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The maternity ward as mirror

Maternal death, biobureaucracy, and institutional care in the Tanzanian health sector

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Chapter 3: The Problematic Birthing Body: The Evolution of Maternal Healthcare Services in Tanzania and the Construction of the Problem of Maternal Death

3.1 Introduction

Birthing bodies have long been a site of governance, historically and across societies. In Tanzania, British colonists first took an interest in African birthing bodies in an effort to ensure conscripted labor and to (re)produce governable subjects or to gain access to and a favorable position among local populations. In post-independence, socialist Tanzania, reproduction was a part of nation building. Governments have long had an interest in reproduction for these reasons and more. I argue in this dissertation more broadly that today, the post-socialist Tanzanian state regards pregnant bodies as a site for the state to “perform” (Butler 1988) legitimacy and efficacy. This particular performance centers on improving the health and reducing deaths of pregnant mothers to accomplish goals set by the global community.

This aim is structured and facilitated by the UN’s Millennium Development Goals (MDGs), which are often used as a yardstick against which to measure progress in countries such as Tanzania. Achievement of the MDGs has become a proxy for the legitimacy of states and their healthcare institutions and can determine their worthiness for aid and investment. Accomplishing the MDGs has been complicated by the residual influence of colonial rule on healthcare institutions across Africa. In Tanzania, these colonial structures were subsequently transformed, but not replaced by, socialism, and neoliberal structural adjustment programs. This makes healthcare institutions a vital site for understanding colonial and post-colonial trajectories in the expansion of biomedicine as they intersect with today’s global system and the subjectivities of healthcare providers and patients.

In this chapter, I discuss the development of these institutions in Tanzania, as well as trace the origins and construction of maternal death as a global health problem, not simply a personal, community, or state issue. The historical data provide insight into the on-going challenges to healthcare institutions within Tanzania but also the Rukwa region more specifically. The descriptions of and from Ufipa in the first half of the 20th century demonstrate the important influence of geography on healthcare worker retention in that region of the country, while also describing the challenges Ufipa faced in building healthcare infrastructure. A second important message from the archival records, and which continues to resonate today, is the central role of the debate around home (domiciliary) versus institutional (hospital) births and the pros, cons, and challenges of each. Along with this debate came, at the time and continuing in the present moment, concerns about recruitment and training of nurses, the role of local/indigenous midwives/birth attendants, and physical infrastructure-roads, transportation, and biomedical buildings. All of these debates continue to influence the Tanzanian health sector and, ultimately, the conditions at the Mawingu Regional Hospital.

3.2 The Development of the Tanzanian Medical System: An Overview

Starting in 1884, German trade companies began settling Tanganyika. Karl Peters' company, The Society for German Colonization, commenced official occupation of the territory in 1887 (Kinambo and Temu 1969:102). During this time period, the focus was not on forming Tanganyika as a settler colony but on extracting resources from the country in order to enrich Germany. Probably due to a low number of Germans actually living in the country, under German colonial rule between 1891 and 1919, only a relatively small number of hospitals were constructed and staffed; this included twelve general hospitals, the largest of which had a 75-bed capacity (Turshen 1984:140). These hospitals were largely for the support of the German army

garrisons and, later, for those colonial settlers who did take up residence in the country (Turshen 1984:140). Most healthcare services were for the use of the European population or were to be used in order to keep the African workforce healthy (Turshen 1984:141). This is in line with the colonial interests throughout the continent, which tended to be primarily focused on maintaining a sufficiently large labor force, both in urban and rural areas (Turshen 1984:35; Beck 1977). As late as 1910, nearing the end of Germany's presence in the territory, there were only 43 doctors serving the more than 10 million inhabitants of German East Africa (Beck 1977). In a 1910 letter, the German colonial secretary wrote, "A system of medical care for the blacks, even in the government sector of the medical services, does not yet exist. The introduction of such a system is our goal although the means to secure it will probably surpass the present capability of the protectorate" despite the fact that providing medical services was widely viewed as a crucial aspect of maintaining stable relations with the African population (as cited in Beck 1977:31). The Germans were slow to provide medical services to the broader African population largely due to a lack of doctors, funds, and lack of easy access to large, remote expanses of the territory (Beck 1977). The Germans also were unable to effectively leverage the missionaries throughout the country who were sometimes the only presence in the more remote areas of the country and often provided medical services (Beck 1977).

After World War I, the Treaty of Versailles, signed in 1919, awarded a large portion of the German protectorate in East Africa to the United Kingdom. The British inherited the roads, telegraph system, and the few medical buildings built under German rule, including a laboratory and hospitals in Tabora and Dar es Salaam (Crozier 2007:8). The British Colonial Service continued healthcare policies similar to those of the Germans until Tanganyika was incorporated into British East Africa, after which the colonial government reassessed its goals in the region

and sought to decentralize services and increase their accessibility to the local population (Crozier 2007:9). The local authority dispensary system was introduced in 1926, at which time the rural African population was included in curative medical services through small, basic-level healthcare facilities (Turshen 1984:141).

The organization of the health care system under the British largