation of POW (ibid.). It is important to note that not all donors agreed to contribute to the HBF. In 2015, five donors (Denmark, Ireland, UNFPA, UNICEF, and the World Bank) were contributing to HBF (URT 2015b: 12).

The reforms brought some improvements in the provision of health services particularly with the expansion and improvement of health facilities. However, the reforms instigated a healthcare milieu in which the poor and the rich are served differently. Exemptions and waivers that intended to help vulnerable groups (pregnant women, under five children, the elderly and disabled) to access health services effectively are still not adequately implemented (Mujinja and Kida 2014: 33). Furthermore, public health facilities still face problems with medical supplies, drugs, and labour force, which compromise the quality of care. There are also many problems with CHF whose coverage and finance are very limited (Renggli 2019; Mamdani and Bangser 2004).

3.5 The Safe Motherhood Initiative and Its Adoption in Tanzania

Maternal health began attracting international attention from the mid-1980s onward. Before this time, it was not a matter of so much concern in international debates. The new statistical methods to account for maternal deaths developed in the late 1970s indicated high rate of maternal deaths. It was estimated that around 500,000 women were dying annually most of whom in developing countries (Allen 2004: 36). Concerned epidemiologists of the Columbia University, Deborah Maine and Allan Rosenfield wrote a short article calling for global attention on maternal health. They argued:

> In discussions about MCH, it is commonly assumed that whatever is good for the child is good for the mother. However, not only are the causes of maternal deaths quite different from those of child deaths, but so are potential remedies (Rosenfield and Maine 1985: 83).

They argued further that the major causes of maternal mortality were universal which included, haemorrhage, infection, unsafe abortion, toxaemia, and obstructed labour. They indicated that, according to various studies, 75 percent of maternal deaths in developing countries resulted from the mentioned causes (Ibid: 84). They identified the problem in developing countries as a being biased to rural areas. They also mentioned cultural and financial barriers preventing women from using the services. Finally, they proposed ways of reducing maternal mortality which included, expansion of family planning services, training of health workers and traditional midwives, as well as investing in comprehensive maternity care according to Taylor and Berelson model.[37]

Responding to the observations made by Rosenfield and Maine, the Safe Motherhood Initiative (SMI), which was launched in Nairobi Kenya in 1987, suggested appropriate measures of addressing maternal mortality in developing countries (Starrs 1987). The development of the initiative was funded by UNFPA, WHO, and the World Bank, which were later joined by UNDP, UNICEF, IPP, the Population Council and Family Care. Together they formed the SMI Inter Agency Group-IAG (AbourZahr 2003: 16). Most advocates of the initiative were strongly influenced by the Alma Ata declaration of 1978 that called for a holistic approach for health improvement (Berry 2010; Allen 2004; Storeng and Béhague 2016). Thus, they suggested a comprehensive approach that included the improvement of the health system and socio-cultural factors affecting women's health in general (Starrs 1987; Mahler 1987).

Within a funding competitive environment and dwindling health standards in developing countries due to SAPs, the proposed approach could not be accommodated. After the Alma Ata

[37] The model outlines that for rural areas there should be small maternity centers serving a population approximately 4000 with estimated 160 births per year. Each of these be staffed with auxiliary midwife and a village assistant. This team would be responsible for antenatal care and education, family planning services, provision of normal births, and management of early complications of pregnancy. Moreover, for every 100,000 women there should be a 20-bed rural MCH centre, staffed by physician with obstetric experience and several nurse-midwives. These centres would be referral centers for high-risk pregnant women. Some women could still die of hemorrhage or eclampsia before they reach the MCH centre, but a great many lives would be saved (Rosenfield and Maine 1985: 84).

declaration in 1978, donors resorted to selective primary health care as opposed to comprehensive primary health care. The former was more financially appealing to donors because it enabled them to tie their finances to specific interventions and outcomes. The whole idea of the Alma Ata declaration was thus downsized to particular cost-effective interventions whose effects could be statistically measured (Storeng and Béhague 2016: 994).

For funding demands, the SMI was compelled to narrow down to interventions that can have measurable effects (Berry 2010: 92). Three main approaches were identified as most important to support the reduction of maternal mortality in developing countries. First, the provision of antenatal care for the detection of danger signs and referrals. Second, training of TBAs to deal with the shortage of healthcare providers especially in the rural areas and third, the provision of family planning services (Allen 2004; Storeng 2010). These three measures were supported by funders and were adopted at the global level with the expectation of reducing maternal mortality by 50 percent by the year 2000 (Storeng 2010).

Responding to the global demand to reduce maternal mortality, Tanzania adopted the SMI in 1989 (URT 2008a: 1). Reporting about the ethnographic observations done in the SMI meetings in Tanzania in 1989, Allen (2004) shows that, the country's proposed solutions were in line with those of the SMI, except that the meeting organized by TAMWA raised some issues not mentioned in the SMI. Members in this meeting expressed their concerns about harsh treatment of women by healthcare providers and the expulsion from school girls who got pregnant. These concerns, however, were not heeded, not because they did not matter but because they were not the targets of the interventions at the time.

While interventions to reduce maternal mortality were being implemented, the 1994 United Nations International Conference on Population and Development (ICPD) sparked discussions on reproductive health that called for a comprehensive approach of improving not only maternal health but also women's health in general. The involvement of men, concerns on HIV and AIDS, female genital mutilation and abortion were discussed (UN 1995). The 4th World Conference for Women held in Beijing in 1995 emphasized on the matters discussed at the ICPD conference (Haslegrave and Havard 1995). The SMI failed to broaden its approach due to funding constraints but supported the proposal on safe abortion to avoid maternal deaths resulting from unsafe

abortion (Storeng and Béhague 2016). Tanzania responded to the part of the proposed actions on reproductive health made in the ICPD conference by introducing Reproductive and Child Health sections (RCH). The RCH focused broadly on issues of (in) fertility, health of the mother, father, and the child (URT 2008a).

3.5.1 Emergency Obstetric Care and Giving Birth with the Help of a Skilled Birth Attendant

Ten years after the launch of the safe motherhood initiative (SMI), maternal mortality declined slightly (Berry 2010: 87). This raised concerns and questions about the effectiveness of the interventions. In a conference held in Sri Lanka in 1997, the initiators of the SMI intended to create a new zeal on maternal health in order to raise support to the initiative whose failure had begun to discourage funders. Several maternal health stakeholders including program planners, safe motherhood specialists, national and international organizations attended the conference (AbourZahr 2003). Several research findings were presented about the three SMI's interventions. It was argued that although antenatal care could improve maternal health by promoting some aspects of maternal health such as nutrition and screening of high-risk pregnancies, was not an effective way of predicting obstetric emergencies (McDonagh 1996). There were also inconclusive research opinions on the contribution of TBAs in the reduction of maternal mortality. The only intervention that did not raise conflicting opinions was family planning. The involved members of the SMI agreed that access and use of family planning would contribute to the reduction of maternal mortality (Starrs 1997).

New approaches to the reduction of maternal mortality had to be designed. To do that, examples were drawn from developing and developed countries that had managed to reduce maternal mortality. Sri Lanka itself was an interesting case. As a developing country, she had managed to reduce maternal mortality continually from 2,200/100,000 live births in 1935 to 70/100,000 live births in 1996. This success, it was pointed out, resulted from availability and accessibility of quality and free biomedical maternal healthcare service, extensive use of professional midwives, the use of family planning and high status of women in society. Nearly all births happened in the hospital attended by a professional midwife (Ibid: 8). Other examples were drawn from China, India, Bangladesh, and Russia with the same conclusion, that is, access to quality health services and the use of professional midwives (AbourZahr 2003; Starrs 1997).

It was thus proposed that the use of a skilled birth attendant (SBA) who has all core midwifery skills was invaluable to reduce maternal mortality. This implied a wider approach that included expansion and improvement of the quality of health services and the increase of medical personnel. Regarding antenatal care, instead of screening for high-risk pregnancies, all pregnancies were regarded as potentially risky that needed to be attended by a SBA, and that; emergency obstetric care ought to be made readily available (Starrs 1997: 25).

Cementing on the importance of emergency obstetric care, Maine and Rosenfield published another article in 1999 arguing that emergency obstetric care was the most effective means of reducing maternal mortality in developing countries:

> It is often assumed that improving emergency obstetric care is too costly. This assumption implies that other solutions that are equally effective but cheaper exist. In the case of maternal mortality, this is not true. No matter how many resources are devoted to improving women's education and nutrition, or prenatal care and training of traditional birth attendants, no substantial reduction in maternal mortality will result without access to emergency obstetric care. Effectiveness, in turn, strongly influences cost effectiveness. An intervention that is not effective, cannot be cost effective (Maine and Rosenfield 1999: 482).

In their article, Maine and Rosenfield recognize the importance of other factors including community related factors but they emphasize on this approach mainly because funders wanted to focus on particular interventions rather than broader approaches whose success and cost effectiveness are hard to assess quantitatively (Storeng and Bahagué 2016; Berry 2010). The use of SBA and emergency obstetric care became major interventions of the SMI. Consequently, the indicators of progress in the reduction of maternal mortality included the proportion number of women receiving emergency obstetric care and attended by a SBA during childbirth (UN 2015: 39).

3.5.2 Maternal Health in the Context of MDGs and SDGs

The importance of reducing maternal mortality was again recognized in the year 2000 millennium development goals (MDGs), which primarily intended to improve the lives of people in the poorest regions of the world by eradicating poverty and improving health. Goal number 5 had two aims, "to reduce maternal mortality ratio by 75 percent between 1990 and 2015" and "achieve, by 2015 universal access to reproductive health" (WHO 2005a: 11). Millennium

development goals brought new impetus and efforts among global actors and nationals. New alliances between philanthropic agencies and non-governmental organizations were formed to reach the target of reducing maternal and child mortality (Storeng and Bahagué 2016). In 2005, representative from some of the developing countries, international nongovernment organizations and foundations, the United Nations, professional bodies, academia, and civil society met in New Delhi India to strategize about maternal and child health. They agreed in taking an integrated approach that brought maternal newborn, child and adolescent health (MNCAH) under one umbrella (WHO 2005b). African governments in the Abuja Declaration in 2001 had also committed to allocate not less than 15 percent of the national's health budget to maternal and child health (WHO 2011). While budgetary allocations for maternal and child health continue to be a challenge, the partnership, has not resulted into equal funding to all integrated elements (Storeng and Béhague 2016). Until today, child health services receive more support than other aspects because some funders are more interested in child health than in maternal health (ibid).

In line with the global commitment, Tanzania included the reduction of maternal mortality in nearly all her development strategies that were related to other MDGs. The HSSP II (20032008) named the reduction of maternal mortality as one of its targets. In 2007, the Health Policy mainstreamed maternal, newborn, and child survival. The policy was also translated into HSSP III (2008-2015), which focused on partnership for delivering MDGs through two major programs: The Primary Health Service Development Program (PHSDP 2007-2017), which was intended to ensure fair, equitable and quality services to the community. Another program was the Human Resource Strategic Plan (HRSP), which addressed the question of healthcare workforce. Improving maternal health was also the main priority area of the National Strategy for Growth and Poverty Reduction (NSGPR-2005-2010), as well as the Big Results Now (BRN 2013-2017)[38] initiative that aimed to accelerate the achievement of development goals. All plans

[38] The BRN initiative was a broad transformational approach to economic development and service delivery introduced by President Jakaya Mrisho Kikwete (2005-2015). The initiative was copied from Malaysia. Regarding maternal health, the initiative had plans to expand and improve the quality of emergency obstetric care (Dutta et al. 2016: 2). However, its activities were discontinued in 2017 by His Excellence President John Pombe Magufuli

of reducing maternal mortality were guided by the first national roadmap strategic plan of accelerating the reduction of maternal newborn and child health (2000-2015), which is also referred to as One Plan (URT 2008a).

Approaching 2015, it was evident that most developing countries would not meet the MDGs. Tanzania had managed to reduce maternal mortality to 454/100,000 live births by 2010, which was still far from meeting the target of 133/100,000 live births (URT 2014a: 4). In 2014, some global health stakeholders led by the WHO, started preparing new strategies for the post MDGs era. In 2015, the WHO released ending preventable maternal mortality (EPMM) report, which declared that reducing maternal mortality was challenging but possible through focusing on both clinical and non-clinical factors (WHO 2015a). The very approach that funders had been reluctant to support.

Proceeding from the human right approach, EPMM laid a framework of guiding policy makers and planners without naming any specific intervention but providing various aspects to be considered for effective interventions. This includes paying attention to contextual needs of women, improving quality of health services and increasing cooperation between different sectors (ibid.). The guiding principle of this framework is empowerment of women, girls, family and the community to enable the people to access reproductive health services, participate in decision making in matters pertaining to reproductive health and addressing historical and economic determinants of gender inequality (WHO 2015a). Furthermore, the framework calls for government, stakeholders and development partners' commitment to financial support and transparency in the management of funds and reporting progress towards the reduction of maternal mortality (Ibid.).

Ending preventable maternal deaths guides SDG number 3, which among other things has targeted the global reduction of maternal mortality to 70/100,000 live births by the year 2030 (UN 2015: 18). The reduction of maternal mortality in Tanzania is now guided by One Plan II

(2015-present) for reasons that were not made clear to the public. https://mtanzania.co.tz/mpango-wa-matokeomakubwa sasa-wavunjwa/. Accessed on 10.10.2020.

(2016-2020), which has carried on and introduced some other measures that were not started in One Plan I. In both plans, access to quality maternal health services is identified as the central aspect in reducing maternal mortality. Moving towards the SDG number 3, the plan intends to reduce maternal mortality to 292/100,000 live births by the year 2020 by increasing the use of biomedical maternal healthcare services. Furthermore, the plan intends to increase the utilization of ANC services from 43 to 70 percent, increase SBA from 51 to 80 percent, increase access to emergency obstetric care in district hospitals from 59 to 100 percent, and improve institutionalization of CHWs to 75 percent (URT 2016).

Tanzania continues to expand and upgrade health facilities especially in the rural areas to enable more women to access biomedical maternity services. An interview with the Secretary of the MoHSW affirmed that the government was committed to building one dispensary in every village, a health centre in every ward, and upgrading the existing health centres to enable them to provide basic and comprehensive emergency obstetric care. However, progress has been slower than it was expected due to funds limitations:

> We have been cooperating with councils, citizens and even private organization to make sure that the building of a dispensary in every village is fulfilled but the main challenge is money. You know we have not started now or in the year 2007, that was a formal statement. Since 2004 we have been requesting money from the World Bank to assist us with building (...) but mostly we use our internal resources, the situation is not easy, but we are trying as much as we can (IDI, Secretary MoHSW).

In November 2016, the then Minister of Health, Ummy Mwalimu announced that the World Bank approved the government's request to assist in the upgrading of 150 health centres (Rai 2016). Between 2007 and 2015, the number of dispensaries increased from 4, 676 to 6640 in 12,545 villages, and health centres increased from 481 to 695 in 4420 Wards (Kapologwe at al. 2020; URT 2007). Although PHSD phased out in 2017, more dispensaries and health centres are still under construction (URT 2020).

Addressing the situation of maternal health in the meeting with the White Ribbon Alliance Tanzania (WRAT) in September 2017,[39] the former Minister of Health, Ummy Mwalimu

[39] https://youtube.be/L97-QI-pr2k. Last accessed on 11.12.2020.

expressed her worries about the increasing maternal mortality rate and insisted that the government will continue to expand and upgrade health services in order to improve maternal health:

> We have been able to reduce the under-five child deaths by 40 percent. Maternal mortality statistics showed that in every 100,000 live births about 432 women were dying from maternal complications. What shocked us are the government statistics of 2015/2016. If I contradict them, I may be seen as… I do not know; but they say we have moved from 432/100,000 live births to 556/100,000 live births despite all the efforts we have made, all the investment we have done; have we really gone back? But at the end of the day I sat with healthcare professionals and I said, whether 432 or 556 are still very many (...) because by the millennium development goal we should have gotten to 293/100,000 live births. We have looked at the challenges in which we have seen are obstetric complications and we have decided to expand and upgrade maternal health services, this will be the largest mark left behind by the present government (Ummy Mwalimu 2017).

3.6 Conclusion

Most of the challenges faced by maternal health interventions across different historical periods are still relevant up to the present. The colonial administration intervened the maternal body with the aim of increasing population growth for labour supply to support the colonial economy. Focusing on cultural practices as the main problem, they denounced traditional practices of childbirth and childcare and redefined ideal practices according to European standards. Intervention on the maternal body also entailed moving childbirth from home to health facilities. It took a long time to convince women to give birth in the health facilities and when they finally responded and started using the services, it was revealed, the available medical services could not accommodate the increasing demand. Financial and medical personnel resources were limited to expand the services. Until the end of the colonial period, home births were encouraged to reduce pressure in areas that were experiencing greater responses to giving birth in health facilities.

Although there were no particular interventions for maternal health in the first decade after independence, advancements made in the second decade were remarkable. Maternal mortality in particular, showed great improvements. The achievement was attributed to improved budgetary allocation and training of MCHA who were recruited and posted to the same areas which they were familiar. This helped with the understanding of women’s practices. The primary healthcare

system was doing relatively better although there were reservations on how aids were allocated in different departments in the Ministry of Health that made some departments such as that maternal and child health perform better than others.

The era following the introduction of structural adjustment was defined by the weakening of the health system. Specific global health problems received more support as opposed to the general improvement of health services. Maternal health was narrowed down to a medical problem. Health sector reforms that began in the early 1990s have led to some improvements. However, the health system is still too weak to serve the people adequately. Despite acknowledgements of the importance of a comprehensive approach, maternal health interventions are focusing more and more on getting women to use biomedical maternal healthcare services. To meet both the MDGs and SDGs, Tanzania has put particular emphasis on the expansion and upgrading of health facilities especially those in rural areas in order to increase utilization and reduce maternal mortality. How this actually works and what women's and healthcare providers' experiences are in rural areas where biomedical maternal healthcare services are available and accessible, is the broad question I will address in the following four chapters.

Chapter 4

Beyond Safe Motherhood: Family Planning, (In)Fertility, and Gender Relations in the Neoliberal Context

4.1 Introduction

In a usual antenatal care session at Upendo Dispensary, on the 30th April 2015, one of my interlocutors, Miriam, a 27-year-old woman who was eight months pregnant with her fifth child, arrived for her second and last antenatal care visit before going to Umoja Regional Hospital for childbirth. When Nurse Zaina called out her name, looking at the clinic card that Miriam had submitted, she started talking to Miriam, "You started your clinic late; you should not forget that you are supposed to go to a referral hospital for childbirth. I do not want to see you here when you are about to give birth because I will not attend you." When Miriam sat down, Nurse Zaina continued telling her, "A fifth child in nine years is not good for you at all. It means you are giving birth every day. With the current condition, how will you be able to educate all these children? When you go to Umoja Regional Hospital, you better agree that they insert for you a loop (also called an intra-uterine device-IUD) or Implanon. If you go on like this, you will die on the labor bed." Miriam replied in brief, "Okay nurse" and sat quietly while Nurse Zaina proceeded to check her blood pressure.

I met Miriam in March 2015 when she and her husband went to Upendo Dispensary for her first antenatal clinic visit. Like many other women, although she acknowledged the importance of biomedical antenatal care, she delayed starting antenatal care clinic until the pregnancy was five months old. As I walked with Miriam from the dispensary after the clinic session, I asked what family planning method she was intending to use between the two that the nurse had suggested. Instead of naming the family planning method of her choice, Miriam told me that she was still going to give birth to more children and would use family planning later. Miriam's reply was not any different from what I heard from several other women whom I had interviewed. They indicated their intention to use family planning when they were done with giving birth. Why did Miriam agree with what the nurse told her and during our conversation showed no intention to

use family planning as advised? Was she not afraid of a maternal death as the nurse had told her? What about educating her children?

In an attempt to provide answers to these questions, the present chapter examines local conceptions of (in)fertility and state's efforts to (re)shape these conceptions and practices. This allows me to analyze how, through family planning services, healthcare providers attempt to shape women's subjectivities on fertility, women's responses; and, in dialectical terms, knowledge, practices and experiences that emerge in the process. This analysis will bring to light ways in which women and men collude with, alter, or resist the interventions, thereby highlighting areas of modification and collaboration for both successful implementation of the interventions and well-being of women, men and their children (cf. Wendland 2017; Denham, 2012; Browner and Sargent 2011). The provision of family planning services and women's experiences can be comprehended when located beyond safe motherhood; that is, within local conceptions of (in)fertility in the neoliberal context where it acquires a situated meaning.

The interaction between Nurse Zaina and Miriam clearly mirrored different conceptions and experiences of (in)fertility in the complex border zone of global and local intersections (Gupta 1998: 6). For Nurse Zaina, who worked as an agent of the state, the use of family planning was understood within standardized biomedical and development rationalities and, thus, limiting the number of children would reduce the risk of maternal death and allow Miriam and her husband to have children they could manage to take care of and educate. When Nurse Zaina mentioned about the current situation, she was referring to the difficult economic situation in the country that would make it difficult for Miriam and her husband to educate many children. Nurse Zaina expected Miriam to be responsible for her own well-being and that of her children by making a rational choice to use a long-term family planning[40] method.

Conversely, Miriam's understanding of her fertility practices emanated from her experience with contextual realities that marked the different perspectives on what was at stake (see Kleinman

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[40] Often when talking about family planning nurses addressed women as individuals without inferring the responsibility of men as well. This may be because they wanted women to fill the urgency of using family planning.

1999b: 70). High fertility, as will be shown in the discussion, enabled women to make sense of their lives in terms of gender identity and relations, moral and economic concerns that emerged from neoliberal developments. To understand reasons people behave differently even when biomedical risk is made evident, Lupton (2010b: 102) argues that, we need finer grained assessments of how people cope with states of vulnerability morally and socially (see also Dilger 2006; Chapman 2010). Rather than worrying about the probability of a maternal death and the inability to send children to school due to economic difficulties, more children enabled Miriam and other women to increase chances of having good children amidst perceived increased moral corruption. Equally important insight from the above interaction is that, Miriam was not totally against family planning but how and when was the right time to use respective methods, which was in contrast with the authoritative knowledge expressed by Nurse Zaina.

Nurse Zaina's view of Miriam as being responsible for making a biomedical rational choice about family planning, echoed the neoliberal thinking in healthcare interventions based on empowerment and individual responsibilization (see, for example, Dilger 2012; Denham, 2012). In the implementation of maternal health interventions, the state strives to produce rational subjects who will be responsible for managing risks and refrain from actions that may harm themselves and/or their fetuses (Ruhl 1999; Lupton 1999a). The interventions, using "technologies of the self" (Foucault 1988: 17), entail re-conceptualization of how both women and men relate to their bodies as well as local moral worlds. Women are classified so that they may be compared to others, their attributes assessed according to whether they fall within the norm or outside it and hence, requiring expert advice, surveillance and self-regulation (Lupton 1999a: 61).

When men accompanied women for the first ANC visit, they were asked by the healthcare providers to support their partners to use family planning. Nurse Zaina used an expression about the possibility of dying on the labor bed and inability to educate children to discourage Miriam's high fertility. She emphasized the risks and the importance of using family planning to avoid the risks. This was intended to urge Miriam to make a rational choice to use family planning and

"normalize" her reproductive practices. Reality about safe motherhood, which promoted some modes of being and thinking, was created.

The insights from Miriam's case form the main argument of this chapter that, the biopolitical truths about family planning do not automatically structure the ways in which (in)fertility is understood and experienced in local moral worlds. I argue that local conceptualizations and experiences are (re)shaped less by family planning interventions by state institutions than continuous reflections of men and women on culturally shared knowledge and practices of (in)fertility as well as gender relations, social, economic and moral changes. I will show that resistance to family planning was shaped by culturally shared knowledge of (in)fertility and emergent cultural practices within the neoliberal context that encouraged fertility and fear from infertility. Attention on women and men's experiences show what is at stake as well as how the at stake is (re)produced in a particular historical context, and the emergent cultural meanings. I underscore that, people's responses to interventions should be understood as discursive ways men and women make sense of their lives in the ever-changing local moral worlds.

This processual view of culture, which points to the power of the state to shape subjectivities and agency of individuals to discursively respond, inevitably brought me to close examination of Foucault's theorization of biopower, on the one hand, and James Scott's theorization of everyday forms of resistance, on the other hand. In his works on clinics, prisons, and other institutions, Foucault theorizes on the relationship between the state, healthcare institutions and the production of subjectivities (Foucault 1977). He shows how experts' knowledge and discourses shape peoples' own understanding to produce self-discipline and responsible individuals who internalize and uphold understandings of the world propagated by discourses developed by those in power (Foucault 2000; 1988). Central to his theorization, are concepts of biopower and technologies of the self that govern individuals and eventually, the population to adhere to biopolitical truths (Foucault 1978).

Nurse Zaina's suggestion to Miriam can be viewed in terms of what Foucault (1980: 123) suggests in "Truth and Power" as a war-like relation between a patient and a doctor. Whereas the powerful, that is, the healthcare provider, takes the upper hand in the war, it does not mean the

patient is powerless, or will lose the war. Nurse Zaina waged a war on Mariam by proposing an ideal standardized conception of fertility practices. Miriam's reaction, on the contrary, can be understood better in terms of James Scott's notion of everyday forms of resistance in which people use "weapons of the weak" to develop opposed meaning and conduct in the margins of dominant discourses, which allow them to mediate between social orders, and "the moral priorities formulated by communities and families" in relation to (in)fertility and motherhood (Keihlmann 1998: 138; Dilger 2012: 76).

4.1.1 Everyday Forms of Resistance: Countering Biopower

James Scott developed the notion of everyday forms of resistance in his two books, *Weapons of Weak* (1985) and *Domination and the Art of Resistance* (1990). He shows how subtle forms of resistance defy popular notions of resistance which generally emphasize on purposeful organized collective action. Scott (1990: 128) argues that, "If the logic of a pattern of domination is to bring about a complete atomization and surveillance of subordinates, this logic encounters resistance from below." As healthcare providers strove to exert control over reproductive practices, strategically and reflectively, women resisted the control. According to Scott (1990), everyday forms of resistance are shown through the behaviors of individuals that lie between passive, subtle and persistent actions where the subordinated use weapons of the weak to express their needs and concerns that are suppressed by the powerful. The everyday forms of resistance include:

> (...) foot dragging, dissimilation, false compliance, feigned ignorance, desertion, pilfering, smuggling, poaching, arson, slander, sabotage, surreptitious assault and so on. These are ordinary means and techniques of first resort in those common historical circumstances, in which open defiance is impossible, or may entail danger. They are disguised, avoid direct confrontation and thus do not require direct response (Scott 1985: 29).

Although the everyday forms of resistance do not have one organized action that can be reduced to a particular purpose(s), "they constitute a form of collective action which may have aggregate consequences all out of their proportion to their banality when considered individually" (Davis 1993: 6). Any account which ignores them is often disregarding the most vital means by which people at the margins manifest political interests that may have devastating effects to the state.

The underutilization of biomedical maternal healthcare services when they are available and free of charge can partly be explained on the basis of everyday forms of resistance. Scott (1987: 192) describes everyday forms of violence as "infra-politics of the powerless" which allow consideration of a wide range of strategies that go beyond the Marxist theorization of oppression and resistance. As Comaroff and Comaroff (1987: 192) point out, the Weberian and Marxist traditions have been looking for expressions of collective consciousness in the wrong places, that is, in formal statements and institutions rather than in the texture of the everyday."

Scott (1990) points out further that, everyday forms of resistance are difficult to suppress because they use spaces that are difficult to control. For instance, women in Lalta used gossip, especially when they walked and met at water wells. They talked about a range of issues, including their reproductive practices and experiences in clinical interactions. The wells were turned into spaces of political meaning. New forms of knowledge and experiences that challenged biomedical authoritative knowledge and the embedded mechanisms that sought to govern them were shared. Often, my discussions and interviews with women when I secured a trusted position in their lives were also turned into spaces of political meaning. Women expressed their concerns about biomedical maternal healthcare services. As they communicated about their clinical experiences, women named and categorized the healthcare providers according to how they treated them in clinical interactions. Gossip and rumors as everyday forms of resistance were used to communicate experiences, perceptions and reactions towards biomedical maternal healthcare services.

For medical anthropologists, the notion of resistance has served to bring attention to cultural practices which resist increased biomedical interventions in people's lives as well as the encroachment of hegemonic cultural forms (Good 1994: 58). It is obvious Miriam was not ready to lose the war waged by Nurse Zaina. She seemed to agree with what the nurse was telling her but as revealed during our conversation, after giving birth she would not use either of the suggested family planning methods. Recognizing her position in power relations with Nurse Zaina and the biomedical authority, Miriam's resistance was disguised behind false compliance. She did not want to raise an argument and protest against the use of family planning as advised. Her reaction can be understood based on her position as a patient who needed maternity services

but also on the basis of education and economic differences between her and Nurse Zaina. The best way for her to avoid confrontation was to express agreement to the advice, which after our conversation it was revealed that the agreement was in fact, resistance.

Reading between Foucault's theorization of subject formation and Scott's plurality of everyday forms of resistance entails that one must maneuver back and forth between Foucault's emphasis on the dominant power of the state in subject formation, which runs the risk of annihilating human agency, and Scott's trust in the ability of the dominated to overcome domination, which may border on idealism and hinder adequate understanding of discursive forms of domination and resistance (Keihlmann 1998: 193; see also Agrawal 2005: 170). Grounding analysis on either side can be problematic in understanding women and men's experiences and subjectivities. Therefore, rather than focusing strictly on either, I pay attention to the space between them. This means recognizing that resistance is "enmeshed in power relations and it resists bits and pieces of power and it is never outside the network of power; It does not originate within the subject, but is something that arises in the combination of subjectivity, milieu and interaction," as well as social and moral relations (Lemke 2015: 9-10: Dilger 2012: 76).

To understand rationality on resistance, in this case, one must move beyond clinical interactions and take into account contextual factors that operate along with biopower to fashion local conceptions, practices and experiences. As Unger (2017)[41] points out, it is important to pay due attention to local practices and knowledge in order to avoid thin ethnographic representation of people and resistance as merely an act of opposition but "(…) an act of creativity and transformation in multiple social engagements." Prioritization of impinging external powers at the expense of local subaltern knowledge "produces thin ethnographic accounts, which mask internal politics of the dominated group, cultural richness of the group, subjectivity, intensions, desires and fears." To avoid this, Ortner (1995: 190) argues that ethnographers need to focus on thick description in the double sense implied by Clifford Geertz. Explaining about thick

[41] There are no page numbers. It is an online published conversation between Sherry Ortner and Sussan Under. https://css.lsa.umich.edu/2017/06/12/more-thoughts-on-resistance-and-refusal-a-conversation-with-sherry-ortner/. Accessed on 05.12.2017.

description, Geertz (1973: 6) gives an example of a twitch and a wink in which the difference between the two lies on the underlying meaning of the act, that is, does one have a piece of the dust in the eye or is one trying to communicate something with the wink? Thickness, in this sense, is not only about the richness of details but also about meanings, values and intentions such richness helps one unearth (Ortner 1995: 190).

What follows is an attempt to provide a thick description of local conceptions and experiences of (in)fertility as women and men in Lalta came into contact with family planning services for safe motherhood. The discussion is divided into four sections; in the first section, I pay attention to state's efforts to govern fertility and produce fertility control selves for the reduction of maternal mortality, which connects with developmental goals of population control. Here, truths about family planning that are intended to govern people to use family planning are discussed. To connect the truths about family planning to the local contexts, the second section focuses on local conceptions of (in)fertility as well as experiences and ideas about gender, sexuality, marriage, pregnancy and childbirth. Practices and experiences of (in)fertility are discussed in relation to women and men's experiences of family planning. The third section draws from discussions that emanated from an outreach service providing longterm family planning methods. I will show that resistance to family planning is located within cultural notions of (in)fertility that contradict with the rationality of family planning. Also, ongoing moral, social and economic changes (re)shape both men and women's preferences of many children in ways that encourage high fertility. This is followed by a discussion that locates conceptualizations and experiences of (in)fertility and family planning within the neoliberal context in section four. The final section provides concluding remarks.

4.2 Governing Fertility: Modern Family Planning for Reduction of Maternal Mortality

"This is your third child, right? Family planning will help you breast feed the baby very well." Nurse Lucia said this to one of the women in the post-natal care ward who had just given birth to her third child. The conversation caught my attention and it reminded me of the healthcare providers' talks about family planning to women and men in Lalta. Nurse Lucia had just started a conversation to convince the woman to opt for one of the long-term family planning methods

(implanon or intrauterine device-IUD/loop). The woman had to make a decision whether or not to use family planning.

From the very beginning of my fieldwork, I noted particular emphasis on family planning among pregnant women and mothers who took their children for monthly clinic checkups at the two village dispensaries. The emphasis was greater to women with four children or more. During the second phase of fieldwork, I heard several conversations like that by Nurse Lucia in Umoja Regional Hospital[42]. To understand the importance of family planning in maternal health interventions, one must look at the historical context of fertility control measures and its connection to maternal mortality. In Chapter 3, I have shown that during the colonial period, due to the need for labor, the colonial administration encouraged reproduction and initiated interventions to curb maternal and child mortality.

However, the situation changed after the Second World War. Population growth became one of the main concerns at the international level. The neo-Malthusian view that population growth is a cause of poverty influenced fertility control (Richey 2008a). The poor were blamed for their poverty, which was attributed to uncontrolled fertility and they became the main object of surveillance for their own good, their nations and the world. It was feared that if left out of control, population growth in developing countries would drain world resources (Ahlburg 1996). Just as Foucault (1977) explains, when the population became a concern of governance in Europe in the 18th century, its numerical variables became a problem and an object of surveillance. Population growth in developing countries became a problem. International organizations such as the United States for International Development (USAID) and The World Bank provided financial support to control fertility (Richey 2008a).

Despite several criticisms that were raised against the Neo-Malthusian model (see, for example, Mamdani 1976; Myers and Simon 1984), in development discourses, population growth is still linked to poverty and underdevelopment (Ahlburg 1996; Sinding 2009). In Tanzania, family

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[42] Being under the Catholic Church, Mshikamano Hospital did not provide modern family planning services since the Catholic Church is against modern family planning methods.

planning services were first introduced in 1959 under *Chama cha Uzazi na Malezi BoraTanzania* (UMATI) and they were officially merged with maternal and child health services in 1974[43]. Yet, it was not until 1987 following launch of the Safe Motherhood initiative that family planning gained particular importance for the reduction of maternal mortality at the international level (Chola et al. 2015). At that time, international and national organizations that were interested in maternal health and population control expanded provision of family planning services (Richey 2008a). Reduction of maternal mortality became one of the most important indicators of the improved quality of life, intrinsically linked to development (ibid.).

While in the broader development discourses family planning is envisioned in terms of population control, its primacy in maternal health interventions is on the potential to reduce maternal mortality in the sense that not all pregnancies result in the birth of a child but all pregnancies increase the risk of maternal death (WHO 1998). Frequent pregnancies even when they do not result in the birth of living children, weaken the uterus and increase the chances of maternal deaths (Prata et al. 2010: 315). Family planning is also identified as being important in avoiding unwanted pregnancies (Starrs 1997: 51). This connection to the reduction of maternal mortality has made family planning services female inclined with antenatal care, postnatal care and routine monthly clinic checkups for children being important venues for reaching women. The focus on long-term methods for the reduction of maternal mortality has further made women the main target of family planning services.

According to Nurse Lucia with whom I had a long conversation about family planning, healthcare providers encouraged women to use long-term family planning methods because such methods ensured that women were protected against conception and could get pregnant only when they wanted:

> Now we tell women about long-term methods because they are reliable. They are not like pills that a mother can forget to take or injection, she can easily forget the return date for another injection (...). It is not that these other methods (referring to pills and injections) are not good but because they need memory and women may sometimes forget. Thus, it is the reason we call them short-term methods because women can use them for a short

[43] For more information about the politics of population control in Tanzania see Richey 2008a.

> time. Now if a woman wants to protect herself, let's say, maybe for four years, it is very difficult to take pills or get injections for all four years. But if it is just for a year then it is okay she can take pills or even use injection and other shortterm methods like condoms. However, for long-term, once a woman has the implanon or the IUD it reduces disturbances of taking pills or being injected. Moreover, women can request for their removal when they are ready to get pregnant (IDI, Nurse Lucia, Umoja Regional Hospital).

Although Nurse Lucia framed the explanation in terms of practical reasons and convenience to women, the promotion of long-term family planning methods mirrored the efforts to gain more control over women's fertility. The emphasis on long-term family planning methods is stated clearly in the 2016-2020 national roadmap strategic plan to improve reproductive, newborn and adolescent health in Tanzania (URT 2015a). Generally, the intention is to increase the use of family planning services from 27 percent to 45 percent by the year 2020 (URT 2016: 25). In the strategic plan, adolescent girls are brought under the surveillance of modern family planning due to the persistence of high incidences of teenage pregnancies in the country (URT 2015a: 11-12). Dodoma Region in particular, with the rate of 39 percent ranks third among regions with high teenage pregnancy rate (URT 2016: 111). The ealthcare providers said they were allowed to provide family planning services to adolescent girls from 14 years without consent from their parents or guardians.

Ideally, according to the national guidelines on family planning, healthcare providers were supposed to tell women about all family planning methods including natural methods like the calendar rhythm, periodic abstinence, lactational amenorrhea and withdrawal/pulling out (URT 2013). Moreover, healthcare providers are required to guide women to make informed choice of the methods they would prefer to use (ibid.). However, as I noted, natural family planning methods were rarely mentioned. This could be because of the need to meet the target of increasing the use of modern family planning methods. Also, the healthcare providers mentioned that natural methods of family planning were unreliable and hard to adhere to. Furthermore, I was told by my interlocutors that the healthcare providers who managed to convince women to use long-term family planning methods during outreach services by the Population Service International (PSI-Tanzania), were given some money as an incentive. Women who agreed to use the long-term methods were presented with *khanga.* Along with the PSI-Tanzania, the government via Kondoa

District Hospital and Marie Stopes Tanzania, provided long-term methods through outreach services. Village dispensaries provided only pills, injections, and condoms.

Men were encouraged to allow their partners to use modern family planning methods and accompany them to the clinic to get family planning services. Women too, since they had the opportunity to get the lessons during clinic visits, were encouraged to let their husbands know about their intentions of using modern family planning methods. I observed that after women consented to use modern family planning methods, they were presented with a consent form to sign and the healthcare providers urged them if convenient[44], to let their husbands know that they were using a family planning method. Posters about family planning in health facilities also expressed the truth that the healthcare providers talked about (see also URT 2013: 16). I grouped the truths about family planning in three categories, biomedical, social and moral truth.

First, women were told about the safety of the methods to address what the healthcare providers referred to as misconceptions about family planning, which affected the acceptance and utilization of modern family planning (see also Muanda et al. 2017; Richey 2004). Women expressed concerns on side effects of modern family planning methods (mostly learnt from experiences of other women they knew) such as the adverse impacts on fertility, unease and sick feelings as well as the fear that using the methods may cause cancer or death. The healthcare providers assured women that the methods were safe. They explained to them that although conception may not happen soon after the discontinuation of using a particular method, they did not cause infertility or cancer. Regarding the unease and sick feelings healthcare providers told women those were temporary and would disappear after a short time. The healthcare providers described the sick feelings as minor inconveniences (*maudhi madogo madogo*). Some of my interlocutors were using family planning pills and they said that they felt nausea, dizziness, headache and lack of sexual desire.

The second group of truth explained the advantages women would get from using modern family planning methods. The healthcare providers told women that they would have enough time to

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[44] This is because most men in Lalta were against the use of modern family planning methods.

breastfeed their babies without worrying of getting pregnant and would have a manageable number of children that they could be able to provide with necessary needs, especially education. The emphasis was on the quality and not the quantity of children. Furthermore, the healthcare providers said women would have enough time to look after themselves and their husbands, work as well as contribute to the family income compared to when they gave birth frequently.

The third was the (sexual) moral truth. The use of modern family planning methods was "normalized" for teenage girls as Nurse Lucia mentioned during the interview; "(…) to use family planning is not prostitution (*kutumia uzazi wa mpango sio umalaya*) but a way of protecting girls who face sexual pressures of adolescence." The use of family planning, in this case was advocated not as a way of encouraging girls to engage in sexual relations but protecting themselves from pregnancy which may eventually result in maternal deaths whose rate was high among teenage girls (UNICEF 2011).

These truths about family planning can be understood in terms of what Foucault (1988: 17) calls "truth games." Foucault claimed that over the 25 years of his academic career, his main concern was to sketch out a history of different ways that humans develop knowledge about themselves (ibid: 18). The main point he argues, is not to accept this knowledge at face value but "to analyze these so-called sciences as very specific truth games related to specific techniques that human beings use to understand themselves" (Foucault 1988: 18). With specific techniques, Foucault refers to technologies of power and technologies of the self, which were his main concerns in governing individuals in accordance to games of truth. Whereas the standardized truths and technologies of the self to govern individuals to use modern family planning methods are defined by global health actors, it is free individuals within specific networks of practices of power who speak the truth about family planning (cf. Dilger 2012). As Rabinow and Rose (2003) show, tactics and strategies that are used to determine the truth differ depending on place and time in which one lives. It means that individuals in particular historical time and context can escape from the standardized games of truth by playing the game differently. What matters then is not the standardized truth or the relative truth but governmentality of individuals to allow domination, reactions of the individuals and forms of knowledge that arise in the process.

The globalized games of truth about family planning were geared to govern fertility by enabling women to make rational choices to use family planning and for men to support their partners. The intention was to reduce chances to maternal deaths and enhance socio-economic improvements for individuals and families. To express the truth about modern family planning, sometimes the healthcare providers demonstrated themselves as examples. For instance, during one of the antenatal care sessions at Upendo Dispensary, Nurse Vivian who had two teenage sons in a private secondary school in Dodoma City, said:

> You all know I have two children. Do you think I do not like having many children like you? What will I feed them? How will I send them to school? I want my children to have good life that is why I decided to have only two and this is my twelfth year that I'm using IUD. Have you ever seen me sick? (referring to getting sick from the IUD). Have you ever seen me pregnant? I can even take care of myself well. Otherwise, I would be attending you here while smelling milk (*ningekua nawahudumia hapa huku nanuka maziwa*).

Rather than forcing women to use family planning through the use of technologies of power as Van Hollen (2003: 153) shows in the case of India, both women and men were governed to support and use modern family planning methods through technologies of the self embedded in the standardized games of truth about modern family planning. On the other hand, women and men who did not abide by the truth were despised. Without articulating historical and cultural contextual realities that determined the readiness of women and men to abide by the standardized truths, the healthcare providers labeled women and men who refused to use family planning as ignorant and careless about their own health and that of their children. For example, in the quoted statement, Nurse Vivian tried to rationalize with women about her own use of a modern family planning method and the limited number of children she had. There is no doubt that family planning helped Nurse Vivian to limit the number of children. However, although Nurse Vivian and the women were in the same place and time, they shared different socio-economic and cultural domains that made them see family planning from different perspectives. It is the cultural context that women as well as men experienced and made sense of family planning that I now turn to.

4.3 (In)Fertility, Marriage and Children

When I talked to the healthcare providers about family planning, the discussion revolved around limitation of fertility for the physiological, social and economic well-being of women, men and children. My discussions with women and men revealed that rather than limiting fertility, enhancement of fertility was desired. Fertility was connected to the well-being of the land and society at large. The discussions brought me to women and men's concerns about fertility and infertility (*kukosa uzazi/ugumba/utasa*), marriage and children with contextualized views that contradicted the rationality expressed by the health care providers about family planning. Observations and interviews revealed different ways in which individuals may play different games of truth that bring to light relevant processes for uncovering the truth in particular contexts.

The manner in which women and men in Lalta made sense of (in)fertility challenged the universal rationalization of modern family planning that limiting the number of children and pregnancies would lead to improved socio-economic conditions and reduce maternal mortality. Notwithstanding the acknowledgement of the role of family planning in reducing maternal mortality (Starrs 1997), in Sub-Saharan Africa, fertility rate is persistently high and so is maternal mortality. Some scholars predicted that with the increasing socio-economic improvements, Sub-Saharan Africa would start experiencing fertility decline (see, for example, Caldwell and Caldwell 1987) but that does seem not to be the case. Paradoxically, while other parts of the developing countries note a decline in fertility rate, Sub-Saharan Africa does not. Together with delineating the cultural context in which family planning is experienced and understood, the discussion provides some insights to the said paradoxical situation.

4.3.1 "If They Have Seen the Menstrual Blood, They Are Not Young Anymore:" Becoming a Woman

In analyzing about the place of the moon and the sun in the Sandawe religion and rituals, Raa (1969) and Lim (2010) show that the moon is associated with the annual fertility cycle of the area and the lunar cycle is associated with the menstrual cycle of a woman. The moon, which is feminine is described as fertile and gives birth to large numbers of children. However, the moon cannot have children on her own, she needs the power from the sun (which is characterized as

masculine) to procreate. The role of the sun and the moon in the creation of life among the Sandawe mirrors sexual relations between men and women for the purpose of procreation (Raa 1969: 23). Like the land which is expected to produce enough food for the people, women in Usandwe are expected to give birth to many children (Lim 2010).

My interlocutors expressed the connection between the menstrual period (*siku za mwezini*), women's fertility and the ability of the land to produce crops. The importance of a woman's fertility began with the onset of menstruation that was also expressed as an important indicator of transition from childhood to womanhood (cf. Ussher 1989). Until the recent past, the onset of menstruation was celebrated with the female circumcision ritual[45]. Most of my interlocutors admitted to being circumcised, a practice that is now prohibited (for young women under 18 years) under the Sexual Offense Special Provision Act of 1998. However, at the time of my research, female circumcision[46] was still practiced. To avoid being caught, some parents circumcised their daughters while young, mostly before the first birthday. They believed that uncircumcised women had a higher sexual drive than that of men and could easily be tempted to premarital and extramarital sex.

Some of the men I interviewed expressed their hesitation to marrying uncircumcised women for the fear that it would be difficult to satisfy their sexual needs as Justin, a 30-year-old married man, expressed:

> For me, marrying an uncircumcised girl was not an option and my father was adamant that I find a woman who is circumcised because the uncircumcised women can sleep with anyone even after being married. Now I see others do not care if a woman is circumcised or not, they just marry (....). Even if I would be given a chance to marry today, I do not know but I think I would look for a woman who is circumcised (IDI, Justin, Wairo Village).

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[45] The form of circumcision practiced among the Sandawe is clitoridectomy which involves a total removal of the clitoris (Bingi 2007).

[46] A healthcare provider narrated a case of a mother who was arrested in November 2014 for circumcising a 2-yearold old baby and it was discovered when she brought the baby for a monthly clinic checkup. Cases of female circumcision in Dodoma Region are still high among the Wagogo and the Sandawe. For more information about female circumcision among Sandawe see Bingi (2007).

Such strict stance to marrying circumcised girls was fading away locally as some men were willing to marry uncircumcised young women. However, some of my female interlocutors still praised female circumcision. They said it gave young women respect and a grown-up feeling. Hidaya, a 38-year-old married woman recalled how she felt after being circumcised in the1987:

> I remember when I was circumcised, we gathered together, we were three, we had all seen our days (referring to menstrual period) that month. We knew what was going to happen. Thus, we had to be brave. (…). One grandmother (*Bibi*) circumcised us at her house... but she is no more. Before being circumcised we stayed with her for six days. (…). She was teaching us about taking care of our ourselves during our (menstrual) days and things of grown up people (*mambo ya watu wazima*). We were circumcised in the morning of the 7th day. Thereafter, I felt that I was really changed, not young anymore. (...). It hurts very much but I do not know how to explain it to you, it is good pain, I do not know if you understand me. If you do not cry your mother and other women give you many presents, it was truly a good feeling (IDI, Hidaya, Magambua Village).

Female circumcision also provided an opportunity for young women to learn about taking care of themselves during the menstrual days, the dangers of premarital sex, and preparation for becoming good wives as well as mothers. Being able to tolerate the pain of circumcision signified the ability to tolerate the labor pain during childbirth, an important feeling of transition to womanhood. The teachings of how to take care of the menstrual blood were very important during the circumcision rituals. The menstrual blood was believed to have magical powers that could attract evil forces, which could cause infertility. Given that circumcision was practiced in secret and on young children, the teachings about taking care of the menstrual blood had become the responsibility of mothers and other older female relatives. The association of the exposed menstrual blood with evil forces was emphasized in the teachings as Mama Askari, a 56-year-old TBA in Magambua Village explained:

> (...) that blood is very dangerous if you let other people see it, especially witches. We are teaching girls to wash well pieces of clothes they use during their (menstrual) days because when you throw such piece of cloth in the open, at night it shines like a lamp and witches can see it. If they get hold of it, you may be unable to have children because they will be using it in their bewitching activities (...). When someone wants to make you *nsataa* (barren, in Sandawe) may look for the piece of cloth you use during your days and take it to a traditional healer (IDI, Mama Askari, TBA, Magambua Village).

Menstrual blood was a mark of fertility, which was celebrated and a threat to fertility if not taken care of properly. Similarly, being respectful in terms of refraining from sexual relations was

stressed to avoid the loss of virginity, premarital pregnancy and infertility. Getting pregnant and losing virginity before marriage was a dishonor to a young woman and her family and especially to a young woman's mother who would be blamed for failing to teach her daughter good behavior. In the past, a mother whose daughter would be married a virgin was presented with a cow for the good work of taking care of her daughter. Once a young woman had spent the first nuptial night with her husband and was to be found a virgin, a calabash filled with maize flower was sent to her mother and the mother would expect to get a cow within seven days. If the young woman was not a virgin, an empty calabash symbolizing shame was sent to a young woman's family. Although calabashes were no longer exchanged during the time of my research, indicating a declined importance attached to virginity upon marriage, premarital pregnancy was still feared. The fear of premarital pregnancy was felt more than it was in the past because after completing standard seven young women were selected to join secondary school instead of being betrothed and married.

Furthermore, my interlocutors expressed that when a young woman is involved in premarital sex even when it does not result in a pregnancy can cause infertility. Sexual intercourse especially with different men it was believed could push the cervix from its original position and cause infertility. Mothers observed their teenage daughters closely to make sure that they knew when they started menstruating. However, mothers reported that knowing if young women had started menstruating was becoming a challenge because they were taught about menstruation in school. For instance, Martha, a 38-year-old, separated woman with four children said:

> They learn about it (menstruation) in school and if you are not keen enough you will find out she has started (menstruating) a long time ago. These children have hard hearts to hide such things; we could not do that in our days. Many mothers complain that their daughters do not say because they are taught in school, so they think they know everything (...). These days we do not wait for them to tell us we ask them, and we warn them about playing with boys (referring to sexual intercourse). (IDI, Martha, Magambua Village).

When I talked to Teacher Victoria Mshana, she said the rate of teenage pregnancy in Lalta Secondary School was alarming. She estimated that each year about ten young women were expelled from the school due to pregnancy. In 2014, seven young women were expelled. An important thing to note at such alarming rates of teenage pregnancies is that most parents saw it

as a problem so long as the man responsible did not acknowledge responsibility for the pregnancy and marry the young woman. The problem was that sometimes young women were impregnated by young men who were not ready to marry, or men who impregnate them did not acknowledge responsibility and sometimes they ran away for the fear of being jailed for impregnating a school girl.

When I tried to inquire if women associated teenage pregnancy with maternal mortality, the general impression I got is that age was not an issue of concern. Most of my interlocutors reported to have been married at the age of between 16 and 18 years. Some of them considered 23 years a late age to get married. Even the nine teenagers I interviewed did not associate themselves with high chances of maternal death. During one of my interviews with Imelda, a 33-year-old married woman and a mother of four children, I asked about early marriage and pregnancy. She said:

> They are children yes, they are taken care of by their parents but if they have seen the menstrual blood, they are not young anymore. (...). If one can sleep with a man and get pregnant, she cannot be young. She is ready to get married, that one you cannot say she is young like a girl who does not know men (IDI, Imelda Ilasee Village).

Being young was socially and biologically defined, less in terms a specific of age than the ability to become pregnant. However, this does not mean men and women in Lalta did not care about maternal deaths. Instead, the truth about age and maternal death was not interpreted in the similar way as the biomedical maternal healthcare services suggested.

Moreover, although parents were worried about their daughters getting pregnant before marriage, they perceived the use of family planning as encouraging premarital sexual relationships by eliminating the fear of getting pregnant. Rehema, a 35-year old married woman who had five children including a 15-year-old daughter, objected the use of modern family planning methods as solution to teenage pregnancy. She had this to say:

> I cannot let my daughter use family planning. It will be like I tell her that 'go and do the bad habit (referring to sexual intercourse), there is no problem you will not get pregnant.' I do not think that there is a parent who can let her child use family planning. It will be teaching the child bad habit. For sure I cannot, I cannot! (IDI, Rehema, Magambua Village).

The government of Tanzania allows teenage girls to be provided with modern family planning methods without the consent from their parents, an approach which seems to be working in urban areas where youth friendly services are established and are highly supported by NGOs (Sambaiga 2013). However, the healthcare providers at the two village dispensaries reported that teenage girls were not showing up for family planning services. The three unmarried young women who were among my interlocutors were aware of modern family planning methods but did not consider using at the time.

4.3.2 Achieving a Complete State of Womanhood: Marriage and Childbirth

Whereas the onset of menstrual blood was the sign that a young woman had moved from childhood to womanhood, the transition was incomplete. Being married, the ability to get pregnant and give birth were perceived to be important in the transition to a complete state of womanhood. Getting pregnant and giving birth when married was cherished and celebrated. Those who got pregnant and gave birth before marriage acquired a womanhood status because they experienced the labor pain, but they were less respected. Hilda, a 26-year-old married mother of two who was expecting her third child, expressed the significance of the labor pain in the transition to womanhood. She stated, "If you have not experienced labor pain you are not a woman yet." (*kama hujasikia uchungu hujawa mwanake bado*). Hilda's statement was also expressed by other women who mentioned that going through labor was a transformative process; "When you push, you feel that you have done the job. You feel different. It is really a different experience," expressed Miriam during an in-depth interview.

While the two statements point to transformation of the self (in a phenomenological sense) inherent in the process of giving birth, having children also changed the social status of a woman. Those who were married and had many children were called *haboosa ghawee* (literally meaning a mother of many children). In the past it was a must for a husband to give a cow to his wife if she gave birth to more than seven living children because she gave her husband respect in eyes of other men. If the husband would not give a cow to his wife, the wife's relatives would take the woman until the husband paid the cow as a token of thanks to his wife. I was told by my interlocutors that it was usual to find a woman with up to fifteen living children. While women were no longer rewarded for having many children, they still preferred to have many children.

One of my interlocutors, a 40-year-old married woman had her fourteenth living child in May 2015. Many others mentioned seven as the ideal number of children they would like to have.

In indicating the social status of womanhood and motherhood, a woman with a child or children was addressed by the name of her first child. In informal conversations it was disrespectful to address a woman with a child by her given name. A woman who had given birth to twins, even when she had other children, she was addressed as *Pasaa Iyoo* (a mother of twins). Unlike in other societies such as the Komo of Nigeria where the birth of twins is despised as a bad omen (Ball and Hill 1996), among the Sandawe, twins are a symbol of a woman's great fertility which is cherished and honored (cf. Lim 2010). One of the healthcare providers who was a twin recalled vividly the celebration when her mother gave birth to a second set of twins:

> I remember I was in standard five (2002) when my mother got twins again. Everyone who arrived to see our mother before greetings danced and made noises of joy (*vigelegele*). They carried a lot of food and gifts. We did not miss meat. Sometimes people brought goat's meat or lamb's meat. There was plenty of food and it went like that for two months, just because my mother had given birth to twins for the second time (IDI, a Healthcare Provider, Magambua Village).

The birth of twins among the Sandawe has particular importance in association with fertility of the land (cf. Lim 2010; Raa 1981). After the birth of twins, a ritual (*iyari*) that connects the woman's fertility and that of the land is performed. In performing *iyari*, the parents of the twins sit on a bed, with the mother and the twins on the left of the bed, and a mother's brother sitting with the father of the twins on the right. The mother is also accompanied by her sister-in-law. A goat or sheep is slaughtered and the intestines are taken out. Then, the brother of the mother climbs on the rooftop with two cooking pots and a knife. He makes a hole on the rooftop leading to the room where the parents are seated. In addition, he makes holes on the pots and passes through the intestines which the parents roll around their necks. Women dressed in black clothes (*kaniki*) from the waist down go inside and performed a ritual dance allowed only for women with children. Thereafter, the parents rub soot on their faces and bodies. Soot is used because they believe that blackness keeps lightning away, which may strike the twins and their mother. The ritual is associated with encouraging the rain and lightning stands in opposition to the rain (Lim 2010: 104). Throughout their lives, the twins and their mothers, regardless of where they

are, in times of rain they must have soot or charcoal to rub on their foreheads to protect themselves from lightning.

After the ritual dance, the next step is to take the pots to a *leba* tree, which is a special tree dedicated to twins. The tree has great capacity of sustaining drought and stays green throughout the year. It symbolizes fruitfulness of the land and therefore, is not supposed to be cut even when clearing land for farming or settlement. The pots are placed upside down under the *leb*a tree and it is the duty of the mother as well as the twins to take care of the tree throughout their lives. If the twins die after birth, a ritual is performed, and the mother is supposed to take care of the tree. Each set of twins must have their own *leba* tree, it should not be share. After the ritual is over, food is prepared and liquor is served for celebration.

In times of drought, women with children perform a ritual dance under a *leba* tree requesting for rain. In 2014, for example, women in Manantu Village performed a ritual under a *leba* tree because the rain had delayed. One of my informants, Maria a 26-year-old married woman and a mother of three who participated in the ritual dance narrated its effectiveness:

> Last year, the rains delayed. As women, we decided to perform a ritual. In the morning, we went to the *leba* tree down there (showing me the direction they went to). We danced and sang around the tree asking for rain. You cannot believe, that very night it rained heavily. We just did not get good harvests because the rain did not last but it rained (IDI, Maria, Manantu Village).

While limiting fertility was a priority for biomedical maternal healthcare interventions, the Sandawe's ideas revolved around protection of fertility before marriage and encouraging it after marriage. Central to the protection of fertility was the limitation of premarital and extramarital sexual relationships. Particularly, women had to stay faithful to their husbands and female circumcision was practiced to limit women's sexual desire. The expressed danger of infertility due to premarital or extramarital sexual relations and shaming of premarital pregnancy served the purpose of controlling women's sexual practices. Although this did not work perfectly as evidenced by the high rate of teenage pregnancy, resistance to family planning stemmed from concerns that it would encourage young women to engage in sexual practices by eliminating the fear of premarital pregnancy. Both the state's health interventions and the people were concerned about teenage pregnancy but had different ideas on how to address the problem.

Figure 4.1: Pots under a *leba* tree (Photo by Anitha Tingira 2015).

4.3.3 The Dilemma of Infertility, Treatment Searching and Gendered Trajectories of Blame

While getting pregnant before marriage was despised, failure to get pregnant after marriage was feared and women desperately looked for solutions whenever infertility was suspected. Women who failed to get pregnant in marriage faced many problems at personal level as well as at family and the community levels (cf. Inhorn 1994; Sundby 1997). Allen (2004: 10) shows that biomedical maternal healthcare interventions address mainly what she calls "dangers of motherhood," which have implication for maternal mortality rather than "dangers to motherhood." Fertility control measures in this sense addressed dangers of fertility rather than dangers to fertility that women were more concerned about.

The primary purpose of marriage among the Sandawe was to have children and women were expected to conceive within the first year of marriage. The failure to become pregnant was blamed on women (cf. van Balen and Inhorn 2002). From the interviews I had with men, they admitted that it could happen for a man to be infertile but such cases were very rare, that is why the blame and the burden of searching for fertility treatments fell on women. This, as Inhorn (1994: 2) notes, is because infertility is often connected to women's bodies, and although men's infertility can be admitted in theory, it does not mean it is accepted in practice.

Among the Sandawe, the importance of a woman to give birth after marriage was related to more than the transition to womanhood and social status. Children gave a married woman a sense of belonging to her husband's lineage and those who gave birth to many children, especially male children, were praised for expanding their husbands' clans. My interlocutors expressed that a woman without children was connected to her husband through sexual intercourse but not to his family or clan because her blood and that of her husband's family are not connected (*damu hazijaungana*). This important aspect of childbirth for women became obvious when I visited one of the TBAs in Wairo Village. Saumu, the TBA's daughter who was 29 years old at the time, faced primary infertility for six years and had recently given birth. When I visited the TBA, Saumu had just returned from Umoja Regional Hospital where she went for childbirth and was taken care of by her mother. I noticed that she was so excited to give birth especially to a baby boy. To learn more, I channeled our conversation towards Saumu's infertility experience. She was excited because giving birth had finally connected her to her husband's clan. Saumu explained:

> When you have not given birth, you are really disrespected and for us the Sandawe, when you are married you are connected to your husband but when you give birth, your blood connects to your husband's clan. For example, before I got pregnant, my fatherin-law was very displeased with me. He did not reply to my greetings. He said I had not born them a relative (*sijawazalia ndugu*), thus, I was useless to them. (...). When I became pregnant, he started accepting my greetings because my blood was going to connect with theirs. Now I have given birth to a boy; their relative. He (the father-inlaw) came yesterday to see the baby! (IDI, Saumu, Wairo Village).

For Saumu, the birth of the child gave her a sense of belonging to her husband's family and earned her respect and acceptance by her father-in-law and her husband's relatives. The situation was different for my other informant, Mama Kevin, a 33-year-old separated woman who faced secondary infertility. Narrating her experience, she said when she got married:

> The first pregnancy was really easy to get. It was like touch and get stuck, but the problem came when I started looking for the second pregnancy. My first child was almost two years old. I tried all means you know; I went to the hospital but there was nothing. They told me they did not see any problem. My menses were just normal, but I was not getting pregnant. My husband was calm for the first two years but in the third year, he started accusing me of cheating and sometimes he said I used family planning secretly that is why I could not get pregnant. His relatives also started talking. There were really many acquisitions. I was devastated. When he started sleeping with other women, he was

> beating me almost every day. I saw that it was enough. I was not barren I had a child. So, I moved to Arusha. I worked in a women's salon for nearly three years until I was able to start my own small salon plaiting women's hair. Then I met another man in 2011. I decided I would try again to look for some medicine and I went to mount Meru Hospital. They told me my hormones were not balanced. They gave me some medicines but they did not work. My friend took me to alternative medicine (*tiba mbadala*) and I started using their medicine for six months and now you see me, I am pregnant (IDI, Mama Kevin, Magambua Village).

Although the birth of her first child had already connected Mama Kevin to her husband's family, the mistreatment she got after the failure to get another pregnancy forced her out of marriage. Saumu had also faced the pressure for separation from her husband's family but when they were looking for fertility treatments, they became born again Christians (*waliokoka*) and Saumu's husband promised he would never leave her.

The blood connection was also important as in case of death of a husband. Following a husband's death, a woman without children would be asked to leave her husband's house and she would not be entitled to inheritance. In case of separation or divorce she could not claim anything from the man. Similarly, a woman without a male child could not be entitled to look after beehives, which were passed over to male children only and they were important inheritance among the Sandawe.

Saumu and Mama Kevin's cases highlight the dilemma of infertility for women and point to treatment seeking. As I mentioned before, infertility among women was attributed to witchcraft and illicit sexual practices. As I talked to women, chronic and persistent urinary tract infections (UTIs), or UTI *sugu*[47] as women called it, was also mentioned to be the cause of infertility. All three of my informants with whom I had detailed discussions about their infertility experiences distanced themselves from illicit sexual practices as being the cause of their infertility due to its moral implications. Instead, UTI *sugu,* whose symptoms were mentioned to be similar to those of the uterus being pushed inside due to illicit sexual relations, was suspected to be the cause. The UTI *sugu* symptoms they mentioned included fever, back pain, pain under umbilicus and pain during urination.

[47] Something that is very hard to get rid of.

As we discussed about the source of Saumu's infertility, it was evident that there was no particular cause that they were certain about and so, different treatments were sought. The TBA was, however, keen to note that illicit sexual practice was not considered but UTI *sugu* was suspected. In the past, Saumu had several urinary tract infections, which were treated at Faraja Dispensary. To further distance Saumu from illicit sexual practices, she claimed that she knew her daughter well that she had good habits. She referred to Saumu as a victim of infertility in which she speculated that someone had done something to her especially after realizing that the delay to get pregnant was abnormal. The normal delay was defined in terms of failure to get pregnant within a year. The TBA expressed that:

> At first, I thought it was just a normal delay. (...). Some get pregnant early, some delay. We are different you know. So, I tried the traditional medicines to help her get pregnant, but they did not work. After almost ten months, I started getting worried. I thought maybe someone had done something (referring to witchcraft) to her. We started looking for treatment. (...). We went for *simbo* and then we started going for healing prayers (*maombi*) but she was treated at Umoja Regional Hospital. They gave her some medicines and after three months, she became pregnant. It was like a miracle l did not believe. I was very happy (IDI, Saumu's mother, TBA, Wairo Village).

UTI *sugu*, they claimed, was the main reason that Saumu went to the hospital. After the tests at Faraja Dispensary, she was told that she had no UTI and the doctor advised her to go to Umoja Regional Hospital to see a gynecologist for further evaluation. At the hospital, it was found out that she had fungal infection which had affected one of her fallopian tubes (*mirija ya uzazi*). Fortunately, the other fallopian tube was still fine. She was given some medicines and after three months she conceived. In one of my conversations with Nyemo, she told me that although women would not admit to experience infertility as the result of illicit sexual practices, several women were seeing her for help. Nyemo used a chicken feather to insert gee into the cervix to pull the uterus to its original position. She then gave women some traditional medicines to take for a period of three months after which they could conceive.

Whereas UTI *sugu* and the displaced uterus could be noted by their symptoms, infertility caused by witchcraft hardly showed any symptoms. In case symptoms showed, it helped women to focus on one form of treatment. Naimani, a 39-year-old married woman who could not get pregnant five years after giving birth to her third child, tried some home remedies and sought help from

the hospital without success. When she started noticing diminished menstrual flows, she was certain that witchcraft was responsible for her infertility. She sought help from a traditional healer and after five months of treatment, she became pregnant. By the time I met her for the first time at Faraja Dispensary, she was six months pregnant and about three months later, she was assisted to give birth by the traditional healer.

This particular traditional healer that Naimani consulted was also referred to me by other women because of her ability to treat infertility. When I got to meet her for an interview, she said she had been working as a traditional healer since 1991. However, she was not ready to tell me the details of the medicines. She claimed that it was a taboo to tell other people about her medicines. She said she inherited her healing skills from her mother and since then she has helped many women to conceive. She explained that although it was difficult to detect witchcraft as a cause of infertility, sometimes signs showed. She said getting too little blood or missing menstrual period were the signs that witches had taken hold of the menstrual cycle. That is why Naimani was certain that witchcraft was responsible for her infertility.

Regarding assisting childbirths, she told me that it was for the safety of the baby and the mother because the one responsible for causing infertility could try to attack the mother during pregnancy or childbirth. In this case, during pregnancy, the woman had to keep seeing the traditional healer for protection. However, she did not stop women from attending the antenatal care clinic but insisted on assisting them during childbirth. The traditional healer only assisted births of women she helped to conceive and did not consider herself as a traditional birth attendant.

In all the three cases, men were not mentioned as being responsible for infertility. For instance, Saumu's husband accompanied Saumu in search for treatment but did not receive any treatment himself. For the other two, men were hardly involved in treatment seeking. Woman's relatives, especially mothers were active in assisting their daughters to look for treatment. On the other hand, women's infertility experiences at the community level were made worse by fellow women who had children. For Mama Kevin and Naimani who faced secondary infertility, the situation was easier than for Saumu. The other two got pregnant with their first children within the expected time. For Saumu who experienced primary infertility, the label of being infertile seemed

to stick with her even after she had a child. During one of our meetings, two months after she had given birth, she said that other women still ridiculed her. She explained:

> Until now when I take the baby to the clinic, they laugh at me. (...). Yes! My fellow women laugh at me and they say ah! Even old people give birth these days, but I do not care, let them laugh I have my baby, and I am happy that I am a mother too. One day when they will see me getting another baby and another baby, they will stop talking (IDI, Saumu, Wairo Village).

The Sandawe, as I have already explained associated menstrual blood with the ability to get pregnant. They also associated the end of menstruation with old age. Therefore, giving birth at a young age was desired. However, despite her age, Saumu believed that with the help of God she would still get many children even though some other women called her old.

When I myself caught a urinary tract infection and sought treatment from Faraja Dispensary, I had an opportunity to discuss with Doctor Busara about UTI *sugu* that women had identified as the cause of infertility. According to Doctor Busara, UTI was a big problem in Lalta affecting mostly women. He explained to me that:

> You know here, the most troubling problems are typhoid and UTIs because of the water problem. We have a big problem of water and the water sources are unsafe. It is easy for women to get infected rather than men because of the physiological makeup. When we started providing (health) services, many women were found to have UTI and they were treated. Now when they (women) get sick, they come here and they say they have UTI. When we run the tests, we may find it is true they have UTI and sometimes we find it is gonorrhea or syphilis and sometimes fungus. Sandawe know a lot of herbs and they try to treat even sexually transmitted diseases themselves. Sometimes women come here when they have already developed pelvic inflammation which can easily lead to infertility (IDI, Doctor Busara, Magambua Village).

Connecting UTI *sugu* to infertility marked a shift in epidemiological explanation on the causes of infertility, which opened doors to seek for help from biomedical facilities. It is important to note this epidemiological conceptualization of UTI. According to Dr. Busara, women sought treatment for UTI and not sexually transmitted diseases (STDs). When they were found having STDs, before receiving treatment, they had to bring their sexual partner(s). The important thing was that it opened doors for men to go to health facilities although not as primary seekers of treatment. In biomedical maternal healthcare interventions, sexually transmitted diseases (STDs)

were tested and treated among pregnant couples but those who sought to get pregnant were not covered by the interventions.

As a result of seeking fertility treatment from health facilities, some men were gradually considering the possibility of being the source of infertility. One day in July 2015, a woman and her husband came to Faraja Dispensary seeking for the sperm analysis service after the tests in Kondoa District Hospital indicated that there was not any dictatable problem on the woman. When I approached the woman and tried to talk to her, she was open and told me they had been married for four years but she had not been able to get pregnant. After seeking many different treatment options, the doctor in Kondoa advised her husband to undergo the sperm analysis test. The advice was given in December 2014, and finally he agreed to do it on that day. Commenting on the man's step, Dickson admitted had he been in a similar situation, it would be very difficult for him to undergo the test. I did not get to meet the couple after that day as they came from another ward, but the man's willingness to undergo the sperm analysis test was an indicator that men can also accept that they can have fertility problems and seek treatment. I cannot claim that men's willingness to test will lessen the blame on women in Usandawe but points to another trajectory of blame on men too.

In my discussions with men, male fertility was described in terms of impotence (*uhanithi*), which was said to be a result of a navel string falling on an infant's penis. Attribution of men's infertility to impotence put men who could have sexual intercourse and ejaculate out of the blame. While most of my interlocutors pointed to two particular men in Lalta who were not married due to what they claimed to be impotence, the idea that men could be infertile even when sexually functional was challenged during a focus group discussion with men. One of the informants making things clear explained:

> For us Sandawe, it is very difficult for a man to be infertile. Since I was born, I only know two men who have no children and they are not married because they cannot sleep with women. (...). I will tell you why it is difficult. When a male child is born, seven days after birth, when the navel string falls, the uncles take the baby into the bushes and they observe him urinate to see if his thing (referring to the baby's penis) is strong. After seeing that the baby is fine, he is returned home and he is given a name. When the boy reaches puberty, the uncles take him again to the bush (...). This is done in a group of boys in puberty, they are circumcised, and then, the uncles inspect if they can erect. Then, they

> are given bows and arrows ready to learn ways of grownup men. If a boy has a problem, the uncles will know from very early and there is nothing that can be done. They stay like that for the rest of their lives and they do not marry (FGD2, Male, Magambua Village).

To prevent the navel string from falling on an infant's penis, women tied and watched it closely until it detached. If a man faced impotence when he was grown up, it was associated with witchcraft. In this case, there was a possibility of blaming the wife if the man was married and had no multiple sexual partners. A woman who wanted to have extra marital affairs took to a traditional healer the piece of cloth used to clean a man's semen after sexual intercourse in order to disable him from performing sexual intercourse. Men with multiple sexual partners could not be sure who was responsible. Nonetheless, when it happened, traditional healers could resolve the problem and restore a man's erectile function. In such cases, women were blamed for being the causes of harm rather than men's promiscuous behavior.

The Sandawe's knowledge, experiences and practices related to fertility and infertility show different games of truth through which they made sense of (in)fertility, sexual practices, gender relations, and the moral world at large. Browner (2000: 774) points out that, women become pregnant in a specific network of social arrangements which shape how sexuality and reproduction are experienced. Such social arrangements can be supportive or antagonistic (ibid.). Family planning services promoted a different kind of social arrangement that contradicted the way in which the Sandawe understood their world. In biomedical terms, high fertility rate was a risk factor to maternal deaths but for the Sandawe it was celebrated, protected and encouraged. This does not mean men and women in Lalta did not care about maternal deaths, but they believed a different truth which explains their rationality of resisting the use of modern family planning methods.

An outreach service to provide long-term family planning methods in Magambua Village stirred my discussions with women to the direction that highlighted further the cultural context in which family planning was resisted. As scholars have increasingly argued, rather than focusing on preexisting cultural practices and how reproductive practices reflect socio-cultural systems, anthropologists can highly benefit from viewing reproduction itself as a key sight for understanding the ways in which people re-conceptualize and re-organize the world they live in (Ginsburg and Rapp 1995; Davis-Floyd and Sargent 1992). The outreach service to provide long-

term family planning methods served as a catalyst to show the different ways fertility was connected to the ongoing moral, social, and economic changes in ways that are informative for biomedical maternal healthcare interventions. Women's responses to the use of modern family planning methods showed that the ways in which individuals (re)conceptualize their lives in the ever changing world hold the key to understanding the reasons some forms of knowledge are appropriated, while others are modified or even resisted despite the rationality embedded in the technologies of the self promoted by the national states and global actors.

4.4 An Outreach Service for Long-term Family Planning Methods

During one of the children's clinic sessions at Faraja Dispensary, it was announced that there would be visitors on the 12th May 2015, who would provide long-term family planning methods. The nurse asked those who had attended to send the message to others to come on the said date. In the following two weeks, the announcement was repeated to make sure the message was sent. The same was done at Upendo Dispensary. On the said date, Marie Stopes' nurses came to Faraja Dispensary. Nurse Vivian and Zaina from Upendo Dispensary were also present. Dada Juliana introduced me to the visitors. Several women had arrived and others were still coming. Dada Juliana opened the session at around 10:15 am by introducing the visitors. She said they were nurses of Marie Stopes from Kondoa District and they would be providing long-term family planning methods. Women were urged to listen to them attentively. She then welcomed one of the nurses to talk to women about the methods.

Holding the IUD and the implanon, the nurse asked if women knew about those things. The general answer was, "no," but I could hear some who answered "yes." The nurse said she would teach them about long-term family planning methods. She identified the two methods as IUD and implanon. She explained that the two methods would help women to plan their families by getting the number of children they wanted and avoid unwanted pregnancies. She then demonstrated how each method worked and its duration. She said the implanon, which is inserted on the upper arm, above the elbow could prevent pregnancy for three years. The IUD which is inserted in the uterus could prevent pregnancy for seven years and could be inserted even during the menstrual period.

Furthermore, she emphasized on safety and advantages of the methods. She said the IUD was a non-hormonal method that was suitable for overweight women and those with blood pressure. She also mentioned what she called “minor inconveniences” (*maudhi madogo madogo*) that women may experience from using the methods. She said the IUD could cause minor pelvic cramps, spotting or irregular periods while the implanon could cause headache, nausea, breast tenderness and dizziness. As she wrapped up the lesson, she announced that women who were ready to get the service could be tested for pregnancy right there (they had come with pregnancy test strips) and get the method of choice inserted. She then welcomed questions. Women remained silent for a moment and then one woman raised up her hand. She said she had heard that during sexual intercourse, a man can push the IUD and it can disappear in the stomach. As a result, a woman can get pregnant or it can go up to the heart and cause death. Holding a demonstration of a woman’s reproductive system, the nurse showed once again the place the IUD stays. She assured women that it was a safe method and whatever other people were saying against the method was not right and insisted women to listen to healthcare providers. There were murmurings in the group but I could not figure out what women were saying.

Another woman asked if the methods did not cause cancer. The nurse had talked about that when providing the lesson about the methods. She once again assured women that what they were hearing from other people were “wrong beliefs” (*imani potofu).* The murmurings did not stop and the nurse told them to ask their questions instead of talking among themselves. Another question was about the removal of the methods. The woman was concerned that one of her relatives had the implanon inserted but when she wanted to remove it after two years, she was told that the nurses at Faraja Dispensary did not know how to remove it. She was asked to go to a hospital in Kondoa or Dodoma. She had to look for money for the fare to go to Kondoa Hospital. Above that, she was charged 10,000 Tanzanian Shillings (equivalent to 4 Euros) to remove the implanon. Other women supported her. One of them said; “You put for us without payment but you remove with money.”

Related observations are reported by Richey (2008b: 484-485) who shows that women who used long-term family planning methods had to provide convincing reasons for providers to remove them. The nurse assured her that it was free to remove the methods and soon the nurses at the

village dispensaries would be taught how to remove the implanon and the IUD. After the nurse finished answering the questions, the murmurings continued, indicating that women were dissatisfied but they were not asking more questions. Dada Juliana stood up and told them not to let her down and get the method of their choice. She insisted that having many children was a thing of the past (*mambo ya kizamani*), they could have a few children and take good care of them. The two nurses moved to the checkup room to wait for women, but no women went to get the service. The nurses were disappointed, but it was not something they did not expect. They mentioned that in the other village where they had gone the previous day, only two women showed up for the service. Discussing the situation, the nurses lamented about the lack of education that many children were a problem especially for women because they risked their lives during pregnancy and childbirth and carried the burden of taking care of the children.

4.4.1 "I have not Finished Giving Birth Yet:" Modern Family Planning as A Threat to Fertility

During one of our conversations after the outreach service, Imelda, a 31-year-old married woman with four children, mentioned that she was ready to use family planning. I asked why she did not go for the service and just like Miriam she replied, "I have not finished, I still want two or three children. Once I have them, I can start using but not now." Imelda and several other women I talked to, considered using modern family planning methods after getting the desired number of children. Drawing from her sister's experience, Imelda expressed the use of modern family planning methods as a threat to fertility if a woman still wanted to have more children. She narrated her sister's experience:

For her, it was just like this (referring to an outreach service), during that time it was PSI (Population Service International). They were coming, giving pieces of *khanga* to those who agreed to use the IUD and the implanon. My sister went and put the implanon that they say lasts for three years. Then she was breastfeeding. When her husband started demanding for another child, she went to Umoja Hospital where they took it out, but she did not become pregnant. She waited and even started going to the hospital. They were just telling her to wait. She waited for two years! It caused a lot of trouble in her marriage. I do not want that trouble (IDI, Imelda, Ilasee Village). The concern raised by Imelda was also expressed by other women who drew from

experiences of other women they knew. Rather than dismissing women's concerns as misconceptions, it should be understood that women rationalized the use of family planning methods according to what mattered to them. For instance, to Imelda it was the (emotional) suffering following the failure to get pregnant as expected after using a particular method. Shunning the long-term family planning methods was an act of resistance to effects such methods could have on their bodies and most importantly, to their fertility, which was connected to the marital well-being. After giving birth to the desired number of children, the use of family planning was considered although some were still skeptical regarding the side effects.

However, this does not mean that women did not care about child spacing or all women avoided modern family planning methods. Like in many other African societies, avoiding pregnancy during the breastfeeding period was observed by my interlocutors (see also Bledsoe, 2002; Mbekenga 2013). Women were concerned about getting pregnant while breastfeeding for the fear of *kubemenda.* This is a condition that affects a child whose mother gets pregnant while breastfeeding or sleeps with men other than the child's father. Pregnancy or semen from other men it was believed spoiled the mother's milk and made the child sick. Signs that the child was affected by the condition included frequent diarrhea, weight loss and lack of physical strength. The child's legs became weak such that the child could not walk even when s/he was old enough to start walking.

Kubembenda was shameful for the mother who was perceived as being unable to take a good care of her child and could raise rumors of extramarital sexual relations if it turned out that the woman was not pregnant during the breastfeeding period. Most women considered two years as an ideal time for child spacing and enough for breastfeeding. To avoid *kubemenda,* some women abstained from sexual intercourse until they stopped breastfeeding. In the past, women who felt that they could not control their sexual desires used a traditional family planning method called *pigi*, which was provided by older women. It was made from pieces of a tree called *pigi* and tied with a rope from a fruitless baobab tree. To prevent conception women wore the rope around their waists. This way, they could have sexual intercourse with their husbands and avoid pregnancy for the child's safety. Therefore, the reluctance to use modern family planning methods can also be argued was not because women did not want to plan pregnancies but because

they wanted to avoid the effects the methods would have on their bodies, fertility and eventually, social well-being.

4.4.2 “Their Medicine is to Keep Them Pregnant:” Men’s Resistance to Family Planning

Four of my interlocutors reported to use pills to avoid conception but did so in secrecy because their husbands had not allowed them. As I talked to men, it was obvious that they did not want their wives to use modern family planning methods. Fatuma, a 25-years-old married woman with three children was using family planning pills because she wanted to delay conception for three years. When we met, her youngest child was four months old. She buried the pills outside the house and would secretly take them at night when she went outside to urinate because her husband did not want her to use family planning. She believed that men did not really care about the problems women faced when they conceived without spacing, instead men thought only of ejaculating during sexual intercourse:

> If you are not careful, he just comes and demands sex. He knows that you are breastfeeding, but what he needs is to get himself relieved. He will put down his load and rest, while for you, the work begins (referring to pregnancy) (IDI, Fatuma, Magambua Village).

I asked if she was experiencing any side effects. She said that the pills gave her some headaches that the nurse told her would go away after some time. Despite what she called a long break of three years, she did not want to use any of the long-term methods. Her decision to use pills gave her sense of control in the sense that she could stop taking the pills any time she wanted.

Generally, men’s support to modern family planning was minimal. Some of them believed that family planning provided women with an opportunity to have extra marital relations. When Sharia a 29-year-old man discovered that his 27-year-old wife was taking pills, he asked her to stop and soon after, she got pregnant with their fourth child. Justifying his action, Sharia said:

> You know women...ah! If you let her look good, she will go outside and start sleeping with other men. Their medicine (*Dawa yao*) is to keep them pregnant every time so that they can stay faithful. (...). If my wife starts taking the medicine (referring to family planning pills) again, I will just know because her taste changes. (...). When I sleep with her, it feels different, her private part becomes too dry (IDI, Sharia, Ilasee Village).

Although illicit sexual relations were associated with the risk of infertility, extramarital relations were common for both men and women. By keeping women pregnant, men could manage women's sexual practices.

Furthermore, being a patriarchal society, men expressed the need for many male children to expand their clans. Men's preference for male children evoked women's desire to give birth to male rather than female children. In the past girls were mostly preferred because many cows were paid for bride price. During the time of my research, men were not paying much for bride price (mostly men were paying around ten goats) especially when a young woman became pregnant before marriage. In such a situation the parents became desperate to get the young woman married to avoid the shame. While the reasons for men's preference of many children were clear, one can assume that women had many children to meet men's demands. The *haboosa ghawe* status was just a name, in practice women were no longer rewarded for having many children. Further discussion with women revealed that they critically reflected on moral changes that increased their preference to have many children.

4.4.3 The Good and The Bad: Economic and Moral Value of Children

My discussion about family planning with Imelda revealed another aspect that rationalized women's resistance to family planning. When I asked why she thought four children were not enough for her, she said:

> I still want more children because when you give birth, you do not know what is ahead of you; there are good and bad children. When you get children, you do not know whether they will grow up to be good or bad people. Thus, it is better to get many children, like seven children and out of those, if some turn out to be bad, you cannot miss some who will be good (IDI, Imelda, Ilasee Village).

Fascinated by her rationality, I asked what she meant by bad children. She told me, "Children who do not help their parents and have bad habits." She added that:

> These days things have changed a lot. You can find that some of the children are not helping you much, but they are good children. (...). They have good habits. You can find others are bad children with bad habits. (…). They can be drinking alcohol or smoking marijuana and they do not help you at all. Thus, it is better if you have many of them you know some of them must be good (IDI, Imelda, IlaseeVillage).

Hearing Imelda's views, I decided to pose the question in one of the focus group discussions with women. I asked them of the benefits they got from having many children. First, the discussion leaned towards the expectation of economic support from children during old age. Then, one of the women recalled an incidence that happened in the African Inland Church some past few Sundays:

> You remember that Sunday, they called a woman and asked us to pray for her because she lost her two children in a car accident in Dodoma. She had only two children. If she had like five, she would have been sad but looking at those who are left she could be comforted. Now, she has none, the two are gone. She does not even want us to call her Mama Raphael (A mother of Raphael, one of her deceased sons). She says 'I am not a mother. I have buried all my children.' If you can give birth to many children just give birth because you do know what might happen (FGD1, Female, Magambua Village).

While others agreed with her that it was important to give birth to many children to avoid an experience like that of Mama Raphael, I challenged; "You can just have a few who are well educated like the nurses say." In response, one of them said:

> Well educated! Such education itself these days is of no great use. How many children here have finished form four and have nothing to do? You see, like Teacher Shemsa, she has how many? (She was asking others). Three children; the first two boys have finished secondary school, what are they doing? They spend all the daytime at Barazani drinking *viroba.* The other one has even started making dreadlocks (*ameanza kusokota marasta*) and he looks like a mad person. They have reached form four! We then thought maybe the last born would be a good child, but see what? She got pregnant in form three and gave birth at home. Until today she is just at home and they had sent her to an expensive school in Dodoma (FGD1, Female, Magambua Village).

Others agreed with her that there was a problem and another one added:

> That is why we tell you that if you give birth to one or two, it is not good. If God has given you the ability to have children, why should you not give birth? If you bear only a few and you find out that they are all bad children, you will have given birth just for the sake of giving birth to escort others or to just clean your stomach (FGD1, Female, Magambua, Village).

In developing countries like Tanzania, high fertility rate is associated with economic instability and old age security (Hoddinotti 1992; Simon 2013). However, as the presented discussion shows, it is also about getting morally upright children, an aspect, which could not be guaranteed

at this particular historical time. Getting many children was the way of increasing the chances of having good children. For a woman to have all bad children symbolized failure morally and economically. Having some good children even when others turned out to be bad gave women a sense that they had not given birth for nothing. Although women agreed that men pressured them to give birth to many children, their own preferences of economically and morally valuable children pushed them to have many children.

4.5 (In)Fertility and Family Planning Under Neoliberalism

To understand why women and men resist, appropriate, and modify the use of family planning, we must locate local conceptions of (in)fertility in the broader political economy context. Fertility has always been valued and protected among the Sandawe but the reasons to such value and protection change according to social, economic, and moral developments. Ginsburg and Rapp (1995: 2) argue that, in local-global interactions, reproduction provides a terrain for imagining new cultural futures." They point out further that "even when cultural practices appear to be continuous with the past, their cultural production cannot be taken for granted as people increasingly struggle to sustain their lives under conditions different from those of prior generations" (ibid: 10). Healthcare providers expressed the preference of many children as a thing of the past and urged women and men to adapt to a modern practice of having few children that they could take good care of and provide them with education. The assumption of the healthcare providers was that the preference of many children was shaped by the Sandawe's old customs and traditions that had to be abandoned.

On the other hand, according to the Sandawe's customs, to prevent premarital and extramarital sexual relations and infertility, women's sexuality had to be managed. Furthermore, being a mother was important for achieving a complete state of womanhood, having many children was important for a social status of *haboosa ghawe*, and children provided married women with the sense of belonging to their husbands' families. Women's fertility, especially with the birth of twins was connected to fertility of the land and community well-being. Governing fertility on the basis of individual control for individual and family well-being overlooked the importance of fertility on the well-being of society at large. For instance, allowing unmarried young women to

use modern family planning methods was interpreted as encouraging them to engage in sexual relations without the fear of getting pregnant. The Sandawe had in place a different game of truth to self-control women's sexual practices rooted in female circumcision, infertility due to illicit sexual relations and shaming of premarital pregnancy. Although the use of modern family planning would address the problem of teenage pregnancy, it threatened the moral mechanisms used by the Sandawe to control female sexuality, which was important for maintaining gender relations and sexual social order.

Furthermore, the Sandawe's knowledge, experiences and fertility practices were (re)shaped by the ongoing moral, social and economic changes in ways that did not favor the limition of fertility. For example, when Imelda mentioned that women were unsure of raising good children, she was referring to the moral context in which children grew, that parents felt they had little control. As I have shown in Chapter 2, the moral and the economic contexts in Usandawe had undergone significant changes from the early 1990s. When the Sandawe started migrating to urban areas, Usandawe became more open to the forces of modernity. The reference of Teacher Shamsa's sons making dreadlocks and drinking alcohol was an example of how the new social developments produced bad children. For women, having many children was a way of taking charge of the prevalent moral decay and the uncertain future. What mattered in this case was the economic and moral value of the children.

Having few children and providing them with education could not ascertain a good future for them and their children. Reference to little hope women expressed on education can be understood on the basis of the prevailing situation of unemployment among youth in Tanzania (Ndyali 2016; Suleiman et al. 2017). Sending children to school seemed rational but did not guarantee that after graduating they would get employment or become good children. However, this does not mean that my interlocutors were against education. The broader social, political and economic context produced conditions of uncertainty in which even when children were sent to school, the chances of succeeding and becoming good children could not be assured as the healthcare providers tried to rationalize. It means that no matter how much education was provided on modern family planning methods, the everyday forms of resistance towards family planning would continue because what women and men lacked was not education about the

importance of family planning. Many children provided a terrain through which women made sense of their changing local moral worlds and (re)imagined the future. From men's perspectives, modern family planning methods empowered women and diminished their ability to control women's sexual engagements (cf. Bawah et al. 1999). With these different perspectives interacting in the same space of fertility control for safe motherhood, modern family planning methods found less success.

In this cultural context, the use family planning may find success among older women who have had 'enough' children rather than young women who still wanted to have more children. Similar observations are reported by Bledsoe et al. (1994) in her study about the use of family planning in rural Gambia in which women appropriated and modified modern family planning for child spacing and increased the chances for getting as many living children as possible. According to Bledsoe family planning had been successful in Gambia, albeit, not in the logic of family planning for fertility control.

4.6 Concluding Remarks: Beyond Safe Motherhood

In this chapter, I have shown that to facilitate the reduction of maternal mortality through the provision of family planning services healthcare provider strove to develop fertility control selves. I have shown that family planning truths revolved around the reduction of maternal mortality, limiting teenage pregnancy, allowing child spacing and enabling the well-being of women and their families. These truths contradicted with local knowledge and practices that insisted on the management of women's premarital and extramarital sexual relations, the connection of fertility to women and men's identities, gender relation and societal well-being. This does not mean that people did not care about maternal mortality or the well-being of their families but what was at stake was different.

The discussion has also shown that women critically reflected on their own experiences and/or experiences of others and, in turn, appropriated, modified or resisted the use of modern family planning methods. Women feared temporary infertility that could have resulted from using modern family planning methods but reconsidered the right time to use modern family planning methods being when they did not want to have more children. This way, family planning was

resisted but also modified and accommodated in a way that would work to limit unintended pregnancies but not the number of children.

Furthermore, moral, social, and economic changes reshaped how both men and women conceptualized as well as experienced (in)fertility and family planning in ways that necessitated the need of many children. For men high fertility was important to control women's sexual engagements and expand their clans, and for women, having many children was important to ensure that they had good children. The perception that having many children was a thing of the past, or women and men were ignorant of the advantages of family planning masked dynamics that shaped how family planning was understood, experienced, and practiced in local moral worlds. Although infertility was feared and fertility was encouraged, factors that shaped the value of high fertility were not static. The way people deal with changing contextual realities need to appear in documents of governments and international organizations designing maternal health interventions (Chapman 2010: 30). Closely related to the value of fertility and the fear from infertility are pregnancy care and birth practices that I turn to in the next chapter.

Chapter 5

Pregnancy Care Practices and Underutilization of Biomedical Maternity Services in Lalta

5.1 Introduction

In the present chapter, I pay attention to how women took care of pregnancy, childbirth, and the postnatal period. Healthcare providers expected women to use biomedical maternalcare health services and when I asked my interlocutors about the services, they all expressed that they were important, and they appreciated their availability and close accessibility. Some even mentioned the advantages that they got from using the services, such as getting multivitamin pills, ensuring the baby's safety and safe childbirth. Nonetheless, most of my interlocutors did not use the services as expected. The underutilization of biomedical maternity services was noted in late initiation of antenatal care and less than four recommended visits for antenatal care, outside of facility/home birth and nearly total absence of the use of postnatal care. During clinic observations, conversations and interviews with healthcare providers, women's underutilization of the services was attributed to "ignorance" (*ujinga*) "little understanding about the importance of biomedical maternity services" (*uelewa mdogo juu ya umuhimu wa huduma za uzazi*), and "the lack of care" (*kutokujali*).

The healthcare providers' views, which mirrored those of policy makers and healthcare planners entailed that when biomedical maternal healthcare services are available, women would become knowledgeable about their importance and they would use the services as instructed. However, women acknowledged the importance of biomedical maternity services and still underutilized the available services. It is apparent that the simple correlation of being knowledgeable and using the services, or conversely, lack of knowledge and the underutilization of the services cannot suffice to fathom the amalgamation of the acknowledged importance of the services and the underutilization of the same. Mark Nichter (2008) argues that, although health interventions are

important, we should be wary of simplistic representations of the people in particular contexts. He cautions that:

> (...) employing a single biomedical lens to view what people say and do leads to skewed perceptions of local worlds: it filters out context, pays little attention to reasons for actions taken or not taken, and ignores life contingencies. Moreover, placing emphasis on what a population does not know deflects attention from what they know and how they learn. (...). It is a practice (...) that pays little attention to local practical knowledge and the role this might play in health as well as disease management. People tend to be pragmatic, they appropriate, reinterpret and make use of new resources following the process of cultural assessment (ibid: 7-8).

Like Nichter, anthropological scholarship of reproduction that is increasingly concerned with simplistic representations and unidimensional models has shifted attention from biopower and the control of women bodies (see, for example, Martin 1987; Jordan 1978), to exploring women's engagements with reproductive interventions in specific contexts (Rapp and Ginsburg 1995; Lock and Kaufert 1998; Bledsoe 2002; Obermeyer 2000; Van Hollen 2003; Allen 2004; Berry 2010; Chapman 2010; Fordyce and Maraesa 2012). These studies all call for attention on women's (in)actions and rationalities that underlie them.

Following the similar direction as mentioned studies, I will show that, reasons for the underutilization of biomedical maternity services in Lalta were more complex than the healthcare providers in the two village dispensaries suggested. Women's maternity experiences showed that presence of multiple knowledge systems of maternity care, women's reflective engagements with biomedical maternity services, personal maternity experiences, and environmental as well as socio-economic changes shaped maternity care practices, decisions and thus, the use of biomedical maternity services. Women's experiences indicated that global flows of interventions do not culminate into homogeneity as anticipated but are molded by individuals as they actively engage with them (cf. Dilger 2012; Ginsburg and Rapp 1995).

I argue that, the diverse reasons and rationalities for the underutilization of biomedical maternal healthcare services suggested that women were neither ignorant nor against the services. Rather, as I have shown with the use of modern family planning methods in Chapter 4, when and how to use the services, which did not match with the requirements of biomedical maternal healthcare services and interventions (cf. Van Hollen 2003: 16; Dureau 2009: 271). Biomedical knowledge

was accorded authoritative status in some situations and devalued in others, depending on what was at stake for women and their families. In other cases, women were constrained from using the services by particular circumstances. It is evident that, despite the availability of the services women were neither passive recipients nor free agents. Their maternity experiences indicated the interplay of agency and social structural forces.

This chapter adds to the understanding of pregnancy care practices and how biomedical maternal healthcare services are provided and experienced in rural areas of Tanzania, the manner in which biomedical maternal healthcare services and interventions shape women's maternity experiences and the way in which they are shaped in return. It illuminates on ground practices and diverse experiences which produce local forms and subjectivities about maternity care. The discussion underscores that the experiences of the services and interventions remain a cultural phenomenon (cf. Obermeyer 2000; Berry 2010; Dilger 2006).

5.1.1 Authoritative Knowledge, Uncertainty and Whole Maternity Experience

To make sense of women's maternity care practices, their use of maternity services and healthcare providers' interpretation of women's actions, I draw from Brigitte Jordan's notion of authoritative knowledge, which is knowledge that counts in a particular context (see subsection 1.6.5.1). Michael Foucault (1978: 140) explains the authority of biomedical knowledge as a form of biopower, which involves disciplining of the body with the use of technologies of power and the self to achieve subjugation of bodies. This subjugation includes biomedicalization of bodily processes like pregnancy and childbirth as well as development of institutions within which such processes are supposed to be monitored or take place.

For biomedical maternal healthcare services and interventions, biomedical knowledge is authoritative and is presented as the only knowledge system that can work to reduce maternal mortality in developing countries (Rosenfield and Maine 1999; De Brouwere et al. 1998). However, in Lalta, not all women submitted to the biomedical knowledge as the only truth. Others prioritized the devalued knowledge systems including the knowledge they possessed by virtue of their own experiences or experiences of other people they trusted. This does not necessarily mean that women were against biomedical knowledge for maternal health as a

whole. [48] Instead of passively accepting biomedical knowledge, women's experiences demonstrate that there are other ways of knowing that are relevant in particular contexts but are not acknowledged by global and national actors who define what counts as authoritative knowledge for maternity care.

Other scholars, following on Jordan's footsteps have expanded the application of the notion of authoritative knowledge to understand how women in particular contexts creatively incorporate and modify biomedical knowledge to suit their particular needs, concerns and situations during pregnancy and childbirth (Davis-Floyd and Sargent 1997; Browner and Press 1996; Root and Browner 2001). This expansion illuminates diverse structural and contextual specific factors that come to play in shaping women's maternity care practices. For instance, Naimani (Chapter 4) used antenatal care services but she was assisted by the traditional healer during childbirth. Nonetheless, her three previous births took place in health facilities. Her experience shows that the enforcement of biomedical knowledge and devaluation of other forms of knowledge did not prevent women from moving between different forms of maternity care according to their particular needs.

The situation shaped what counted as authoritative knowledge that Naimani pursued. Due to Naiman's experience of infertility, the traditional healer's knowledge was the knowledge that counted. Without understanding her rationality, it is easy by using the biomedical lens to judge Naimani's action as ignorance or lack of knowledge about the importance of biomedical maternity care. Women's use of biomedical maternity services and maternity care practices in my research show that women had a definite sense of making rational choices depending on situations they found themselves in and what was at stake in such situations.

While the notion of authoritative knowledge can account for the incorporation and modification of biomedical knowledge in particular contexts, it cannot explain why women who had accepted biomedical knowledge at face value and intended to use the services were not always successful.

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[48] Van Hollen (2003: 15-16) opines that, "although allopathy may indeed be the dominant form of maternal and child healthcare (…), it is not taken for granted as the *only* naturally legitimate form of care (…). It, therefore cannot be viewed as hegemonic.

Locating experiences in the wider political, economic and the cultural contexts of social actors help to reveal about constraints on the practice of the accepted knowledge in particular contexts (see, for example, Dilger 2012; Janes and Chuluundorj 2004; Cooper and Pratten 2015; Janes and Corbett 1999).

In their edited volume titled *Ethnographies of Uncertainty in Africa,* Elizabeth Cooper and David Pratten (2015: viii) point out that:

> Rich applications of life course analysis to developing country experiences, as well as deeper approaches to experiences of time, and related emotions of hope and aspiration, are offering more meaningful ways of understanding how different individuals experience, influence and are shaped by complex, and often rapid, processes of wider social change.

They contend further that:

> (...) uncertainty has become a dominant trope, an 'inevitable force' in the subjective experiences of life in contemporary African societies (ibid: 1).

Neoliberalism has led to the widespread conditions of temporariness in developing countries in which the poor struggle to maintain a sense of permanence in economic, social and moral relations (Shipley, Comaroff and Mbembe 2010: 659). It is in this context that "people weave their existence, ways of knowing and being." This context also enlightens the "power of the unforeseen and people's relentless determination to negotiate conditions of turbulence to introduce order and predictability into their lives" (Mbembe and Nuttall 2004: 349). By looking at women's "failure" to use the services and equating it to ignorance or lack of care, reduces context and masks the nuanced interplay of different factors affecting women's use of the available services.

My conversations and interviews with women brought to focus another theoretical concern that I find relevant in delineating women's maternity experiences. When I talked to women I noticed that in explaining about their immediate maternity care practices, they made reference from their past maternity care experiences. I decided to probe for brief historical accounts of maternity experiences. In addition, the use of the extended case method enabled me to empirically follow women from pregnancy to childbirth and see how women and their families made decisions about maternity care including the use of the biomedical maternity available services.

In this regard, I propose that women's maternity care practices and the use of biomedical maternity services can be thickly explained when we look at such experiences in terms of what I call "whole maternity experience." By this, I refer to two micro-temporal dimensions, which are previous maternity experiences, and the totality of the maternity course from pregnancy, childbirth and the postnatal period. Both of these micro-temporal dimensions are envisioned through macro-processes in which they are embedded. This illuminates the interaction of different factors that shape women's use of biomedical maternity services over a period of time as well as how women interpret their experiences and project future use of biomedical maternity services. Greenhalgh (1995: 22) looks at people as "real demographic actors" and argues that the temporal dimension is important in understanding how people make decisions, act and produce culture within micro and macro contexts. Practices of real actors, she argues, "have a development structure that works itself overtime as individuals fine tune their practices when the need arises" (ibid: 22).

The discussion that follows is divided into four sections that draw from three case studies. The first section looks at antenatal care services, the entry point to biomedical maternity care. In this section, first, I show changes in the model of delivering antenatal care services and the stipulated services that women should receive during pregnancy. This will be followed by an actual clinical encounter showing how antenatal care services were provided in Lalta. The clinical encounter introduces the first case study that I follow through to show women's use of antenatal care services and pregnancy care practices in local moral worlds.

The second section focuses on childbirth experiences. Through the second case study that draws from an incidence of on the way to the dispensary childbirth, and two home births that happened in the same day, I will show that home/out of health facility childbirths resulted from more than women's choices. The interplay of the local conditions of provision of birthing services and difficult economic conditions shaped women's experiences of the childbirth services. The third case study shows how environmental and neoliberal socio-economic changes played part in shaping women's childbirth experiences. The fouth section brings into focus the question of postnatal care, which as I will show, was almost nonexistent in the provision of biomedical

maternity services at the village dispensaries. The fourth section will comprise concluding remarks.

5.2 Provision of Antenatal Care Services and Pregnancy Care Practices

Antenatal care forms an important component of biomedical maternal healthcare services and interventions that introduce women and their partners to biomedical maternity care ((Barker et al. 2013; WHO 2002; Campbell et al. 2006). Besides, it is identified as being important in establishing the continuity of biomedical maternity care from pregnancy to childbirth and the postnatal period (WHO 2002). However, the contribution of antenatal care in the continuum of biomedical maternity care is contested. Based on the number of antenatal care attendance, some studies have shown a positive statistical correlation between the use of antenatal care services and giving birth in health facilities (Berhan and Berhan 2014; Amoah et al. 2016). Others have shown no correlation (Kasaye et al. 2016; Boah et al. 2018). The case study of Vaileti, Mama Wawili (subsection 5.2.3.1) and many other women in Lalta relate with the latter. Their experiences show that the number of antenatal care visits did not influence women's decisions to give birth in health facilities. The discussion also shades some light as to why while the number of antenatal care visits declined, facility-based births remained relatively the same[49].

5.2.1 Improving Provision and Reinforcing Rationality with Focused Antenatal Care

In 1978, the WHO established guidelines for the identification of high-risk pregnancies during antenatal care visits in order to improve pregnancy outcomes. This model was adopted by developing countries in the 1990s (Kearns 2015 et al. 2015: 5). Women were required to make 16 visits during which they were screened for risk indicators that were identified by the WHO (Kearns et al. 2015: 6). This model of antenatal care was intended to identify high-risk pregnancies for highly attentive care in the prenatal period and influence preparations for referral care in the time of birth. However, the model proved to be expensive for developing countries to

[49] The number of women making the recommended number of at least four antenatal care visits showed a decline from 62 percent in 2004/2005 to 43 percent in 2010, and an increase to 54 percent in 2015/2016. In the same period facility based births showed a steady increase from 41 percent, to 63 percent (URT 2016).

implement. Furthermore, women hardly made the required 16 visits. Faced with the pressure to lower the costs of antenatal care, improve the quality of care and increase utilization, in 2001, the WHO developed a new model of antenatal care termed, "focused antenatal care" (ibid: 5).

Focused antenatal care (FANC) is a goal oriented approach of pregnancy care that was suggested and recommended by researchers after randomized trials in different countries that proved its effectiveness (WHO 2002). Instead of identifying high-risk pregnancies as it was in the previous model, an integrated approach to care was proposed through health promotion, disease prevention and detection, treatment of existing diseases and birth preparedness. Focused antenatal care assumes that every pregnancy is risky but majority of women would not develop complications during pregnancy or childbirth. Rather than requiring all women to make 16 visits, through integrated care, those with problems and preexisting risk indicators can be identified and enrolled in specialized as well as individualized attentive care (ibid: 7-12). The minimum of four antenatal care visits was suggested with the first visit within 12 weeks, the second at 26 weeks, the third at 32 weeks and the final visit between 36 and 38 weeks of gestation (Kearns et al. 2016: 4-6). Focused antenatal care encourages individual counseling as well as an interactive approach between pregnant women and healthcare providers together with the involvement of male partners who are recognized as important stakeholders in improving maternal health (WHO 2015b).

The changes in the ANC model can be located within the wider changes for the improvement of biomedical maternal healthcare in developing countries that took place in the turn of the millennium. The changes came along with the new approach for the reduction of maternal mortality that emphasized on skilled birth attendance and abolition of TBAs (Chapter 3). Focused antenatal care, through this interactive approach was intended to facilitate biomedical rationality for pregnancy care and influence women's decisions to give birth in health facilities. Tanzania adopted and started implementing the FANC model in 2003 (URT 2015a: 15).

The FANC model gives particular uttermost importance to the first ANC visit in which healthcare providers are required to first ask for personal information to see if a woman has a history of any health problems that may affect the pregnancy and the mother. Along with personal history, healthcare providers are required to ask about family history including the birth of twins within

the family, diseases like diabetes and blood pressure, obstetric history about cases of stillbirth, neonatal death, caesarian section, premature birth, miscarriage, abortion and ectopic pregnancy (WHO 2002).

After gathering personal, family and obstetric history which provides the first step in understanding the health condition of the pregnant woman and the likelihood of a risky pregnancy, a thorough clinical examination follow. Measurements of weight, height, blood pressure, pulse, respiratory rates and head to toe assessments (conjunctiva, lymph nodes, breast examination, fundal height, fetal heart sound and other masses) must be conducted. Where necessary, it is recommended that health providers should conduct genital inspection for female genital mutilation, sores, swelling and discharge. Women should also be tested for syphilis, HIV status, malaria, tuberculosis, albumin and sugar, hemoglobin, blood group and rhesus factor. After that, a birth date should be estimated and a joint decision should be made on the place of birth (ibid.). In practice, the joint decision means that healthcare providers should influence and persuade women to give birth in health facilities and those identified with highrisk pregnancies to go to referral hospitals for more examination and care (WHO 2002).

During subsequent visits, measuring blood pressure, hemoglobin estimation, weight gain, testing urine for albumin and sugar, measuring fundal height and movement are recommended. Women friendly care is emphasized whereby healthcare providers are required to explain and speak in a simple language that women understand, respects, beliefs and permit cultural practices that are not harmful. Furthermore, healthcare providers are needed to obtain informed consent prior to examination and ensure privacy as well as confidentiality. Also, healthcare providers have to advise women about diet, danger signs, resting, personal hygiene, breast feeding, use of medicines and immunization, safer sex to protect themselves from STDs including HIV, sleeping under treated mosquito nets to prevent malaria and the use of family planning (URT 2007b).

The observed antenatal clinic sessions in both dispensaries in Lalta showed that they were not conducted in the exact way as stipulated in the FANC model but took on distinctive contours that mirrored understandings of local actors and availability of resources at a specific place and time (Spangler 2012: 139). According to the FANC model, attending one pregnant woman would take between 30 to 40 minutes (Kearns et al. 2015: 6). However, the highest time noted during

antenatal clinic observations in the two dispensaries was 35 minutes when a twin pregnancy was suspected. Most the ANC assessments took between 15 to 20 minutes. Sometimes the assessment for subsequent visits would take lower than 10 minutes, depending on what the healthcare providers would need to know from a woman. While referral advice was given for birth care based on maternal referral criteria, I encountered only one case of antenatal care referral (see subsection 2.8.5.3).

5.2.2 Local Provision of Pregnancy Care Services: Vaileti's First Antenatal Care Visit One

Thursday morning of July 2015, I went to Upendo Dispensary to observe an antenatal care session. I found Nurse Vivian preparing to attend women who had already gathered at the verandah of the dispensary. I greeted the nurse who welcomed me politely and asked me to sit on the bench along with five women who were waiting to be attended. I was pleased with the welcome I got given the encounter we had two weeks before (Chapter 2). When she finished setting the place, Nurse Vivian collected clinic cards from the waiting women but one of them had no clinic card. It was her first antenatal care visit and Nurse Vivian told her she would attend her first. Her husband who was sitting on the corner of the verandah joined his wife.[50]

Nurse Vivian first asked her name, age and the number of pregnancies she has ever miscarried, if she ever had a stillbirth or delivered by operation, and the age of her pregnancy. I learnt from her answers that her name was Vaileti, she was 25 years old, had two living children and that it was her third pregnancy, which was six months old. To be sure of the age of the pregnancy, Nurse Vivian asked when Vaileti found out that she was pregnant; to which Vaileti replied that it was in December (2014). Probing for more specificity, the nurse asked if Vaileti remembered the last day she saw her menstrual period. Vaileti remained silent, she did not seem to remember the exact date. Complaining on how she would be able to estimate the due date, Nurse Vivian asked Vaileti if it was at the beginning, middle or end of the month. Vaileti replied hesitantly that it was

[50] All antenatal care tests were carried out in the veranda, expect for fundal measurement, listening to fetus heartbeats and other physical examinations which were done in the labor room.

in mid-November. After estimating the due date, Nurse Vivian told Vaileti that, “you will give birth on the 18th of August,” Vaileti nodded her head, indicating that she agreed with the nurse.

Nurse Vivian noted the estimated due date on the new clinic card for Vaileti and then she turned to her and asked why she took so long to come to the clinic. Vaileti replied that her husband had not been around. During the first clinic visit, it was mandatory for women to go with their partners. This was necessary for HIV[51] and STDs testing in order to protect the unborn child. Turning to the husband, Nurse Vivian told them that they were lying to her, they did not want to go early because they did not care. “You knew your wife was pregnant but you did not care to come back to accompany her to the clinic,” Nurse Vivian told Vaileti’s husband who replied that he was working as a casual laborer in Singida and could not leave lest he would lose the job. Not paying much attention to his explanation, the nurse asked Vaileti to stand on a scale and noted down the weight on the clinic card. The couple sat silent as the nurse continued talking about the alleged lack of care. While talking she reached to a white bag besides her chair and took out three rapid testing gadgets for HIV, Malaria and Syphilis, and placed them on the table. She then asked Vaileti to place her arm on the table so that she could check her blood pressure. While checking Vaileti’s blood pressure the Nurse asked her if the baby was playing in the belly, to which Vaileti replied it was playing. After she finished checking and noting Vaileti’s blood pressure, Nurse Vivian told Vaileti and her husband, “I will now test you for HIV and Syphilis.” She drew blood from Vaileti’s finger and put the drops on the rapid tests and did the same with Vaileti’s husband. While waiting for the results on the rapid tests before them, Vaileti covered her head with one of her two pieces of *khanga*. Her husband looked aside and I felt uneasy. Other women on the bench did not seem to be bothered or concerned. Meanwhile, the nurse asked Vaileti to remove the *khanga* and checked her eyes (presumably) screening for signs of anemia. She then pricked Vileti’s finger and put a blood drop on the Malaria rapid test. After between 3 and 5 minutes, the nurse said to the couple, “congratulations, you do not have malaria, syphilis or HIV but you will now need to have (referring to Vaileti) the sugar test (*kipimo cha sukari*).”

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[51] In Lalta, according to the record at Faraja Dispensary, HIV prevalence among pregnant women is around 3.2 percent, lower than the national average of 8 percent (URT 2016: 69).

She then took malaria tablets from the bag beside her chair and asked Vaileti to take a cup of water from the office and take the malaria tablets that were intended to protect her from malaria infection that can be fatal for the mother and the child (URT 2008:4). The nurse told Vaileti's husband to make sure that he allowed his wife to have enough time to rest and help her with work. Thereafter, Nurse Vivian asked them to go to Faraja Dispensary for the sugar test. Upendo Dispensary had a blood sugar testing device but according to the nurse, the testing strips were finished since September 2014. They requested from the district many times but each time they were told the Medical Stores Department (MSD) had not provided the strips. "Since they (health administrators) gave us the device which came with some strips, they have not brought us more strips. We are still waiting and for now, pregnant women have to go to Faraja Dispensary and test at the laboratory there," Nurse Vivian explained to me. She kept the clinic card aside and told them she would give it to them together with multivitamin pills when they returned the sugar test result[52]. Other women were also called one after another. A set of questions followed, "Is the baby playing?" "Do you still have multivitamin pills?" Then weight and blood pressure were measured and women left. Vaileti and her husband were able to go to Faraja Dispensary where they had the sugar test and came back to pick up the clinic card. The clinic sessions at Faraja Dispensary were not different from those at Upendo Dispensary.

They were carried out in a space that was used as a car park at night for the dispensary's land cruiser. However, HIV, malaria and syphilis tests were run in the laboratory by the laboratory technician using the rapid tests. At both dispensaries, fundal measurements and listening to fetal heartbeats were carried out occasionally when healthcare providers felt the need to do so. This clinic session like others I observed revealed several critical issues in the local provision of antenatal care services including how the healthcare providers followed the protocols in provision of the services, delays in the procurement of medical supplies, as well as the depth of examinations and assessments conducted on pregnant women. In this particular interaction, I was interested on Vaileti and her husband. I wanted to understand reasons for their late initiation of antenatal care. Many other women too, like Vaileti delayed initiating antenatal care. How were

[52] The sugar test cost 4,000 Tanzanian Shillings (equivalent to 1.60 Euro)

they taking care of pregnancy prior to initiating antenatal care? When Vaileti and her husband returned to pick the clinic card, I asked for an interview with them, they agreed and Vaileti directed me where they lived.

Figure 5.1: A Couple undergoing tests at Upendo Dispensary during the first ANC visit (Photo by Anitha Tingira 2015).

5.2.3 Pregnancy Care Practices and the Use of Antenatal Care Services

5.2.3.1 Cultural Pregnancy Care Practices in Local Moral Worlds: The Case Study of Vaileti and Mama Wawili

The following day I went to visit Vaileti and her husband. I found Vaileti cooking *Ugali* outside while her husband was sitting under a shade of a tree in their compound. They invited me in and after we had eaten *Ugali* with *mlenda* they were ready to listen to what I wanted to talk to them. I wanted to know why Vaileti delayed starting antenatal care clinic and our conversation took us to cultural practices of pregnancy care.

As I have shown in Chapter 4, pregnancy was desired especially among married women. While there were no preparations done before a woman got pregnant (unless a woman faced infertility problems), after getting pregnant, women were concerned about carrying the pregnancy to term

and give birth safely. Although for some, as we shall see shortly, going to the clinic was considered right after pregnancy was suspected, for most of my interlocutors it was not the first thing they considered. In taking care of pregnancy in the early months, women depended on experiences of older women, especially their mothers who observed and advised them of what to do. For instance, Vaileti told me that when she became pregnant for the first time, her mother who was also living in Magambua Village was occasionally visiting and asking if she was fine. She said:

> When I became pregnant with this one (pointing to her oldest child), my mother came many times to see me. She asked if I felt nauseated or had fever and sometimes sent my young sisters to help me to go to fetch water. (…). I knew about going to the clinic but she told me to wait for the pregnancy to catch (*nisubiri mimba ishike*). I went to the clinic when the pregnancy was around three and half months.

Vaileti, like all other women in Lalta, did not need a pregnancy test to confirm that she was pregnant. When she missed her menstrual period twice in a row, she told her mother and her husband. Pregnancy was suspected and her mother started observing how Vaileti was feeling which confirmed that she was pregnant. The importance of a mother in observing pregnancy was associated with the first pregnancy when a woman was considered inexperienced. Women who had no mothers or whose mothers were living in distant places told closer female relatives they trusted. Vaileti told me it was forbidden to tell the mother-in-law about being pregnant.
This was confirmed by other women too who told me it was something that had to be avoided. For instance, Imelda (see Chapter 4) insisted that:

> She is the mother of your husband, how can you go and tell her 'you know your son got me pregnant!' It is not good at all. You cannot talk about such issues with your motherin-law. She is an older person and when she looks at you, she will know. You do not need to tell her (IDI, Imelda, Ilasee Village).

Vaileti explained that others too would find out with time because one could not hide the pregnant belly (*huwezi kuficha tumbo la mimba*). Women expressed that it was not good to announce about pregnancy for the fear of miscarriage, which could be a result of bad luck or caused by witchcraft. To avoid miscarriage, women waited for the pregnancy "to catch" (*kushika*) before initiating antenatal care. Similar practice is reported by Chapman (2003: 449), who shows that women in Mozambique hid pregnancy waiting for it to hold. During the early months of pregnancy when

the pregnancy has not caught, a pregnant woman was vulnerable to witchcraft and bad eyes that could also cause miscarriage. Keeping pregnancy a secret in the early months was necessary as explained by Zamda, a 23-year-old married woman, who was four months pregnant with her second child. She said:

> It is not good at all to tell everyone that you are pregnant. I tell you the truth Dada. This is not a joke. There are people with bad eyes (*macho mabaya*). When they look at you and may be they do not like you and they know that you have an immature pregnancy (*mimba changa*) you may find yourself miscarrying because of their bad eyes. People's eyes are not good for the immature pregnancy (IDI, Zamda, Manantu Village).

In order to protect herself from bad eyes, Zamda informed only her mother and her husband about the pregnancy. Additionally, she obtained some bathing medicine from her mother to protect herself in case people found out that she was pregnant before the pregnancy caught. Others like Naimani (Chapter 4) obtained some medicines for protection from traditional healers.

Moreover, women observed pregnancy related taboos. For example, sitting on a stone while pregnant was believed to cause difficulties during childbirth. Pregnant women were supposed to sit on the ground or wooden stools. Sitting at the doorstep was avoided because it was believed that bad spirits entering the house could harm the mother and eating small intestines (from chicken, cow, goat, sheep or any other animal) was prohibited because they believed that the intestines could strangle the baby and kill it. Although they did not have any special diet during pregnancy, most of my interlocutors reported to drink rosella juice, which they believed increased blood levels.

Traditional birth attendants were not involved in taking care of pregnancy. They were only consulted during childbirth. The four TBAs I interviewed did not provide pregnancy care services and they argued that women should go to the dispensaries for antenatal care. The TBA in Wairo, Saumu's mother (Chapter 4), took care of Saumu during pregnancy because she was her mother and she insisted on the importance of biomedical antenatal care. Saumu started attending antenatal care when the pregnancy was about three months old.

Unlike Chapman (2003), who shows that seeking antenatal care presented a danger of revealing the pregnancy and make a woman susceptible to sorcery, to a large extent, the cultural practices

of pregnancy care in Lalta did not appear to prevent women from initiating antenatal care within the recommended time (cf. Obemeyer 2000). Most of my interlocutors said that after missing the menstrual period for three months they were sure that pregnancy had caught and could go to the dispensary for antenatal care. On the other hand, the practice of waiting for the pregnancy to catch and late initiation of antenatal care was reinforced by the healthcare providers' insistence on initiating antenatal care at three months and not before. Those who went before three months were denied antenatal care services and were told to return when the pregnancy was three months old. Devina, a 20-year-old married woman with the first pregnancy who, together with her husband went to the clinic soon after she found out she was pregnant explained:

> I knew that when one gets pregnant has to go to the clinic. (...). I already heard other women say and even in the radio they say, 'go to the clinic as soon as you find out that you are pregnant.' When I did not see my period, I told my husband and we went to Faraja Dispensary. The nurse asked me if I was really pregnant and they told me there was nothing to measure (*hakuna cha kupima*). The nurse told me I should return when the pregnancy is three months, then, they can even see by looking at the stomach (IDI, Devina, Manantu Village).

Devina's mother had already passed away and so she shared her experience with her *Mama mdogo* (literally, young mother, the younger sister of her mother) and one of her friends who had two children. Her *Mama mdogo* told her that if she felt fine, she could wait. As a result, she went back to the clinic when she was five months pregnant and the pregnancy belly was visible for the healthcare providers to see. The view that healthcare providers did not want them to go early was common knowledge among women. This contradicted with information about going to the clinic as soon as a woman finds out that she is pregnant that Devina considered seriously.

When I asked the healthcare providers why they turned away those who went early, they told me that they preferred women to start ANC at three months because then they could feel the baby and be sure a woman was pregnant (cf. Chapman 2010: 199). A woman's own embodied experience of being pregnant was considered inadequate to confirm pregnancy. Faraja Dispensary had an ultrasound but was rarely used for pregnancy assessments because it was not covered by the government for women getting ANC services at the village dispensaries. I saw Doctor Busara using the Ultrasound only once when a case of twins was suspected. Blood tests were not administered to confirm pregnancy and both dispensaries had no pregnancy test strips.

However, not all women delayed initiating antenatal care because they were consciously waiting for the pregnancy to catch. Others such as Fausta, who was 21 years old, married with the first pregnancy, did not know that she was pregnant until when the belly started protruding. Explaining how that happened, she said she was getting her menstrual period but as time passed, the belly started growing. She went to Faraja Dispensary for evaluation, and she was told that she was four months pregnant.

5.2.3.2 "The Baby is Playing:" Developing Pregnancy Care Knowledge from Embodied Experiences

Neither cultural practices of pregnancy care, nor being turned away by going early for antenatal care played part in Vaileti's delay to initiate antenatal care. Vaileti knew she had to start attending the antenatal care clinic at three months but she had to wait for her husband. She observed the progress of her pregnancy by drawing from her previous pregnancy experiences in relation with how she was feeling in the present pregnancy. She said:

> With the first two pregnancies I went to the clinic early (three months), and I returned on every date I was told to go, but with this pregnancy, I saw nothing new. There is nothing I do not know. If there was anything wrong, I would know and I would go to the dispensary.

Unlike the previous two pregnancies that Vaileti counted on her mother's knowledge for guidance, in the present pregnancy, Vaileti made her own decision about when to go for antenatal care. At a quick glance, Vaileti's delay to initiate antenatal care may read as a result of her embodied pregnancy experience but her husband's migration for casual labor is ultimately decisive for understanding Vaiti's delay.

I asked Vaileti if she would have delayed initiating antenatal care had her husband been around and she said she would have gone sooner than she did. Her husband had migrated to look for casual labor because, as he explained, the economic situation in the village was difficult. Even if Vaileti wanted to go early, she could not be attended because her husband had to be present for the first antenatal care visit for HIV and syphilis testing. This shows how the local conditions of provision of antenatal care services can interfere with economic realities and affect the utilization the services. For both Vaileti and her husband, the job rather than the pregnancy was at stake.

When I inquired further how Vaileti was sure that the pregnancy was safe without going to the clinic, she explained how she assessed the safety of her pregnancy by using the criteria that were often used by the healthcare providers that she had learnt from her previous antenatal care visits. She said:

> I was listening if the baby was playing (*nilikua nasikiliza kama mtoto anacheza).* The baby was playing; I knew I was fine. During the first pregnancy, I did not feel the baby playing until I was seven months. However, with this one, when I was like four months, I started feeling it playing. This baby is playing very much. (...). Even my legs are fine; they are not swollen (showing me her legs). This pregnancy is not disturbing me at all; even the nausea is not like the previous pregnancies. The only thing that disturbs me is the heartburn.

By listening if the baby was playing, Vaileti was referring to the common question ("is the baby playing?") that women were asked by the healthcare providers during antenatal care visits. Although women were sometimes taught about the danger signs like observing if they had swollen feet, it was meant to prompt them to go to the clinic. So long as Vaileti did not detect any problem according to how she felt, and did not see the danger signs, she considered it safe to wait for her husband's return. When I asked her why she went to the clinic while she could monitor herself, she told me that in the dispensary they were tested for various diseases something she could not do herself:

> When we go to the clinic, we are tested for many things. We are being tested for malaria, pressure and many things. Now if I just stay at home, I cannot get tested or even get the multivitamin pills (*vidonge vya vitamini*). Thus, I think it is important going to the clinic. Even if you are late, you must go to be tested.

Asteria, a 28-year-old married woman with the fourth pregnancy which was five months old reported a somewhat similar experience. Hidaya (Chapter 4), with whom they were friends, introduced me to her. Asteria was proud that she had managed to conceal her pregnancy for five months. Only a few people including her friend Hidaya knew that she was pregnant. Until the time we met, she had not initiated antenatal care. When I asked why she did not go for antenatal care until then, she said that she could not run to the clinic as if it was her first pregnancy when she did not know anything. She explained:

> I cannot run to the clinic like a *chekechea*[53] as if it is the first time I have become pregnant. What don't I know with the fourth pregnancy? I know what they do at the clinic, I will go, I know I am fine, I have not seen anything wrong with my pregnancy. It grows well and since last week I have been feeling the baby moving (IDI, Asteria, Wairo Village).

Asteria was implying that those who were young, with first pregnancies were the ones who were supposed to go early because they had no experience.

Vaileti and Asteria's actions may seem as lack of care or ignorance, but the manner in which they paid attention to what was happening in their pregnant bodies, applied the knowledge obtained from previous antenatal attendances in assessing the safety of their pregnancies and rationalized their actions proved that they were far from ignorant or careless. They both cared for the safety of their pregnancies in their own meaningful ways. They assessed themselves and they were sure that their pregnancies were safe. During our conversation Asteria went a step further and challenged how antenatal care services were provided. She said:

> Even if I go early, what do they do? Mostly I will be tested only. Usually when we go the nurses tell us, 'stand on the scale' and then she asks, 'is the baby playing?' If you say yes, it is done until the other date the nurse writes for you to return. Like for me, the baby has started playing. I will just go but not this week, maybe next week (IDI, Asteria, Wairo Village).

Biomedical maternal healthcare interventions endowed the authority to ensure the safety of pregnancies to healthcare providers through biomedical knowledge but women drew from other knowledge systems to assess as well as ensure the safety of their pregnancies. One important thing in their accounts of delaying to initiate of antenatal care is the use of embodied pregnancy experiences and pregnancy assessment criteria learnt from previous antenatal attendances. They saw antenatal care as an art that they could also practice (Schühle 2017) except for the medical tests that they could not undergo themselves. Seeing them as careless (*wasiojali*) or ignorant (*wajinga*) overlooks how they strategically incorporated knowledge acquired from attending antenatal care in taking care of pregnancy while at the same time challenging how antenatal care services were provided. Women such as Vaileti and Asteria were not ignorant or even against the

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[53] A kindergarten kid, a metaphor that was used even by healthcare providers to refer to young pregnant women

antenatal care services but reinterpreted when and how to use the services, depending on their situations, the perceived importance of antenatal care and quality of the services.

Vaileti attended antenatal care as recommended in her two previous pregnancies but being required to go with her husband for the first antenatal visit forced her to reinterpret the use of antenatal care services because her husband was away doing casual labor in another region. While Vaileti ended up making three antenatal care visits, Asteria made only two visits. Unlike Vaileti, Asteria's delay was a result of the critical reflection of how antenatal care services were provided (cf. Van Hollen 2003; Obemeyer 2000). Talking about the quality of the services, other women expressed dissatisfaction with one of the healthcare providers who was using harsh language during antenatal clinic sessions. For example, Miriam complained:

> That nurse (…) is very unpredictable, sometimes when we go she laughs with us and the clinic session goes well. Other times it is as if evil spirits (*mashetani*) get into her head, she shouts at us as if we are small children and uses abusive language. I tell you she knows how to abuse, she can make you fill very bad. To say the truth, women do not like her. If she wakes up with a bad mood and you are late to go to the clinic she can even tell you to sweep the dispensary's compound before she attends you (IDI, Miriam, Magambua Village).

The observation made by women about the provision of antenatal care services indicated the shape the FANC model had taken in Lalta and how women interpreted the provision of the services. While the FANC model emphasized on the interactive approach, during antenatal clinic sessions healthcare providers gave instructions that women were required to follow. For example, Asteria lamented that they were not told why they needed to have the sugar test. Most women knew why they were tested for HIV and malaria but did not know why they were tested for sugar and blood pressure. Furthermore, most of my interlocutors did not know about the changes in the antenatal care model. Some of those who made the four recommended ANC visits told me that they were just following the healthcare providers' advice to return on the date indicated on the clinic card. However, they had no idea that they were required to make at least four visits. Others thought if they had gone early, they would be told to return many times. Helena, a 22-year-old married woman with a second pregnancy who initiated antenatal care when she was five months pregnant said:

> I think going early is not so good because you will have to go so many times and the clinic card has not enough spaces to fill in many attendances. Maybe if they will give us another card but for me, I thought if I started early, I would have to go many times. (…). In the first pregnancy I went three times, I started when I was four or five months, just like this one. (IDI, Helena, Wairo Village).

Some posters at both dispensaries had explanations about the FANC model and the number of the recommended visits. Only a few of my interlocutors knew about the recommended number of antenatal care visits. This was the case with Mama Wawili, who demonstrated a very good understanding of antenatal care services.

5.2.3.3 Selective Compliance: Mama Wawili's Adequate Use of Antenatal Care Services

Mama Wawili's use of antenatal care services was exemplary. Several other women used antenatal care services as required but Mama Wawili stood out for attending antenatal care adequately but giving birth at home. I learnt about Mama Wawili in one of my conversations with the TBA in Wairo Village. She had stopped assisting home births but in some cases when complications arose during home births, she was called to help. Mostly she would advise the family to take the woman to the dispensary and in rare cases, she would try to help. Among one of the rare cases of an emergency during a home that she addressed was of Mama Wawili, her neighbor, which happened about three years before. Mama Wawili had given birth to twins and faced difficulties in expelling one of the placentas and the TBA was able to help her. She mentioned about Mama Wawili's case because she had recently given birth at home, something the TBA did not expect. Even though Mama Wawili was giving birth at home the TBA was amazed at how she attended antenatal care, something she said many women in the villages did not observe:

> Even if you ask the nurses, they will tell you, she goes to the clinic very well and they praise her for that, but the problem comes during the time of birth, she never goes to the hospital. I thought that after the problem she got with the twins, she would never give birth at home but she has surprised me, she has given birth at home again (IDI, TBA, Wairo).

After I learnt about Mama Wawili's use of antenatal care services, I paid her a visit. I was interested to know why she attended antenatal care and gave birth at home. Mama Wawili was a 33-year-old married woman with five children (including a set of twins). During the interview, I

was struck to learn that she was a primary school teacher with a diploma in primary school teaching. Her husband was also a primary school teacher. Education level has often been linked to adequate use of all components biomedical maternal healthcare services (Makonnen and Makonnen 2002; Dimbuene et al. 2017; Weitzman 2015), but was not the case with Mama Wawili. She demonstrated a high understanding of antenatal care services for safe pregnancy including the importance of monitoring blood pressure, fetal development and management of danger signs. It turned out that Mama Wawili was attending antenatal care to make sure her pregnancies were safe according to biomedical standards in order to ensure safe home births. She explained:

> I do not see giving birth at home as a problem. If I go well to the clinic and I know that the pregnancy is fine, I do not see any reason why I should go to give birth in the hospital (...). My mother is here, she lives with us and she assists me during childbirths. She (referring to her mother) gave birth to eleven of us, all at home (IDI, Mama Wawili, Wairo Village).

Mama Wawili was advised to go to a referral hospital for childbirth when she was pregnant with twins but she did not go. Her mother assured Mama Wawili that she would give birth safely at home. The problem she had with the placenta did not prevent her from giving birth at home once again. So long as the placenta came out, she saw no reason to stop giving birth at home. Like Berry (2010: 170) shows, some of the women in Kaqchikel Village in Guatemala considered encountered obstetric complications as problems only when they could not be resolved at home. Mama Wawili and her mother did not disregard biomedical knowledge but considered it to be important in case of birth emergencies that could not be resolved at home.

5.2.3.4 "I Think Going Once is Enough:" The Power of the Clinic Card

Since 1978 when the WHO introduced the clinic card for pregnant women it has become an important item for keeping information about the health status of pregnant women and pregnancy progress. Langwick (2001) shows that, the clinic card is used in the management of pregnant women making them discrete, predictable and ideal individuals for therapeutic practice. Clinic cards for pregnant women contained observations made during antenatal care assessments. For example, the HIV status was crucial information for healthcare providers to know before assisting women with childbirth in order to protect themselves. Women without clinics cards especially in

the two referral hospitals, were required to undergo HIV testing before being assisted with childbirth.

Most of my interlocutors delayed initiating antenatal care and several others made only one visit, the reason to which being to get the clinic card. During my conversations with Vaileti and Mama Wawili, the need for the clinic card was mentioned but was not the main reason for going to the clinic. It was different in the case of Regina who was 24 years old, married and had just given birth to her third child. Regina explained clearly that she attended antenatal clinic in order to obtain a clinic card. When I asked about the test assessments, she said they were necessary when a pregnant woman was sick. Her explanation revealed how she came to the decision to make only one visit. Regina said:

> When I became pregnant for the first time, I thought women go to the clinic every month. When I went, I was four months pregnant... (...). I just considered that the right time to go because I knew it was important to go to the clinic. (…). I just knew it was important I even heard other women talking. The nurse checked me and told me to go back after two months. I went back after two months and again, she told me to return after two months. I did not go every month as I thought (…). Maybe, because I was not sick the nurse did not see the importance of me going every month. In the second pregnancy, just like this one (referring to the one she had just given birth), I went only once and I did not return until the time of childbirth, that is when I went to the dispensary. (...). I think if you are not sick, going once is enough. They give you the clinic card on the first day you go. (...). They test you and they give you the clinic card. To say the truth, I went because I needed the clinic card. (...). The nurses ask about it when you go to give birth but I was not sick or feeling bad. If you do not have a clinic card the nurses become very harsh, they say they cannot know the problems you have (IDI, Regina, Ilasee Village).

Regina thought the nurse told her to go back after every two months because she was not sick and in the following pregnancies, she decided to go only once. Like Valeria and Asteria, Regina referred to her own experience in taking care of pregnancy. However, unlike Mama Wawili, Regina thought giving birth in a health facility was important. She needed the clinic card so that she could be accepted at the village dispensary during childbirth. Regina's husband on the other hand, although he did not insist his wife about antenatal care attendance, thought that giving birth in a health facility was important and supported Regina to go to Upendo dispensary for childbirth. For others, getting the clinic card was important for them to be accepted at the dispensary in case of a complication during a home births, or when taking the newborn to the dispensary for check-

up. Sheila, a 26-year-od married woman who had just given birth at home to her second child and had attended antenatal clinic only once explained that:

> Without the clinic card they (healthcare providers) will not accept you even if you have a problem. (...). There was one-woman last year she got a problem when she was giving birth at home (...). I don't know they said the baby refused to come out, she did not have the clinic card. When she went to Upendo Dispensary, the nurse refused to attend her. She went back home and she was lucky the baby came out. If you do not have the clinic card, they also disturb you to register and give the clinic card to the baby (IDI, Sheila, Manantu Village).

Other studies (Chapman 2010; Allen 2004) have also observed that women attended antenatal care to get the clinic card. Collaghan-Koru and colleagues (2016) argue that, the FANC model might have contributed to fewer visits since all the tests are administered on the same day unlike previous times when they were administered one at a time as women attended the clinic. The need for the clinic card regardless of the intension to give birth to a health facility may explain the high percentage of women making at least one antenatal care visit. Ninety-eight percent of pregnant women in Tanzania make at least one antenatal care visit while 54 percent make the recommended four visits (URT 2016: 168). The experiences and rationalities of using antenatal care services show why there is no correlation between antenatal care attendance and giving birth in health facilities. Additionally, women knew about antenatal clinic attendance from communicating among themselves, with their elders like Valeria indicated and even listening to the radio as Davina mentioned. This means that information about antenatal care that circulated among women was based on subjective experiences of particular individuals who shared the information or advised women about pregnancy care. This also point to male partner involvement in pregnancy care practices and antenatal care attendance.

5.2.3.5 "Pregnancy is a Thing for Women:" Male Involvement in Pregnancy Care

Male involvement in pregnancy care is one of the main things emphasized in the FANC model (WHO 2015b). Being the main decision-makers and bread winners in the families, men's involvement is associated with positive pregnancy outcome and reduction of maternal mortality (ibid). During home visits, CHWs encouraged men to accompany their partners to the antenatal clinic especially during the first visit where they could also learn about pregnancy care. I observed

men accompanying their wives during the first antenatal care visit but I did not see them doing the same in subsequent visits. Men's involvement in both accompanying women for subsequent antenatal care visits and helping them at home like several other studies have reported was minimal (see, for example, Maluka and Peneza 2018; Vermeulen et al. 2016).

My conversations with both men and women, and observations in daily interactions revealed that although men were the first to get information when pregnancy was suspected, most of them were not involved in pregnancy care decisions like when to start attending antenatal clinic, or providing assistance especially on household chores. Women expressed the desire for support from their partners during pregnancy, which was however, difficult to get. The lack of support from men during pregnancy can be understood through the local provision of antenatal care that did not foster the idea of male involvement as intended in the FANC model, and gender relations that associated pregnancy and antenatal care attendance with women rather than men. During clinic sessions, I noted that the healthcare providers did not emphasize men to accompany their partners for subsequent visits. They however, insisted about helping women with manual work like farming, providing them with a balance diet, and protecting them from STDs by staying faithful. When Vaileti and her husband made the first ANC visit, the healthcare provider mentioned nothing about the need of Vaileti's husband to accompany her in subsequent visits but insisted that he should help her with work and give her enough time to rest. Thus, to most men, pregnancy care meant accompanying their partners during the first antenatal care visit. Those who could not go with their partners for the first visit were required to present a letter from the village government stating why their partners could not accompany them. For example, Vaileti's husband, who was 29 years, considered accompanying his wife during the first visit as enough support:

> I know I must go with her for the first visit. It is just because I was not around but I knew I had to go with her. (...). They want us to go and do the tests. (...). You know, it is a must to go for HIV testing. It is the duty of us men to go with our wives for the tests. (...). I cannot go with her every time, what will I go to do there while she is the one carrying the pregnancy? I finish my duty that one time, HIV testing is a hard thing, that is a very big duty (IDI, Vaileti's Husband, Magambua Village).

Vaileti's husband also indicated concerns about mandatory HIV testing for pregnant couples, which was expressed by other men as well. For example, Regina's husband who was 27 years

old complained that the healthcare providers compelled pregnant couples to test for HIV as if it was an easy thing. He said:

> They tell us we must test to protect the baby but AIDS is not like malaria to say you will drink medicine and be healed. When your wife gets pregnant you start thinking about the test. Until you go to the dispensary a lot of thoughts have gone around your head. It is not easy if you think about it (IDI, Regina's husband, Ilasee Village).

Chapman (2010) and Wendland (2017) show that women in Mozambique would avoid going to the antenatal clinic for the fear of finding out about their HIV status. Maluka and Peneza (2018) as well as Vermeulen and colleagues (2016) show that mandatory HIV testing for men during the first visit acts as a barrier to early antenatal care attendance in Tanzania. They show that men's reluctance to HIV testing is associated with the fear of disclosure and stigma (cf. Bohle, Dilger and Groß 2014). Generally, HIV testing did not appear to present a barrier to antenatal care attendance in Lalta but rather, men expressed concerns about mandatory HIV testing.

During one of the focus group discussions with men, I asked their opinions about accompanying women for antenatal care and if they were ready to learn about pregnancy care. Miriam's husband, a 30-year-old man responded first. He said:

> You know, your questions are favoring women a lot. Now, why should we go to the clinic while pregnancy is a thing for women? We men know very little about pregnancy. They (women) know what to do to take care of themselves. If my wife needs me to help, I can help but women themselves know better than us men. That is why we leave it to them to take care of themselves (IDI, Mariam's husbands, Magambua Village).

Other men agreed with Miriam's husband that knowledge about pregnancy care was the domain of women and they had little to contribute. Most men accompanied their wives for the first clinic but were selective with other aspects of pregnancy care as advised by the healthcare providers and CHWs during home visits. Some men helped their wives with farm work but did not do the same with household chores. They attributed certain types of work and pregnancy care practices to women. Accounting for men's little involvement in pregnancy care Nyemo explained that:

> The Sandawe men are not concerned with pregnancy care. (...). It is just like that. It is only women who need to pay attention. Men do not understand many things about pregnancy and they do not care. Even when I was still giving birth, when I carried pregnancy, I did not stop working. I did everything; I was going to the farm and doing

> housework. I gave birth to all my children without any problem (IDI, Nyemo, Magambua Village).

Men also viewed pregnancy as a normal thing that should not stop a woman from doing especially household activities she had been doing before becoming pregnant. Some saw assisting women in such tasks as compromising their masculinity and the hierarchical relationship within marriage. Juma, a 32-year-old married man and a father of four said:

> At the beginning when my wife started going to the clinic, she started demanding that I must help her with farm work. She just started being lazy such that she did not even want to work at the small farm at home. (...). Yes, I was told to help her but I do not think it was the pregnancy that made her demand for help. She just wanted me to do the work alone and she did not want to go to the farm. She became stubborn and I told her she must go to the farm. In other pregnancies she did not ask me to help her, she was doing everything. These women, if you start helping them they make it a habit such that you may find they can get even the confidence to send you to wash clothes. When she gets that confidence, she builds a habit. I cannot allow that (IDI, Juma, Ilasee Village).

Even those who helped their wives were selective of activities to do. Saumu's husband was very positive about assisting his wife during pregnancy but was selective of what activities he could and what he could not do. He said:

> I help my wife very much. I do not see any problem if I have to go to the farm alone. Sometimes pregnancies disturb them. (...). I cannot help with the cooking or cleaning. She can still do that herself but I can go to fetch water. I have a bicycle and I can carry the gallons on the bicycle. I see no problem in helping her with that. (...). The household works, when you start doing them people will start to say that your wife has sat on you (*amekukalia*) and you cannot control her, you just follow what she wants. (...). They are just small works that I think she can manage to do herself but if she is sick I can cook (IDI, Saumu's Husband, Wairo Village).

Saumu's husband just like Juma, singled out activities he could do without compromising his masculinity, the hierarchical relationship within marriage and being termed as being "sat on" by his wife. Saumu, on the other hand, appreciated the help she got from her husband and she had no problem doing household activities and whenever she needed help, her mother was ready to do so.

My conversations with women revealed that the lack of spousal support weighed heavily on them and made pregnancy period stressful. Salama who was 34 years old with her seventh pregnancy

was one of the women who found the pregnancy period very stressful because her husband who used to be supportive was no longer helping her. She had this to say:

> My husband has no love for me anymore. I remember when I became pregnant for the first time; he was even fetching water when I told him I was not feeling good. But he has changed. These days I cannot ask him to help me with anything. He is very harsh such that he does not want to listen to anything. With this pregnancy, I still go to the farm and he does not care. (...). If I refuse, he can even beat me. Thus, to avoid confrontation, I just go to the farm. My children are still young but they are the ones helping me. He is busy going around with other women because he knows he has already closed me[54]. With this stomach I cannot do anything. (...). He knows very well I cannot sleep with other men (IDI, Salama, Manantu Village).

According to Salama, male support depended on a man's love to his wife. This was a concern that was raised by most of my interlocutors. Women complained that their husbands did not care because they had no love for them. Hidaya, for example, said:

> It is truly difficult for our men to help us. When he takes you that one time (for the first antenatal care visit) he sees that he has finished the job, he just waits for childbirth. To say the truth, they help during childbirth. (…). They help us to buy things in preparation for childbirth but they are so difficult with helping during pregnancy. Maybe if he loves you, he can help, otherwise you cannot say they will help because they are told (by the healthcare providers) to help or you ask him to help, no. If you feel that you need help, you have to stand for yourself. For example, for me, my husband knows that when the pregnancy reaches five months, I no longer go to the farm; that is my stance. If you wait for them to tell you to stop going to the farm, you will give birth in the farm. They do not care. They just talk things that have no meaning. Haven't you heard they say that pregnancy is not a disease for them to help you? You do not know the Sandawe men. To them, pregnancy is not a problem. If it is a problem, it is for women not them (IDI, Hidaya, Magambua Village).

To restore love and get support from their husbands, some women resorted to using charms from traditional hears. Although this practice was not limited to pregnancy, the charms were mostly sought during pregnancy because men tended to sleep with other women and abandoned their pregnant wives. Men expressed bitterness about this practice and for some, their refusal to help

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[54] Being pregnant in Swahili is referred to as having (in the stomach) something heavy (*kuwa mjamzito)* or carrying something heavy (*kubeba ujauzito*). Giving birth is referred to as *kujifungua,* meaning to open oneself. So once a woman has given birth, she is free from the weight she has been carrying.

was a demonstration that they were not "bewitched" (*kulogwa*) by their wives. For example, Shabani, a 30-year-old married man explained:

> We men do not like what women are doing. They want to force us to help them even to wash clothes and dishes. Many women here go to traditional healers to bewitch their husbands. I have told my wife not to try to do that because if I happen to know that she has bewitched me, I will leave her. It is not normal for men to do household chores. If you see a man doing them, you know he is already bewitched, no man in his full sense can sit and start washing dishes while his wife is there, not sick, just pregnant. (IDI, Shabani, Manantu Village).

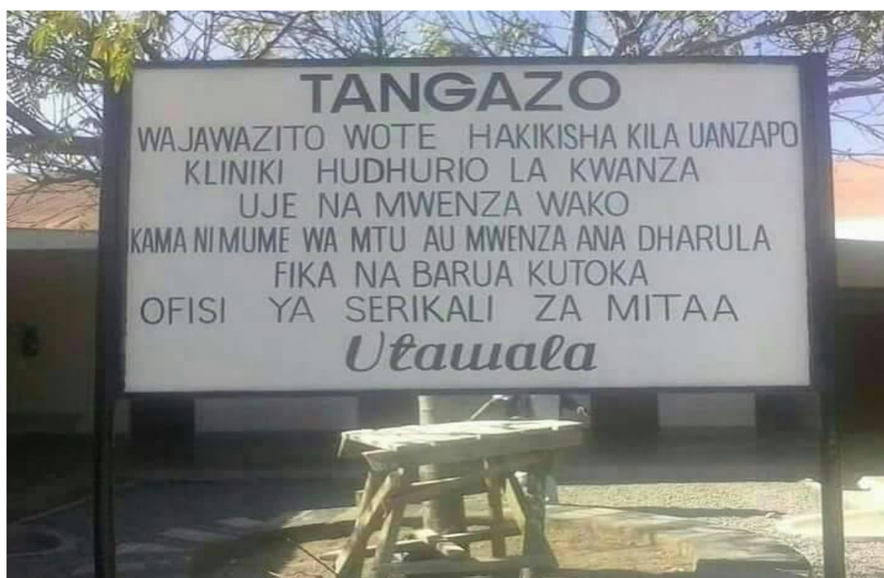

Figure 5.2: A poster in one of health facilities in Tanzania instructing women to go with their partners during the first antenatal care attendance[55]. (Photo credit: Dennis Mganyizi, used with permission).

5.3 "They are So Ignorant:" Out of Health Facility Births

Incidences of childbirth out of the village dispensaries in Lalta were many. While some of the women gave birth at home, others gave birth on the way to the dispensaries. During the time of

[55] The poster reads; "All pregnant women, make sure that you come with your partner whenever you start the first antenatal care visit. If your partner is someone's husband or your partner has an emergency come with a letter from local government."

my research, there were 7 incidences of births on the way to the dispensaries and I interviewed several women who had given birth out of health facilities. One way to understand the situation can be as healthcare providers suggested, women were ignorant and did not care about giving birth in health facilities. Given the availability of birth service, women's underutilization of biomedical maternity services may seem to support the healthcare providers' view. Nonetheless, a closer look at women's childbirth experiences provides a more complex picture, which like in the use of antenatal care services, shows the interplay of biomedical services and other knowledge systems, social, history and individual wishes of collective position and personal choice. In other words, rather than being guided by the availability of the birth services to give birth in the dispensaries, as socially embedded actors, women's birth experiences showed imbrications of structure and agency in a particular context.

5.3.1 Why Women Gave Birth at Home

One of the main reason anthropological scholars have delineated about women's preference for home birth are the meanings attached to home birth and the comfortability it provides (Burns 2014; McCourt et al. 2016). For example, Berry (2010) shows that, among the Mayan in Guatemala, the moment of childbirth requires the presence of some of the woman's relatives, each playing a specific role in assisting with childbirth that reinforces family relationship. She shows that biomedical maternal healthcare interventions threatened this social aspect of childbirth by emphasizing on hospital-based births to which women were, however, reluctant to comply.

In this regard, understanding women's preferences to home births despite the availability of the services entails looking at how childbirth was conceptualized among the Sandawe. As I have shown about pregnancy care practices and the use of antenatal care services, childbirth too was considered a women's area, although men supported materially in the preparations for childbirth. Besides, Raa (1981) shows that, childbirth among the Sandawe had been considered a normal thing that provided women with an opportunity to show their strength, especially when they were able to give birth alone in "the bush" (ibid: 183). This does not mean that women were not assisted during childbirth or they were not concerned about the possibility of maternal deaths, but it was the choice they made to demonstrate their feminine strength. Raa (1981: 181) shows,

when an impending birth of twins was suspected, the possibility of a maternal death was feared. Instead of letting a woman give birth alone, experienced women were prepared to assist with the childbirth at home.

When I talked to Nyemo, she corroborated the information that sometimes women gave birth in "the bush" (*porini*), something she never did herself. Unlike these days when hospital birth services are available, she said in their time (1950s and 1960s), the services were unavailable. Women gave birth at home, assisted by their relatives. Nyemo said, to ensure a smooth childbirth, in the last the month of pregnancy women would start grinding millet on a grain grinding stone which would help to push the baby down ready for birth:

> You see that stone there, (pointing to a curved smooth stone in front of us), I have had it since we moved here from the hills (referring to the resettlement during villagization) and I used it in preparation for childbirth. Millet grinding helps to show the way to the baby. However, if the woman is lazy and does not want to grind, she will get problems because the baby will be struggling to find the way. These days women take millet to the (milling) machines (*mashineni*) and that is why they run to the hospital to give birth. The do not help the baby to find the way (IDI, Nyemo, Magambua Village).

Despite the availability of birthing services that women were urged and compelled to use, some women's preference to home birth can be understood against this background in which childbirth is seen as a normal thing that can be managed at home. For example, Mama Wawili never had a facility birth experience, and even the question of being mistreated during childbirth in health facilities (Chapter 6) did not feature into her preference for home birth. Her choice to give birth at home was influenced by her mother's experience. According to Mama Wawili, her mother gave birth at home, and never experienced any problem. Giving birth in a health facility was not considered necessary for women like Mama Wawili, unless as I have mentioned before, a problem was encountered during a home birth and could not be resolved at home. Mama Wawili chose to use the ANC services, but still counted on her mother's knowledge during childbirth. Her husband had no objection about his wife giving birth at home.

Others like Naimani were flexible and navigated between biomedical and traditional forms of maternity care, according to their particular needs and concerns. Whereas Naimani was assisted by the traditional healer for the fear of witchcraft that could harm her and the baby, Miriam gave

birth to her fourth child at home because she wanted a ritual to be performed to enable her to give birth to a boy child. I have shown in Chapter 4 that, giving birth to a boy was of particular importance to both women and men. Miriam's first three children were girls and she wanted a boy child. Her mother advised her to give birth at home so that a ritual to enable her to have a boy child could be performed in case the child she was carrying was not a boy.

When a woman wanted to have a child of a different gender, after birth, the placenta was turned inside out and the woman mentioned the gender of the child she wanted. The placenta was then buried inside the house and it was believed that when the woman would become pregnant, she would give birth to a child of the gender she mentioned. Miriam's fourth child was a girl and a ritual was performed. The fifth child was a boy and she gave birth at Mshikamano Hospital. Whether the ritual worked, or it was a sheer coincidence that she gave birth to a baby boy is less important than the need to have a boy child that compelled her to give birth at home to allow the ritual to be performed. The fact that Miriam planned and went to give birth to the referral hospital during her fifth pregnancy, indicated how women made use of the different knowledge systems according to particular needs regardless of the availability of birth services and the risk of maternal death associated with home births.

Other women's home births were a result of their experiences from using biomedical maternity services. This group comprised of women who had confidence in biomedical birth services but were either denied the services or mistreated during childbirth in health facilities. Some of the women, as I show in Chapter 6 were denied birth services at the village dispensaries because they were categorized as being at a higher risk of developing obstetric complications that the village dispensaries could not handle. Denying them services was a way of compelling them to go to referral hospitals. When they could not go, they gave birth at home. Some women, despite being mistreated, still had confidence on biomedical birth services, and for others, it was the beginning of considering the possibility of a home birth. When I met Ashura, a 28-year-old married woman, she had just given birth to her third child at home. This was the second time she had given birth at home, the first time was when she was unable to go to the referral hospital because of lack of money. Accounting for her decision to give birth at home, she said:

> When I was pregnant with my first child I went to the clinic, the nurses told me I must go to the referral hospital for childbirth because it was the first pregnancy. They said I should not go to the dispensary because they will not receive me. My mother told me that I should not worry because she would help me during childbirth and she did without any problem. (...). My husband had no money to give me to go to Mshikamano Hospital that is why I gave birth at home. When I became pregnant again, I said let me go to the dispensary, the nurses said I should go to give birth at the dispensary. I prepared the things and when I got the labor pain, I went with my mother to the dispensary. I gave birth well but I did not see much difference from a home birth. (...). With this pregnancy, I just did not want to go to the dispensary; my mother came and helped me again. There is no difference, you do all the work, you push and the nurse receives the baby (IDI, Ashura, Manantu Village).

Ashura wanted to experience childbirth at the village dispensary to which she saw no difference and decided to continue giving birth at home. Other women in this group had experienced negligence and harsh treatment during childbirth, especially in referral hospitals. I am not suggesting that women were not mistreated at the village dispensaries, for being turned away itself was a mistreatment. However, apart from this bureaucratic procedure intending to governing women to go to referral hospitals for childbirth, most women expressed satisfaction with childbirth services at both village dispensaries. Some were of the opinion that they were treated better in village dispensaries than in referral hospitals. After the second phase of fieldwork in the two referral hospitals, I had the same opinion (Chapter 6). In the villages, pregnant women were accompanied by their relatives and enjoyed their assistance until they felt they were ready to give birth. The dispensaries were also never overcrowded by pregnant women. For some women who had experienced mistreatment in referral hospitals, when they were required to go, the choice was to give birth at home. This corroborates the observation made by Berry (2010: 2) that, during childbirth what women care about is not only avoiding a maternal death but how they are treated by biomedical practitioners. However, not all out of health facility births were a result of women's choice, for others it was purely circumstantial. Several of my informants had planned to give birth at the village dispensaries but ended up giving birth either at home or on the way to the dispensary.

5.3.2 Three Out of Health Facility Births

Friday 12th August 2015, started like any other day. I had one scheduled interview in Manantu

Village and I returned home at around 01:00 pm. After I had some food, I joined Mrs. Ng'atwa who was removing maize from the cobs at the back yard. After some time, I heard a motor bicycle packing in the front yard. I assumed it was Samson, the *bodaboda* rider I had hired to take me around the villages. As I suspected, it was indeed Samson. He came directly to the backyard and greeted the two of us quickly. I could feel the excitement in his voice. He told me, "Dada Anitha lets go, there are three women today who have given birth at home. They are all at Upendo Dispensary now!" Without wasting time, I got inside and changed the *khanga* I had on, grabbed my purse which I had not unpacked (so I knew the notebook and the recorder were inside) and got on the motorcycle. When we reached at Upendo Dispensary, we found two women with their newborns and some of their relatives sitting on the veranda. One of them was Shangwe, one of my informants whom I was following closely.

I walked into the nurses' office where I found Nurse Zaina and Vivian together with another woman with a newborn and a man. I greeted them and stood aside as Zaina and Vivian questioned the woman as to why she gave birth at home while she could come to the dispensary. Nurse Zaina overwhelmed by what had happened turned to me and said "I tell you the Sandawe women are so ignorant; they are so ignorant. You see, this one has given birth at home: she is saying she was afraid of coming to the dispensary because she was drunk. She carried the pregnancy but her husband is smarter than her." Her statement was supported by Nurse Vivian who said that women did not care about giving birth at the dispensaries. In her explanation, Nurse Zaina said the woman was afraid of coming to the dispensary because when the labor pain began, she had taken *choya* (a local beer) thus, she was scared a nurse would scold her for being drunk. She was assisted to give birth by one of her friends who happened to be her neighbor. When her husband, who was not at home came back, he insisted that they should take the baby to the dispensary. He had supported his wife to prepare things for childbirth and expected that she would give birth in the dispensary. The woman herself was planning of taking the baby to the dispensary on the next day when she would no longer smell alcohol. The woman and her husband were asked to pay 10,000 Tanzanian Shillings (equivalent to 4 Euros) as a fine for giving birth at home. Without paying the fine, they would not get a clinic card for the newborn. The husband pleaded with the nurses to be excused from paying the fine but Nurse Vivian told him it was compulsory. The other two women were attended and they too, were asked to pay 10,000 Tanzanian Shillings. I knew

Shangwe had planned to give birth at the dispensary. I told her I would go to see her in the following morning. I asked the other woman if I could also talk to her on the next day, she agreed.

5.3.3 Use of Herbs to Accelerate Labor: Adjusting to the Local Provision of Birth Services

The following day I visited Shangwe in the morning at around 10:00 am. She was living in Ilasee Village. She was 27 years old, married and that was her third pregnancy. From our conversations since I met her in April 2015 when she was five months pregnant, had planned to give birth in the dispensary. When I arrived, her mother invited me inside Shangwe's small bedroom. She gathered herself and sat on the bed to let me see and carry her newborn baby girl. I asked Shangwe what had happened to her plan of giving birth in the dispensary. She told me she did not give birth at home as the healthcare providers claimed but had given birth on the way to the dispensary and was assisted by her mother.

Shangwe gave birth to her first child in Umoja Regional Hospital after waiting for two weeks at Matazamio maternity waiting home. During the second birth, Shangwe went to the dispensary as soon as the labour contractions started. It was in the afternoon but she gave birth at mid night. All the time while waiting to give birth she sat outside on the Upendo Dispensary's verandah. The nurse had asked her to go home and come back later but the pain was strong and she thought she would give birth anytime. Intending to avoid waiting for a long time at the dispensary, Shangwe's mother gave her a herbal concoction to accelerate labor when the contractions started in the morning. When the contractions got stronger, Shangwe and her mother started walking slowly to the dispensary. Unfortunately, before they reached, Shangwe gave birth. Instead of going back home, Shangwe and her mother decided to take the baby to the dispensary for check-up.

Upendo Dispensary had a small labor room and women waiting to give birth had no waiting room except the verandah. Faraja Dispensary had a women's ward but in case women used the ward, they had to pay 2,000 Tanzanian Shillings (equivalent to 80 Cents-Euro) because birth services provided at the dispensary did not include admissions.

5.3.4 Limitations of Free Biomedical Maternity Services

After I finished talking to Shangwe, Samson took me to the home of the other woman in Magambua Village. Her name was Levina, she was 22 years old, and that was her second birth. When I entered inside her room, she seemed to be in pain and she told me since the previous day, after she had given birth, she had severe stomach pain. She told me she had planned to give birth at the dispensary and her husband who was working in Arusha promised that he would furnish things needed for childbirth in the village dispensary. Unfortunately, the labor pain came before the estimated due date and she had nothing prepared without which she would not be accepted at the dispensary. She explained:

> I wanted to go to give birth at the dispensary. My husband is coming this week and because I was told I would deliver anytime from next week so, I was not worried. I thought my husband would be here in time but in bad luck, he was not able to come. (...). I could not really go without the things. I would make the nurses angry. My mother called our neighbor (an elderly woman) and they both assisted me to give birth. Thereafter, we went to the dispensary as you found us yesterday (IDI, Levina, Magambua Village).

Levina admitted that she was somewhat worried since her first birth had taken place in Umoja Regional Hospital but she had no other choice. One of the messages used to encourage women to give birth in health facilities was that the services were free. However, women had to prepare the supplies including gloves, a small basin, cotton, plastic sheet to spread on the labor bed, a razor blade, a thread to tie the navel string, and new *khanga* to wrap in the newborn and some for the mother. Provision of free biomedical maternal healthcare services was used to encourage women to give birth in health facilities but when women could not prepare the required things, free services were still not enough to allow them to use childbirth services.

5.3.5 "Lack of Relatives is Great Poverty:" Lack of Family Support, Drought, Alcoholism and Birth on the Way to the Dispensary

The presented childbirth experiences show how the local conditions of provision of birthing services limited women's use of the services. While Levina had no necessary supplies for childbirth in the village dispensary, Safina's case study (subsection 5.3.5.1) shows further the manner in which pregnant women's experiences were influenced by economic changes that affected family relationships and fashioned the outcome of the decisions to use childbirth

services. Mattes (2016) shows that, life with anti-retroviral drugs (ARVs) can only thrive if patients are able to receive care that exceeds the efficacy of biomedical treatment especially from close family members. Safina's birth experience presents fairly a similar situation with the use of biomedical maternal healthcare services in Lalta. Safina had prepared herself to give birth at Faraja Dispensary but the lack of family support made her give birth on the way to the dispensary. Safina's experience, like that of Levina, present the power of the unforeseen in the planned use of birthing services.

5.3.5.1 Meeting Safina

I met Safina for the first time in April 2015. She was a 25-year-old woman, married with two children aged three years and four months. One of my interlocutors had talked about her during the interviews that she had given birth on the way to the dispensary and it caught my attention. Many women in Usandawe gave birth on the way but what was specific about Safina was the way the woman I was interviewing talked about her. She described Safina as being, "clean and smart like a town woman" (*msafi na nadhifu kama mwanamke wa mjini*) but she had given birth on the way to the dispensary. I asked if she could take me to her and she agreed to take me on the next day. When we arrived at Safina's home in Manantu Village, we found her sewing a dress with a sewing machine in her small and tidy sitting room. She welcomed us with a bright smile. The woman introduced me and Safina agreed to talk to me on the following day. For about one hour, the three of us talked and discussed about general problems women faced in Lalta. I then left the two women continue talking because I had to walk back to Magambua Village where I lived.

On the next day I went to see Safina for an in-depth interview. She welcomed me and after we exchanged greetings, I asked for her consent and whether I could record our conversation to which she agreed. As I was getting the recorder ready Safina said, "She told you (referring to the woman who brought me to her on the previous day) I gave birth on the way, everyone knows. You do want to know about me giving birth on the way…" She started talking in a low voice and our long conversation about her childbirth experience began.

Safina was married in 2011 and got her first born who was then three years old, in 2012. She was originally from Mpwapwa District where she met her husband and they moved to Usandawe. When they came to Usandawe she was already pregnant with their first child. Because she was advised to give birth in a referral hospital, she went back to Mpwapwa to give birth at Mpwapwa District Hospital. Three months after giving birth, she returned to Usandawe.

At one point during the interview, her husband walked in, a strong smell of alcohol filled the small sitting room. I greeted him but he did not reply, he stared at me and asked Safina, “who is this?” I looked at him and it was obvious, he was drunk. Safina was embarrassed and asked me to leave. As she walked me out, she asked me to come back the next day before noon. I left feeling sorry for her. The next morning, I woke up early and got ready to go to Safina’s home. I found her sweeping the compound. She was sorry about the previous day and I told her not to worry. When we started the interview, she explained about her husband drinking problem which she said started around the end of 2013.

> You see, he had a *bodaboda* (a motorcycle) and he was earning some money but I do not know who convinced him to sell it and go to rent a farm in Kondoa to grow sunflower. You know, the rains were not good and he got nothing. Since then, he does nothing expect drinking *viroba* all day.

According to Safina, her husband had been drinking but mostly the local brew (*choya*) and occasionally, *viroba*. However, drinking had become a big problem over the past one year because he had been drinking *viroba* almost every day. Safina complained:

> This modern alcohol (referring to *viroba*) they have brought will kill our men. I tell you my sister. Imagine, a man can get drunk for 500 (Tanzanian) Shillings (equivalent to 25 cents-Euro). His relatives are blaming me that I did not advise him properly that is why he sold the *bodaboda*. What could I have told him? He had already decided himself.
> (…). He did not tell me; one day he came without the *bodaboda* that is how I got to know he sold it.

Safina said because she had a sewing machine, she could provide for the family with the little money she got from sewing clothes. “Otherwise, with the increasing and prolonged drought, we would die from hunger,” she explained.

I asked her what happen until she gave birth on the way. Safina looked at me and I could feel a change in the tone of her voice as she said, "my sister lack of relative is great poverty, had my mother been here I would not have given birth on the way." She said when she became pregnant, her husband did not care like the first time. However, he went with her for the first antenatal visit when the pregnancy was three months old. Her husband's relatives did not pay attention to her as well. Safina said the relatives did not like her because she was not from Usandawe and they perceived her as a bad wife because she could not advise her husband to stop drinking. Safina knew the importance of support from other people closer to the time of giving birth but she could not count on the help of her husband's relatives. Thus, she prepared the necessary things needed during childbirth in the dispensary. Safina said she got labor pain in the morning, but her husband was not at home and her neighbors had gone to the farm:

> I thought I could wait for them (the neighbors) so that they could take me to the dispensary. I had everything ready, the basin, the *khanga*, the cotton and the razor, everything was ready; but as time passed, the pain got more intense. I was afraid to start walking to the dispensary alone. It is a long distance with the labor pain and I could not leave my child at home alone. Therefore, I waited. I did not think I would give birth on the way. The labor pain in the first pregnancy lasted for more than twelve hours. I thought this one would be the same. I was wrong.

I could see tears forming in her eyes as she talked. She said, the neighbors came back in the afternoon and carried her on a bicycle to take her to the dispensary but she ended up giving birth on the way. Safina offered to take me to the place she had given birth. "I can take you there, where I gave birth, it is not that far from here," she told me and I accepted. She carried her young baby on her back and took her three years-old child to her neighbor's house. We had walked for approximately seven minutes on the main road leading to Faraja Dispensary when she suddenly stopped and pointed to the side of the sandy road, "It is here," she said. "I was on a bicycle but when we got here, I could not tolerate anymore, I laid down. My neighbor's husband rushed with the bicycle to call the TBA from Magambua and she came in time and assisted me to give birth." It was an open place with hardly any trees around such that one could at least think of laying under a tree. "I laid the *khanga* I was carrying on the grass," she told me while standing on the place she had laid. But, there was hardly any grass, just a few patches of dry grass here and there. The openness of the place in a broad day light would let anyone see what was happening from a

distance. I told her I was so sorry about her experience. While we were there, she noticed a dry blood spot on a big stone stack on the ground closer to the place she said she had laid. She tried to scratch it with a small stone. Standing still, I watched her scratching the blood spot on the stone and thought of how much risk it took for one to give life. Unfortunately, giving birth on the way to the dispensary was the experience of many women I talked to during the course of my fieldwork in Lalta.

After visiting the place where Safina had given birth, I had no strength to carry on with the interview, she seemed sad and I was devastated. I asked her if we could meet some other day because I still wanted to learn more about her childbirth experience. I met Safina after one week at Faraja Dispensary. We talked about what happened after she gave birth. Just like other women who gave birth outside health facilities, Safina's ordeal did not end with giving birth on the way to the dispensary. When she arrived at the dispensary, the baby was checked but Safina herself was not. When I asked her about the check-up, she was puzzled; she did not seem to know that she had to receive a medical checkup after childbirth. "Checked like I had given birth or? (...) Mh! they did not even give me water to clean the blood." Moreover, she was asked to pay 10,000 Tanzanian Shillings (equivalent to 4 Euros) for not giving birth at the dispensary.

5.3.5.2 The Penalty: Governing Autonomous Individuals

Women who gave birth outside health facilities, whether deliberately or by chance were penalized for being indifferent about the use of the available birth services. The penalty was intended to influence them to give birth in a health facility in the following births. When I talked to Nurse Asia of Faraja Dispensary, she told me they learned about fining women from their fellow healthcare providers of Chamwino District (one of the districts in Dodoma Region) when they met for a seminar in Dodoma City in 2010. She explained:

> We went for a seminar and when we talked to our fellows from Chamwino, they told us that they fine women who do not give birth in health facilities. (...). They told us that they were charging them 10,000 (Tanzanian) Shillings (equivalent to 4 Euros). When we came back, we decided to do the same. (...). The money is used for the dispensary's needs, but I heard in other areas, the village government has made the fining practice official because women like giving birth at home. I think our leaders here should do the same (IDI, Nurse Asia, Magambua Village).

The availability of birthing services and information on the importance of giving birth in a health facility managed to govern Safina but circumstances originating from the wider context determined the outcome of Safina's choice to give birth at the dispensary. On the other hand, the healthcare providers did not take into consideration circumstances of such women. The fine was for all mothers who gave birth out of health facilities regardless of their intentions of going to the dispensary.

When I talked to the healthcare providers to know why they did not take into consideration circumstances leading to births outside of the dispensaries, they expressed that if they did so it would encourage women to cheat and give birth at home. Nurse Vivian said:

> You know, others give birth at home and they come and tell us that they have given birth on the way. In the past, we were not charging them but they took that advantage such that whoever would come would say, 'I have given birth on the way.' Thus, we do not make any exceptions. The services are here. We do not even ask them to pay for them (IDI, Nurse Vivian, Magambua Village).

With such a generalized approach, even women who had embodied the importance of using biomedical maternal healthcare services but constrained by circumstances were classified as ignorant and careless and thus, they had to pay the fine just like those who gave birth at home by choice. Regardless of the circumstances, healthcare providers generalized women's experiences. Safina's experience points to the fact that reproduction of social forms and experiences is the result of what people do and not what they intend to do. Thus, governing of the self must be linked to the context in which the intention is fashioned and challenged. The rural context which is continuously changing sometimes enables or constrains women's choices, shaping experiences and subjectivities in different and complex ways.

5.3.5.3 Ascertaining the Future

Cooper and Pratten (2015: 2) note that uncertainty although often used in its negative and constraining sense in referring to lack of absolute knowledge and inability to predict the outcome of events, can also be seen in a positive, fruitful as well as productive framing. In addition, uncertainty can be a "social resource and can be used to negotiate insecurity, conduct and create relationships and act as a resource of imagining the future with the hopes and fears that this

entails." That way, uncertainty becomes "the basis of curiosity and exploration; it can call forth considered action to change both the situation and the self" (ibid.). Safina's childbirth experience did not discourage her about the use biomedical services for childbirth. Instead, she planned to avoid such circumstances in the future. Besides, she had plans to start using contraceptives. I was amazed by her openness about the use of family planning because many women in Lalta expressed no interest in using family planning when they were still in need of getting more children (Chapter 4). She said:

> I cannot have seven children just because I want to make my husband or my in-laws happy while I walk with a torn dress because of the burden of taking care of children. No one is helping me here with the children, not even my mother-in-law. You saw my husband, he is just drinking and I do not know when he will stop. (...). I want one more child but not now, I will start taking pills until when I am ready. (...). I do not know maybe after two or three years, it depends, but when I become pregnant, I will not stay here. I will go home to my relatives (IDI, Safina, Ilasee Village).

Other women I interviewed also complained about alcoholism and the lack of support from their partners as well as diminished support from their relatives. The lack of support was a raising problem to pregnant women and mothers on top of the hunger that had hit the area. While Safina had a choice to go back home and get support from her relatives, for others, the future was uncertain. The only option they had was to wait and see how it would unfold as expressed by Mwanaidi a 27-year-old married woman with three children and was five months pregnant. She said:

> If your partner does not care about you, who do you think will care about you, no one! Even other relatives will not pay much attention. They know that you are married and thus, your husband must take care of you. If you are lucky to have your mother alive, then you have no problem but this alcoholism is very bad for us pregnant women. I do not know what I will do when I give birth. With this hunger, who will take care of you after giving birth? People have not enough to eat; no one will pay attention to you. Their alcoholism gives burden to other people and problems to us (IDI, Mwanaidi, Manantu Village).

Even the burden of taking care of the family fell on women as explained by Zakia, a 30-yearold married woman with four children. She said that:

> Mmh! I do not know what we will do. For us married women, the burden of taking care of the family falls on us. Many married men here in the village do not take care of their

> families. I tell you, by now you must have seen it. They want to find food at home but they do not know where that food comes from. Like me, these days I do not even ask my husband to give me money because even if I ask him, he does give any money. I go around if I get something to do like helping someone to harvest I get little from the harvest; during *mnada* days I sell *maandazi* (a type of local fried bread) and chapatti. I take care of the family because my husband does not care (IDI, Zakia, Wairo Village).

Alcoholism, drought and deteriorating rural economies challenged men's positions as family providers and the safety net of family support that women depended on was declining. Lack of family support, just like Safina said, was another kind of poverty rising in Lalta thereby constraining the use of birth services for some of the women. To understand these experiences, rather than looking at women as ignorant or indifferent about biomedical maternity services, we should be able to connect even the seemingly normal occurrences of births out of health facilities to historical moments, political, social and environmental contexts. Thus, health planners and policy makers should also take into account women's experiences, which enlighten the complex context of childbirth experiences.

5.4 "They Did Not Even Give Me Water to Clean the Blood:" About Postnatal Care

Safina described her childbirth experience as a bad one because she gave birth on the way to the dispensary and did not have anyone to take care of her in the postnatal period (*kula uzazi*)[56]. Among the Sandawe the time after childbirth is important and it is necessary to assist a woman to return the energy and blood lost in the process of giving birth. In addition, the back is said to be tired from carrying the weight of pregnancy for nine months. The period of resting after childbirth ranged between seven days and three months and my interlocutors said the first seven days were the most important. In the first seven days, women were supposed to have complete rest and avoid going close to open fire, which was associated with clogging the blood. Thus, mothers had to avoid cooking in the first seven days and most of my interlocutors mentioned to observe this prohibition. While open fire was considered dangerous, eating warm foods and bathing with hot water was encouraged to assist in the expelling of dirty blood from the stomach.

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[56] *Kula uzazi* was used by women to refer to the resting time after childbirth that women had to rest and be taken care by their families and relatives.

Given the importance attached to care after childbirth, some of the women such as Mama Kevin, travelled back to the village from Arusha City in order to get support from their relatives. After giving birth, Safina had no one to take care of her. The neighbors helped her for the first two days, but on the third day she had no choice but to enter into the kitchen to cook for herself and her child. Narrating her experience after giving birth Safina said:

> No one came (referring to her husband's relatives). After I gave birth, my neighbors helped me for two days because they too have their families. Had I just sat and waited for someone to come and cook for me and my child we would have died from hunger. I had to break their taboo (referring to the prohibition of going close to open fire). I have a few chickens. Thus, I went outside and slaughtered one and I made some soup. I will not forget that day. I left some soup and my husband came and drank it all! *Yaani* it was just problems (IDI, Safina, Manatu Village).

The postnatal period is also identified as the important period in biomedical maternal healthcare interventions but as I observed, it was not prioritized in the two village dispensaries. As noted from Safina's narration, when she went to the dispensary after giving birth, she was not even given water to clean the blood. The Safe Motherhood Initiative suggests that after childbirth, regardless of presence of complications or not, women should receive a four times routine postnatal checkup within 24 hours after childbirth, at 7, 21 and 42 days (WHO 2004b: 9). In Tanzania, postnatal care is low with only 34 percent of mothers receiving at least one postnatal care checkup, that is, within 24 hours after childbirth (URT 2016: 174). Most of my interlocutors, regardless of place of birth, had no clear ideas about biomedical postnatal care. When I asked them if they went to the dispensary after giving birth, many of them said that they did, but later, I realized that they were taking the newborns for check-up while women themselves were not checked. Even those who gave birth in the village dispensaries were allowed to go back home just a few hours after giving birth. In practice, the adequate use of biomedical maternal healthcare services in Lalta meant the use of antenatal and birthing services while postnatal care received no emphasis, and was hardly mentioned to women after childbirth.

Lack of emphasis on postnatal care at least for the first 24 hours was noted mainly in the village dispensaries rather than in referral hospitals where women were told to wait for sometimes after giving birth. The silence of the healthcare providers on postnatal care signified even a much larger picture. Postnatal care was a late comer in biomedical maternal healthcare interventions

and started receiving emphasis as an important element in the reduction of maternal mortality in the early 2000s, and its support from funders is also minimal (Storeng and Béhague (2016). Family planning, antenatal care and birthing care are the most funded components of the Safe Motherhood Initiative (ibid.). In this case, postnatal care can be seen as a deprived enclave within the components of the safe motherhood initiative. Shiffman and Smith (2007), and Storeng and Béhague (2016) have paid considerable attention to the internal dynamics in the funding of the Safe Motherhood Initiative. They show that donors dictate where their funds should go and ever since biomedical maternal healthcare interventions have been recombined with child and infant interventions the mother is disappearing in the picture. They point out further that the mother is important so long as the baby is attached to her body. After childbirth, attention is shifted to the child.

Only five women among my interlocutors received postnatal care at the village dispensaries after they experienced some complications. For instance, Mama Eliza, a 23-year-old unmarried woman and a mother of two developed an infection after childbirth. When she went to Upendo dispensary, she was told to take care of hygiene and was asked to buy some medicine (antibiotics) from Faraja Dispensary. Paula who was 21 years old had a different experience. She gave birth to her first child at Mshikamano Hospital and when she arrived at home a day after childbirth, she started bleeding and she was rushed back to Mshikamano Hospital where she was admitted for a week.

When I inquired about the obvious lack of postnatal care for women, healthcare providers directed the blame to women by claiming that they preferred home care. I think if women had been aware about postnatal care the situation would be different. The fact that women in Lalta took newborns for checkup soon after birth in case of out of facility childbirth, and vaccination one month after birth presented a window to provide such services and ask mothers if they experienced any complications. For example, Levina had severe cramps that she handled by drinking hot tea. The pain lasted for about two weeks. However, she did not think that she could seek help from the dispensary and never mentioned about the pain to the healthcare provider when she took the baby for the first postnatal care after one month.

5.5 From Pregnancy, Childbirth and the Postnatal Period: Concluding Remarks

In this chapter, I have shown that the underutilization of biomedical maternity services, despite their availability can be understood within the context of the presence of multiple knowledge systems of maternity care, the local provision of biomedical maternity services and socioeconomic changes within the neoliberal context. Several observations that show the manner in which the provision of biomedical maternal healthcare service and the implementation of biomedical maternity interventions shaped maternity experiences of pregnant women and mothers, and how they were shaped in return, have been discussed. I would like to highlight five things concerning the underutilization of biomedical maternal healthcare services in Lalta.

First, most studies on the use of biomedical maternity services in Africa have noted the lack of financial resources, distance to health facilities, mistreatment by healthcare providers and cultural practices as being the main barriers to the use of the services (see, for example, Chimatiro et al. 2018; Sumankuuro et al. 2017; Roberts et al. 2017). To understand further how cultural practices affect the use of biomedical maternity services, Chapman (2010) suggests focusing on the ways in which the neoliberal economic changes contribute to the reproduction of cultural practices that discourage the use of biomedical maternity services. She shows how economic difficulties in Mozambique foster jealousy and fear of witchcraft targeted towards pregnant women (ibid.). Therefore, avoiding ANC was a way of keeping pregnancy a secret and protecting it from witchcraft. In Lalta, cultural practices of maternity care did not prevent the utilization of ANC, but Vaileti' s experience pointed to another direction in which socioeconomic changes affected the use of ANC services.

The absence of Vaileti's husband coupled with the local conditions in the provision of antenatal care services services triggered Vaileti's reinterpretation of when to start antenatal care and how to take care of her pregnancy. The reinterpretation was also a result of critical reflections of the quality of antenatal care services and how they were provided. The neoliberal socio-economic changes shaped women's use of biomedical maternity services in several other different ways. For example, Levina's experience shows how the lack of financial support even with the provision of free childbirth services was still a barrier for pregnant women to access childbirth services. Safina's childbirth experience, on the other hand, shows that socio-economic changes

affected family relationships and constrained women from using the biomedical maternity services.

The presence of multiple knowledge systems, which affected how biomedical maternal healthcare services and interventions were adopted in Lalta is the second thing I want to highlight. Van Hollen (2003: 189) notes that in developing countries, biomedicine is never a whole entity in practice, but rather is made up of shifting constitutive parts that are constantly being put together in new ways at multiple levels of the local. Mama Wawili complied to the use of antenatal care services but counted on her mother's knowledge for birth care and considered biomedical birth services important only in case of complications that could not be addressed at home. Even with the availability of biomedical maternity services, other knowledge systems were not abandoned and women navigated between them according to their needs and concerns as Naimani and Valeti's experiences show. Biomedical knowledge was not accorded authoritative status once and for all but reconsidered according to situations.

Other forms of maternity care other than biomedical maternity services, also presented women with the opportunity to adjust their decisions according to various circumstances. The woman who gave birth at home because she was drunk could easily opt for a home birth because there was a possibility, while Ashura did not see any difference between giving birth at home and at the dispensary. Men accompanied pregnant women for the first ANC visit because it was compulsory and they did not abserve helping pregnant women at home as advised by the healthcare providers. Even those who chose to help like Saumu's husband selected tasks they could do without compromising their masculinity and hierarchal power relations within marriage. However, the situation was different during childbirth where women acknowledged receiving support from men.

Third, the underutilization of biomedical maternity services can be understood through the healthcare providers' (re)interpretation and implementation of biomedical maternal healthcare interventions that affected how women experienced and made sense of the services. Sullivan (2011: 301) using Annemarie Mol's conceptualization of multiplicity of reality, proposes that biomedical practice should be understood not as a unified whole but rather, in terms of plurality differing not only from hospital to hospital, but also from one department to another and even

from one healthcare provider to the other. Biomedical pluralism, she argues, is shaped by financial dynamics in the global health arena which prioritizes some diseases and neglects others thereby creating both conditions of scarcity and plenty in the same institution (ibid.). The provision of biomedical maternity services in Lalta reflected what aspects were prioritized likeHIV testing and birth care that received more of donors' support compared to postnatal care, which had less support (Storeng and Béhague 2016). Moreover, scarcity of medical resources fashioned how the healthcare providers reinterpreted when pregnant women should start attending antenatal care, which as we have seen in the case of Devina, affected the utilization of antenatal care services.

Fourth, is about the provision of postnatal care services. I emphasize, like Mrisho and colleagues (2009) have shown, the lack of attention on postnatal care for the mother. Home care comprised the largest part of care after childbirth, but biomedical postnatal care is also important. Due to the lack of information women delayed to seek for postnatal care when they experienced problems after childbirth or did not seek for postnatal care at all as it was the case with Levina.

Fifth, the goal of biomedical maternal healthcare services and interventions is to make biomedical knowledge for maternity care hegemonic. Insights from this chapter show that achieving such a state will be difficult. Appreciating other knowledge systems can be highly beneficial for both the reduction of maternal mortality and improving the well-being of pregnant women and mothers. Berry (2010: 2) notes that when the reduction of maternal mortality becomes the main goal of the interventions and the use of biomedical knowledge at the centre of the endeavor, other knowledge systems that can also work for both the reduction of maternal mortality and the well-being of women are neglected. An example of such case is the abolition of TBAs whose services were still needed by pregnant women (explained in Chapter 7). I suggest that maternal health interventions should strive for the development of authoritative knowledge that involves both biomedical and local knowledge systems that can be productive, especially in rural areas, and pay attention to emergent situations that shape the use of biomedical maternal healthcare services.

Chapter 6

Everyday Forms of Violence: The Maternal Referral System, Childbirth Experiences and Healthcare Providers' Dilemmas

6.1 Introduction

> I have helped so many of them (women with high-risk pregnancies) to give birth, right here, I was not worried (...). Yes, we advised them to go to the hospital but they could as well come here without any problem... but now the situation is different. If a woman dies in your hands, nobody listens; you end up getting a letter, a warning (...). It means (*yaani*) all the time you have to be careful, and if you decide to help, you better pray that nothing bad happens because no one will ask you. But if it happens that a mother dies they (referring to district health administrators) will come with their cars to question you. It is easy when a child dies but not a mother (IDI, Nurse Vivian, Magambua Village).

The above extract indicates the healthcare providers' dilemma when attending women with higher risk pregnancies. Despite the availability of maternity services in Lalta, not all women could access childbirth services at all times at the village dispensaries. This chapter addresses the uncertainty of accessing the necessary childbirth services. I have indicated in Chapter 5 that, during antenatal care assessments, women were categorized as having either less or high risk pregnancies as stipulated in the reproductive and child health card-4 (URT 2006). Women in the latter category, who were said to be more susceptible to developing obstetric complications, especially during childbirth, had to seek for childbirth services from referral hospitals preferably before the onset of labour.

Figure 6.1: The reproductive and child health card: RCH-4.[57] (Photo by Anitha Tingira 2015).

The referral system for maternity care which has been implemented in Tanzania since the early 1990s, intended to enable expectant mothers to access emergency and comprehensive obstetric care which were lacking in (village) dispensaries (Fathalla 2012; Fournier et al. 2007; Murray and Pearson 2006). Healthcare providers in this case were required to advise and convince women with high-risk pregnancies to go to referral hospitals for childbirth. However, being identified with a high-risk pregnancy did not automatically imply that this identified segment of pregnant women would develop obstetric complications during childbirth, except that the chances were higher. Conversely, women identified to have less risky pregnancies eligible to

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[57] Categories A, B and C identify the risk indicators. Category A: Age below 20 years. Ten or more years since the last pregnancy, previous cesarian section, previous childbirth or perinatal death within the first after birth, two or more abortions, hearts disease, diabetes mellitus and tuberculosis.

Category B: Five or more pregnancies, heignth less than 250 centimeters, pelvic deformity, first pregnancy at 35 or more years, previous cesarian section or vacuum delivery, excessive bleeding and retained placenta in the previous delivery.

Category C: Blood pressure more than 140/90, Hemoglobin less than 60 percent (8.5 mg/dl), albumin in urine, sugar in urine, Gestational age more than 40 weeks, intrauterine foetal death, abdominal lie after 36 weeks, odema of the legs, face and hands, Spected twin pregnancy, and fundal height too big or too small for gestational age.

give birth in village dispensaries could develop complications. In such cases, it was advisable that immediate referral had to be made for emergency obstetric care.

Ideally, it was expected that women would understand the impending risk and would go to referral hospitals for childbirth[58]. If women adhered to the referral advice and received the emergency obstetric care whenever the need arose, half of maternal deaths in developing countries could be averted (Murray and Pearson 2006: 2205). Access to emergency and comprehensive obstetric care was therefore identified as key in the reduction of maternal mortality in developing countries and was central to the Safe Motherhood Initiative ((De Brouwere et al. 1998; Singh et al. 2016; Maine and Rosenfield 1999; WHO et al. 2009; Kongnyuy et al. 2009). However, the persistence of high maternal mortality rate in Tanzania (URT 2016: 317) is evidence that the maternal referral system and other interventions are yet to succeed. Several pregnant women I talked to in Lalta did not adhere to the referral advice. This trend therefore raised the following puzzling questions, where did they give birth. Why could they not go to referral hospitals? What were their childbirth experiences? What about those who went to referral hospitals, did they get the care they sought for?

With respect to these questions, my focus in this chapter is the implementation of the maternal referral system and its impacts on women. As Kleinman, Das and Lock's (1997: x) observe, bureaucratic procedures on rationalized interventions to social problems often intensify suffering due to unforeseen and untoward effects; I argue that, although the maternal referral system intends to help women and it does help women access emergency obstetric care, its implementation subjects some of the women to suffering and the risk of maternal death. I contend further that, the maternal referral system poses challenges to healthcare providers' moral stances, working, and social relations.

During antenatal clinic sessions, I noted that after being identified as having high-risk pregnancies, pregnant women were highly encouraged and repeatedly told by the healthcare

[58] Most maternal referrals for my interlocutors were because of age, below 20 years and five or more pregnancies. In referrals hospitals I encountered pregnant women with identified indicators.

providers to start preparing to go to referral hospitals for childbirth early enough – usually around two weeks before the estimated due date. These expectant mothers were persistently warned not to try to seek for childbirth services from the village dispensaries. I realized the intensity of these warnings when I started encountering cases of pregnant women who gave birth at home because they could not go to referral hospitals mainly due to the lack of financial resources. When some of these women tried to go to the village dispensaries, they were denied the childbirth services, and were asked instead to go to referral hospitals. Other mothers such as Sara (Chapter 1) were fortunate to be attended in the village dispensaries. These women's chances of being attended at the village dispensaries were compromised by the healthcare providers' fear of maternal death, which would put their jobs and reputation of the dispensaries at stake.

The manner in which some of the healthcare providers in Lalta chose to attended women and other healthcare providers who chose not to do so made me see the healthcare providers' experiences beyond working under shortage of resources, being overburdened, and being lowly paid that characterize most accounts of healthcare providers' experiences in developing countries (see, for example, Street 2014; Kwesigabo 2012; Wendland 2010; Sullivan, 2011). Studies show that ethical guidelines of health interventions may also pose challenges to healthcare providers even when the above factors are not issues in question (Pauly 2012; Whyte et al. 2010). Whyte and colleague's (2010) ethnographic account which indicates the moral dilemma faced by healthcare providers in a small village in Uganda entangled between abiding by ethical provisions of confidentiality of HIV status and/or AIDS patients certification for help in accessing ARVs, and being community members where they felt (morally) obligated to help the sick and protect others, underscores that, the subjective experiences of healthcare providers are shaped with more than the scarcity of resources or individual material needs.

With the emphasis on referral care, one would expect women to receive attentive care in referral hospitals. However, I observed that not all women received good care. My observations were supported by the experiences of my interlocutors who had given birth in the two referral hospitals, and their narrations of the experiences of other women they knew. Some women gave birth with limited support from healthcare providers, while others ended up losing their lives or the lives of their newborns.

Aware that poor health services in developing countries are mainly due to the lack of human and medical resources, one way of understanding this situation could be to look at the public (referral) hospitals in Tanzania which historically, are faced with the overflow of patients, shortage of human and medical resources (Thomson et al. 2017). While I agree that the above situations help us to understand the poor medical services patients receive, such situations do not explain why some women from rural areas received good care and others did not even when they were in the same hospital at the same time. As Gupta (2012: 24) points out, the key to the understanding of the systematic production of arbitrary results lies on the examination of daily bureaucratic procedures in the provision of social services; I argue that, understanding the different experiences of women in referral hospitals entails looking at the daily provision of maternity services and the manner in which healthcare providers are discursively engaged with the overflow of pregnant women, and shortage of human and medical resources.

In their daily practice, the healthcare providers subjected some of the pregnant women and mothers to suffering by either following the official guidelines of the maternal referral system or in the process of dealing with structural constraints. Attending those who should go to referral hospitals in the village dispensaries meant exposing them to the risk of maternal death. The right thing for the healthcare providers to do was to encourage them to go to referral hospitals. Nonetheless, getting to the hospital was one thing and getting good care was another. Still, according to the WHO and the Ministry of Health of Tanzania, the maternal referral system was insisted on as the key in the reduction of maternal mortality (URT 2006). In addition, women were governed by healthcare providers to embody the conceptualization of high-risk pregnancy in order to seek for childbirth services from referral hospitals.

Foucault argues that governmentality can have consequences that can put lives at stake. Delineating this notion further, he talks about the shift from the sovereign right to kill to the power to reject into death that characterize the modern exercise of biopower (Foucault 1976: 180). Other scholars have described this implicit aspect of governmentality as “violence done unto life” which is justified and rationalized in the name of fostering life (Reid 2013: 92).

Fassin (2009: 53) points out that, “to make life implies making implicit and sometimes explicit choices of who shall live, what sort of life, and for how long.” In most cases, the biopolitical

violence embedded in these choices is not formulated explicitly. However, choices in terms of health policies such as the maternal referral system have measurable impact on pregnant women in particular contexts.

My analysis of the maternal referral system in Tanzania intends to re-direct the focus and revisit its implementation to help women in rural areas access emergency and comprehensive obstetric care and use the available biomedical maternity services. Several other studies have also raised concerns about the maternal referral system in Tanzania. Allen (2004) for example, discusses the unintended consequences of the maternal referral system in the very early stages of its implementation in the 1990s. Pembe et al. (2008; 2010; 2017) conducted a series of studies about the functioning of the maternal referral system and the reduction of maternal mortality in Tanzania. While these studies focus on the lived experiences of women, the present study subsumes experiences of women and healthcare providers.

The discussion that follows is envisioned in four related levels, as identified by Baer and Singer (1995: 64-74). The referral system is a global initiative (macro social level) which is mediated (intermediary) in medical institutions and configured by practices and concerns of healthcare providers, particular institutional achievement needs, and shortage of medical and human resources. Conversely, these influence relationships among providers and administrators as well as the interaction between healthcare providers and patients in terms of how medical services are provided and experienced by patients at the micro level. I will show that, often, the impacts of implementing health interventions are felt the most by low rank healthcare providers, in this case nurses/midwives who were in contact with women and their families. Lastly is the individual level which focuses on subjective childbirth experiences of women with high-risk pregnancies.

The discussion is divided into three sections; in the first section, I will look at how decisions on referral care were made, what prevented women from going to referral hospitals, how they prepared for childbirth and their childbirth experiences. I will further look at how healthcare providers in rural areas perceived the maternal referral system and how its implementation affected them. Following women in referral hospitals, the second section will examine women's and healthcare providers' experiences in referral hospitals. I will look at how women prepared themselves to go to the referral hospitals and their living arrangements since they were advised

to go before the onset of labour. Looking at women's birthing experiences in referral hospitals, I will show how healthcare providers' engagements in the provision of maternity care shaped the good/bad childbirth experiences including the healthcare providers' own experiences. The third section will provide concluding remarks.

6.2 Shani's Homebirth

I first met Shani on the 3rd of June 2015, just a day after she had given birth. I learnt about Shani's homebirth from Miriam (Chapter 4) during a follow up interview. As we talked, Miriam mentioned an incidence of a young woman she knew who had given birth at home the previous night after being turned away from Upendo Dispensary. I had already heard stories of women giving birth at home after being turned away from the village dispensaries but I had yet to encounter such a case. I wanted to talk to Shani and her family, so I asked if she could direct me to where they lived. Luckily, Miriam knew the address and thus directed me. Because it was already in the evening, I decided to embark on this exercise in the following morning. Thus, I called Samson and asked him to pick me up the following morning.

When I arrived at Ilasee, it took me a little while to find the house because it was a bit far from the village centre. As I was approaching the house, I saw three middle-aged women sitting under the shade of the small *tembe* house. I greeted them and introduced myself. Shani's mother, a 36-year-old woman, who was among the three women, told me to wait because Shani was eating. When Shani finished eating, her mother invited me inside where I found Shani sitting on a small bed; beside her a baby was lying wrapped in a colourful *khanga*. Shani greeted me as I was sitting on the bed carefully not to disturb the peacefully sleeping baby. Shani's mother took a small stool (*kigoda*) and sat closer to the door. I congratulated Shani and I asked if the baby was a boy or a girl, she replied shyly that it was a girl. I looked at Shani as she carried the sleeping baby from the bed and passed it to me. As I carried the baby, I started the conversation by asking how old she was.

Whilst I was interested in knowing about how Shani had given birth, I was equally interested in understanding the wider background of her pregnancy. Shani, who was 16 years old at the time, was just like many other young women in the villages. She had finished standard seven the

previous year but failed to join secondary school. She stayed at home with her mother helping her out with the cultivation of vegetables, which was the main source of income for the family. Shani's father had left her mother for another woman because Shani's mother could not get pregnant after giving birth to Shani and her young brother who was then 9 years old. When Shani got pregnant, her father was not concerned and told Shani's mother that it was her problem.

Shani was impregnated by an older married man, a retired soldier who lied to her that he would leave his wife and marry her. When Shani found out that she was pregnant, she told her partner, who to her disbelief, denied responsibility. Confused, she decided to keep the pregnancy a secret and find a way to terminated it but her mother found out about the pregnancy before she was able to accomplish this goal. Shani's mother went to confront the soldier and threatened to tell his wife about it. After the confrontation, Shani's partner agreed to take care of the pregnancy and gave Shani's mother 10,000 Tanzanian Shillings (equivalent to 4 Euros). Shani's mother believed that the soldier would take care of the pregnancy, not knowing that this would be the only money she would ever have gotten from him. When the pregnancy was three months old, Shani's mother took her daughter to Upendo dispensary for ANC. She told the nurse that the man who got her daughter pregnant had ran away that was why she had taken her to the clinic. This lie, which she regretted telling, worked and Shani received a clinic card.

Shani's mother admitted that the nurse told them to prepare themselves to go to a referral hospital because Shani was young and this was her first pregnancy which could be risky for her life during childbirth. She did not worry about going to the referral hospital as she was confident that the soldier would support them. When she told him about going to the referral hospital, he did not object. As time passed by, however, the soldier did not provide any further support but she kept hoping that when they would be ready to go to the referral hospital, he would support them. When Shani was eight months pregnant her mother asked the soldier for money to go to the referral hospital but he told her he had no money. "I was truly confused, I myself had no money, even the vegetable business I relied on could not support us to go to Mshikamano Hospital, it is like it does not exist because the pond (for irrigation water) is dry, I was truly confused I tell you" she explained. Shani's mother decided she would take Shani to the village dispensary because she

did not want Shani to give birth at home. Shani's mother had given birth to both of her children at Upendo Dispensary. Shani started feeling the labour pain earlier that afternoon but her mother was not around. When Shani's mother returned in the evening, she called one of her relatives who was living nearby and asked her to accompany them to the dispensary. Explaining what happened on that fateful night, Shani's mother said:

> We left to the dispensary, I think it was nearly six o'clock; we walked very slowly because she (Shani) was complaining a lot about her labour pains, but we encouraged her to continue walking to the dispensary. At around 7 o'clock, we arrived at Upendo dispensary and I went to call the nurse. The young nurse known as Zaina came round and looked at Shani's clinic card. She then asked her to go to the labour room. I followed them and stood outside, after a while she came out with Shani and told us to go back home. She said Shani was not ready to give birth because the cervix was not open. I was hesitant but she insisted that we should go back home and return the following morning. I looked at Shani she was in pain but because the nurse asked us to leave, I told my relative 'let's go back home, we will come back tomorrow,' she also, just like me showed some doubts but we did not object and we started walking back home. I do not know the exact time but I think it was around 8 or 9 o'clock we arrived at home and my relative told me she wanted to take her leave to look after her own children. She promised to return later; my other child was there too. Now I remained alone with Shani, I was scared, praying that the dawn comes fast so that we could go back to the dispensary. However, maybe God did not hear my prayers or maybe He planned it to happen like that. It was not even a long time since my relative left, Shani started shouting, she was lying on that bed (pointing to the bed we were sitting on), and she shouted 'Mama! Mama! Look at me, look at me.' When I looked I did not believe the babys' head was coming out, I did not know what to do, my brain was telling me to shout for help but I didn't, I stayed right there, I encouraged her to push and I received the baby. I helped her all alone, I myself. Until now I do not believe it, I feel like my hands are still shaking (IDI, Mama Shani, Ilasee Village).

After she received the baby, before she cut the umbilical cord, she went outside and shouted for help and people started coming. One of her neighbours went inside, cut the umbilical cord and cleaned the baby. All that time Shani's mother said she was in disbelief of what happened. She told me that she had never assisted anyone to give birth, the only experience she had was giving birth to her own children. Although Shani had a safe birth, her mother could not stop complaining about being told to go back home. In addition, when they took the baby to the dispensary the next morning they were asked to pay 10,000 Tanzanian Shillings (equivalent to 4 Euros), a fine for giving birth at home. Shani's mother complained:

> Can you believe we have not been given a clinic card for the baby until we pay 10,000 Shillings? Right now I do not have that money; I am waiting for the *mnada* day if I sell something and get the money, we will get the clinic card. (...). I do not depend on the father (the soldier) anymore. He hasn't shown up even to see the baby.

It was the 3rd of June; 17 days away from the *mnada* day which was on every 20th of a month, the child would not receive a clinic card until the fine was paid. Three weeks later when I met Shani and her mother again, they had managed to pay the fine and the baby was given a clinic card. The soldier had neither gone to see the baby nor provided any support.

6.2.1 Decision Making About Referral Care

Shani's story helps us to understand several issues including how decisions to go to referral hospitals were made. When I talked to women who wanted to/went to give birth in referral hospitals, their main reason was seeking for safety during childbirth. Shani's mother wanted for her daughter this same thing. Most women who were advised to go to referral hospitals revealed that it was primarily important for them to express the need to go to the referral hospital and see if they would get support from their partners and relatives. However, it was different in Shani's case. Her mother was more active in making decisions on her behalf. Shani's mother decided Shani would keep the pregnancy and after the antenatal care visit, she decided that she would take her to Mshikamno Hospital for childbirth. She sought for financial support from the soldier without success. Shani said that she too wanted to go to the hospital but it was apparent that she was influenced by her mother who had developed a biomedical self and trusted biomedical birthing care.

The decision making in Shani's case entailed questions of power and trust. Shani depended on her mother economically but also trusted her mother's decisions. Women's moral and financial dependence on others rendered them passive in expressing their opinions about choices of care. The situation was more complex when more people were involved in the decision-making process and providing support. These people could be for or against the prior decision made by a woman.

The involvement of other family members in seeking support for referral birthing care was common in Lalta which sometimes challenged women's prior decisions as illustrated in the case

of Hekima. I met Hekima in May 2015 when she came to Faraja Dispensary for the second antenatal care visit. When the nurses asked her whether she was prepared to go to the hospital she told her she was and would go. Hekima was a 31-year-old married woman and was seven months pregnant with her fifth child. When I talked to her, she told me she had decided to go to the referral hospital and convinced her husband to support her. Explaining how she managed to make her husband accept her decision, she narrated her first maternity experience in which she was forced to give birth at home although she wanted to go to the hospital. She said:

> When I got my first pregnancy that time I was young, 18 years old, back in 2003. I was just married and became pregnant. I went to the dispensary and I was told I should go to the referral hospital for childbirth. The nurse told me that my body was very small I could get problems when giving birth. I was not like I am now; I was as thin as a stick. I was scared after being told that by the nurse. When I went home, I told my husband, he ran to his mother to break the news. You know that time, it is better now you see women going to the hospital for childbirth. Previously, giving birth at home was very normal. My mother-in-law told my husband we should not waste money to go to the big hospital. My sisters-in-laws also supported their mother that I just wanted to go to stay at the hospital because I was lazy. My mother-in-law had never given birth in a hospital (...). Even my sisters-in-laws, all of them just had given birth at home. I was new in marriage I could not refuse, my own mother told me to listen to what my husband said; she was not worried about me giving birth at home. (...). They did not take me to the dispensary. I will never forget the day I got the labour pain, I gave birth but I faced fire, the pain was so intense. Since it was the first time, I thought I was going to die. I was torn badly until sitting was difficult, I was sitting leaning on the sides. They burned me with (hot) water (*walinichoma maji*[59]) and after two days my husband and my mother took me and the baby to the dispensary. My husband was told to buy me some medicine. After some time, I was healed but since then I said I will never give birth at home again (IDI, Hekima, Manantu Village).

In the following pregnancies, Hekima gave birth at Faraja Dispensary until her fifth pregnancy when she was advised to go to a referral hospital for childbirth. Her husband was present when the healthcare provider gave the advice and Hekima told him right away that she wanted to go to give birth in Umoja Regional Hospital. Hekima had made this decision since she had her first

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[59] *Walinichoma maji* literally means they burned me with (hot) water. In the context, the phrase was used to refer to being bathed with hot water (extra hot water than used in regular baths). This was done to accelerate the discharge of 'the dirt' after giving birth.

home birth. This time her husband agreed and did not tell his relatives until when he was leaving to work in Dodoma to get money to enable Hekima to go to Umoja Regiona Hospital.

Hekima attributed her husband's support to her increased involvement in contributing to the family income. She referred to herself as a hard-working person (*mchapa kazi*). She was selling tea and chapatti to patients at Faraja Dispensary thus contributing to the family income. The contextual circumstances in which the decision was made and supported had changed, lessening the power of other relatives, and increased that of Hekima.

In some other cases, the therapy management group (Janzen 1978) made decisions that were in line with women's choices. In the case of Saumu for example (Chapter 4), a mutual decision was reached between her, her husband, and her mother. She got all the support she needed to go to the hospital. Likewise, Mama Wawili (Chapter 5) and her mother were in favour of homebirth. Mama Wawili's husband did not object although he had the ability to take Mama Wawili to the hospital. Like his wife, he trusted the knowledge of his mother-in-law and they both agreed with giving birth at home.

Whereas most women struggled to get support to go to referral hospitals, I did not encounter a woman who wished to give birth at home but did not because a husband or family members forced her to go to a referral hospital. All those who gave birth at home out of their own volition got the support of their partners and family members. Supporting or challenging the referral advice can be understood by looking at how people in Lalta perceived maternity risk. Despite various conceptions of risk, (Beck 1992; Douglas 1992; O'Malley 2004); Lupton (1999b: 5) argues that the most important thing is to look at risk as a socio-cultural phenomenon. For example, how people perceive being at risk and what sort of information they draw to develop their logic of risk. During antenatal clinic visits, women identified with highrisk pregnancies were expected to see the impending risk which some did, and others did not. Similarly, not all people who surrounded the pregnant woman supported the view of high-risk pregnancy that the healthcare providers explained during ANC visits.

When the TMG went against the referral advice, they neither meant to expose women to the risk of maternal death nor overruled the possibility of an obstetric complication. Instead, they looked

at risk from a different perspective in which a solution of dealing with an obstetric complication was to be sought when it emerged and not before (cf. Pembe et al. 2017). This explains why during emergency referrals, family members were more willing to offer support than when women wanted to go and wait for childbirth at the referral hospitals.

6.2.2 Unfulfilled Decisions for Referral Care

6.2.2.1 Poverty, a Major Barrier

Not all women who decided to go to referral hospitals for childbirth managed to realize their decisions mainly due to poverty. During my conversations with women, most of them attributed their financial constraints to drought that affected the area since the previous year. Similar findings are reported in a study by Craig and Chuluundorj (2004) who examined the link between neoliberal economic reforms and maternal mortality in Mongolia. Their findings show that women became more vulnerable to maternal mortality due to fluctuating rainfall that affected their livelihood and capacity to seek for healthcare which was no longer free. Elsewhere, Craig and Corbett (2009: 171) call for attention to environmental changes to identify the health vulnerability of local populations. Given the prevalent situation of the lack of rains in Lalta, I locate women's accounts of financial crisis in relation to the continued drought that affected the ability of women and their families to seek referral maternity care. In particular, Shani's mother attributed her lack of financial capacity to the poor performance of her vegetable business which she said was not doing well because the pond that she depended on for the irrigation purposes was dry. The lack of 10,000 Tanzanian Shillings (equivalent to 4 Euros) to pay the fine showed how critical the financial situation of Shani's mother was. I am not assuming that had there been no drought Shani's mother would have enough money to take Shani to the hospital, but that drought made the situation more difficult for her.

Another experience I came across was that of Lillian, a 29-year-old woman I met in March 2015, when she was five months into her sixth pregnancy. She was advised to seek for childbirth services from a referral hospital and as we talked, she was positive that she would go to Mshikamano Hospital but gave birth at home in June 2015. I was surprised, Lillian and her husband seemed certain and she had already been to Mshikamano Hospital twice for childbirth

and this would have been her third time. However, although they had the money enabling her to go to the hospital, the immediate problem was with whom to leave the children. The previous time she went to the hospital for childbirth the children had stayed with Lillian's mother but the preceding year her mother lost her eyesight. Her mother-in-law was not ready to take care of the children and suggested that she gave birth at home. Her husband, who was a carpenter, had to continue working in Lahoda Village and could neither go with her nor stay back with the children. Lillian said even the other relatives refused to help because of the food crisis. She explained that:

> People here cannot feed themselves, who would agree to look after five children? They do not mean to be bad but even if it were I, would think twice before agreeing. To say the truth, I do not blame them. If my mother had good sight, I would have no problem but last year (2014) she did not cultivate because she got a problem and her eyes cannot see, she also need to be taken care of, I looked, I said okay I will give birth at home. (...). My husband agreed with my decision. (...). My sister helped me during childbirth. (...). She was trained as a TBA. (...). She is not working as a TBA anymore but she had already helped some few women, and my mother was there too (IDI, Lillian, Wairo Village).

Lillian and her husband did not have enough finances for maintaining the family and at the same time going to the referral hospital. Lillian had to weigh between her health and the needs of her family. She changed her decision especially when her mother-in-law suggested giving birth at home and luckily, it was a successful birth. In Chapter 5, I have shown how drought can shake family income and strain family relations affecting women's use of the available services. Similarly, lack of enough food due to drought in Lillian's case affected the family support that she depended on to be able to go to the referral hospital. All Lillian needed was someone to look after her children and provide them with food, something she would not have to worry about had there been no food crisis.

When I went for the second phase of fieldwork I visited Lalta and I had the opportunity of talking briefly to the expatriate doctor of Faraja Dispensary who was on leave during the first phase of my fieldwork. I asked him what he thought compelled many women into giving birth at home, he remained silent for a while, lowered his face and when he raised his head, he told me; "Poverty! Ah! Here, people are very poor, *very poor*." (His emphasis). The doctor agreed that some women preferred giving birth at home but poverty was the main factor preventing them from going to especially referral hospitals. He said that at times of emergency referrals they had

to provide transport on credit and the relatives had to pay for the loaned transport in several instalments[60].

Despite the fact that the maternity services were provided for free, going to the referral hospital required preparations that needed money. Women and their families had to prepare some money for transport and food while waiting for childbirth in referral hospitals or maternal waiting homes. These preparations depended on the financial status of a particular family as well as the social support of other family members. The free maternity services reduced the burden of paying for biomedical maternity care but not the expenses of travelling and waiting for childbirth in referral hospitals. Thus, the assumption that those who did not go to referral hospitals preferred giving birth at home overlooks the experiences of women who would have liked to go, but they could not due to financial difficulties. Most of these women and their partners had made decisions to go but changed their minds and decided to either go to the village dispensaries or give birth at home after realizing that their financial position could not cover for the expenses of accessing childbirth services in referral hospitals. In their analysis of maternal referral system in Africa, Murray and Pearson (2006: 2211) caution that if persistent poverty in rural areas is not addressed to enable women to access and get emergency obstetric care, the maternal referral system would not be effective in reducing maternal mortality.

6.2.2.2 The Fear of Operation

As I talked to women about giving birth in referral hospitals, I was stunned at how some of them were keen asking about the increased rate of operations in referral hospitals. Some women requested me to make inquiries for them as to why operation rates had increased. The WHO recommends Caesarean section to facilitate the reduction of maternal mortality in developing countries but also cautions that it is effective only when such operations are performed for medical reasons (WHO 2015c: 1). I shared the women's concern with the healthcare providers in the referral hospitals, who to my surprise confirmed that there was an increase in Caesarean

[60] The expenses for transport to Mshikamano Hospital during emergencies using the Faraja Dispensary land cruiser ranged between 80,000-100,000 Tanzanian Shillings (40-60 Euros).

sections but indicated that this was mostly among women from urban areas who wanted to avoid the pain of childbirth. Most other women were operated only when it was deemed medically necessary because Caesarean sections were expensive.

The fear of operation was highly evident in the case of Alice whom I met in March 2015. Alice was 18 years old, newly married, and was six months old pregnant with her first child. She was advised to go to a referral hospital because that was her first pregnancy and she was very young. Like several other women, Alice decided that she would like to go to a referral hospital for childbirth. Her husband was supportive of her decision but on the 16th of June 2015, she gave birth at home. When I went to see her, she told me the prospect of operation changed her mind. She explained that:

> I wanted to go. I truly wanted to, even on the first day when the nurse told us (referring to her husband who was present during the first antenatal clinic visit) about going to the hospital I told my husband I wanted to go. When I told my mother I would like to go to Mshikamano Hospital for childbirth, she asked me why I would not want to give birth at the dispensary. When I told her the nurse told me to go to the hospital, she told me if that was the case, it was not good to go to the hospital because they do operations and if they operate me now I may not be able to get children anymore. I was scared I told my husband about what my mother said. (...). He did not insist that should I go to the hospital. (...). When I was about to give birth I went to stay with my mother (...). The TBA assisted me (IDI, Alice Wairo Village).

Alice's change of mind was influenced by her mother, who saw operations as a threat to fertility. The reason for the fear of operation can be understood within the wider socio-cultural context in which fertility and giving birth to many children was valued for various reasons (see, Chapter 4). Alice's mother had no problem with Alice giving birth at the village dispensary.

Warning Alice against going to the hospital for childbirth was intended to protect Alice's ability of having many children which could have been put at risk if operated. Rather than the potential to address the risk of maternal death, to Alice's mother, the referral hospital was a threat to Alice's fertility. The refusal of seeking for maternity care from hospitals for the fear of operation and the loss of fertility is also reported by Berry (2010: 181-183). She shows that women in Kaqchiel Village in Guatemala did not differentiate between tubal ligation and Caesarean section, which were both addressed as operation. When women in Lalta talked about operation, they

specifically referred to the Caesarean section. The threat to fertility was associated with the limited number of children a woman who has undergone a Caesarean section could have (cf. Cosminsky 2012). Many believed that once a woman is operated, especially in the first pregnancy, she could have only four children and any attempt to have more children could lead to death.

Alice said that her fear of operation increased because of the death of a woman in Wairo in December 2014, two months after her childbirth operation at Mshikamano Hospital. This woman's death was used by many women as an example when discussions about operations ensued. Operations were also feared for the long period it took to heal and restrictions imposed against doing manual labour. Women described operations as being disabled (*kupewa kilema*). Giving birth via Caesarean section also changed the cultural meaning of giving birth and the significance of labour pain during child birth as Rehema (Chapter 4) described:

> When you give birth by operation you cannot compare yourself with someone who has gone to labour (referring to labour ward). She gives birth but when you are operated a child is taken out, you are given a child (IDI, Rehema, Magambua Village).

During antenatal care visits, I noted that healthcare providers did not discuss about the prospects of operation in referral hospitals which women had many questions about. I suggest that women should be informed of the possibility of operation and its importance. Some women from rural areas went to the hospitals with herbs (taken in the form of tea) to accelerate labour in order to avoid operations. Healthcare providers discouraged the use of these herbs because accelerating labour without the right dosage and monitoring could be fatal (cf. Wendland 2017: 252-253).

6.2.3 Birth Experiences and Emotional Suffering

Some of the women who realized that they could not go to the referral hospital took the warning seriously and planned for homebirth while others tried their luck by going to the village dispensaries. Often, when women brought their newborns to hospitals for checkup after home births, the healthcare providers considered homebirths as women's preference. However, to some women, it was a choice they had to make after the failure of going to referral hospitals. (cf. Cogburn 2019). Although all the women I talked to gave birth safely either at home or at the dispensaries, the emotional turmoil was apparent in their childbirth accounts when compared to

those who gave birth at home out of their own will. Homebirth was an option but not the safest for them and if they could, they would have avoided it. Shani gave birth successfully but her mother could not stop thinking of the stressful moment when she assisted her daughter to give birth. Shani's mother recalled how even after the childbirth, she could still feel the uneasiness and looking her grandchild she relived the moment. She expressed that:

> Every time I look at the baby (her grandchild) I remember it is me who assisted her (Shani) to give birth, I still do not believe it because I am scared of these things but I helped her myself (IDI, Shani's mother, Ilasee Village).

Shani's mother had mixed feelings about doing something she never thought she would be able to do. Standing before and deciding whether to shout for help or assist her shows how difficult that moment was for her. Shani also reflected on the moment of giving birth as being the most difficult for her, but it was obvious she was less affected emotionally than her mother was. Throughout the pregnancy Shani's mother was supportive of her daughter as she said she could not abandon her. She was also against the idea of terminating the pregnancy by referring to her own experience; "My conception is difficult (*uzazi wangu mimi ni mgumu*), I thought what if she is like me. I did not want her to get rid of the pregnancy." Shani followed instructions from her mother who made all the decisions, and in the end, she was the one who bore the most emotional suffering.

Other women also shared the emotional suffering they experienced during homebirth after failing to go to referral hospitals. Rebecca, a 37-year-old married woman with her seventh pregnancy, described giving birth at home as difficult because she could not stop thinking what the nurse told her about the danger of maternal death:

> I was pushing while praying very hard that I give birth safely because a problem can happen, I remembered what the nurse said and I was scared. (...). The nurse said, I could die because I had given birth to many children already. You know, you peep into death; and then you are at home, not in the hospital! I prayed so hard on that day, and I thank God I gave birth safely (IDI, Rebecca, Manantu Village).

Rebecca admitted that giving birth was frightening but giving birth at home increased her fear of death. For Sara (Chapter 1), the fear of death was the reason she insisted to be taken to the dispensary. Sara said, when she tried to give birth at home, she had no peace of mind. She wanted

to go to the dispensary regardless of her uncertainty. I cannot imagine what would have happened to Sara had she been told to go to the referral hospital. However, it was clear that even those who accompanied her were worried. Her mother-in-law said they would go back home but she was unsure of what would happen to Sara. When I asked Lillian whether she was worried about giving birth at home, she said she was. She planned for homebirth and got assistance from her sister, but she was still scared. She said:

> There is fear because giving birth is not something easy. (...). It is not a matter of how many times you have given birth; the fear must be there but what will you do if you cannot go to the hospital? You leave it to God because we poor people are helped by God (IDI, Lilian, Wairo Village).

The emotional suffering was apparent among women who failed to go to the referral hospital, regardless of their successful births. Some of these women still had trust on biomedical maternity care but for others it was the beginning of trusting homebirth. For Shani's mother, however, her daughter's childbirth incidence did not change her mind about biomedical maternity care. She still hoped to have another child in case her husband returned; she said, she would go to the hospital for childbirth and hoped that Shani would do the same in the future.

6.2.4 The 'Real' Danger of the Maternal Referral System

6.2.4. 1 I Can Lose my Job

Two days after talking to Shani and her mother, I had an interview with Zaina, the healthcare provider who I was told asked Shani and her mother to go back home until the following morning. Young, in her mid-twenties, this was her first post after graduating from a nursing school in Dar es Salaam. This was not our first interview, we had talked before and we had several informal conversations during the ANC sessions and childbirths at the dispensary. Therefore, when I told her I wanted to talk to her again, she readily agreed and we arranged to meet at the dispensary in the afternoon. Upendo Dispensary rarely had more than five patients a day. Many went to Faraja Dispensary that served around 25 to 30 patients a day. Afternoon was a suitable time as Zaina was not expecting patients after morning hours. I wanted to hear her side of the story. When I hinted about the topic, she looked at me with a sad smile and said, "Dada Anitha, to say the truth

I could not, even if I had wanted to." When she arrived at the village almost two years ago, fresh from a nursing school the only experience she had was working as an intern for three months in Masasi District Hospital. She was worried of being posted at the village dispensary but after starting the work, she realized it was less burdensome compared to what she had experienced in Masasi:

> There, hardly a week could pass without going to the mortuary to bring a dead body. It was either a mother or a child, there were so many deaths that I got used to the crying sounds of the relatives who were told that the mother or the infant had died. For me coming here was somehow a relief. At first, I was worried, you know how people talk of villages and village life but I come from Morogoro, it's not far from here (IDI, nurse Zaina, Magambua Village).

With the relief she felt and after realizing there was less work and deaths than in Masasi, she was helping even those who were coming to the dispensary but were supposed to go to referral hospitals. "You know we are not supposed to assist them, even in seminars we are told to insist that they should go to referral hospitals but I was looking at the situation and I helped." The two nurses at Upendo dispensary worked in shifts and when pregnant women of a high-risk category arrived it was at the discretion of the healthcare provider on duty as to help her or not. According to Zaina, her senior, Nurse Vivian, was not talking so much to her about helping women who were supposed to go to referral hospitals, but occasionally reminded her to be careful. Zaina explained that helping was not a big problem until two years earlier when a pregnant woman died during childbirth at the neighbouring dispensary in Lahoda Village. This incidence alerted her about the dangers of helping. She explained that:

> Our fellow in Lahoda had bad luck, a mother died during childbirth. It was a big issue; people from Kondoa (health administrators) came to probe about the death. (...). It was bad because the woman was supposed to go to a referral hospital, but he was trying to help. (...). He was given a warning and they said if it happens again, he will lose his job. You see I cannot help anymore you cannot know what will happen; I can lose my job (IDI, Nurse Zaina, Magambua Village).

According to Zaina it would not be a big problem if the woman was not supposed to give birth in a referral hospital. This scared her, and since then, no matter the situation, she no longer accepted to help pregnant women who were supposed to go to referral hospitals. Since she arrived at the dispensary, she only had one case of a stillbirth in which she was required to fill in the record

book and write a report. She distanced herself from helping women with high-risk pregnancies by explaining to them that she was not supposed to assist them and told them to look for transport to go to Mshikamano Hospital. However, she was fully aware that many women she advised to go to Mshikamano Hospital gave birth at home. All the healthcare providers I talked to had not experienced maternal deaths in their dispensaries' premises. However, this does not mean that maternal deaths never occurred in Lalta. It means they occurred elsewhere, either at home or in referral hospitals.

According to Nurse Vivian, who had been working at Upendo Dispensary since 2002, attending women with high-risk pregnancies had not been a problem until 2008 when the government became stricter about going to referral hospitals. Comparing the past and the present situation, Nurse Vivian was worried about the strict measures against healthcare providers following maternal deaths as she expressed in the quotation at the beginning of this chapter.

More conversations with the providers at Faraja Dispensary indicated that encouraging women to go to referral hospitals and avoiding to attend them went beyond the fear of losing one's job. For example, Dada Juliana tried to make sure that women who were supposed to go to referral hospitals were not accepted at the dispensary even when she was not the one helping them. Married to one of the medical doctors at the dispensary, she had worked there since 1999. In our daily interactions, interviews and informal conversations I noticed that she identified herself with the dispensary and protection of the integrity and reputation of the dispensary was her priority. Faraja Dispensary had been trying to acquire the status of a health centre since 2012 but had not met the required criteria. Having a maternal death happening on its premises would jeopardise the efforts of transforming it into a health centre.

6.2.4.2 "I Cannot Just Let Them Go:" Challenging the Implementation of the Maternal Referral System

Dickson worked at Faraja dispensary as laboratory technician and was known for helping pregnant women who were supposed to go to referral hospitals. Born in Ovada (a village near Lalta), in the early years of his childhood he moved to Tanga where his sister was working as a medical doctor. After completing his secondary school education, he underwent a medical

training as a laboratory technician. He worked at a private health centre in Morogoro for two years and then he decided to come back to the village to help his aging father. He applied for the position of a laboratory technician at Faraja Dispensary and started working in 2010. My first close encounter with Dickson was during the incidence of the twin birth in April 2015 (Chapter 1). When I had an interview with him, he said that he was also trained about maternity care. When he started working at the dispensary, there were no clear boundaries between a laboratory technician and a nurse. On a number of occasions, he would be called to help pregnant women, and sometimes women and their relatives sought help from him even after working hours.

His problem with the dispensary and especially his immediate senior Dada Juliana began in 2013. This happened when he attended a woman with a ninth pregnancy that faced some difficulties during childbirth but she finally gave birth safely. It was around the same time that a woman had died in Lahoda and the dispensary administration warned the healthcare providers against attending women who were supposed to go to referral hospitals. However, this incidence did not stop Dickson from helping women with high-risk pregnancies who went to the dispensary looking for help. During the interview, he admitted that he knew the risks of what he was doing. He said that:

> Sometimes I tell myself this time I won't do it, you see if it is during the working hours at least there is someone else there to send them away not me. But when they come to my door and I know even when I go and call someone else to help no help comes through, I brace myself and help them. I cannot let them go when they come at my door and you look at the woman the bottle has broken (*chupa imepasuka*[61]) and the child has come down and you know clearly they cannot make it to Mshikamano Hospital, I decide to help them (IDI, Dickson Magambua Village).

Dickson's standpoint of helping pregnant women not only presented him with the potential of losing his job if a maternal death happened but also exposed him to criticisms from his fellow healthcare providers especially Dada Juliana. Such criticisms weighed much on Dickson. His job was at stake even before anything bad had occurred. In the end of June 2015 when I travelled to Dodoma to meet the Regional Medical Officer, one of my interlocutors called to tell me that a

[61] Breaking waters during labour was described by healthcare providers as breaking the bottle

confrontation ensued at Faraja Dispensary. Dickson had helped another woman despite repeated warnings from Dada Juliana. This time again the medical doctor was not around and the other doctor and the volunteer midwife were still on leave. Dickson was attending other patients substituting the absent doctor when a woman came with her relatives looking for childbirth service. Dada Juliana told them to go to Mshikamano Hospital because it was still early but Dickson insisted that she should be helped because she could not make it to the hospital and the bus passing by Mshikamano Hospital had already left. Dickson stopped attending other patients and went to attend the woman. Dada Juliana was not happy and asked for the keys to the dispensary from Dickson and insulted him with bad words. The next day Dickson did not go to work, he too was angry that Dada Juliana insulted him in front of patients. After I returned from Dodoma, I talked to Dickson. He was unhappy and told me he was thinking about his fate at Faraja Dispensary. He explained that:

> She told me I am pretending to know too much (*mjuaji*) while I am not a nurse. She forgot that I was trained and I have been helping since I arrived here. I am a laboratory technician but I was trained and if I want to help them, it is I but she has made it a personal matter. She insulted me in front of patients as if what I was doing was a sin (IDI, Dickson, Magambua Village).

Whether Dada Juliana who insisted on telling women to go to referral hospitals or Dickson who challenged the maternal referral system was right or wrong depends on how one looks at the issue. In such conflicting situations, individual choices can only be understood when located in a particular context and what is put at stake by opting for a particular choice.

6.2.4.3 The In-between: Being Healthcare Providers *and* Community Members in a Rural Area

Looking at what the health providers considered risky in helping women with high-risk pregnancies, one begins to question the usefulness of the maternal referral system and its potential in reducing maternal mortality. Also, its implementation shows what it entails to be a healthcare provider, providing maternity services in a rural setting such as Lalta. When Nurse Zaina started working at Upendo Dispensary, she was ready to help but her readiness to help was inhibited by the uncertainty of what could happen during childbirth. Had a pregnant woman died, her job would have been at risk.

Referring women with high-risk pregnancies to referral hospitals was a way of avoiding the immediate problem posed by attending these women rather than helping them to get better care. As Allen (2004: 169-170) reports, sometimes healthcare providers in Bulangwa would help women to look for transport to go to hospitals just to wash off their hands. Allen points out further that in other cases women were denied the services because some of them were unable to pay for the medical supplies and drugs (ibid: 173). Therefore, sending them to referral hospitals was a way of avoiding them. Similarly, Pembe et al. (2017: 4) show that providers in Rufiji would let these women give birth in the dispensaries on the condition that if anything happened (presumably a maternal death) it should be clear (for the relatives) that they were advised to go to referrals hospital but declined. Several times during the time of my fieldwork there were media reports of healthcare providers denying childbirth services to pregnant woman because they were supposed to go to referral hospitals[62]. For Dada Juliana, these women presented a potential obstacle for Faraja Dispensary to become a health centre should a maternal death(s) occur. This also explains why obstetric emergencies of women with less risky pregnancies were immediately provided with the available transport at Faraja Dispensary while phones calls were made to Mshikamano Hospital to alert them of the coming emergencies.

By helping women, Dickson was an immediate danger not to pregnant women he was trying to help, but to the reputation of the dispensary. By the time I went back for the second phase of fieldwork, he was no longer working at the dispensary. I was told he had gone to Dodoma to further his education. In our informal conversations, Dickson had mentioned about going to study as a way of taking a break from all the drama at the dispensary. What I was not sure about was whether he would come back to Faraja Dispensary or look for a job elsewhere.

Providing maternity services under the maternal referral system meant taking a stance leaving the healthcare providers in dilemma questioning their ability to help pregnant women. They developed a sense of hopelessness. For instance, Zaina reported how difficult it was for her not to help even when she could. Dickson on the other hand, sometimes thought of not helping but

[62] https://www.youtube.com/watch?v=rEy16MOptqY, accessed on 12.12.2019.

he could not stop helping. Some of the healthcare providers in Lalta found themselves in a precarious situation no matter what decision they took.

However, the decision of whether to help or not to help did not appear to affect healthcare providers' relationships with the community members which were important for their social life. In a rural context such as Lalta, helping others in times of need is the basis for strong social relations. Because of this, despite being warned that they would not be accepted at the village dispensaries, pregnant women tried to seek for help from these facilities. These women were also not strangers to the healthcare providers. They knew them from antenatal clinic visits and also met them in other social spaces such as church services. Nonetheless, I noted that when they were not helped, women did not resort to speaking bad publicly against the healthcare providers or disrespected them.

For instance, Shani's mother complained about being sent away; however, she did not express any bad feelings against Nurse Zaina. At first, I thought that it was because of the power differences, in that she was afraid of expressing her anger. However, when I talked to Nyemo I understood why Shani's mother refrained from expressing ill feelings towards Nurse Zaina and why healthcare providers were respected even when they did not help women. Nyemo told me that among the Sandawe a person who assisted others to give birth was to be respected. She said, during childbirth a woman was weak and her life was in the hands of the one assisting her. The Swahili saying *usitukane wakunga na uzazi ungalipo* (Do not insult midwives while you are still fertile) appeared to work in Lalta, in its literal sense. Women would need the healthcare providers' services for birth care in the future. They also attended sick people and so jeopardizing a relationship with them was avoided.

This cultural aspect of respect gave healthcare providers a navigating space between local moral worlds where they could be healthcare providers, protecting what mattered to them and live peacefully with others despite denying pregnant women the necessary birth service. Dickson could have chosen not to help and still enjoyed the respectable position in the community. Challenging the implementation of the maternal referral system kept his job at stake, but what was really at stake for him was the need to help pregnant women. Dickson demonstrated what Kleinman (2006) discusses in his book *What Really Matters: Living a Moral Life amidst*

Uncertainty and Danger on how people make choices and struggle to live a moral life even when conditions put their peace at stake. However, this does not mean healthcare providers who refused to help women were wrong.

Besides, the dilemma faced by the healthcare providers indicated that health interventions did not affect only the targeted group, in this case women, but also the healthcare providers, especially those who were the main implementers on the ground. This is why in recent years, healthcare providers' experiences in the provision of biomedical care and implementation of health interventions has attracted research interest of anthropological studies (Andersen 2004; Street 2014; Martin 2009; Wendland 2010; Sullivan 2011; Mattes 2016). Even though the healthcare providers in Lalta worked as agents of the state, they were also subjects of the state in the sense that they were under hierarchical observation (see Ferguson and Gupta 2002; Sullivan 2011). When the nurse Vivian said, "they will come to question you with their cars," she was referring to healthcare administrators who supervised the provision of biomedical maternal healthcare services and the implementation of maternal health interventions on the ground. To understand further the birthing experiences of women and the dilemma of healthcare providers, the remaining part of this chapter explores the childbirth experiences of women who went to the referral hospitals and the subjective experiences of the health providers in these hospitals.

6.3 From the Village to the Referral Hospital

As I have illustrated in the foregoing discussion, poverty was the main limitation for most women who wanted to go for childbirth services in referral hospitals. However, some managed to secure funds and accessed the services. Given the distance to referral hospitals, most of these women had to wait for childbirth in maternity waiting homes or accommodation provided by the respective hospitals. I have shown in Chapter 2 that, Umoja Regional Hospital had a maternity waiting home named Matazamio while Mshikamano Hospital provided accommodation in a room closer to the maternity ward. Women had to carry their own food and caution money. In most cases, accommodation in both hospitals was overcrowded. Matazamio maternity waiting home had the capacity of accommodating 15 women but during the entire period of my study the number ranged from 60 to 70 women. The room at Mshikamano Hospital could accommodate

20 women but the number ranged from 30 to 40 women. Those who had relatives living close to the referral hospitals opted to stay with their relatives.

6.3.1 Delivering in Referral Hospitals: Women and Healthcare Providers' Subjective Experiences

From the very beginning of my fieldwork, when I met women who had given birth in referral hospitals, the main thing I noted from their narratives was the diversity of experiences about giving birth in referral hospitals. Some of these women had bad experiences to the point of swearing never to return, while others had good experiences and would not hesitate to go back if advised to do so. I began to understand the two extremes of women's experiences when I started observing the daily provision of maternity services in Umoja Regional Hospital and Mshikamano Hospital.

To comprehend women's and healthcare providers' experiences, I build on prior anthropological studies that focus on patients' and healthcare providers' experiences in biomedical hospitals of developing countries (Allen 2004, Berry 2010; Fordyce and Maraesa 2012; Wendland 2010; Sullivan 2011; Martin 2009; Andersen 2004; Street 2014; Mattes 2016). In these studies, patients' distressing experiences are linked to the failure of the state and biomedical institutions to meet the service provision needs, and how healthcare providers struggle to provide biomedical services and implement global (medical) interventions in conditions of institutional instability and medical uncertainty, while dealing with their own personal needs and concerns. While poor behaviours of healthcare providers have been reported as discouraging and hurting patients, these studies do not shoulder the blame on healthcare providers. Instead, they shed light on how it is like to provide biomedical services in what Street (2014: 11) describes as "an unstable place," where healthcare providers use their agency to discursively deal with challenging situations, which unfortunately, may be damaging and even fatal to patients (Andersen 2004: 2011). Adding to these studies, in the following section, I look at how healthcare providers in the two referral hospitals dealt with working conditions and how biomedical instability including healthcare providers 'reactions produced arbitrary childbirth experiences.

6.3.2: At Umoja Regional Hospital

My observation began at Umoja Regional Hospital in January 2016. The maternity ward was located on the right-hand side after going through the administration block which was the first building one faced after arriving at the hospital. The administration block housed the reception and outpatient department (OPD). Structurally, the maternity block had three wards built separately but close to each other. The main maternity ward was referred to as *chumba cha mangojelezeo* (the waiting room) or Ward Number 15. This ward had 30 beds for women who were in active labour, waiting for childbirth; as well as those who were waiting for Caesarean sections. This room also comprised a small unit for healthcare providers and for storing medical supplies.

Next to this room was the labour ward which was even smaller. It had 6 birth beds, which were separated by green curtains. Women who were ready to give birth would be shifted from Ward Number 15 to the labour ward. Afterwards they moved to Ward Number 17, the postnatal ward where they were being monitored until the time of discharge. The postnatal ward had 15 beds, which during my entire time of fieldwork at the hospital were used on shared basis by two women and their newborns. This was the most crowded ward of the maternity block. Since I observed the birth of twins (Chapter 1), I made up my mind that I would not be going in the labour ward when women were giving birth. My research activities were therefore between the waiting and the postnatal wards where I talked to women and observed them through the process of labour and after childbirth. I entered the labour room only when women were examined before being admitted to the waiting ward.

The morning I arrived in the maternity ward I found two nurse midwives[63] who had taken over a night shift crosschecking the records and inspecting medical supplies at their small unit within the labour ward. A moment later, another nurse midwife arrived and joined the other two. These three midwives together with other two nurse assistants[64] and the nurse in-charge (a nursing

[63] These are grade B nurses who receive two years of training. They can work in the maternity ward or other wards in the hospital.
[64] These receive one-year training and usually helped with observing cleanness in the maternity wards.

officer[65]) of the maternity ward were to take charge of women in the waiting ward, the postnatal ward and assist women during childbirth. From this very first day, I could see how the shortage of medical supplies shaped the healthcare providers' actions in this biomedical setting. The healthcare providers were keen to make sure that they had enough medical supplies, checking and asking those who were handling the shift if the supplies were available and in what amounts. In case of shortages, relatives accompanying pregnant women were asked to buy.

The healthcare providers were mostly busy except when it was time for breakfast or lunch when they would take turns to go and have something to eat. Given the busy nature of the maternity ward it was hard to have formal interviews during the working hours. Not less than 10 children were born on the daytime alone. This excluded emergency cases that needed immediate attention. The waiting and postnatal wards were rarely silent with the healthcare providers being called out many times by the pregnant women and mothers.

6.3.3 Bahati's Successful Birth

By the third day, I started getting acquainted to some of the women. I knew our encounters would be short because most women were discharged a day after giving birth. Occasionally, I visited those who were at Matazamio maternal waiting home. On the 12th January 2016 at around 8:00 am, a woman named Bahati arrived accompanied by other two pregnant women. Bahati was from Chikola Village, and for the past three weeks she had been waiting for childbirth at Matazamio. She was 24 years old, married and that was her second pregnancy. Her first pregnancy ended with a premature birth at sixth months. Diagnosed with high blood pressure and anaemia during antenatal screening, Bahati was advised to give birth in a referral hospital to which she complied. When Bahati arrived, she was received by one of the nurses in the waiting ward. Before she was given a bed, the nurse took her to the labour ward and asked for her clinic card. A series of questions followed about when the labour started and how she felt the labour contractions. After the regular checkups which included head to toe assessment, listening to foetus heartbeats and

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[65] Nursing officers are grading A nurses who have a four-year bachelor degree or a three-year diploma in nursing. They mostly they supervised the provision of maternity services work and some of them were in administrative positions as well.

viginal examination, the nurse asked Bahati about the things she had prepared for childbirth. Bahati had a small bag which contained some *khanga* for wrapping the newborn and some for herself. She also had a plastic basin, a pair of surgical gloves and a string to tie the umbilical cord. Then, the nurse left the room with Bahati's clinic card and went to the nurses' unit where she talked to another nurse about Bahati's anaemia. There after she showed Bahati a bed in the waiting ward. When the doctor passed for a round that morning, he prescribed blood transfusion for Bahati.

Later that afternoon, Bahati had labour contractions but they were not strong. The nurse instructed her to call her when the contractions got stronger. In the evening as I was about to leave, the nurse did a viginal examination but Bahati's cervix was not dilated enough to give birth. The next morning when I arrived, Bahati had given birth to a healthy baby boy. When I met her, she was happy that she had received good services and would not hesitate to come to the hospital again. She was however, eager to be discharged because the postnatal ward was crowded. She shared a bed with another woman and feared that the baby was breathing the air from so many people which she said was not good for the health of the baby. Bahati was also concerned about the overcrowding at the maternity waiting home where she spent about three weeks waiting for childbirth. Although the situation in Matazamio would not discourage her from coming to the referral hospital next time, Bahati wished to have the living conditions at Matazamio improved.

Studies looking at maternity waiting homes in Africa suggest the re-examining of the conditions of the waiting homes and the role they may play in encouraging or discouraging women to wait for childbirth closer to referral hospitals (Gaym et al. 2012; Mramba et al. 2010). Besides overcrowding, Matazamio had no transport to transfer women to the hospital. Women in labour had to look for transport on their own. Most of the time they used *bodaboda* which cost 2,000 Tanzanian Shillings (equivalent to 1.80 Euro) to get them to the hospital which was one kilometre away from Matazamio. Other women such as Bahati walked to the hospital accompanied by fellow pregnant women. At night, women were sometimes denied access in the hospital by the

hospital security guards ending up giving birth in the nearby bushes[66]. Incidences like these, although rare, might discourage women from using the maternity waiting homes.

6.3.4 Johari's Still Birth

The following morning after Bahati had given birth, another woman known as Johari arrived. Johari was not from the maternal waiting home but came directly from the village. Accompanied by her husband and mother she looked exhausted and did not seem to be familiar with the geography of the hospital. The three walked hesitantly towards the maternity building. As they approached the building, the nurse stopped Johari's husband and let Johari and her mother in the labour ward for examination and admission procedure. Johari was 22 years old from Kongwa District and that was her first pregnancy.

Following the usual procedure, the nurse asked Johari for her clinic card, which she handed to her. She then asked them as to why they came earlier while the estimated due date was on the following month. The nurse told them they were supposed to go to Matazamio. Johari's mother explained to the nurse that the previous night Johari had what they thought was labour pain (*uchungu*). Accordingly, they decided to come to the hospital. The nurse listened to the foetus heartbeats and told Johari to wait for the doctor who was finishing the round in the waiting ward. When the doctor examined Johari, he suspected false labour and wrote a prescription for Johari to have an ultrasound. Knowing that she was new to the hospital, I offered to accompany her. From the labour ward, we walked slowly to the ultrasound room, which was located on the opposite side of the maternity block. Although it was still early, we found a long queue of people waiting for the service. Some had been waiting from the previous day. When we submitted the prescription paper that the doctor wrote, we were told to wait for the radiologist who had not yet arrived and we joined others in the line. After some time, it was announced that the radiologist had an emergency and could not make it and we were informed to come back the following day. I could see the disappointment on the faces of many patients in the waiting queue, some started

[66] http://edwinmoshi.blogspot.com/2015/04/wajawazito-waandamana-hospitali-ya.html, accessed on 12.12.2019

complaining, and others were contemplating of seeking for ultrasound service at Aga Khan Hospital which was a private hospital nearby.

We returned to the waiting ward but I did not see the nurse who had attended Johari earlier. I approached another nurse and told her Johari could not get the ultrasound done. The nurse said she would have to ask the doctor about the next step. The waiting ward was full, Johari stood near the entrance while waiting for the answer from the doctor. After about 30 minutes, the nurse returned and told Johari she would have to sleep in the ward until the following day when the doctor would see her again. As she showed Johari a bed to sleep, which she had to share with another woman, the nurse asked for the supplies she prepared for childbirth. Johari had nothing except a few *khanga.* The nurse was agitated and told Johari to make sure she bought the things she was supposed to have. When the nurse left, Johari covered herself with a *khanga* and squeezed herself to lie on a small space the other woman had left for her.

The following morning when I went to the waiting ward, I did not see Johari and I thought she had gone to queue for the ultrasound. When I went to the postnatal ward I found Johari, she was fast asleep and the nurse told me she had an emergency operation the previous night. I wondered what happened and I longed for Johari to wake up and tell me the full story. I visited Johari in the afternoon; she was awake but looked tired and sad. The only thing I managed to say to her was sorry. Then I asked her, what happened (*imekuwaje*?). Johari told me at night she started feeling sharp back pain which was followed by bleeding. I remembered during the examination when they arrived, Johari had mentioned to the nurse that she felt back pain and the nurse told her it was normal to get backache during pregnancy. The doctor was called and finally an operation was undertaken. Unfortunately, the baby was stillborn.

6.3.5 Shortage of Medical Supplies, Drugs and the Problem of Hospital Facilities' Dependence

Generally, Bahati and Johari’s experiences mirror the experiences of several other women I observed at Umoja Regional Hospital. There were those like Bahati who got satisfactory services and others such as Johari who were disappointed. Umoja Regional Hospital served women from different parts of the region with a significant number of them coming from rural areas

responding to the referral advice. Based on appearance and accent when speaking Swahili, one could easily tell if a particular woman was from a rural or urban area. Another way that differentiated them was the number of visitors, those from rural areas had one or two people at most and at times had no visitors at all. While this did not make a difference on how they were treated by the healthcare providers, it did in the manner they prepared for childbirth. Regardless of the provision of free maternity services, women were required to prepare some of the medical supplies. It was necessary for women to have plastic sheets to spread on the labour bed, buckets for showering and when they could not go to the toilet the buckets were used as makeshift toilets. Women were also expected to have prepared enough *khanga* for themselves and for the newborns, cotton, or sanitary pads for use after giving birth. Healthcare providers also seemed to appreciate when women came with surgical gloves and syringes. To the healthcare providers, these women were "good patients" (Andersen 2004: 2009).

Bahati had prepared better for childbirth, which contributed to the smooth admission without agitating the healthcare provider. Several times, I heard the healthcare providers using harsh words when women came for childbirth without sufficient supplies. Those who waited for childbirth at Matazamio seemed to be better prepared than women such as Johari who came directly from the villages. While at Matazamio, women were advised to prepare for childbirth and sometimes the healthcare providers checked for the supplies before the onset of labour. Similarly, those from urban areas seemed to be better prepared for childbirth because they were informed during antenatal clinic visits of the things they needed to prepare. Sometimes the healthcare providers in rural areas used the free maternal health services rhetoric to insist women to go to referral hospitals. Taking it at face value, some women came to the referral hospitals with only *khanga* expecting to get all the rest of the things from the hospitals.

In such cases, the hospitals provided medical supplies for birthing care but one thing I noted was that medical supplies were not available all the time. Sometimes the relatives of the pregnant woman were asked to buy. This was also expressed by Nurse Aisha of Umoja Regional Hospital. She said:

> You may find that may be you know you will need ten or twenty syringes and you fill in the request form and send it to the pharmacy but they give you five. That is already a

problem and you must continue working. You cannot stop a mother from giving birth (*huwezi kumzuia mama kujifungua*) she must give birth and you cannot leave her. In situations like these, the fast way to help the mother is to ask the relatives to buy the things that we need. (...). Other people understand but others are very stubborn and you have to tell them if you do not bring the things we will not take care of your relative (IDI, Nurse Aisha, Umoja Regional Hospital).

Besides shortage of medical supplies, Nurse Lucia was concerned about the lack of enough drugs:

> I do not disagree that it is a problem telling women to buy the medical supplies. They are a big problem especially for those from rural areas. But for me there is another problem I see in our hospital that I think needs to be addressed. I mostly work in this ward of women who have given birth (postnatal ward). You find a mother has given birth, stitched, but she is not taking antibiotics. The doctor prescribes them but you find there is none to give to the mother so the relatives must buy them for her. Sometimes we discharge them and ask them to buy the antibiotics and you do not know if they will buy them or not. This is a big problem for sure, because a mother can get infections and develop other complications (IDI, Nurse Lucia Umoja Regional Hospital).

Shortage of medical supplies and drugs was also expressed by healthcare providers at Mshikamano Hospital. One of the medical doctors explained that the government which was supposed to assist the hospital in providing free maternity services did not fulfil its responsibility as expected. He explained that:

> Many times, we request medical supplies but we do not get the full amount. Now we work with the government and there are many problems with the medical supplies and drugs because they are not brought in time and when they come, they are not enough. All the time we work under shortages, every time you look, there are shortages. This affects the provision of maternity services in a large part (IDI, Doctor Mshikamano Hospital).

Similar concerns were raised by another doctor of Umoja Regional Hospital who claimed that the biggest problem was the shortage of medical supplies and drugs. Umoja Regional Hospital was collecting around 40 million Tanzania Shillings (equivalent to 16,000 Euros) per months from hospital charges but the budget to cover for the full hospital needs and enable the hospital to perform effectively was between 100-125 million Tanzanian Shillings (equivalent to 40,000-50,000 Euros). This explains why the hospital administration did not react to women's complaints about being told to buy medical supplies. In our interview, the Regional Medical Officer (RMO admitted that the problem of shortage of medical supplies was common to all health facilities in the region, a situation facing nearly all public hospitals in Tanzania (Mkoka et al. 2014; West-

Slevin and Dutta 2015). The hospitals depended on the Medical Store Department (MSD) for supplies, but when they ordered for the supplies they did not get everything they requested. Sometimes the MSD itself was short of the medical supplies. According to the RMO, as opposed to other hospitals, Umoja Regional Hospital had the potential of receiving more funding from the government because it was moving its headquarters to Dodoma Region. He further explained that the hospital did not depend solely on the government and was thankful that they were getting donations from individuals as well as private institutions.

The budgetary constraints reflected in the shortage of medical supplies and drugs shaped how women experienced maternity services in the two hospitals. The healthcare providers were more likely to be at ease and less harsh on women when they received more supplies than was the case when they had less. Nonetheless, the lack of medical supplies did not mean that women did not get services at all. Johari was operated although she only had a few *khanga*. The healthcare providers also admitted women to the labour room even without the plastic sheets; but much to the resentment of the healthcare providers, this meant extra work to clean the bed before another woman laid on there for childbirth. In such situations, healthcare providers were harsher to the women and sometimes used abusive language.

The fact that other women could get birthing services even without bringing medical supplies made other women and their relatives accuse healthcare providers of selling the medical supplies provided by the government for free maternity services. These accusations against healthcare providers were also perpetuated by the political rhetoric about free maternity services that was mainly emphasized by the Minister of Health and other political leaders. Lack of clarity about 'free' maternity services resulted into hostility between people and healthcare providers.[67]

In her study on social and institutional dynamics in Rukwa Regional Hospital, Strong (2015) points out that the allegations on healthcare providers selling medical supplies have historical background. In the past, due to low wages, providers sold medical supplies and drugs to patients.

[67] Most of my interlocutors reported to have bought medical supplies for 15,000-20,000 Tanzanian Shillings (equivalent to 6-8 Euros) but were not charged for the birth service.

While low wages were still a critical problem to healthcare providers, I did not see the healthcare providers in the referral hospitals where I did my research selling medical supplies to women and no woman reported to have bought the supplies from the healthcare providers. Even though the practice had largely been eradicated there, many people still believed healthcare providers were secretly selling the medical supplies meant for pregnant women and in turn asking them to buy the supplies on their own.

Johari's birth experience also sheds light on how working in collaboration with other hospital departments can delay treatment for pregnant women. It was important for Johari to have an ultrasound undertaken to determine the problem and the course of action. Since the radiologist was not around, Johari had to wait until the following day which was too late because she lost the baby. Umoja Regional Hospital had only one radiologist and in his absence, ultrasound services were not provided. Those who could afford to have ultrasound done from the nearby hospital, returned the results to respective doctors, and continued with treatment. In instances when particular medical equipments were broken or certain specialists were absent, the provision of care was affected. In situations like these, even the healthcare providers themselves felt helpless. For example, the only maternal death that happened during my presence at Umoja Regional Hospital was the result of lack of blood in the hospital blood bank. The woman who needed blood transfusion after birth had an O negative blood group that was not available in the blood bank and efforts to find people to donate blood for her did not succeed.

6.4 Shortage of Providers and Dealing with the Workload

Closely related to the deficiency of medical supplies and drugs was the shortage of medical providers in the maternity ward which influenced directly the kind of treatment women received. In both hospitals, nursing officers, nurse-midwives, and assistant nurses were the main healthcare providers in the maternity wards. Doctors went for rounds every morning and attended emergency cases whenever they were called to do so. Umoja Regional Hospital had 17 nursing officers, 83 nurse/midwives, and 109 assistant nurses. The maternity block had the highest flow of patients more than any other ward in the hospital. All the time the maternity ward was occupied with between 70 to 80 women. The situation was not very different in Mshikamano Hospital.

The hospital underwent major renovation of the maternity building in 2010, which enabled the admission of 70 women.

Upon entering the gate to Mshikamano hospital, the maternity ward was located on the lefthand side and one could read the sign to the maternity ward just a few meters from the main gate. The entrance to the ward was preceded by an entryway; the room on the left was the labour ward, and the room on the right was the nurses' unit. After the two rooms, which were separated by a corridor, there was a door leading to the waiting ward. This room comprised 40 beds. From the waiting ward, another entrance led to the postnatal ward, which had 30 beds out of which 10 beds were for special care nursery. Mshikamano Hospital had 12 nursing officers, 39 nurse-midwives and 67 assistant nurses.

By observing the provision of birthing care, it was apparent that the healthcare providers in both hospitals were overburdened by a big number of women.[68] This was reflected by the number of the healthcare providers assigned to the shifts in the maternity wards. The maternity ward in Umoja Regional Hospital had three shifts: the morning shift (7am-2pm), the afternoon shift (3pm-7pm) and the night shift (8pm-6am) in which the nurses rotated. After a week of night shifts, healthcare providers had a day or two off duty before changing to another week of a day shift. In Mshikamano Hospital, there were only two shifts where nurses worked for up to 12 hours followed by two days off duty before changing to another shift after every seven days.

In the day shifts, maternity wards in both hospitals had up to three midwives and one nursing officer. The three midwives were assisted by two or three assistant nurses. In both hospitals the night shifts were particularly understaffed compared to the day shifts. I did not do observations during the night but I met healthcare providers who were on the night shifts in the morning. While Umoja Regional Hospital had one midwife, one nurse in charge and two assistants, Mshikamano

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[68] Daily Umoja Regional Hospital served around 700 patients in the outpatient department (OPD) and had 359 beds for inpatients. The nurses along with other 214 medical providers of other cadres were divided to provide services to both in and outpatients. Mshikamono Hospital which served around 300 outpatients daily had 180 beds for inpatients and 104 medical providers of other cadres. However, it was common to find a significant number of providers absent attending seminars, trainings or away due to other emergencies, as it was the case with the radiologist.

Hospital had two nurses and one assistant nurse for the night shift. The biggest difference between the two hospitals was the number of pregnant women they served. Umoja had around 8,000 admissions of pregnant women per year while Mshikamano had around 4500 admissions per year. After birth, women at Mshikamano Hospital spent up to two days in the postnatal ward compared to those at Umoja Regional Hospital who were discharged sometimes less than 24 hours after giving birth in order to allow space for other women who had just given birth.

In between admitting and examining women, the healthcare providers had to deal with paperwork notably filling in partographs[69] (*grafu ya* uchungu) for women in labour at the waiting ward and those who moved to the labour room. Filling in the partographs was necessary because it was expected to alert healthcare providers about prolonged labour. During an interview with one of the doctors at Umoja Regional Hospital, he claimed that "without the partographs "women would be dying like chickens." Those in the waiting room who were in the first stage of labour[70] were to be checked after every four hours. Once a woman moved to the labour ward, the partograph had to be filled after every half an hour. This was described as the second stage of labour and pregnant women in this stage were expected to give birth anytime. The rules of filling in partographs were however, not always observed. Providers had to recheck for the stock of medical supplies and where necessary fill in the request forms. There was a constant movement of providers between the different sections of the maternity wards. While I was able to observe the busy routine of the healthcare providers in the wards, I further comprehended how they dealt with the workload from women's expressions of how they were treated by the healthcare providers as well as how the healthcare providers themselves perceived their work and mechanisms they developed to deal with the workload.

[69] Since 1994 partograph has become an essential tool proposed by the WHO for the reduction of maternal mortality in developing countries. A partograph is used to track different stages of labour in order to avoid prolonged and fatal distress and alert the healthcare providers when to undergo particular interventions (WHO 2014b). Providers were required to fill in partographs in the women's files and on the clinic cards.

[70] During the first stage of labour the cervix is firm and not dilated to allow childbirth. This stage as I observed lasted for between 5 to 24 hours.

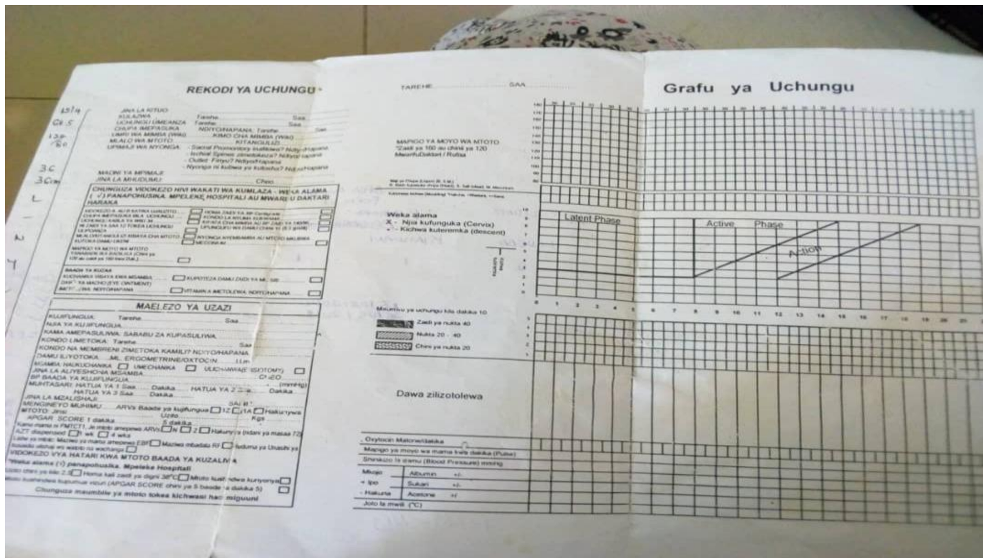

Figure 6.2: Unfilled Partograph on a pregnant woman's clinic card (Photo Anitha Tingira 2016).

6.4.1 Uncaring Healthcare Providers

As I talked to more women depending on how they experienced maternity services in the two hospitals, they classified the healthcare providers as those who care (*wanaojali*) and those who do not care (*wasiojali*). Johari thought that healthcare providers were not caring enough. After returning to the ward that morning Johari was told to lie down and wait. Up to the time I left the hospital, Johari had not been examined and the provider inquired about her progress only once. According to Johari, she was attended to when she started bleeding. The nurses examined her and called the doctor who finally performed an operation on her. Johari explained that:

> Since that morning when the doctor came and said I should go and get checked no one came to look at me, in the afternoon only one nurse came and asked me how I felt and whether I had contractions, but I was not feeling anything. (...). At night when I started bleeding, my fellow (referring to the woman she was sharing a bed with) helped me to call the nurse, I was too dirty with blood and my stomach was hurting so much. The nurse looked at me and left. After sometime, the doctor appeared, he checked me and after sometime I was taken to the other room where I was operated but I was told the baby was already dead (IDI, Johari, Umoja Regional Hospital).

Unlike Johari, some other women gave birth successfully but left with the impression that the healthcare providers in referral hospitals were not caring. Chiku was among these women. I met Chiku at Mshikamano Hospital in March 2016 two weeks after I started working at the hospital. She was 32 years old, married, and had just given birth to her fifth child. Chiku arrived at the

hospital the previous evening but I saw her in the morning. I had decided to go to the hospital earlier than usual that day as other people went to see their relatives and brought them breakfast. In the maternity ward, some women were sitting with their relatives taking breakfast and two nurses were in their unit. There was no woman in the labour room. I noticed Chiku when I started walking around the ward greeting women. Her facial expression and panting made me realize that she was in labour and had a lot of pain. Another woman sitting beside her, who I later learnt was her aunt, was trying to calm her down asking her to drink the tea she had brought.

At 6:30 am, a bell rang to alert the visitors that the visiting time was over. Chiku's aunt went to the nurses' unit and told them her relative was in labour and that she needed help. One of the nurses replied dismissively that they were aware about that. They then asked her to leave the ward because the visiting hours were over. When Chiku's aunt left, Chiku herself tried to call out for a nurse and one of them told her to wait because they had another job which they were doing. The two nurses were getting ready to handle over the shift. Chiku called out loudly whereupon she was told to wait and to stop making noise otherwise she would not be attended. She lowered her voice but no one went to check on her. After a while, she stood up slowly and started walking to the labour room. Seeing that, one of the nurses who arrived to take over the shift followed quickly behind Chiku. After approximately 30 minutes later, Chiku gave birth to a baby boy. Both the boy and the mother were sent to the postnatal ward to wait for discharge.

Curious to talk to Chiku, I went to see her at around 10:00 am. Although she was happy that she had given birth safely, she told me the nurses were not caring. She explained her experience since her arrival at the hospital the previous evening. She said that:

> When I got here, it was already getting dark. I came with a *bodaboda* with my aunt but she was told to find somewhere else to sleep. I remained alone; the nurses did not look at me as such. (...). One nurse examined me and said I should wait, then she showed me the bed and left. At night when they passed they told me since it was my fifth pregnancy, I must be well experienced, I thought they were joking but when they did not attend me the whole nigh I saw that they do not care, I tolerated the pain until this morning. When I felt like the baby was coming out, I decided to go to the labour room like others. (...). Since yesterday I saw women walking themselves to the labour room, if I had not gone, I would have given birth in front of others (IDI, Chiku, Mshikamano Hospital).

Experiences like these of Johari and Chiku reminded me of some of the experiences of being neglected during labour narrated by some women when I started my fieldwork. One of the narratives was that of Sophia, a 35-year-old, married woman, and by the time I met her in March 2015, she had given birth to her sixth child in Mshikamano Hospital in November 2014. During one of the child clinic sessions, I heard Nurse Asia asking Sophia to take the baby to Muhimbili (the national referral hospital in Dar es Salaam) before it was too late. I was interested in knowing what was wrong with the baby. When I finally had an interview with Sophia, she told me her baby seemed to have a problem in the brain resulting from prolonged labour, as she was told. While pregnant, Sophia was advised to go to a referral hospital. She and her family chose Mshikamano Hospital. It was her second time. Her fifth child was also born in Mshikamano Hospital. For more than two weeks, she waited for childbirth. When the labour pain finally began, she went to the maternity ward. She thought it would be like all other births in which she gave birth without any problem. However, this one was different as she explained:

> The labour was going on very slowly (*uchungu ulikua unaenda taratibu sana*), the nurse told me to walk around, I climbed the staircases but every time she (the nurse) examined me, she said I was not ready. It went on like that for the whole afternoon. In the evening when they changed shifts, another nurse came to check me. I told her I had the pain since morning, she listened to the heart beats of the baby, they were very far, she told me the baby was very tired and she was lamenting that the other nurses have left problems for her. She then went to call the doctor who said I would need an operation. Right there I was prepared for an operation; they gave me the forms to sign and they took me to the theatre but the baby was too tired, it did not cry and you see him as he is now, he is not like other children he stares at one place like a person who is absentminded. They (healthcare providers) are telling me to take him to Muhimbili, where will I get the money? (IDI, Sophia, Magambua Village).

Like Chiku and Johari, Sophia blamed the delay to the uncaring healthcare providers who were on duty throughout the day. Sophia was hurt because the child was suspected to have brain damage and was unsure of what would become of the child and her future caring for the child with brain damage. She thought if the same nurse who attended to her that evening had been around since morning, she would have given birth to a healthy baby. To her, a caring nurse would have made a big difference. Sometimes women did not experience the lack of care themselves but saw it happening to others and it was enough to let them doubt about giving birth in referral

hospitals. Kulwa, a 24-year-old married woman who gave birth to her first child at Umoja Regional Hospital in June 2015, explained that:

> I gave birth safely, they didn't do anything bad to me, but when I went to the other room after giving birth (referring to the postnatal ward) it was mid-night. One woman we were sleeping together had also given birth but was bleeding until I could see her *khanga* was soaked in blood. She called for help but the nurses did not come. (…). They were busy in the labour room. They were late to look at her and the woman died in the morning when they were putting blood for her. Now I don't think if I will go to that hospital again (IDI, Kulwa, Manantu Village).

Another one explained how one the woman lost her child after Caesarean section at Mshikamano Hospital:

> My fellow woman gave birth well by operation and the child was health, it was very big. When she woke up the nurse took the baby to her for breastfeeding. She was awake but still hallucinating (*alikua ameamka lakini alikua bado na maruweruwe*). The nurse left the baby with her but by bad lack she fell asleep while the baby was still sucking and the breast prevented the baby from breathing. The nurse said she killed her baby but she was not fully awake from the operation (IDI, Nyawe, Ilasee Village).

Ideally, according to the code of conduct for midwives in Tanzania, midwives are required to attend women with care and dignity (TNMC 2007). My conversations with the healthcare providers revealed that it was not easy to provide care as they were required theoretically. In their opinion, this was due to a combination of factors, heavy workload being one of them. When the labour wards were fully occupied by women who were ready to give birth, attention to those in the waiting and postnatal wards was minimal. Even going through each woman's clinic card attentively at the change of shifts was practically impossible.

6.4.2 Abusive Treatment as a Different Kind of Care

The WHO recognizes the presence of verbal and physical abusive, negligence, and disrespectful treatment of women during childbirth and describes them as "abusive treatment," a violation of human rights which must be stopped (WHO 2014a: 1). In mitigating abusive treatments, it is important to understand why such treatments occur in the first place. While educating healthcare providers on the WHO's recommended ideal treatment of women during childbirth is commendable, locating healthcare provider's actions within particular contexts of their

occurrence would provide a comprehensive understanding of their actions and how to deal with them in order to improve the experience of women during childbirth in biomedical institutions. Although I observed abusive treatments in terms of verbal abuse and negligence and some of my interlocutors reported physical assaults such as being slapped or pinched while giving birth, none of the healthcare providers I talked to admitted that such actions were intended to hurt women. This situation presents a paradox that can be understood as "a form of agency as healthcare providers strive to deal with the conditions of hospital work and meet the demand of providing care to patients" (Andersen 2004: 2011), to which I add that, may be interpreted as a different kind of care. My intention is not to justify these acts but to amplify the role they play in the provision of maternity care as described by healthcare providers themselves and how they shaped women's arbitrary experiences.

The role of abusive treatments in the daily provision of birthing care was elaborated to me by three nurses at Mshikamano Hospital after I approached and asked one of the nurses who had just scolded a woman who was crying loudly of labour pain. When the nurse returned to their unit where two other nurses were seated, I followed her and initiated a discussion about the healthcare providers' mistreatments to women. The nurse who had just scolded the woman told me; "*hata sisi tuna moyo" (*we also have heart). I asked was she meant by that. She said that they cared about women but it was difficult for them to serve many women without being harsh but that did not mean harm, they were not heartless. She explained further that when they talked politely and persuasively (*kwa upole na kwa kubembeleza*) women tended to disturb them so it was important being harsh (*kua mkali*) to reduce disturbance and to be able to divide their focus to all women (cf. Bech 2013: 90). Being harsh in this sense was meant to enable the healthcare providers to 'manage women' and be able to attend them without much difficulty. In similar lines, nurse Malaika articulated the negligence to the lack of enough healthcare providers. She expressed that:

> You find you have come and you have to go to the labour room to assist a woman to give birth, that means (*yaani*) you don't even have time to breathe. There was a day I came for the night (*nilikuja* night) and I delivered fourteen children. (...). We were two, it happens. At the same time you must look if everything is fine after women have given birth. You find it is hard to divide ourselves and take care of all women, even if a woman calls for help, you tell her to wait; and they think we are bad hearted (*roho mbaya*) or we hate

> them, which is not true. Sometimes maybe you are too tired you have been standing for a long time, when they call, you just tell them to wait because you want to breathe for a short time (IDI, Nurse Malaika, Mshikamano Hospital).

Although it was not always that the healthcare providers delivered many babies, during the night shifts the maternity wards were notably understaffed which made it difficult for healthcare provider to be attentive to each woman as expressed by nurse Maua:

> Here we have many women who are waiting to give birth, we are supposed to check them regularly to see how the labour progresses and at the same time assist others to give birth. It is hard to pay attention, sometimes you only look at those you have noted are closer to giving birth and you leave others. (...). Sometimes it is true you miss to notice others and they go to the labour (ward) themselves (*wanaenda leba wenyewe*). It is much better in the daytime because there are three or four of us and the sister incharge who is usually around. During the day you can at least pay attention but at night it is very difficult (IDI, Nurse Maua, Mshikamano hospital).

While being harsh and negligent was necessary when they had to provide care to many women, it was sometimes done habitually as in the case I observed. There was no woman in the labour room, the nurses had just finished their night shift, and the maternity ward was fairly quiet expect for this one woman who was crying loudly of labour pain. Rather than checking and calming the woman, the healthcare provider scolded the woman and asked her to stop making unnecessary noise. Furthermore, slapping, pinching or beating women was described as being necessary when a woman was stubborn (*msumbufu*)[71]. Explaining why sometimes providers resorted to scolding or slapping/pinching women, Nurse Aisha told me of one of her experiences in which she had to slap a woman during childbirth. She said:

> One day a Chagga[72] woman came here, her labour was going on well, but she was very stubborn, she was crying all the time. When giving birth, she did not want to open her thighs, I told her to open her thighs, she was tightening them, what do you do to a person like that? I persuaded her but nothing, I called my fellow to help me but it did not work, I saw now she will strangle the baby, I started telling her to open her thighs with slaps. She opened her thighs and gave birth well (IDI, Nurse Aisha, Umoja hospital).

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[71] Being stubborn was described in terms of those who did not listen (*wasiosikia*) when they were told not to shout/cry loudly during labor or failed to follow particular instructions given by healthcare providers during examinations and childbirth.

[72] One of the ethnic groups in Kilimanjaro Region, northern Tanzania.

Even at home, some of my interlocutors told me they were threatened or actually beaten during childbirth. This was intended to help women to give birth safely. Allen (2002: 199-200) notes that during homebirths in Bulangwa, women were forbidden from making noise, were told to remain calm during labour and sometimes scolded, threatened, or actually beaten if they did not follow the instructions of TBAs. This was done to enable TBAs to control labouring women. It was alleged that if women were left without control they would kill their babies during childbirth. Similarly, for the healthcare providers, scolding and sometimes beating women was meant to help women give birth safely rather than mere infliction of pain. Van Hollen (2010: 133) reports that providers in Tamil Nadu (India) told women not to shout too much in order to preserve their energy, sometimes threatened to beat them though they did not usually do so.

The fact that the healthcare providers had to attend a big number of women with limited resources contributed to the normalisation and persistence of abusive treatment intended for care. The extent to which abusive treatments were interpreted as acts of care by women themselves depended on the manner in which they experienced them. The important thing noted was that most women did not appreciate these treatments (cf. McMohan et al. 2014). In some cases, the aftermath of such treatments affected women psychologically and emotionally as was the case with Sophia who could not imagine the future with a mentally challenged child. The beatings could also be extreme with fatal consequences. For example, in April 2015, a healthcare provider in Chamwino District caned a woman during labour leading to stillbirth and endangering the woman's life.[73]

Despite its consequences, looking at abusive treatments in the light of care signifies not only the healthcare providers' desperate efforts of providing care within challenging environments, but also the failure of the health system in addressing the situation as well as the unstable contexts upon which global interventions are implemented and expected to produce positive results. Providers were fully aware of the midwifery code of conduct but the reality was not supportive. The hospital administration was aware of these abusive treatments but not much was done to stop them. There were opinion boxes which women could anonymously use to express their concerns

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[73] http://www.mwananchi.co.tz/habari/Kitaifa/1597296-2696940-72nmg9/index.html, accessed 12.12.2019.

but these boxes were rendered useless. The healthcare roviders developed and adopted mechanisms that helped them to simplify their job. Unfortunately, these mechanisms affected some of the women who sought for childbirth services in the referral hospitals.

Figure 6.3: An entrance to the labor ward, Mshikamano Hospital (Photos by Anitha Tingira 2016).

Figure 6.4: A sign to the Maternity Ward, Mshikamano Hospital (Photos by Anitha Tingira 2016).

6.4.3 Midwifery as a Call

Despite being overwhelmed with the workload, some of the healthcare providers made extra efforts to pay attention to women. Women described such healthcare providers as caring. One of them was Nurse Neema, who according to my observation expressed a high degree of care. Nurse Neema was a 39-year-old married woman who had worked as a midwife for fifteen years, ten of which had been at Umoja Regional Hospital. When I requested to interview her, she cheerfully invited me to her house. During the interview, she told me the midwifery work was not easy; it needed a lot of heart (*inataka moyo sana*). To help women, one had to be tolerant. She explained that:

> This work is not just like any other work, we deal with peoples' lives all the time, if it is not your call you cannot do it well (IDI, Nurse Neema, Umoja Regional).

To Nurse Neema, midwifery was not just a job, but a commitment that required personal qualities that not everyone had. To her midwifery was a call (*wito*). To emphasize the call of the midwifery job she explained how she dealt with the difficult working environment and still helped women wholeheartedly:

> No one denies that our working environments are difficult. Yes, they are very difficult, not all the time you have all the supplies you need. One time you are missing this and another time you are missing that, and sometimes mothers come without any of the things they are supposed to bring, and you look at them and think what I will do. In such situations, it is very difficult for us and if you have something in your pocket, you give the relatives to go and buy the things that are needed so that you can help their relative immediately and ask them to return the money later. (...). I have bought things when I used to work in Mpwapwa Hospital but not here. Sometimes the situation in the hospital was so difficult, you find even just gloves are not there and you decide to help a woman. In a way you also help yourself because you cannot work without gloves (IDI, Nurse Neema, Umoja Regional Hospital).

Mattes (2016), demonstrates similar dilemmas faced by healthcare providers in the administration of ARVs in Tanga where they had to go an extra mile by giving money from their own pockets to help patients in difficult situations. According to Neema, it takes not just any person to do that but a person with a call. Working selflessly was also identified by Suzana, a nurse at Mshikamano Hospital, who like Neema devoted much effort in serving pregnant women. However, according

to Nurse Suzana, although the working environment had improved in terms of the new maternity ward; the big number of women was so demanding. She explained that:

> You know we were not providing free services, we were charging women for childbirth, and there were not so many coming like now (...). We started working with the council (Ikugi District Council) in 2009 maternity services were made free, had you come at that time (before the expansion of the maternity ward), the ward was small and it was so full. Other patients were sleeping on the floor and nurses were few. I think the entire hospital had 46 nurses only. We were working until we were getting confused. Now the nurses have increased but more women are coming as well. You ask yourself whether you will be able to serve them well but you have nothing to do than to continue working and trying to do your best (IDI, Nurse Suzan, Mshikamano Hospital).

While Suzana saw the increasing number of women as a problem to providing good care, Neema was hopeful that things in Umoja Regional Hospital would get better. She talked of the new maternity building (then) yet to be finished hoping that it would reduce the problem of small space. A similar observation is made by Sullivan (2011: 116) that improvement of physical infrastructures gives healthcare providers a feeling of working in a more professional environment. To Neema the new building was an indicator of a better working environment.

Figure 6.5: The new maternity block of Umoja Regional Hospital opened in October 2018 (Photo, Michuzi Blog. Used with permission).

6.4.4 Working to Fulfil Responsibility: Giving up and Letting Things Take their Course

Besides the shortage of medical supplies and heavy workload, the healthcare providers' actions towards women can be understood in the context of healthcare providers' concerns about low salaries, lack of overtime payment, lack of proper management and administrative support (See Sullivan 2011; Mattes 2016; Sargent and Rawlins 1991; Ruck 1996). These concerns were raised many times during my conversations and interviews with the healthcare providers. I noticed these weighed heavily on them to the point of lowering their working morale, even among the most devoted healthcare providers such as Neema and Suzana. For instance, comparing her salary and the amount of work she did, Nurse Suzana was of the opinion that their work was underrated. She said:

> If I tell you how much I am paid you will be surprised, in this country I think it is us nurses and teachers who are paid meagre salaries while taking heavy loads, we are truly paid very little salary[74] and our claims are not addressed. The government owes many of us many claims for holidays, arrears, uniforms, and others have been transferred here but have not been paid the transfer allowances. Since 2009 until today, we are still claiming (IDI, Nurse Suzana, Mshikamano Hospital).

Commenting on the salaries of healthcare providers, Nurse Aisha considered low salary and unpaid allowances as a problem not to all medical professionals but to ordinary nurses (*manesi wa kawaida*) like her. She had this to say:

> We ordinary nurses depend only on salary. We do not have overtime or allowances, even if you stay back because of an emergency they (administrators) just say we will be paid but we are never paid, but you see the doctors, it is different for them. They have commission with each operation they perform. (...). They are not paid for the childbirth operations but they do other operations, they are paid commissions. (...). Other patients pay for the operations and doctors have their commissions. We cannot compare ourselves with them; for us, it is only the salary, the economic situation is very hard for us (IDI, Nurse Aisha, Umoja Regional Hospital).

The healthcare providers also raised concerns about the lack of appreciation from their superiors especially when they made extra efforts in performing their duties. Narrating the experience, nurse Malaika (assistant nurse) of Mshikamano Hospital explained how some weeks before my

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[74] The nurse's salary ranges between 300,000-600,000 Tanzanian Shillings (equivalent to 120-240 Euros) per month

arrival she felt discouraged after being scolded by the nurse-in-charge when she tried to assist a woman who was tired and could not push during childbirth. She explained that:

> She was ready to give birth but the baby was still up, by the time it came down the mother had no energy to push; I thought what should I do, there your brain works faster because if you play a bit (*ukicheza kidogo tu*) you can lose the mother or the child. I decided to pull the child with a vacuum, you know we are not allowed to use that. (...). Only midwives and doctors are allowed to use the vacuum but sometimes you are forced to, like me I was forced to, so I pulled the baby out but it took long to cry. I was scolded by the sister-in-charge that I was quick to use the vacuum because she suspected the baby might have brain damage. It is so hard when you think you are helping but then it is as if you are doing nothing at all (IDI, Nurse Malaika, Mshikamano Hospital).

Lack of motivation was also mentioned by Nurse Neema who, apart from striving to do her job well amidst the shortage of medical supplies and heavy workload, she was disturbed by the manner in which the hospital administrators were harsh on healthcare providers when maternal deaths occurred. She said:

> There are things that discourage us; you work so hard, but these days when a woman dies it looks like it is your fault. First, you will have to write a report to explain how the death occurred, it will not end there. You will be called to explain and they (hospital administrators) will ask many you questions as if they do not know the situation (...). Sometimes it is even not you but you took over a shift and found a critical case, it is so hard to explain yourself when it looks like your fault (IDI, Nurse Neema, Umoja Regional Hospital).

Neema found it ironic that administrators were hard on healthcare providers when maternal deaths occurred as if they did not know anything about the challenging working environments. A similar case is reported by Mselle et al. (2011) who reveal that healthcare providers in Mpwapwa District Hospital described a case of maternal death as *kasheshe*[75] that they wished to avoid. However, providers in referral hospitals were hardly subjected to disciplinary measures like those in rural areas.

It is apparent that in some cases providers could be held responsible for infant or maternal deaths. However, most of the time maternal deaths occurred because of the situations that transcended

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[75] *Kasheshe* is word of a Sambaa ethnic origin meaning violence. In the 1990s, it became so popular and was adopted in Swahili usage expressing a difficult situation that is not easy to resolve.

the control of healthcare providers and of the medical institutions at large. To avoid discouraging healthcare providers, the WHO insists less on questioning about maternal deaths and instead calls for more emphasis on supporting and encouraging healthcare providers to do their work better (WHO 2016a: 3). At the same time, international pressure to reduce maternal mortality remains high (see Storeng and Béhague 2016) resulting in shouldering healthcare providers with the responsibility of maternal deaths at the institutional level.

The lack of appreciation was not limited to superiors and administrators but also women and their relatives who sometimes blamed healthcare providers when infants or maternal deaths occurred. Nurse Wema explained that:

> You see, sometimes the complaints come to us when women or newborns die. It is as if it is our fault. But you ask yourself what could I have done? Sometimes, to say the truth, we work to just fulfil the responsibility because no one cares about us. Our problems are so many that we lose excitement for the work (IDI, Nurse Wema, Umoja Regional Hospital).

The demoralization experienced by providers in referral hospitals reminded me of the expatriate doctor at Faraja Dispensary who was described by my interlocutors as "have become like them," implying his changed attitude on treating patients that had become like those of other healthcare providers who were harsh on patients. Upon his arrival in 2007, my interlocutors said he was working past working hours; however, he gradually reduced helping people after working hours except when the patient was a child. The interlocutors said he even shouted in Swahili when people approached him for help after working hours or during weekends. Allen (2002: 197) reports a similar situation among newly employed nurses who were eager to work and more cordial to patients than those who had been working for a long time. Given the challenging nature of the working environments, one cannot guarantee for how long healthcare providers such as Neema would continue working selflessly and contribute to the positive experiences of women receiving childbirth services in referral hospitals.

Moreover, the healthcare providers' morale to work was compromised by the fear of contracting HIV (see also Mattes 2016). Explaining the risk involved, Nurse Malaika expressed that the constant contact with blood in their work cased feelings of uncertainty and fear:

> We are in constant contact with blood, and you know, women test for HIV only once and others come here and you find that they have not tested. You don't know maybe they are infected after the test, you can't know that and you can't stop thinking what if it happens I get infected, these thoughts come into your head, we touch blood all the time and sometimes assist women who are HIV positive (IDI, Nurse Malaika, Mshikamano Hospital).

Recognizing the high-risk of contracting HIV among midwives, the WHO (2003) requires biomedical facilities to provide protecting equipments to healthcare providers. These include gloves, plastic aprons, masks, safety glasses, and long boots. However, these requirements were not always met. Nurses in both hospitals used only aprons and gloves for protection. I saw healthcare providers wearing masks only when entering operation theatres. The risk involved in their work raised the yearning to be appreciated and paid well because they risked their own health while serving others as expressed by Nurse Aisha:

> We are like candles; a candle emits light for others while it burns to extinction. You cannot say I will not help this woman to give birth because she is infected but you don't know what will happen when you prick or cut yourself in the process. (...). One of our fellows pricked herself when preparing a HIV positive woman for a C-section. She was hysterical, she was given PEP (post-exposure prophylaxis) but she did not find the courage to work as a nurse anymore and she is now in Dar es Salaam working at Strategis (a health insurance company). Sometimes when you look, it is better to be paid little money but you know you are safe but to find a job is so difficult these days you just find yourself tolerating. Maybe one day the government will remember us and improve our situation (IDI, Nurse Aisha, Umoja Regional Hospital).

Administrators in both hospitals were not blind to the healthcare providers' concerns but their ability to respond was limited by budgetary constraints. For instance, one of the doctors at Mshikamano Hospital said they did not receive grants (*ruzuku*) for healthcare providers' upgrading, despite requesting for the same every year. The RMO too mentioned of good plans to motivate healthcare providers especially those working in the mother and child sections. The main problem was budgetary constraints.

6.5 Conclusion

As an important element in the reduction of maternal mortality in developing countries, this chapter contextualized the implementation of the maternal referral system by focusing on the experiences of women and healthcare providers. I have specifically explored the provision of

maternity services under the maternal referral system at the dispensary and referral hospital levels. I have shown that despite the good intentions of helping women with high-risk pregnancies to access emergency obstetric care, restricting them from getting childbirth services at the village dispensaries as a governing technique to compel them to abide by the referral advice, affected those who wanted biomedical childbirth care but could not go to referral hospitals mainly due to the lack of financial resources.

Although many among these women gave birth safely at home, the emotional suffering was clear in the accounts of their childbirth experiences. I have also shown that healthcare providers at the village dispensaries were affected by the implementation of the maternal referral system. They had to make a choice between helping women in need, and risking their jobs and put the status of the dispensaries in jeopardy. Other women were able to go to referral hospitals either by emergencies or out of their own plans, abiding by the referral advice. These women expected to get good services in referral hospitals which was not always the case. I have shown that getting good or bad childbirth services in the referral hospitals was a result of a combination of factors none of which can be considered independent of the other.

The experience of childbirth care in the referral hospitals started with the admission process in which among other things women had to show the things they had prepared for childbirth. Although the healthcare providers were more cordial to those who prepared themselves better, there was no guarantee that such cordial treatment would continue. The very same healthcare provider could easily become aggressive when a woman became stubborn, when she was overwhelmed by a big number of patients or when she was tired and needed some little time to rest. The time of birth was also significant. It was relatively easy for women to get attention in the day than during the nighttimes because the night shifts were more understaffed than the day shifts. The healthcare providers were overwhelmed by the many women and paying attention to each of them was practically impossible. Even when medical supplies were available, such a situation could potentially cause maternal deaths and complications that could otherwise be avoided.

I have also shown that the healthcare providers' personal needs and concerns affected the working morale which in turn affected women. Providers were worried about low salaries, heavy

workload shortage of medical supplies, lack of commission, and overtime payment as well as the lack of appreciation from both their superiors and the women they served. Some of them stopped making extra efforts in serving women. For others, regardless of the situation, abusive treatment became a routine in the provision of maternity services as an easy way of reducing the severity of their work while putting at stake the lives of women and their unborn babies.

Notwithstanding the good intentions of reducing maternal mortality, the maternal referral system falls short of the expected results which are bigger than the actual human and physical capacities of the referral hospitals, as well as the budgetary allocations (cf. Haeggström and Mbusa 2008). Listening to women's experiences of abusive treatments, one can easily blame the healthcare providers. However, looking at the actual situation and the daily provision of maternity care, one can begin to see the struggles of these healthcare providers. In addition, budgetary constraints for medical supplies, drugs, provider's allowances, and other providers' concerns interacted in service provision and perpetuated the everyday forms of violence women experienced in the referral hospitals. Besides different working environments, the healthcare providers in both the village dispensaries and referral hospitals shared feelings of hopelessness and uncertainty as they struggled to provide maternity services and abide by the ethical guidelines.

Chapter 7

From Traditional Birth Attendants to Community Health Workers: The Politics of Maternal Health Interventions

7.1 Introduction

This chapter discusses the ongoing changes from the use of traditional birth attendants (TBAs) in assisting childbirth to the use of community health workers (CHWs) for maternal health in order to increase the utilization of biomedical maternal healthcare services and reduce maternal mortality. In accounting for maternal health and childbirth, especially in rural areas of Tanzania and other developing countries, one cannot overlook the role and place of traditional birth attendants (TBAs). For over a decade, the global training of TBAs, which previously equipped them with skills to conduct safe delivery and identify risks during pregnancy and birth, has shifted towards facilitating their new role as 'promoters of facility-based childbirth.' This came about because of limited evidence that TBAs contribute to the improvement of maternal health (Pyone et al. 2014).

Along with the changing role of TBAs, community health workers (CHWs) have been trained to follow up on women in their homes; educate and encourage them about attending antenatal care, facility based childbirth, family planning as well as newborn and child care; and where necessary accompany them to health facilities. Increasingly, TBAs services are vaguely regarded as a type of informal support with no clear guidance on how they should work with CHWs (Devlin et al. 2017: 8).

My conversation with both TBAs and CHWs revealed thereby an overlap of the roles of these two categories of service providers. TBAs expressed dissatisfaction with the shift of their role from being assistants during childbirth to simply being companions of pregnant women on their

way to health facilities. They were also unhappy with the discontinuation of the training they were previously receiving. On the other hand, CHWs who received training in maternal, newborn, child health, and adolescent health (MNCAH) have gained more power, not only as educators and companions for pregnant women but also as overseers of TBAs. Thus, while TBAs and CHWs were supposed to work as a team, it emerged from interviews that TBAs felt that their domain had been invaded and were subjected to hierarchical relationship with CHWs. This conflict of interest made some TBAs to stop working altogether, while others declared that it was difficult for them to stop assisting childbirth because pregnant women still needed them.

How did TBAs, the once praised category of actors in maternal health interventions (Allen 2004: 108) fall out of favour and what does this entail for women in Lalta and the utilization of the available biomedical maternity services? Drawing from Mark Nichter's proposition that in the global health arena, justification of particular policies and programs requires a particular representation of people (2008: 4); I will argue that the use of CHWs for MNCAH and the shifting role of TBAs to encourage the use of biomedical services during pregnancy and childbirth represents women as lacking biomedical rationality. It also overlooks the complex circumstances leading to the underutilization of biomedical maternity services, the circumstances under which the assistance of a TBA may be needed (see Chapters 5 and 6), and the actual capacities of the available biomedical facilities to cater for women's needs (see Chapter 6). These policy changes mirror the ways in which solutions to health problems related to low income countries are designed according to what is considered the best solution at a particular time.

Generally, this chapter provides a critical account of the recent policy changes and their consequences to TBAs, CHWs, women, and the overall objective of reducing maternal mortality by increasing women's utilization of biomedical services. In the following part, I give a historical account of the rise of TBAs and CHWs showing that albeit being professional categories introduced in the 1960s, in different times they both gained global prominence in contributing to the reduction of maternal mortality. The history of their rise and fall reflects global health initiatives and management that operate in different levels from the global, national, and to local actors. Accordingly, I will discuss the manner in which both TBAs and CHWs worked in Lalta and how women experienced their services. Based on my own findings as well as observations

from other studies I will end the chapter with a critical discussion on the practicality of debarring TBAs from assisting deliveries, their changed role, and the use of CHWs for NMCH.

7.2 Traditional Birth attendants and Community Health Workers in a Historical Context

Both TBAs and CHWs are the products of global initiatives intended to improve the availability of health services especially in rural areas of developing countries where health facilities are scarce (Perry et al. 2013; WHO 1978). The WHO took a leading role in their creation, which attracted much global attention after the Alma Ata Declaration of 1978 aiming at achieving health for all by the year 2000. Substituting the shortage of formally trained biomedical personnel in developing countries, local actors with some form of training in biomedical practice were described as an important resource of meeting the goal (WHO 1978).

7.2.1 Traditional Birth Attendants as Global Subjects and Local Actors

The involvement of traditional midwives in promoting maternal and child health in developing countries is thus, not a new thing. In chapter three, I have shown that women responded well to giving birth in a health facility in the late 1940s and early 1950s; as a result, medical facilities were overburdened and some women who seemed to have no complications were encouraged to give birth at home with the assistance of local midwives. The British colonial government suggested the training of local midwives on cleanness during childbirth to help them do better, the job they were already doing. This was expected to be a relief for the government because midwives would not look to the government or native authorities for remuneration (TNA 314/133). The situation was not so different in other colonies. Nguyen (2016) illustrates that when French colonialists failed to relocate Vietnamese childbirth to the clinical setting and transform indigenous birthing traditions, they turned to using traditional midwives which displayed compromises and adoptions to co-exist. However, when the WHO first conceived the idea of a TBA in 1955, the intention was not to collaborate with them as such, but to ‘transform’ traditional midwives and create a standardized and universalized category of midwives in developing countries; which Langwick (2012: 31) calls, “a traditional global subject.”

The creation of a TBA elicits how global health interventions following the biomedical worldview of healthcare devalue local knowledge (Langwick 2012; Choguya 2014; Swantz 2016) and homogenizes people and problems in developing countries to fit into interventions' objectives. The fictive example of Mrs X's[76] maternal death, as presented by the WHO in 1987, which was adopted and retold in 2012 with a few changes, illustrates well the manner in which interventions to maternal mortality have been designed according to fluctuating Western-global norms and ideas. It is this kind of thinking that created the category of TBAs.

From the early 1970s onward, governments in developing countries were urged to recruit and train TBAs. Tanzania received the global call to train TBAs with scepticism. Soon after independence, Tanzania evoked the idea of traditional midwives. However, the government had no intention of either integrating them into the formal health systems or of using them in the long-term. They were a temporary solution while the government was training (biomedical) midwives to be deployed in rural areas (Schulpen 1975: 72).

Langwick (2011) gives a detailed explanation about the historical context of the creation of traditional birth attendants among the Makonde of Tanzania (the situation being the same for many areas in Tanzania). She shows that the concept of traditional birth attendance (*Mkunga wa jadi*) was nonexistent among the Makonde until the 1970s. There were women who assisted pregnant women in giving birth but the term *mkunga wa jadi* came after the beginning of the trainings. Given the diversity of women who assisted other women during childbirth there was a dilemma among global health actors on reaching a consensus on defining a TBA (Langwick 2012). After long discussions, a mutual definition was eventually reached in 1972. A traditional birth attendant was defined to fit the image of a specialized third world woman. She was generally defined as an old woman residing especially in a rural area, who had children herself and was

[76] The retold story of how Mrs. X died based on a lecture by the founder of the safe Motherhood movement, Professor Mahmoud Fathalla. The retold story just like the original story, presents a universal pregnant woman but this time explaining in detail socio-cultural and economic barriers women face when seeking for care during pregnancy and childbirth. Socio-cultural and economic barriers are presented as universal and a universal action is called for to increase community awareness and encourage pregnant women to seek for skilled care (professional midwife/doctor) during pregnancy and delivery. https://vimeo.com/50848172. Accessed on 12.09.2015.

past menopause, an accomplished herbalist, and had no formal education (ibid: 31). Being an accomplished herbalist was however, not a necessary criterion. The four TBAs I talked to in Lalta were not herbalists.

The definition further included a person who assists women during childbirth, and who initially acquired her skills by delivering babies herself or through apprenticeship with other traditional birth attendants (WHO 1992: 4). Some TBAs received no formal training but they had acquired skills through experience. In Lalta, these kinds of TBAs were licensed to assist women during childbirth and like the trained TBAs, they were provided with birth kits by the World Vision International. This definition set the basis for the recruitment and training of TBAs. Since then the TBAs became an important agenda for discussions about maternal health in developing countries. This type of a woman, a TBA, was meant for developing countries in Africa, Asia, and Latin America (Langwick 2012: 31).

Meanwhile, the Tanzanian government was worried that training and integrating TBAs into the formal health system would strain the already limited resources, and that, the international community would offer TBAs as a cheap solution to the health crisis (Langwick 2012: 38). After all, maternal mortality was already showing promising improvements (see Shija et al. 2011: 3). Rather than training and integrating TBAs in the formal healthcare system, the government preferred to train professional midwives. Under these circumstances, the training of TBAs in Tanzania remained very scaled down until 1987 when the safe motherhood initiative (SMI) was launched and thus bringing the training of TBAs into the spotlight.

The SMI re-emphasized on the importance of TBAs in providing childbirth services to women in rural areas and posited them as a hope in the efforts of reducing maternal mortality (Allen 2004: 108). With the support from international organizations notably the World Bank (WB) and International Monetary Fund (IMF), the training of TBAs became a necessary condition for the safe motherhood initiative (Langwick 2011: 124; Allen 2004: 108). Given the economic crisis of the 1980s and the introduction of SAPs, Tanzania had little autonomy over decisions about interventions to her social and economic problems. Dependent on financial support, ideas engineered elsewhere were to be taken as acceptable ways of thinking and doing things (Green 2014: 4; Dilger et al. 2012: 6-7).

Through the Ministry of Health, the government developed training guidelines (Allen 2004: 111). In the 1990s, training began across the country with the projections of training 32,000 TBAs, an average of two TBAs in each village (Langwick 2012: 37). The training was also provided by international organizations in collaboration with the Ministry of Health. For instance, in Dodoma, the World Vision International trained 570 TBAs from 2000 through 2010 when the trainings were officially halted. To aid in the reduction of maternal mortality, TBAs were trained on clean and safe birth to eliminate things that were biomedically considered dangerous during pregnancy and childbirth. They were also taught about recognizing danger signs during pregnancy and childbirth as well as family planning (Langwick 2011; Allen 2010).

Notwithstanding the ambivalence in the recruitment, training and acceptance of TBAs – who had no prior experience in assisting deliveries (see Langwick 2011; 2012; Allen 2004; Swantz 2016), overtime, TBAs who persisted in the practice acquired a prominent position in the communities they served. In Lalta, from the year 2000, two women were trained from each village but not all went on to practice. One of the trained TBA who did not practice after the training was the wife of one of the village chairmen. During an informal conversation, she admitted that she expected that they would later be trained as full midwives but after realizing they were intended just to assist women in the village without any prospects of becoming fulltrained midwives, she lost interest. The four TBAs I talked to were all above 50 years. While two of them became TBAs after the training that was provided by the World Vision International in 2000, the other two had been practicing as *mng'hunga* (a Sandawe word for midwife) long before the training. They all referred themselves as *mng'hunga*. They were passionate with what they were doing and had records of births they had assisted.

A downturn of the use of TBAs in assisting women with childbirth began with the progress review of the safe motherhood initiative (SMI) in 1997 (see Starrs 1997). Statistical data indicated no improvement in the reduction of maternal mortality and most likely the target of cutting the mortality rate by half by the year 2000 was out of reach. In 2004, the WHO suggested that TBAs role shift from birth attendants to women's companions to health facilities and promoters of facility-based birth (WHO 2004a). By 2010, most of the developing countries including Tanzania had stopped the training of TBAs for assisting women during childbirths.

As an introduction to their new role, traditional birth attendants in Lalta received three-day training in 2012 from health personnel from Kondoa District Hospital with the promise of receiving 5,000 Tanzanian Shilling (equivalent to 2 Euros) for every pregnant woman they accompanied to give birth at the health facility. According to the TBAs I talked to in Lalta and district heath administrative officers this was however, not realized. This new role appeared to be too expensive for the government to sustain. However, some TBAs still accompanied women to health facilities when they were called to do so. The new role assigned to TBAs was also conveyed to CHWs who were gaining prominence in international discussions about maternal health from 2008 after the WHO (2008) indicated that they were a potential force in the reduction of maternal mortality amidst critical shortage of healthcare providers in developing countries. Despite being trained in other aspects of reproductive health such as family planning and antenatal care, TBAs drew their identity from assisting women during childbirth. Women did not consult TBAs during pregnancy and called them only during childbirth (Chapter 5). Debarring them from assisting childbirth was robbing them of their main identity. Additionally, they had to share their new role with CHWs who had more governmental support while TBAs were increasingly presented by healthcare providers and medical administrators as a "danger" to the safety of women during childbirth (Wendland 2017: 251; Cogburn et al. 2019: 56).

7.2.2 Revitalizing Community Health Workers for MNCAH

In 2005, the WHO revived the category of CHWs to address the endemic and critical shortage of healthcare providers in developing countries, which was identified as an obstacle to achieving health related MDGs by the year 2015. Strengthening the capacity of CHWs to provide MNCAH received particular emphasis (WHO and UNFPA 2015). Adopted from the idea of barefoot doctors as the guiding concept, the use of CHWs was proposed for the first time by the WHO in the early 1970s, when the inability of the modern western model of trained physicians to serve the needs of rural poor populations was becoming more apparent throughout the developing world. The need for new approaches was obvious, and CHWs were considered as alternative health workers who could compliment the higher trained staff. A book published by the WHO in 1975, which comprised a series of case studies about health workers in different countries became

the intellectual foundation for the international conference on primary health care at Alma-Ata (Perry and Zulliger 2012: 3). Expressed in different names in different countries, a community health worker was an umbrella term that embraced a variety of community health aides who received minimal biomedical training and worked as volunteers in the communities from which they were selected (Lehmann and Sanders 2007: 1). The common task among them all was the provision of preventive and basic curative medicine especially in rural areas (Shaffer 1991).

Tanzania was among the first countries in the world to introduce the idea of CHWs at the national level. The country's main health development strategies as stated in the Arusha declaration and the Ujamaa policy supported the idea of CHWs. The two development strategies, among other things, intended to narrow the gap of health services between rural and urban areas, which during colonialism were more urban-based (see Chachage 2005). Village members both males and females were selected and trained for six months. After the training they were provided with first aid kits for preventive and basic health care in their respective villages. Known as *wahudumu wa afya vijijini* (WAVI)/village health workers (VHWs), they were expected to be role models for other people and catalysts in the attainment of the national health goals. They took part in the national health campaigns notably *Mtu ni Afya* (Man is Health) which began in May 1973. This campaign motto implied that good health is the essence of being alive as a person. The campaign intended to encourage groups and individuals to make physical changes to foster community health through radio programs, printed materials, and trainings (Hall 1978: 33).

WAVI's involvement in the wider national health goals rendered them an important position in the health sector which was cemented by the Alma Ata declaration's concepts of primary health care (PHC) and local participation. In 1983, PHC was adopted as the main strategy for improving access to and equity of health services (Matomora 1989; Vaughan 1984). Nonetheless, the large-scale use of CHWs did not last long. Towards the mid 1980s, the government support to CHWs began to fade as the global economic crisis and the introduction of SAPs crippled the government's ability to support them. It was realized that the program required more financial and supervisory inputs than had originally been envisioned (Perry and Zulliger 2012). Moreover, the evaluation of CHWs in 1988 showed limited evidence that large scale use of CHWs was effective in improving health services in rural areas (Hall and Taylor 2003).

Progressively, with the involvement of more global actors in health interventions, vertical global disease specific intervention with strong donor support became dominant. By 1990, the national level CHWs program had lost momentum but the ideas of using CHWs to supplement the provision of PHC services did not fade (Perry and Zulliger 2012). In 1992, Tanzania formulated the community based healthcare (CBHC) guidelines along with PHC strategic plan, which advocated for political commitment and involvement of all sectors (URT 2008b: 8). Given the dominance of disease specific interventions instead of a well coordinated CHWs program, there emerged fragmented CHWs programs focusing on specific diseases and health problems with the support from NGOs, FBOs and CBOs that proliferated in the 1990s (Tulenko et al. 2013; Dilger 2009). Unlike TBAs who were coordinated at the national level with strong national and international support, CHWs continued to exist but practiced in different capacities in different areas (mostly small scale), depending on specific areas of training and supporting organizations. The fragmentation and lack of coordination made it harder to account for CHWs' contribution in the health sector, thus their recognition at the national and global level remained minimal while policy makers turned their attention away from them (Perry and Zulliger 2012).

The acute shortage of healthcare workers that was identified as an obstacle in achieving MDGs 4 (reduce by two-thirds, between 1990 and 2015, the under-five mortality rate) and 5 (reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio) by the year 2015 prompted the WHO to refocus on CHWs. In 2006, the WHO together with the global health alliance (GHA) argued that CHWs had the potential of being part of the solution to the healthcare workforce crisis affecting developing countries. Task shifting was proposed to expand the health workforce to rapidly increase access to health services, provide outreach services, provide patient homecare, and reach disadvantaged populations especially those in rural areas. Task shifting involved "the rational redistribution of health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resource for health" (WHO 2008b: 2). The 2008 Kampala Declaration and the Agenda for Global Action emphasized further the scaling-up of CHWs to speed up the achievement of health related MDGs. In this declaration, governments of developing countries were urged to organize coordinated policies

for an immediate and massive scaling up of CHWs. The impact indicators focused on sexual reproductive health, HIV and AIDS, MNCAH, Malaria, Tuberculosis, and leprosy (ibid).

Responding to the poor health sector performance and speeding up the achievement of MDGs 4 and 5, Tanzania developed the primary health service development program (2007-2017) *Mpango wa maendeleo ya afya ya msingi* (MMAM). The program aimed at improving access to basic healthcare by strengthening community and health facility linkages, and empowering communities in taking charge of their own health. Focusing on the district level with a more encompassing approach, MMAM aimed at ensuring fair, equitable, and quality services to all Tanzanians by expanding and supporting the health workforce through motivation, training, strengthening and building of more district health facilities. It also intended to promote health seeking behaviour and reduce maternal and child mortality (URT 2007). The training of CHWs for maternal and newborn packages as well as building capacity of TBAs on reproductive health and referral for pregnant women was mentioned on its initiatives (Ibid: 59). The National Roadmap Strategic Plan to Accelerate Reduction of Maternal Newborn and Child Death (2008-2015) also known as, 'the one plan' (URT 2008b: 15) also mentioned the use of CHWs in the improvement of MNCAH but did not say anything about TBAs.

In the early 2012, the MoHWS developed guideline for the selection, training, supervision and monitoring of CHWS for MNCAH. Community health workers were to be selected among the village community members. The health committee of the village government had to announce the positions, let eligible candidates apply and the top candidates were to be selected at the village meetings. Regardless of gender, candidates were required to be above 18 years. They were to be the role models for MNCAH in their communities preferably with at least ordinary level of secondary education and ready to work on a voluntary basis with some little remuneration. The selected candidates were to be trained for 21 days by healthcare providers from district hospitals to enable them identify pregnant women and refer them for ANC, conduct routine home visits and advise women about ANC, danger signs, birth preparedness, birthing with SBAs, postnatal care, family planning, HIV and AIDS (PMTCT), Malaria, maternal, and under five child nutrition. After the training, they had to report to the dispensaries that served their respective

villages and healthcare providers at the dispensaries had to supervise and monitor them on monthly basis.

The training of CHWs for MNCAH began in December 2012 in Morogoro Region as a pilot study area. Later Tanga, Lindi, Mtwara, Mara, Dodoma, and Iringa were included (Roberton et al. 2015). Depending on the availability of resources, the program was expected to cover all regions of Tanzania. Under the MoHSW, the program received support from USAID, Jhpiego and World Vision International (ibid.). In Lalta, two CHWs (one male and one female) were selected from each village and were trained for two weeks by healthcare personnel from Kondoa District Council with the assistance from World Vision International. The CHWs were required to visit at least two households per week and were promised bicycles to facilitate transport. The CHWs had to document activities they did and present a report to the healthcare providers at the dispensaries on monthly basis. I also noted that CHWs were present in some of the child and maternal health clinics listening to the lessons given to women and assisting healthcare providers in weighing children and in the documentation of clinic cards. I did not see TBAs attending or assisting CHWs in the provision of either maternal or child services at the village dispensaries.

7.2.3 Expanding the Horizon: The One Million Community Health Workers Campaign

Approaching 2015, many countries were lagging behind in achieving health related MDGs. Tanzania for example, had made significant progress in the reduction of under five child mortality but the maternal mortality rate was still high (URT 2016: 317). Hence, the partnership of over 150 organizations ranging from UN agencies, civil society, the private sector, to academia launched the One Million Community Health Workers campaign (1mCHW). This campaign marked the development of a new generation of CHWs intended to bridge the gap of healthcare workforce particularly in rural Sub-Saharan Africa (The Earth Institute 2015).

The campaigns proposed three things, first, the recognition of CHWs as a formal cadre of health workers and integrate them into the PHC system, second, the provision of technical assistance to governments and organizations seeking to scale up national CHWs' programs; and third, encouraging organizations to support CHWs and motivate countries to increase mobilization of their own resources and to continue requesting for support from donors until the government no

longer needs such external support. In other words, the 1mCHW campaign called for formalization, standardization, and universalization of the new cadre of CHWs. In this campaign, TBAs and the existing CHWs involved in MNCAH were regarded as nonformalized workforce that could complement and strengthen the trained and formalized CHWs (Ibid: 14).

The first strategic plan workshop for the 1mCHW campaign was held in Tanzania in April 2014. To effectualize the CHWs programs, several international agencies attended the meeting to help country delegations identify tools and strategies that would be to be used in the national formalization and scaling-up of CHWs. Inaugurating the workshop and in agreement with the campaign, the Deputy Minister of the MoHSW said, Tanzania and other Sub-Sahara African countries had to recognize that CHWs were the foundation of the expansion of PHC. Thus, they needed to be strengthened in an effective, coordinated, and sustainable manner.[77]

Further developments on the global efforts of improving health and well-being of the developing world populations added momentum in the proposition of formalizing and scalingup a new cadre of CHWs. In May 2014, the 67th World Health Assembly renewed its commitment towards universal health coverage. Member states requested the WHO to develop and submit a new global strategy for human resource for health. This was followed by the 2015 United Nations completed process of developing sustainable development goals (2016-2030), which were a carry-on of the MDGs 2000-2015. Sustainable development goal number 3 sought to ensure healthy lives and promote well-being for all at all ages with a focus on the reduction of maternal mortality to 70/100,000 live births by 2030. The tasks for this new cadre of CHWs was not limited to Malaria, HIV and AIDS, Tuberculosis, and leprosy as initially intended to meet health related MDGs but were meant to assist in the reduction of maternal mortality as well (WHO and UNFPA 2015).

This proposal was not different from that of the Alma Ata Declaration of 1978 that proposed the use of CHWs in achieving PHC coverage and health for all by the year 2000 (WHO 1978: 1). It seemed like history was repeating itself, but the WHO pointed out that lessons were learnt from the past and steps were proposed to ensure effective implementation of the CHWs program to

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[77] http://1millionhealthworkers.org/2013/04/15/tanzania-hosts-global-one-million-community-health-workerscampaign-forum/. Accessed on 23.09.2018

achieve SDG 3 (WHO 2018: 18). Examples in supporting the program were drawn from countries such as Brazil that succeeded in the earlier Alma Ata CHWs' program and specific success on CHWs interventions on HIV and AIDS and MNCAH (ibid). However, it was also acknowledged that good-practice examples were not necessarily replicated and policy options were not adopted uniformly, a lesson, which anthropological scholarship has insisted on over the years (see, for example, Allen 2004; Berry 2010; Dilger 2012; Ginsburg and Rapp 1995; Lock and Kaufert 1998; Nichter 2008). It was pointed out that successful delivery of health services through CHWs required evidence based models for education, deployment, and management. In this regard, the WHO developed a guideline of assisting national government and international partners to improve the design, implementation, performance, and evaluation of the CHW program (WHO 2018).

Responding to both the 1mCHW campaign and the WHO's call, in 2013, the government of Tanzania through the MoHCDGEC and the President's Office for Regional Administration and Local Government (PO-RALG) started planning for the community based health program and policy (CBHP). The program focused on formalization, standardization, and harmonization of CHWs in order to address issues of coordination, monitoring, and supervision (Devlin et al. 2017: 5). The CBHP 2015-2020 was developed to guide the government and collaborating development partners in the operationalization of the CBHP at the national level. The CBHP was organized around five strategic goals. First by 2020, the plan intended to increase the capacity of local government authorities (LGAs) to coordinate CBHP; second, to train at least 75 percent of the required CHWs deployed by the government; third, to sustain 80 percent of the CBHP for LGAs; fourth, to have the capacity to advocate, communicate, and do social mobilization for CBHP, and fifth, to strengthen the support of the CBHP by 80 percent at all levels (URT 2014b).

As of December 2015, the MoHCDGEC launched the generic CBHP design in which the Ministry of Finance agreed to prioritize salary for at least 2000 CHWs from the financial year 2016/2017. The PO-RALG was committed to support the training of at least 2500 CHWs per year and development partners signed a CHW cost sharing agreement. Following a similar process as in the selection of CHWs for MNCAH, after the applications, new CHWs were approved by community members and the village government, and were then recruited by the

Local Government Authority (District Council) and received a standardized national training. After the training which formalized their practice, they were employed by the government, NGOs, or the private sector with a harmonised salary and work package. They were managed by the LGAs, health facility staff, and the village governments in their respective communities.

The CBHP service package to be delivered by CHWs comprised of both health and social welfare interventions. It included MNCAH, HIV, and AIDS, Malaria, TB and leprosy, neglected tropical diseases, non-communicable diseases, mental health disorders, and emerging and outbreaks diseases. Others included physical injury and trauma, nutrition, oral health, eye care, gender based violence prevention, gender mainstreaming, child protection, vulnerable people such as poor families, people with disabilities and the elderly (Devlin et al. 2017: 12). In this package, CHWs today are required to provide basic curative care, connect people to facility continuum for health problems they cannot treat, engaging in preventive and rehabilitation services, surveillance and collection of vital statistics. Guided by the principle that effective essential services cannot be provided by people working on voluntary basis, the CBHP suggested a harmonised remuneration for the existing short-term trained CHWs and a minimum package of reproductive maternal, newborn, child and adolescent health (RMNCAH), health promotion and disease prevention (URT 2017).

The standardized training of CHWs began in 2016 and was carried out by the MoHCDGEC in collaboration with other development partners (NGOs, CBOs and FBOs) while community members and the private sector were encouraged to support the program through the provision of direct labour, materials, and funds. The intention was to train 24,886 with the target of two CHWs (1 male and 1 female) in each village or urban street. In 2017, the first cohort of 3,000 CHWs completed the training and more trainings continued in different parts of the country (Gottier 2017: 10). After the training, this new cadre of CHWs was expected to work in collaboration with the existing CHWs for MNCAH. As of January 2019, when I last talked to one of village leaders in Lalta, no one was selected for the formalized CHWs training and even the existing CHWs were not yet remunerated for their involvement in MNCAH.

7.3 TBA, CHWs, and Women's Experiences

The CBHP introduced the formalized cadre of CHWs and recognized the existing ones involved in MNCAH as well as TBAs with their shifted role. However, the program did not specify the nature of their collaboration (Devlin et al. 2012). This might have created further confusion which I observed among TBAs, CHWs, and Women in Lalta. In the following part, I will show how women encounters with CHWs defined the extent to which they allowed CHWs' involvement in maternal health issues. The CHWs were struggling to secure a trusted position in women's lives. Whereas some TBAs adapted to the new role, some stopped practicing all together and others accepted the new role but clung to their positions as birth attendants. Even without official recognition as birth assistants, the latter group of TBAs received support from women who counted on their assistance during childbirth.

7.3.1 "Is Mkunga not Available?" CHWs Struggles and Limitations

Among the many things that CHWs were required to accomplish included identification of pregnancies and encouraging women to attended antenatal care for both the first and continuing visits and give birth in health facilities with the help of a skilled birth attendant (SBAs). Identifying pregnancies even after almost two years of practicing was challenging to CHWs as women were not always cooperative as expressed by a male CHWs of Wairo Village. He said that:

> When you talk to them about child health, they tell you everything, the food they give them, and what they do when the child is sick. They tell you everything but ask them about immature pregnancy (*mimba changa*) they become dumb. They do not like talking about that. Sometimes I ask myself twice, should I ask this woman about pregnancy? You know, it is easy when the pregnancy is visible but just asking someone if she is pregnant is not easy. For me I wait until the woman starts the clinic or even before starting when the stomach is visible, I can ask (IDI, Rashidi, male CHW, Wairo Village).

Women's unwillingness to talk about immature pregnancy was embedded in the secrecy women preferred to keep in the early months of pregnancy (see Chapter 5). The problem of discussing pregnancy care was particularly salient among male CHWs who used the waiting technique more than female CHWs. The waiting technique opened doors of discussing pregnancy care and eventual childbirth. Involving male CHWs in this exercise was meant to encourage male

involvement in maternal health and break the gendered view that pregnancy care was women's concern. However, it was not an easy task for these men. As Feldhaus et al. (2015: 8) observe, CHWs in Morogoro region made home visits in a male and female pair to facilitate discussions that were otherwise difficult for male CHWs to discuss alone with women.

In some instances, female CHWs managed to convince women to talk about immature pregnancy. Three of my respondents admitted to initiate the first clinic visit after being asked by female CHWs. This was possible because they had children under five years. When the CHWs visited them to talk about their children, they also talked to them about family planning, pregnancy care, and early initiation of ANC. Otherwise, instead of asking women about being pregnant, CHWs in Lalta obtained the names of pregnant women who had made the first ANC visit from the dispensaries' registers and started a follow up. This changed the whole idea of CHWs identifying pregnancies and encouraging women to attend ANC as early as possible. The fact that many women still delayed ANC and made less than the recommended number of ANC visits showed that despite CHWs visits, still women took charge of when to reveal about their pregnancies, to make the first and subsequent ANC visits.

Another challenge that CHWs faced was on encouraging women to deliver in the health facilities. CHWs made home visits to encourage women to give birth in health facilities but this close supervision was not always appreciated although it was meant for the women's own good. This was often the case when women had no plans of giving birth at a health facility. For instance, one day a CHW accompanied me to an interview appointment I had with Salome, a 29-year-old married woman who was in her fifth pregnancy. Upon our arrival at her home, it was obvious that Salome was not happy to see the CHW with me, and her husband quickly started repairing a bicycle that was lying on the ground and told the CHW that they were preparing to go to the hospital. Later during the interview, I learnt that Salome's estimated due date had already passed and that the CHW knew about it. It was obvious Salome and her husband had no plans of going to the hospital. During the interview, she meekly told me, "I have no one to leave my children with… and the livestock too; there is no one to look after them." When we finished the interview, the CHW encouraged Salome go to the hospital, saying that he would follow up with her. Five

days later, I was told by the CHW that Salome had given birth at home with the help of her mother.

In such situations, women resented the close supervision and felt that their privacy was being invaded. Traditional birth attendants on the other hand, were still appreciated because they were called only when they were needed and they did not visit uninvited. With the marginalization of TBAs, pregnant women gradually had to depend more and more on the assistance of CHWs, who were trying to get closer to them. However, although they reported to be visited by CHWs none of the women to whom I talked admitted to ever being accompanied by a CHW to the village dispensaries. Pregnant women went to the dispensary with either a TBA or a female relative. Community Health Workers would help in educating women and following up on pregnant women but when it came to choosing an escort to the dispensary, TBAs were always preferred. In Lalta, childbirth and accompanying rituals have always been the primary domain of women (Chapter 5). Community Health Workers comprise both men and women, which decreased the likelihood of these CHWs being called by pregnant women. When I asked one of my interlocutors, a 26-year-old woman married woman in her seventh month of pregnancy, whether she would call a male CHW to accompany her to the dispensary, she replied in a somewhat puzzled voice, "I cannot call him to accompany me… *kwani mkunga hayupo?* (Is the TBA not available?) He cannot help me with anything."

It is clear that some pregnant women did not seem to welcome CHWs in the way they were expected to. Despite lack of clarity on how CHWs should collaborate with TBAs, women defined boundaries on who to call for help and how much of involvement of both CHWs and TBAs they allowed into their lives. It seemed TBAs had more support from pregnant women than had CHWs. However, the official recognition and working together with healthcare providers did not give them the acceptance they aspired. Roberton et al. (2015) show that sometimes when pregnant women refused to follow instructions, CHWs reported these cases to the village leaders who convinced these women to comply.

As CHWs struggled for acceptance, they also expressed concerns about lack of incentives and means of transport. They were fully aware that they were working as volunteers. However, the task of conducting home visits and following up was obviously demanding in terms of time. They

certainly expected some incentives, the lack of which diminished their working morale and commitment. Incentives were promised during the trainings but they were hardly provided to CHWs. The CHWs to whom I talked complained of not receiving any incentives since they had started the service.

Some instead of making two or more home visits per week they made only one visit in order to engage in their personal activities. The promise of bicycles to facilitate transport was also yet to be fulfilled. A similar situation is reported by Roberton et al. (2015: 8) and Greenspan (2013: 8) regarding CHWs in Morogoro region. If the current plan to remunerate both new and the existing CHWs is implemented, there is a likelihood of restoring the working morale of CHWs. However, in 2015 the promise of 5,000 Tanzanian Shillings (equivalent to 2 Euros) remuneration per every woman TBAs accompanied to the health facility was yet to be fulfilled; but TBAs were instead rewarded in cash or in kind by the pregnant women they attended or accompanied to the dispensaries.

Figure 7.1: Community health workers in Manantu Village, assisting a healthcare provider to vaccinate pregnant women and children as part of the health services of a mobile clinic. (Photo by Anitha Tingira 2015)

7.3.2 Traditional Birth Attendants' Clashes with Healthcare Providers and Community Health Workers

While CHWs were struggling to get support from women, TBAs' work was not getting any easier. Ideally, the two were supposed to work in collaboration but as long as some of the TBAs were still involved in assisting women during childbirth, they were not the perfect ally to CHWs who were advocating for skilled birth attendance. In one of my several conversations with Jamali, a 52 years old male CHW of Magambua Village, he bluntly blamed TBAs as an obstacle for them to convince women about giving birth in health facilities. He said that:

> These TBAs are our fellows, but they still like to assist women to give birth at home, because they are paid just small things such as soap. Now we have hunger, they are given food so they believe that if they ask women to go to the dispensary they will not be paid. You find them telling women to wait; because they (women) do not call us, we do not know when they give birth, we just hear later this or that woman has given birth at home, a TBA helped her. I have tried to tell them (TBAs) what they are doing is not good because a woman can die... you know that can get them into trouble; but they do not listen they just continue because they get little things (IDI, Jamal, Magambua Village).

Jamali was selected as CHWs for the first time in 1991; he received a six months training and was active until 1994 when he said the importance of CHWs diminished. Community health workers were remembered only during diarrhoea outbreaks where they were called to encourage people on cleanliness or at the time of distribution of free mosquito nets, where they assisted in the counting of household members in their respective villages. When Jamali was re-selected as a CHW for MNCAH in 2013, he felt that his importance was restored and TBAs were presenting an obstacle for CHWs to realize the national goal of reducing maternal mortality. Jamali's criticism against TBA reflected the global argument behind debarring TBAs from assisting women during childbirth. Other newly selected CHWs to whom I talked did not criticize TBAs to the same extent as Jamali did; they nonetheless expressed lack of cooperation between the two as this one said:

> Me since I was selected in 2013 I have never worked with TBAs. (...). To say may be we go together to visit women that has never happened but I see them many times they accompany women to the dispensaries. You know may be because we are doing something that is a bit different from what they are doing. We must make home visits and

> write reports every month that we give to the nurses at the dispensaries (IDI, Batuli, female CHW, Ilasee Village).

Batuli did not have any grievances against TBAs but she distanced herself from them by emphasizing on the official recognition of CHWs, through report writing and supervision by the healthcare providers from the village dispensaries. When they were still officially recognized in assisting deliveries, TBAs were also required to keep clear records of the births they assisted and present them to the village dispensaries. With the shifting role, there was no specific guidance for TBAs regarding keeping of records which in a way seemed to devalue their work. The above CHW differentiated herself from TBAs not from what they did as such but keeping records, which gave their work official value and recognition and thus, more worth than the work done by TBAs.

The lack of cooperation between CHWs and TBAs which I observed in Lalta, is also reported by other studies. For example, Yeboah-Antwi et al. (2014: 2) show that in Zambia, although CHWs and TBAs resided in the same community, they worked independently of each other leading to inefficiency and missed opportunities in the continuum of care. They suggest guidance on teaming up of the two as a potential in sustainable approach in the delivery of MNCAH care. However, TBAs in Lalta did not only face resistance from CHWs but from healthcare providers as well. When they accompanied women to the village dispensaries for childbirth or after childbirth, they were not received with respect as they had been before barred from assisting women during childbirth. For example, accounting for her (then) recent experience when accompanying a woman to Faraja Dispensary for childbirth, Mama Askari, a TBA in Magambua village had this to say:

> It is not even long ago, I think a month has passed I took a mother who was about to give birth but she was afraid that she could give birth on the way. So I went with her to the dispensary. When we arrived, it was afternoon and the nurses were busy. I happened to know the place so I wanted to take the woman direct to the labour room, the nurse came, she is young like my daughter, but I will never forget what she told me. She told me if I wanted to help, I should take a broom and sweep the compound. May be because I was a cleaner, I felt very bad (IDI, Mama Askari, TBA, Magambua Village).

Initially, I thought the reaction of the nurse was a result of a conflicting relationship Mama Askari had with one of the doctors at the dispensary a couple of years ago, which she had narrated to

me. However, when a similar experience on the lack of respect was narrated by other TBAs, I realized that there was more to the relationship between TBAs and healthcare providers than what papered on the surface. Alinda, a TBAs of Manantu village had this to say:

> These days they (healthcare providers) disrespect us so much; it is not like in the past when we went with pregnant mothers; they were telling us to get inside. Sometimes they were even letting us assist the woman to give birth right there in the dispensary. However, these days we end up at the door we are not allowed even to get into the room. There is like that one (…), she even insults us. When the woman you accompany gives birth before you reach to the dispensary, you will find her making noise, a lot of noise. Like me, I do not help women to give birth anymore but when you accompany her to the dispensary the mother may give birth on the way. The nurses say we help them to give at home and we take them to the dispensary. This nurse talks too much and uses abusive language. She does not care whom she abuses; she abuses even an elderly person like me (IDI, Alinda, TBA, Manantu Village).

Furthermore, there were rumours that in other areas, TBAs who were caught assisting women with childbirth were fined 250,000 Tanzanian Shillings (equivalent to 100 Euros). Some of the TBAs stopped involving themselves in maternal health issues altogether while other assumed the new role and encouraged women to go to the health facilities. Others, despite assuming the new role did not stop assisting women with childbirth. Even with the new role assigned to TBAs, the argument behind being debarred from assisting deliveries has given them an image of being "dangerous caregivers" (Wendland 2017: 244; Cogburn 2019: 56). Wendland (2017: 244) points out that stopping TBAs from assisting women during childbirths and the insistence on delivering in health facilities in Malawi evoked a binary and dialectical sense of "legitimate" and "dangerous" care givers. She shows that healthcare providers in Malawi considered childbirth in health facilities as the only legitimate care and birthing services provided by TBAs as dangerous care. Conversely, given the presence of abusive treatments and the prevailing lack of resources in biomedical facilities (Chapter 6), TBAs told women giving birth in biomedical facilities was dangerous but they could provide safe childbirth care. The sense of TBAs being dangerous caregivers was not always upheld by women who still sought services from them (Wendland 2017).

Degrading TBAs was even more hurtful to local midwives who had been practicing long before the training that turned them into TBAs. Faida, a 67-year old TBAs of Ilasee Village, had been

assisting women during childbirth since 1988. Although she did not attend the training like other TBAs, she was licensed to help women and received the birth kits. For her, not helping women was like losing the identity of what she had been doing all of her adult life. She said, "I have learnt this work a long time ago, I cannot stop. Women still need me. They call me to help them." Unlike Wendland's observation in Malawi, Faida did not try to discourage women from going to the dispensary; she was even ready to encourage them to go but she could not stop helping them when she was called to do so.

Figure 7.2: A traditional birth attendant's records of the births she assisted from 2002 to 2006 in Wairo Village, Tanzania (Photo by Anitha Tingira 2015).

7.3.3: "They Still Need Me:" TBAs Assisting Homebirths

Regardless of whether they contributed to the reduction of maternal mortality or not, TBAs were still important birth service providers in rural areas. They are also found in semi-urban areas serving mostly poor women (Kayombo 2013). Logically with the increased availability of health services, one would expect TBAs to cease or women would stop using their services. However, studies show that poor services and mistreatment forms of healthcare in biomedical facilities make women seek services from TBA (Wendland 2017; Berry 2010). I have also shown in this study that even when biomedical services were available conditions associated with some

interventions such as the maternal referral system compelled women to rely on the support of either female relatives or TBAs. In addition, despite the superiority of biomedical knowledge evoked in the creation of TBAs, the place of birth was not relocated, which gave TBAs the autonomy of incorporating local practices and performance of rituals that would otherwise be impossible in biomedical settings. In Lalta, some of the TBAs continued assisting women during childbirth but that did not mean they encouraged homebirth.

For example, Mama Askari said she was not against biomedical services and she encouraged women to go to the health facility for childbirth. What made them assist women were the circumstances under which they were called to provide support. Faida supported this claim in the following words:

> Mothers do not tell us in advance that they would need our assistance during birth; they wait until labour progress then they call us. They would come and ask you to help them, telling you there is a mother who wants to give birth. That has happened to me many times, when they come to me and I go to help them. (...). I know we have to take them to the dispensary. You find for some it is indicated with a star that they should go to a big hospital but if the mother is about to give birth I cannot get there and tell them to take her to the big hospital. You check if the baby is at the door, you cannot tell them to take her to the hospital. In such a situation, it is hard for the mother to walk or sit on a bicycle; she can give birth on the way. May be if she is not ready and I see this one is not ready; the baby is still up I can go with them to the dispensary...I take them, but you may find sometimes women themselves do not want to go to the dispensary. They call and ask you to help them at home, I cannot refuse; they do not want to go to the dispensary; and they ask you to help them there and then (IDI, Faida, Ilasee Village).

Women knew if they told TBAs beforehand that they would need their services or call them early before the labour progressed, they would be told to go to the dispensary. Sialubanje et al. (2015: 5) also reports that TBAs in rural Zambia responded to the shifting role but still assisted women giving birth at home in order to prevent them from giving birth on their way to health facilities. On the other hand, when women did not want to go the health facility, delaying was a way of ensuring that TBA would assist them to give birth at home.

The delay technique was also used to avoid long waiting before childbirth at the dispensaries. This was one of the main concerns among healthcare providers. They complained that women went to the dispensaries late which put them at risk of giving birth on the way. When they reached

the dispensaries and diagnosed as having complications, healthcare providers remained with no choice but to send them to referral hospitals; and some of the women would resort to seeking care from TBAs. Narrating their side of the story women said when they went early to the dispensary they were either told to go back home or wait outside even during the night time (Chapter 5). Pfeiffer and Mwaipopo (2013: 6) report similar findings among women in Mtwara who developed a custom of going to health facilities late after the onset of labour in order to avoid the waiting time and being seen by everyone during labour.

In some other cases, TBAs assisted women out of emergency. When Safina gave birth on the way for example, it was sheer luck that Mama Askari was around and was ready to help her. Safina's case was a second which Mama Askari had to render help to a woman out of emergency. In 2013, she assisted a woman who was denied birthing services at Faraja Dispensary and was told to go to Mshikamano Hospital. Narrating what happened, Mama Askari had this to say:

> A woman came here like two years ago, it was in the year 2013, and the baby was lying in a bad position (breech). The doctor (at Faraja Dispensary) looked at her and told her to go to Mshikamano Hospital, on the way I checked her and the legs were already coming out. I took her to my house and I helped her. (...). She gave birth safely and after that she lost energy. I told my daughter to slaughter a chicken, we made soup and gave it to her, and until today, the baby and the mother are all fine and are now my friends. However, the doctor was not happy with what I did. I was expelled from my job as a cleaner at the dispensary. My child, what should I have done? Not help her as he had done? (IDI, Mama Askari, Magambua village).

Rather than TBAs encouraging women to give birth at home, circumstances that called for their support. As Faida stated, it was women who still needed her and what she did was simply responding to the needs of women. Even those who had stopped assisting deliveries were sometimes called when complications arose during homebirths. Saumu's mother, the TBA of Wairo for example, was called to help when Mama Wawili failed to expel the placenta. Fortunately, she was able to help. When I asked them if they would let women give birth at home because they were paid to help as alleged by Jamali, Faida had this to say:

> It is true that they give us soap. It's for us to wash our hands after we finish assisting them to give birth, but I cannot force a woman to give birth at home just because I want a piece of soap. I don't know if others do so because even when we take them to the dispensary they give us something to say thank you. It is not a big thing that they give us. What we

> do is not business, sometimes they give us money, like 1000 (Tanzanian) Shillings (equivalent to 40 Cents-Euro), or a chicken but there is no agreement. So, I cannot say when I go to help a woman to give birth I will get this much amount of money or a certain thing, no. When they call me, I go and whatever they give is just to say thank you; so, even if they do not pay me anything, I just help them (IDI, Faida, Ilasee Village).

According to Faida, TBAs were being paid either in cash or in kind but that was not a reason for them to assist women at home. Even before being banned from assisting women with childbirth, other TBAs also said it was not something that they did at the expense of helping women.

TBAs were highly motivated, most of those to whom I talked had clear records of the births they had assisted and had few complaints concerning lack of remuneration. None of the TBAs I talked admitted to having experienced a maternal death, though several infant deaths were reported. Saumu's mother explained that:

> Now they tell us it is not safe to assist women to give birth at home, I have stopped. I do not want to get into problems because you cannot know... maybe it is because maternal complications are so many these days, many women die. Me, I have been assisting women to give birth for a long time (ten years) not a single woman died, children die, I have a record, but a mother, it has never happened in my case; but now, the situation is different maternal complications are so many these days (IDI, Saumu’s mother, Wairo Village).

Assisting women to give birth was becoming more challenging for TBAs as they were no longer provided with birthing kits. When women had not prepared gloves, they received babies with bare hands or sometimes they used clothes or plastic bags. This put mothers and their newborns at risk of infections raising many questions as to whether banning TBAs and stopping to provide birth kits was the right thing to do when circumstances still called for their assistance.

Mama Askari was particularly concerned about the termination of trainings which she said they helped her to assist the woman who was told to go to Mshikamano Hospital:

> During the training, we were taught how to help a woman to give birth when a baby is sleeping badly (breech presentation). They had an artificial vagina that they used to show us what to do. So, when I was helping her I remembered what we were taught until I got the baby out. When it cried I knew it was fine but the problem was with the mother, she did not wake up. I started getting worried; I looked at her, she was breathing; then when the placement came out, I was a bit relieved. I covered her with a blanket and I waited

> (...). The bleeding was normal. After sometime, she woke up. When she drank the soup, she was fine (IDI, Mama Askari, Magambua Village).

Although the first training was conducted in 2000 before the TBAs were banned, they received other two trainings, in 2004 and 2008 to upgrade their skills. Mama Askari cherished the trainings and she still had a notebook she used to take notes during the training and she still referred to it when assisting women during childbirth. Some other women I talked to had never given birth with the assistance of TBAs but many women still expressed satisfaction with their services, which calls for the second look about training and integrating them into the formal healthcare system.

7.4 Putting the Cart Before the Horse: Do We Need CHWs for MNCAH?

As scholars respond to the involvement of CHWs in MNCAH as well as the creation of the new cadre of CHWs, the main question that is being asked is whether this new type of professionals would be effective in solving health problems among the poor and marginalized and meeting the SDG number 3. While several public health studies are already praising the program (Geldsetzer 2019; Okyere 2017), others have taken a more critical look that identifies gaps within the program and the conceptualization of CHWs that might compromise the achievement of the desired goal (Gottier 2017; Namazzi et al. 2017). Based on the observations and interviews I had with CHWs, TBAs, administrators, healthcare providers, and women and their families, I propose a critical revisit of the program to take into account what scholars have observed and suggested while the program was still in the initial stages of national scale up.

The endorsement of the 1mCHW program and the following development of the CBHP policy and strategic plan can be interpreted in the sense of economy of appearances. Using Anna Tsing's notion of economy of appearances, Sullivan (2011) shows how health sector strategic reforms in Tanzania led to the production of policies that were appealing to donors in order to maintain a collaborative relationship and secure financial support. However, the HSSR did not improve the situation of health services provision significantly for both healthcare providers and the people, as there were several disagreements between the donors and the government in the implementation and funding of the health sector. Similarly, while the international community is convinced that the scaling up of CHWs at the national level is a cornerstone to the improvement

of the health sector crisis in terms of shortage of healthcare providers, some of the administrators were sceptical about the use of CHWs for MNCAH given the overall unstable state of the health sector. I will illustrate this shortly.

The health sector and healthcare providers are faced with critical problems that can hardly be corrected by training CHWs. Healthcare providers' needs are many ranging from poor salary, work overload, poor working conditions, and lack of appreciation, all of which lower the working morale (Chapter 6). In addition, improvements in the health sector have been rather slow compared to the increased needs and population growth. I have shown in Chapter 6 that referral hospitals are overburdened by large numbers of pregnant women. In addition to the lack of enough healthcare providers, medical supplies and physical infrastructures, the referral hospitals also compromise the health of women and their newborns.

The current functioning of CHWs intends to encourage women to go to the same hospitals that are already struggling to provide maternal health services leading to avoidable maternal deaths (Pembe et al. 2014). Increasing the number of women delivering in health facilities obscures women's experiences that illuminate limitations of these interventions (Wendland 2018: 278). Unless the new cadre of CHWs are trained to conduct childbirth, which they are not, the program does not reduce the workload for healthcare providers especially in referral hospital as the task shifting approach stipulates. Some health personnel have also been highly sceptical of the training of CHWs for MNCAH as expressed by one medical administrative officer at Chemba District Council:

> In 2010, we requested the Ministry of Health to help us with the training of new nurses, because as a region we had an acute shortage: two nurses in Umoja Hospital attend about 60 women during a night shift. The Ministry trained about 600 nurses but only 100 were employed because the Treasury (*Hazina*) had no money to employ all of them. Now we are training CHWs! (IDI, Health Administrator, Chemba District).

According to the above extract, the training of CHWs is a waste of resources – and the work done by CHWs will bear limited fruits as long as local health services and the maternal referral system are not strengthened. Given that two nurses must attend about 60 pregnant women during one nightshift, raises numerous critical issues, including what should happen if more than two women need to deliver at the same time. Thus, even when CHWs encourage women to give birth in

health facilities, and encourage women with risk-pregnancies to seek for care in referral hospitals, there is still no guarantee that they would be assisted by skilled medical personnel. Such structural matters are overlooked when global maternal health interventions are implemented.

In addition to providing health services, healthcare providers have to provide technical supervision to CHWs on a monthly basis. A study conducted in Morogoro revealed that some community health workers could go for over two months without being monitored while technical supervision is identified as a key to improving their performance (Roberton et al. 2015: 11). The mode of supervision is also not clear between the older generation of CHWs for MNCAH and the new generation who receive between nine months and one-year training. The same amount of training is received by nurse assistants and maternal and child health aides (MCHA), who are trained for one year, and the majority of whom are employed in village dispensaries. Issues of collaboration and supervision raise concerns which need to be addressed.

The extract also echoes the lack of communication between ministries in terms of coordinating health interventions. The Ministry of Health, for example, should have known about the (lack of) willingness and capacity of the Treasury and the Ministry of Labour, Employment and Youth Development (MLEYD) to employ the newly trained nurses that they had commissioned. When I was talking the health administrator in 2015, the formal training of the new cadre of CHWs had not yet begun. During the planning phase, the Big Results Now (BRN) program committed to absorb 80 percent of the required CHWs in regions that the program had committed to improve reproductive, maternal, newborn child and adolescent health (RMNCAH) and establish district-led CBHP. In 2016 when the trainings began, President John Magufuli discontinued activities of the BRN program and until the end of my research; it was not clear how CHWs would be employed by the government.

Community Health Workers who have not received nine-month training for MNCAH are acknowledged in the CBHP. The fact that the proposal to remunerate them was not fulfilled as of January 2019, there is a strong likelihood that after the training, some of the CHWs might remain unemployed or deployed to work without remuneration. With only 60 percent of the health sector budget fulfilled in the financial year 2017/2018, it is apparent that the government does not have enough funds to cover for health care needs of the people and the existing

healthcare providers (Lee and Tarimo 2018: 7). The projection that by 2023 the government would sustain the program without the support of donors remains questionable. The WHO itself has warned that, although CHWs are an appropriate solution to the shortage of healthcare providers, it should not be taken as a cheap or an easy solution (Lehmann and Sanders 2007: vi). The proposed monthly salary for a trained CHW is 320,000 Tanzanian Shillings (equivalent to 128 Euros), which corresponds to an annual salary of 3,840,000 Tanzania Shillings (equivalent to 1,536 Euros) per one CHW. This is not so different from an assistant nurse/MCHA, whose salary is 390,000 Tanzanian Shillings (equivalent to 156 Euros) per month (Devlin et al. 2017: 10). NGOs, FBOs, CBOs and the private sector are expected to provide working tools and incentives to the CHWs but this cannot guarantee sustainability of the program at the national scale.

Community Health Workers for MNCAH are reported to be successful in several countries such as India, Nepal, and Bangladesh but their success does not guarantee the same results to other contexts (see Liu et al. 2011). For example, Cogburn et al. (2019) show that maternal mortality in Tanzania occur mainly due to the poor functioning of the healthcare system and bureaucratic procedures that interfere with the continuum of care when women go to referral hospitals. The health sector in Tanzania, as I have pointed out, still needs significant structural adjustment to allow its smooth functioning along with CHWs.

Vigorous measures to improve the conditions of the existing healthcare providers and the functioning of the existing health facilities, I think may benefit the people more than the creation of a formalized cadre of CHWs. Instead, however, nation-wide efforts of improving the provision of health services and conditions of healthcare providers have been rather slow. The construction of the maternity building in Umoja Regional Hospital began in 2007 but because of the lack of funds, it was completed and opened in 2018. CHWs are more of a cover up to the much bigger problem of the unstable health system that need the support and commitment of the international community to improve the situation.

7.5 Persistence and Return of TBAs in Assisting Birth

Some of the medical personnel, I interviewed, questioned the government's commitment of banning TBAs due to what they reported to be the 'ongoing trainings' of TBAs in other areas of Tanzania. In Bunda District, for instance, one interviewee reported that TBAs were still being trained and authorized to help women during childbirth, while in Dodoma the Regional Medical Officer (RMO) was strict against such trainings. There are also reports of TBAs assisting deliveries in different parts of the country without any measures taken against them. The government has left the ban on TBAs somewhat open to interpretation by medical administrators, and there is no consistence in terms of how the ban is implemented nationwide.

This signifies that childbirth services provided by TBAs are still needed. Malawi is the only country that has officially restored the services of TBAs in assisting women during childbirth. TBAs in Malawi were banned from assisting childbirth in 2007. For years following the ban, there was a noted decline in maternal mortality – from 807/100,000 live births in 2007 to 510/100,000 in 2010. However, in 2010, Mutharika, the then President of Malawi lifted the ban because women still sought for the services of TBAs for childbirth. Addressing the need to continue training TBAs, he said:

> We need to train traditional birth attendants in safer childbirth methods. We should not completely stop them, because the work is very important. We should train them to assist us in addressing the health challenges that we are facing (The Guardian 2010).

Commenting on the decline of maternal mortality in Malawi, the National Executive Director of the National Organization of Nurses and Midwives of Malawi (NONM) said that statistically the government of Malawi was losing information about maternal deaths from TBAs who went underground for the fear of being fined a goat, chicken, or money (Godlonton and Okeke 2016: 5). In other words, the decline was not real but was a result of lack of data from TBAs. Lifting the ban was however, not welcomed by the medical personnel who still believed it was a step back to the efforts of the safe motherhood initiative (SMI), and thought the solution would have been to expand biomedical services.

While the government and the WHO consider the expansion and availability of biomedical services as central in the improvement of maternal health, others global health actors have

insisted that the training of TBAs for childbirth is important in areas where there are no biomedical services. Amref Health Africa conducted a study among pastoral communities in Ethiopia and established that pastoral communities were still almost exclusively dependent on TBAs for childbirth services. In 2017, Amref Health Africa made a position statement on the role and services of TBAs. It stated that:

> While Amref Health Africa always operates within the national health system guidelines and laws, the organization believes that TBAs are useful and reliable partners in maternal, neonatal, and child health programs. This belief is based on years of experience in remote and hard-to-reach areas, where health facilities are few and far between and where numbers of skilled health providers are severely limited. Until they are replaced by sufficient skilled birth attendants, TBAs remain the only option for many women. Therefore, Amref Health Africa advocates for their supervision and support in assisting deliveries (Amref Health Africa 2017).

As Amref Health Africa advocated for continual training of TBAs in areas where medical services are scarce, the findings of this study indicate that TBAs are still consulted during childbirth even in areas such as Lalta where the services are available. The circumstances reported by Faida still call for the assistance of TBAs. As Berry (2010) observes, looking at TBAs as birth assistants per se overshadows other roles they play in childbirth and in the trust women invested on them. Berry shows that in Mayan community *iyoma* (local midwives) were believed to be capable of drawing power from the spiritual world, and the power of their prayers was important during childbirth. Even with some form of biomedical training, beyond being birth assistants, *iyomas* were used as the spiritual conduit. In Lalta, TBAs did not all the time encouraged women to go to the health facilities for childbirth, especially when they were told a particular ritual needed to be performed during childbirth as expressed by Faida:

> When others call you, they tell you they want to turn (inside out) the placenta (*kugeuza kondo la nyuma*) you cannot force them to take the woman to the dispensary because you cannot do that at the dispensary. I just help a woman like that to give birth at home, because she has a special need (IDI, Faida, Ilasee Village).

The concern of women upon calling for the assistance of TBAs was more than avoiding maternal deaths but was on the manner they are treated and their needs understood during childbirth.

Realizing that eliminating home deliveries is a challenging endeavour especially in rural areas, other biomedical specialists have suggested further training of TBAs to equip them with better skills of identifying and handling obstetric emergencies. A program implemented in Bangladesh and Nepal of enabling TBAs to handle postnatal haemorrhage, which involved the use of birth mats and pads to estimate blood loss, and giving women misoprostol tablets to prevent postpartum haemorrhage indicate improvements in maternal mortality rates in the study areas (Prata and Bell 2014; Rajbhandari 2017). This is one of the pragmatic examples of enabling TBAs handle emergencies, which should not be taken to mean encouraging women to give birth at home but enabling a safe environment for homebirth. Compelling women to go to health facilities by limiting the services of TBAs does not do them any good.

7.6: Conclusion

CHWs, just like TBAs, have become an emotionally charged topic in global health. On the one hand, they have been viewed (at different times) as a magic bullet to address maternal health in resource-limited countries. On the other hand, maternal health has become an increasingly homogenized biomedical problem, and that the advocated solution for safe childbirth is giving birth with the help of a skilled healthcare provider. The use of TBAs is no longer considered safe and therefore women are encouraged to go to health facilities. This shift, which involves the training of both male and female CHWs for MNCAH, has not taken into consideration women's own understandings of birth, which among the Sandawe has always been the domain of women. For example, understanding why, TBAs delay women from seeking care entails an understanding of the values that women attach to TBAs, who embody cultural experience and knowledge. I do not deny the relevance of other factors such as payment that TBAs might receive from assisting women during childbirth, but understanding why women still call on TBAs and not on CHWs and are likely to continue to do so – questions the viability of using CHWs for MNCAH. The fact that women still give birth at home even when they are followed up by CHWs raises even more questions about the acceptability of CHWs in women's lives.

CHWs for MNCAH are rather new in the field of pregnancy and motherhood, and do not have the experience and trust that TBAs have built among women over the years. Apart from women's

attachment to TBAs, and as Kudetz (2015) argues, the universal abolition of TBAs is being considered because of the lack of conclusive evidence of whether they actually contribute to the reduction of maternal mortality. Maternal mortality rate is also a poor indicator of women's satisfaction with biomedical maternal healthcare services and it is used to justify the use of coercive approaches (Wendland 2018). When women cannot comply with the referral advice or where medical facilities are scarce, women are compelled to give birth out of health facilities where it is female relatives, neighbours, or TBAs who provide support (cf. Pfeiffer and Mwaipopo 2013). In such a situation, banning TBAs raises critical questions about the well-being of women during childbirth.

Training CHWs is in adjustment with the need of increasing hospital-based deliveries but the performance of TBAs does not jeopardise this objective. Investing in CHWs and simultaneously muting TBAs in a country where half of all deliveries in rural areas take place outside of health facilities overlooks the potential of TBAs, who are equipped with experience and the trust of the women they serve. While CHWs derive their power from the support of health care providers, TBAs receive support from local women and their families.

Looking at the current state of maternal health in Tanzania, and in Lalta Ward in particular, I cannot avoid but question whether we truly need CHWs for MNCAH, rather than TBAs. Why give more responsibilities to CHWs, while TBAs could do much of the same thing yet with more experience, trust, and acceptance? It is because not only many resources have been used to train TBAs over the past two decades, but also because the subjective experiences of women regarding TBAs warrant second thoughts about the training of CHWs for MNCAH. The health system as whole requires significant changes in order to meet the target of birthing with the help of a skilled birth attendant. However, mere training of CHWs to motivate women to go to a health facility is insufficient. The Tanzania's case shows that the challenges that TBAs have long faced in their work remain the same today as they were in the past decades, and will most likely be faced by CHWs too, as no substantial improvements have been made regarding the larger health system in which they must operate. Given the realities of women in rural areas and the place that TBAs have secured in their lives, it would seem to make more sense to invest in the training of TBAs rather than in CHWs when dealing with and attending to pregnant women.

Chapter 8

Conclusion

8.1 Introduction

Distance to the health facility is identified as one of the main reasons why women fail to utilize biomedical maternal healthcare services (Mwaliko et al. 2014; Hanson et al. 2017). For over a decade, Tanzania has been committed to expanding and upgrading primary healthcare facilities especially in the rural areas in the efforts of responding to the global demand of reducing maternal mortality by encouraging women to use biomedical maternal healthcare services (URT 2007: 15). However, evidence shows that the use of biomedical maternal healthcare services in rural areas is still low (URT 2016: 167). This, together with persistently high maternal mortality rates raises questions as to whether the expansion is working to the desired end. Bringing together the experiences of women, healthcare providers along with TBAs and CHWs, this study examined the provision and uptake of biomedical maternal healthcare services in Lalta in order to understand how the services are provided and how women are engaged with these services when they are available and accessible.

Given the emphasis on the continuum of different phases of maternity healthcare (Kerber et al. 2007), ethnographic accounts presented in this study focused on four aspects of maternal health services namely, family planning, antenatal care, birthing services, and postnatal care. I was able to follow women throughout the course of pregnancy, childbirth, and after childbirth. As indicated in Chapter 5, the use of “the whole maternity experience” provided me with the opportunity of understanding what maternal health meant to women and see how decisions about maternal healthcare were made in different stages, what influenced them and the constraints women faced in using the available services. To further understand the experiences of women and healthcare providers, I observed clinical encounters in the village dispensaries and in the two referral hospitals where women with high-risk pregnancies went for childbirth services. In addition, I talked to TBAs and CHWs as part of important providers of maternity services beyond the clinical settings in order to understand their engagements and experiences with maternal

health interventions and the manner in which they influenced women to use biomedical maternal healthcare services.

In this chapter, I present the summary of the empirical findings, what they mean in terms of the efforts of increasing the use of biomedical maternal healthcare services in rural areas, and the relevance of the findings in anthropological scholarship on maternal health in Africa. Furthermore, I will present key recommendations aimed at improving the utilization of biomedical maternal healthcare services, the well-being of women and healthcare providers. I will end the chapter by identifying areas for further research.

8.2 Summary of Findings

One of the emerging issues from my study was that the decisions of women and their families to use biomedical maternal healthcare services were continuously made according to various frames of reference. Culturally defined needs and concerns of women and their partners formed one of the frames of references, which informed women's understanding of maternal health and choice of care. Women's rationale of opting out of the use of biomedical services even when they had potential access to these services indicated that women did not narrow their understanding of maternal health to the avoidance of maternal death, the ultimate goal for the provision of the biomedical maternal healthcare services. Indeed, something different was at stake (Kleinman 1999b: 70). In Chapter 4, I have demonstrated that despite high fertility being a risk factor to maternal death that was vividly expressed to women during ANC visits and after giving birth, most women did not use modern family planning methods to limit fertility because high fertility was valued for its connection to fertility of the land, having many children was important for women's moral identity, as well as men's sense of control and prestige. In some cases, women who had earlier given birth in health facilities gave birth outside of health facilities in order to encounter non-biomedical risks that mattered most at the time, or to be able to perform a ritual to influence the change of gender of a child in the next pregnancy. The possibility of a Caesarean section in referral hospitals, which changed the cultural conception of giving birth and the perceived physical effects made several women avoid abiding by the referral advice.

Experiences gained from using the services formed another frame of reference, which prompted women to re-define their engagements with the services in the manner that undermined biomedical knowledge and challenged the universalizing rationality of the interventions. Women avoided the use of modern family planning methods because of the side effects that the healthcare providers termed as minor inconveniences (*maudhi madogo madogo*) that could be tolerated. Delayed conception after women stopped using family planning also contributed to the avoidance (cf. Richey 2008a; Barnett et al. 1999; Chebet et al. 2015). Some of the women considered using family planning when they had a desired number of children, which was more than four, the maximum number of births that the healthcare providers recommended.

Despite the emphasized importance of ANC, its use was perceived as less important because women did not receive thorough checkups in all the visits. During the first visit, women received a number of tests but in the subsequent visits they were asked a number of questions about how they felt, an assessment that hardly lasted for 15 minutes. As a result, ANC was perceived by the women in Lalta as important only when they felt unwell, which warranted a more intensive assessment, and when they needed a clinic card, which was mandatory to have in order to be accepted to give birth in a health facility. The latter can explain why the majority of women in Tanzania use ANC services at least once (URT 2016: 167). While this was identified as an achievement by the healthcare administrators, the drop of the number of subsequent visits observed between 2004 and 2010, and a slight increase observed thereafter tell a different story (Gupta et al. 2014). I argue that, the clinic card, rather than the need for biomedical services as such may be a motivating factor (cf. Myer and Harrison 2003).

Therefore, for pregnancy care, women drew mainly from their own experiences, guidance and advice from older female relatives, mostly their own mothers. More pregnancies provided women with more experience reducing the likelihood of using the services as advised. Interestingly, knowledge gained from clinical assessments was used for self-assessment and which in turn facilitated the underutilization of ANC services. The feeling of a baby playing in the belly (*mtoto kucheza tumboni*) and swelling of legs, which were inquired during clinic visits, were common indicators that women used to self-assess the safety of their pregnancies and delay going for antenatal care.

In addition, the treatment experienced when attended by the healthcare providers influenced significantly women's perception of the services and decisions about their future use. This was mostly the case with birthing experiences. Women had fewer complaints about maltreatment during childbirth in the village dispensaries than was the case in the referral hospitals. Women complained about being verbally and physically abused, and being neglected, things which were also observed during my study and are widely reported in other studies (see, for example, McMohan et al. 2014: 4-7; Chadwick 2017: 497-504; Allen 2004: 1991-199; Van Hollen 2003: 132-133; Brown, 2010: 126-128). Such experiences made women reconsider their decisions of going to referral hospitals for childbirth and they expressed their preference of giving birth at the village dispensaries. This is because women considered the healthcare providers at the village dispensaries as more cordial than those in the referral hospitals.

Others selected and used just a part of the services as it was the case with Mama Wawili (Chapter 5) who used ANC services as advised in order to get assurance from the healthcare providers that her pregnancies were doing well so that she could comfortably give birth at home. For Mama Wawili and several others, giving birth in health facilities was necessary only when they experienced complications during pregnancy, or had a complicated birth at home. Health services in this case were just another option to birthing care, not always authoritative. Others did not use ANC services as advised but preferred to give birth in a health facility.

On the other hand, even when women had intended to use the services their prospects were constrained directly and indirectly with poverty. This was particularly apparent in the use of birthing services. Ideally, like other aspects of maternal health services, birthing services were supposed to be free but in practice only the actual service of being assisted to give birth was free. Women had to buy medical supplies without which they could hardly get birthing services (cf. Perkins et al. 2009). The situation was even harder when women had to seek for childbirth services from referral hospitals, which entailed finding someone to look after the family, getting money for transport and food while at the maternity waiting homes. In Lalta, drought aggravated the already precarious family economies and crippled the ability of husbands and relatives to support women.

The effects of poverty were also manifested in ruptured family relationships which affected socio-moral support women needed to be able to use the available services. Safina (Chapter 5) had everything to enable her to give birth in the dispensary but she gave birth on the way instead, because she did not have someone in time to escort her to the dispensary. Lack of support from partners and relatives was another kind of poverty which was gradually growing in Lalta and increasingly compromising the chances of women to use the services. Women expressed their growing concerns about men propensity of shunning their role of taking care of families, diminishing love, and increasing alcohol consumption. More worries were expressed about the willingness of other family members to help pregnant women when their own husbands could not. Under such conditions, even ascertaining the future use of the services was hard.

In addition to the above-mentioned dynamics, procedures in the provision of the biomedical maternal healthcare services bred grounds that limited the use of the available services. There are two things in this regard. First, policy guidelines such as compulsory HIV and STDs testing for a couple during the first ANC visit appointment reinforced the delay as women waited for their husbands who were away for casual labour in the urban areas. Those who had no partners were required to present a letter from a village government before receiving the service or they had to assure the healthcare providers that their partners did not want to claim responsibility. Also, denying childbirth services to women with high-risk pregnancies at the village dispensary as a means of forcing them to go to referral hospitals left these pregnant women with no choice but to give birth at home and in some cases they tried to seek for childbirth services from the village dispensaries because some of the healthcare providers were willing to help them. For most of these women, the emotional suffering was evident in their childbirth accounts and for others it was the beginning of trusting home birth. Second, omissions and the healthcare providers' interpretations of how to provide the services limited the adequate use of the services. Women who initiated ANC right after realizing they were pregnant were denied the services and were told to return when pregnancies were three months old. Many went back for ANC past the first trimester, which is an important window for various interventions such as PMTCT (cf. 2010: 199).

Even more worrying was the provision of PNC services. Most women were not aware of the biomedical postnatal care for the mother. I observed less emphasis about PNC for the mother mostly in the village dispensaries. After childbirth, the attention immediately turned to the care of the newborn. I agree that newborn care is part of the PNC, but the PNC guidelines require observations and checkups for the mother as well (WHO 2013: 16). Similar observations are made by Mrisho et al. (2009) in their study about antenatal and postnatal care in Mtwara. The study findings indicate that postnatal care for the mother is almost nonexistent. This raises concerns about avoiding maternal deaths during the postnatal period especially in the absence of clear data of maternal deaths that occur out of health facilities.

Despite all the challenges women faced in using the biomedical maternity services, the healthcare providers reduced such failure to ignorance (*ujinga*) and lack of care (*kutokujali*) which warranted punishment. Without attending ANC, women could not get maternity clinic cards, and all women who gave birth outside of health facilities were fined without critical assessment of the reasons. Ironically, even when the healthcare providers knew women could not give birth at the village dispensaries because they had no medical supplies or could not afford to go to referral hospitals, they still scolded and fined them when they brought their newborns for checkups. In Lalta, women were charged 10,000 Tanzanian Shillings (equivalent to 4 Euros) but it has been reported that in other areas the fine can be as high as 50,000 Tanzanian Shillings (equivalent to 20 Euros), much more than the amount they would need to buy the medical supplies (Habari Leo 2017).

The experiences of healthcare providers, TBAs and CHWs revealed that as promoters and implementers of maternal health services and interventions, they were also affected in the process of providing the services. In Chapter 6, I have illustrated that on the one hand, the implementation of the maternal referral system restricted women with high-risk pregnancies from getting childbirth services at the village dispensaries. And on the other hand, it subjected the healthcare providers to moral dilemma and disrupted working relationships. In the referral hospitals, healthcare providers struggled to serve large numbers of women beyond the capacities of the hospitals. Under such conditions, it was not always possible for the healthcare providers to provide care that women expected to get from referral hospitals. The possibility of getting good

care depended very much on the availability of medical supplies at the hospitals which was not guaranteed, whether the woman had brought her own medical supplies, and the willingness of the healthcare providers to provide childbirth services selflessly. Physical and verbal abuses by the healthcare providers, which women resented, were mostly meant to help the healthcare providers to manage the workload and provide care than merely hurt women although, such abuses were sometimes used habitually. The experiences of the healthcare providers in referral hospitals were made worse by being exposed to the risk of HIV infection because of shortage of protective gears, lack of appreciation from administrators and the women they served, and the fear of being held accountable in case of the occurrence of a maternal death.

Following the emphasis on the importance of skilled birth attendance in health facilities, home birthing services offered by TBAs, which were once promoted by the safe motherhood initiative and the WHO as being important in the reduction of maternal mortality, were regarded by the WHO, the government as well as the healthcare providers and CHWs as an obstacle to the reduction of maternal mortality. Instead, TBAs were required to accompany women to the health facilities and stop assisting births (WHO 2015). Some of the TBAs in Lalta stopped assisting childbirths and accompanied women to the village dispensaries. Others despite the ban continued assisting women when they were approached by them. As a result, the image of TBAs in the eyes of the healthcare providers changed from that of partners in the reduction of maternal mortality to some sort of villains whose services threatened the efforts of reducing maternal mortality (cf. Cogburn 2019). In a similar vein, CHWs perceived themselves as superior to TBAs and did not collaborate with them. However, TBAs enjoyed the respect of women and other community members.

Community health workers followed up, educated women about maternal healthcare and encouraged them to use biomedical maternity services. In performing their duties, they faced a number of challenges including the lack of incentives and resistance from women (especially against male CHWs) which raises concerns as to whether CHWs will be committed to work and motivate women to use the services.

8.3 Implication of the Empirical Findings to the Anthropological Scholarship

Looking at the provision and use of biomedical maternal healthcare services by emphasizing on the agentive engagements, perspectives, experiences, and concerns of women, their families and healthcare providers, this study is a continuation and a contribution to critical anthropological scholarship on reproductive and maternal health in developing countries (Allen 2004; Berry 2010; Obermeyer 2000; Chapman 2010; Janes and Chuluundorj 2004). I emphasize that women and their families made decisions of using the services not solely based on the availability and the importance of using the services as they were advised by the healthcare providers and CHWs, but on how the services were provided and how women and their families understood their local moral worlds as individuals and members of society within larger historical, political, social, and economic contexts.

Specifically, I have demonstrated that the biopolitical logic of increasing availability, educating women about the importance of using biomedical maternal healthcare services, and the provision of free maternal health services, which intended to instil biomedical rationality in order to increase utilization, failed to capture how decisions to use the services were continuously (re)shaped by the ongoing social, cultural, and economic changes in the neoliberal context (cf. Ginsburg and Rapp 1995: 11-12). I have illustrated how poverty, which was intensified by drought that affected agricultural production, the main economic activity in Lalta, interacted in complex ways with the conditions of provision of biomedical maternal healthcare services, affected family relationships and limited women's ability to maintain the consistent use of the available services. In addition, the provision of free maternal health services could not enable women to use the services fully because they still had to pay for transport and buy medical supplies. Women also needed money for food while waiting for childbirth referral hospitals or maternity waiting homes.

Even when women clung to practices that in biomedical terms were considered as exposing them to the risk of maternal death, it was partly because such practices enabled women and their partners to make sense of their lives in local moral worlds. For example, I have shown that frequent pregnancies and giving birth to many children was connected to the potential of maternal

death. However, women continued having many children and resisted the use of modern family planning methods. This is because children were desired not only for security in old age or the sense of male control as reported by other studies (see Mbacké 2017; Caldwell 1987; Ainsworth 1996; Korotayev et al. 2016), but also due to the need of having "good children" which was important for the social reputation of women in the community. Getting good children was becoming difficult under conditions of perceived moral decay.

These observations resonate with vast anthropological discussions on neoliberal reforms, poverty, and health in Africa (see, for example, Foley 2010; Dilger 2010; Chapman 2010; Chapman and Pfeiffer 2010; Lugalla 1995). I underscore the necessity of anthropological scholars to continue showing how individuals produce different rationalities as they engage with global health interventions in the neoliberal context (cf. Biel and Petryna 2013: 11). This entails the appreciation of the emic perspective which broadens the narrow and static view of policy makers and health experts that focus on changing subjectivities to suit biomedical rationalities. Women instead appropriated and modified health services and interventions to suit the changing contextual needs and realities.

By using the notion of authoritative knowledge to understand women's different practices and choice of maternity care that is accorded an authoritative status, this study is also an addition to the anthropological scholarship of medical pluralism particularly in Africa (Langwick 2011; Olsen and Sargent 2017; Tilley 2016; Hampshire and Owusu 2012; Murchison 2017; Cremers 2018). I have shown that depending on different circumstances, women used both biomedical and other forms of maternity care which ranged from consulting traditional healers, traditional birth attendants, female relatives, and self-knowledge embodied from the experience of using the services. I particularly want to stress on the embodied experience as a form of authoritative knowledge which was pronounced for pregnancy care among women in Lalta when they delayed seeking for antenatal care. This aspect of authoritative knowledge and self-care, which is also relevant for pregnancy care, is missing in anthropological discussions of other forms of maternity care in Africa.

Furthermore, by increasing the availability of maternal health services and pushing women to use the services by using both persuasive and punitive measures, the state promotes biomedical knowledge of maternity care as the only relevant knowledge and delegitimizes other kinds of knowledge. On the other hand, women's active engagements with these services reject this dichotomy and show the need of appreciating both forms of knowledge. By using other forms of maternal healthcare, women in Lalta were not denouncing biomedical knowledge as such, far from it; they were just flexible and pragmatic, open to all forms of maternal healthcare according to their needs and concerns. This in turn challenged the hegemonic status biomedical knowledge and biomedical maternal healthcare services wanted to achieve. With this observation, I join other anthropological scholars (Jordan 1978; Good 1994; Davis-Floyd and Sargent 1997; Berry 2010; Wendland 2017; Browner and Sargent 2011), who emphasize on the need of appreciating different types of knowledge and forms of healthcare in specific contexts. Based on the findings of this study, I contend that making biomedical care the hegemonic and exclusive type of maternal healthcare especially in rural areas of Africa does not seem to be a viable solution at least for now, and may be so for many years to come.

Unfortunately, maternal health interventions, which are designed at the global level are yet to be sensitive to the needs of women in particular contexts. Women's experiences, knowledge, and voices are overlooked at the expense of funding needs, cost effectiveness of interventions, and the demands of statistical accounts of progress that focus on the number of women using the services and reduced maternal deaths (Storeng 2010; Berry 2010; Adams 2016; Wendland 2018). The negative impacts resulting from maternal health interventions have been presented by anthropological studies as unintended consequences which means different results from those intended by policy makers and planners (De Zwart 2015: 284). This interpretation of especially negative effects as unintended consequences, I argue, masks the role of the state in sustaining such consequences. I propose representing them as 'a form of violence' (Fassin 2009: 53) embedded in the daily provisions and use of biomedical healthcare services, or euphemized violence, which means that the states implement interventions "in the name of social need or national priorities but fail to acknowledge the impact of these interventions in the lives of women" (Ginsburg and Rapp 1995: 3-4). This may call for the attention of the states to be more

reflective and ask different questions that will result in the designing of viable and relevant interventions for the people who have little power to influence decisions that affect their lives.

In efforts to increase the utilization of the available services, the healthcare providers developed mechanisms of punishing women who failed to use the services as advised. Such measures were not questioned by the health administrators, which means they endorsed them silently. When health facilities, which were expected to be the locus of preventing maternal deaths failed to meet the purpose, healthcare providers were held responsible. This re-directed the focus away from systemic problems inherent in the adequacies of health facilities, the shortcomings of the interventions, and more broadly the inability of the state to meet the needs of its people, which has been a prevalent situation since medical services were introduced during colonialism (Chapter 3).

Even with the uncertainty of getting inadequate maternal health services in health facilities, avenues for home birth are closed down. While TBAs were no longer allowed to assist women during home births, CHWs and the healthcare providers motivated women to go to health facilities, which given the shortage of medical supplies and healthcare providers could not serve well those who were already going. Evidence from this study shows that pushing women to use the services without sufficient healthcare providers, adequate medical facilities and supplies intensifies women's suffering and increase challenges to healthcare providers. Moreover, such measures will not result in the reduction of maternal mortality and the improvement of women's well-being.

Generally, the expansion of maternal health services in rural areas is important but more needs to be done. The WHO (2015) has officially recognized the importance of a comprehensive approach to improving maternal health but in practice the emphasis is still on biomedical and facility based interventions. For example, in 2016, the WHO increased the number of antenatal care visits from 4 to 8 in order to increase ANC attendance, which has been on decline for the past two decades (WHO 2016b). Yet factors that prevent women from making the recommended 4 antenatal visits are still prevalent. Attention is paid more on measures to push women to use the services than on addressing the underlying structural factors that limit the use of the services.

Under such a situation one then wonders if the unintended consequences are really unintended. I argue that, further critical analysis needs to be carried out on the unintended consequences that are endemic in the provision of maternal health services in Africa.

On the other hand, this study is an important contribution to anthropological studies on healthcare providers and hospital ethnography in Africa. Most of these studies focus on the challenges healthcare providers face in the context of limited medical supplies, inadequate pay, lack of support from administrators, and how they manoeuvre to provide the best care possible to patients (Street 2014; Kwesigabo 2012; Wendland 2010; Sullivan 2011; Andersen 2004; Martin 2009; Mattes 2016). While these are quite important and help us to understand more about the experiences of healthcare providers particularly in Africa, another body of studies is increasingly focusing on how guidelines to providing healthcare services may result into challenges to healthcare providers in particular contexts (Mattes 2016; Whyte at al. 2010). Adding to both of these strands, I have shown how the healthcare providers dealt with various challenges in the provision of maternity care and how guidelines in the implementation of the maternal referral system were the main source of problems for the healthcare providers. The implementation of the maternal referral system challenged the moral stances of individual healthcare providers and disrupted personal and working relationships in the village dispensaries in Lalta. I propose that the impacts of global health guideline to the provision of healthcare services among healthcare providers in particular contexts need more representation in anthropological scholarship.

This study is also a contribution to the growing body of anthropological scholarship that challenges the abolition of TBAs in developing countries (Wendland 2017; MacDonald 2017; Choguya 2014; Berry 2010). It is also an important addition to anthropological studies on CHWs in Africa especially for maternal health, which are still limited. The ones available do not specifically focus on maternal health (Rafiq 2019; Maes 2017; Gottier 2018). In accounting for both challenges and the struggles of TBAs and CHWs in serving pregnant women in Lalta, I critically analyzed the viability of the abolition of TBAs, their changed role and the subsequent introduction of CHWs (who overtime were expected to replace TBAs) as well as the challenges of collaboration between the two types of health workers. Like in other studies (Wendland 2017; MacDonald 2017; Choguya 2014), I have shown that women sought birthing services from TBAs

despite being discouraged from doing so and challenged the access of CHWs into their lives. The shift from TBAs to CHWs which was expected to reduce maternal mortality, is one of the examples of a magic bullet intended to fix historical, cultural, and structural problem of maternal mortality in developing countries.

8.4 Recommendations for Policy Makers and Health Administrators

Upon request, the Ministry of Health in Tanzania allows the presentation of research recommendations in their policy briefings. While I am yet to do that but planning to do so in the near future, based on the findings of this study I hereby present recommendations for policy makers and health administrators that I think might have positive impacts on women's experiences of biomedical maternal healthcare services and reduce the challenges for healthcare providers.

A system of assisting women when family economies are vulnerable may increase consistence in the use of birthing services at the village dispensaries. One way of doing this is to make sure that the provision of free health services includes all the needed medical supplies. Otherwise women can be provided with delivery kits comprising all the necessary medical supplies needed during childbirth. Uganda has successfully distributed delivery kits, which as research shows, have motivated women to give birth in health facilities (Austin-Evelyn 2016). In the long run and in a broader sense, strengthening rural economies in terms of supporting the people with agricultural extension services, and sustainable markets for their produce will increase family stability and the use of the available services. Empowering women and enabling them to engage in small trading activities may help them to contribute to the family income and increase their negotiation power about maternal health and the choice of care. In urban areas, there are many initiatives of small loans to support women to start small businesses; such services should be extended to rural areas as well.

In addition, allowing all women (regardless of the maternal risk categorization) to give birth in the village dispensaries without implicating healthcare providers in case of a maternal death will give a chance for more women to get birthing services in the village dispensaries. Many of those

who were advised to go to the referral hospitals gave birth without complications, at home, in the referral hospitals or village dispensaries. Women should be asked to go to referral hospitals before the onset of labour only when healthcare providers are certain that a complication will occur. Otherwise, I conquer with Pembe et al. (2008: 129) who suggest that for referral care transport should be readily available in case of emergencies. This is quite important because even those women deemed safe to give birth at the village dispensaries can develop complications. If women must go to the referral hospitals before the onset of labour, then conditions in maternity waiting homes should be improved to include the provision of food and the expansion of the living space. Services provided in referral hospitals also need a serious review for women to be encouraged to go. This entails the availability of medical supplies and sufficient medical personnel.

It is important for District Councils which are responsible for the administration of health services at the district level to have review teams that will periodically assess the manner in which maternal health services are provided and identify areas that need improvement. A very close follow up is made in both village dispensaries and referral hospitals when maternal deaths occur, but the same does not follow to explore the challenges healthcare providers face and how they provide the services. Review teams can also be a catalyst of initiating action when researches identify areas that need improvement.

There is also a need of emphasising on postnatal care (PNC), which as it is a now focuses mainly on newborn care and family planning. Despite the acknowledgment that about 40 percent of maternal deaths are a result of postnatal complications, PNC still remains one of the least emphasized aspects of maternal health (WHO 2013: 6).

Furthermore, considering the well-being of women and the current situation in which the available medical facilities cannot cater adequately for the needs of women, it is important to let TBAs continue to assist women during home births. Moreover, restricting their activities has not stopped women from seeking for their services. Specifically, looking at how TBAs and CHWs fulfilled their duties in Lalta, the experience and trust women had on TBAs, it may be more

worthy and viable to let TBAs do the work that is assigned to CHWs while looking for long-term solutions to the problem of insufficient healthcare providers.

Finally, the emphasis on the use of modern family planning methods has resulted in a blind eye on natural methods of fertility control. During ANC visits and after birth, women were advised only about modern family planning methods, except for Mshikamano Hospital due to its Catholic stance, the use of natural methods was emphasized. Most women despite the fear of using the methods wished to avoid becoming pregnant especially during the breasting feeding period. Natural methods of family planning such as withdrawal, the use of breast-feeding, and the use of the calendar were identified on posters in the village dispensaries but were not mentioned to women. I understand the intention is to meet the national goal of increasing the use of modern family planning methods, but where such methods are not well received, the teaching of natural methods is salient.

8.5 Areas for Further Research

Currently, CHWs are up in the global and national agenda of reducing maternal mortality towards the target set by sustainable development goal number 3 (SDG-3). They are now formally trained for 9 months, and from 2016, the government in collaboration with other organizations started deploying them in rural areas with salaried income (THET 2020). In the present study, I focused on voluntary CHWs who had a two-week training on MNCRH in 2013. In the light of various challenges faced by healthcare providers and voluntary CHWs, it might be interesting to understand the experiences of trained CHWs by using ethnographic research and an anthropological perspective in terms of how they are selected, components of their training, the kind of services they provide, collaboration with healthcare providers, the challenges faced, and the views women and communities have about them. This may be significant in ascertaining the contribution of this category of CHWs in the reduction of maternal mortality. The available literature on CHWs for maternal, newborn, and child health particularly in Tanzania is dominated by public health studies using a mixed method approach (Kanté et al. 2019; Geldsetzer et al. 2019; Lema et al. 2014; Shelley et al. 2018; Shelley 2017; Roberton et al. 2015).

Research on rural areas with close access to comprehensive and emergency obstetric care (CEmOC) may give a broader picture on how the expansion and upgrading of the health facilities work in rural areas, what happens in these health centres, and what it means for district/regional hospitals which are grappling with huge workload. Uvinza District in Kigoma region has five health centres in rural areas providing CEmOC and may be an interesting area of study. This may give a broader picture on the question of availability and uptake of maternal health services beyond what is presented in this study.

Burdening healthcare providers with the responsibility of maternal death has added to their many problems particularly for those in referral hospitals. With limited time spent in the two referral hospitals, I did not investigate how healthcare providers handled the occurrence of maternal deaths, how maternal deaths affect them as individuals, their relationship with administrators, and their implications for the provision of birthing services. Furthermore, the ending preventive maternal deaths plan (WHO 2015) requires the recording and detail reporting of maternal deaths on daily basis. This mostly likely put more pressure on healthcare providers. Such a research will add more knowledge on experiences of healthcare providers particularly on their individual experiences of maternal deaths and strategies they use to handle them.

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Appendix

THE UNIVERSITY OF DAR ES SALAAM

DEPARTMENT OF SOCIOLOGY AND ANTHROPOLOGY

Consent to Participate in the Study

My name is Anitha Tingira from the University of Dar es Salaam. I am also a Ph.D student at Free University of Berlin, Germany. I am researching about the provision and uptake of maternal health services in Lalta Ward. The findings of this study will be included in my doctoral dissertationa and other planned publications.

Purpose of the study

The study aims to collect information of the provision of maternal health services and how women and their families make decisions and use the available services. It also seeks to understand the lived experiences of healthcare providers, community health workers and traditional birth attendants in the provision of biomedical maternal healthcare services and interventions. In addition, the study intends to capture views of different actors such as health administrators, non-governmental organizations' representatives, religious leaders, traditional healers, and village leaders.

What participation involves

If you agree to participate in this study the following will occur

You will sit with me for an interview and you will be requested to answer questions that I have prepared for the study in order to obtain the intended information.

The interview will take approximately 40 - 60 minutes and will be audio recorded. The questions are constructed in a semi-structured format that allows you to be flexible, and follow up questions will develop from your responses.

Confidentiality

I assure you that all the information collected from you will be kept confidential. Only my supervisors and I will have access to the raw data. I will ensure that any information included in my report does not identify you as an informant as I will not put your name or other identifying information on the records of the information you provide.

Risks

No risk is foreseen in this study. However, at any moment if the questions make you feel uncomfortable you may refuse to answer and you may stop the interview at any time.

Rights to withdraw and alternatives

Your participation in this study is completely voluntary. If you choose not to participate in the study or if you decide to stop participating in the study no harm will come to you. You can stop participating in this study at any time, even if you have already given your consent.

Benefits

There are no direct benefits for your participation in the study. I, however, think that the information you provide will help to inform individuals planning maternal health interventions.

In case of injury

I am not anticipating that any harm will occur as the result of your participation in this study.

Compensation

There will be no compensation of time spent during the interview; however, your participation is highly appreciated.

Who to contact

If you have any questions regarding this research study you may contact the following:

The Chair
National Health Research Ethics Review Committee
The National Institute for Medical Research (NIMR)
3 Barack Obama Drive
P. O. Box 9653,
11101 Dar es Salaam, Tanzania

The Local Supervisor
Dr. Joyce Nyoni – +255 603 113

CONSENT

By signing this consent form, I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to me. I voluntarily agree to participate in this research study.

Name of Participant___________________________

Signature of Participant________________________ Date _____________________

Name of the Researcher________________________ Date______________________

CHUO KIKUU CHA DAR ES SALAAM

IDARA YA SOSHOLOJIA NA ANTHROPOLOJIA

Fomu ya Kuomba Ridhaa ya Ushiriki Katika Utafiti

Habari, Jina langu naitwa Anitha Tingira. Natokea chuo kikuu cha Dar es Salaam. Pia ni mwanafunzi wa shada ya uzamivu katika chuo kikuu kilichopo mjini Berlin, Ujerumani. Ninafanya utafiti juu ya utoaji na utumiaji wa huduma za wakinama wakati wa ujauzito na kujifungua. Taafira za utafiti huu zitatumika kwa ajili ya andiko langu la uzamivu na machapisho mengine.

Malengo ya utafiti

Utafiti huu una lengo kukusanya taarifa juu ya utoaji na utumiaji wa huduma za kinamama wakati wa ujauzito na kujifungua na jinsi wanawake na familia zao wanavyofanya maamuzi na kutumia huduma zilizopo. Pia nahitaji kuelewa uzoefu wa watoa huduma za afya, wahudumu wa afya wa jamii na wakunga wa jadi katika kutoa huduma kwa kinamama wajawazito na waliojifungua. Kwa nyiongeza, katika utafiti huu ningependa kupata maoni ya wadau mbali mbali kama, wasimamizi wa huduma za afya, wawakilishi wa taasisisi zisizo za kiserikali, viongozi wa dini, waganga wa kienyeji, na viongozi wa vijiji.

Ushiriki unahusisha nini?

Ukikubali kushiriki katika utafiti huu yafuatayo yatatokea

Utakaa na mimi kwa ajili ya mahojiano ili niweze kupata taarifa zinazohitajika kwa ajili ya malengo ya utafiti huu.

Nitakuhoji kwa takribani dakika 40 mpaka 60 na nitarekodi mazungumzo yetu. Nimeandaa maswali kwa mtindo amabo utakupa uhuru wa kujibu na maswali mengine yatatokana na majibu yako.

Usiri

Nakuhakikishia kwamba taarifa zote nitakazokusanya kutoka kwako zitakuwa ni siri. Mimi na wasimamizi wangu pekee ndio tutaweza kuona taarifa ambazo hazijachakatwa. Nitahakikisha kwamba taarifa za kwenye andiko hazikufichui wewe kama mtoa taarifa, sitatumia jina lako halisi wala taarifa zozote zinazoweza kukufichua.

Madhara

Hamna madhara yeyote yanayotegemewa kutokana na kushiriki kwako katika utafiti huu. Baadhi ya maswali yanaweza kukufanya usijisikie vizuri hivyo unaweza kukataa kujibu swali lolote na unaweza kujitoa kwenye usaili wakati wowote.

Haki ya kujitoa na mbadala wowote

Ushiriki wako katika utafiti huu ni wa hiari. Kama utachagua kutoshiriki au utaamua kusimamisha ushiriki wako hautapata madhara yoyote. Unaweza kujitoa kwenye ushiriki katika muda wowote hata kama ulisharidhia kushiriki.

Faida hakuna faida ya moja kwa moja itakayoipatika kwa ushiriki wako katika utafiti huu. Hata hivyo, natumaini taarifa utakazotoa zinaweza kusaidia katika kuandaa mipango ya utoaji wa huduma za kinamama wakati wa ujauzito na kujifungua.

Endapo utaumia

Hatutegemei madhara yoyote kutokea kwa kushiriki kwako katika utafiti huu

Fidia ya muda

Hakutakuwa na fidia ya muda uliotumika wakati wa kufanya mahojiano au majadiliano katika utafiti huu, ijapokuwa ushiriki wako katika utafiti huu utashukuriwa na kutathiminiwa sana.

Watu wa kuwasiliana nao

Kama kuna swali kuhusiana na utafiti huu wasiliana na

Mwenyekiti, National Health Research Ethics Review Committee
The National Institute for Medical Research (NIMR)
3 Barack Obama Drive, P. O. Box 9653, 11101 Dar
es Salaam, Tanzania.

Msimamizi wa ndani
Dr. Joyce Nyoni – +255 603 113.

Ridhaa ya kukubali.

Nimesoma maelezo ya fomu hii, maswali yangu yamejibiwa na nimeridhika. Nakubali kushiriki katika utafiti huu.

Kwa kusaini fomu hii ya ridhaa, nadhibitisha kwamba, asili na lengo, faida na hasara, zinazoambatana na utafiti huu zimeelezwa kwangu. Kwa hiari yangu nakubali kushiriki kwenye utafiti huu.

Jina la Mshiriki____________________________

Sahihi ya Mshiriki___________________________ Tarehe ______________________

Jina la Mtafiti_____________________________ Tarehe_______________________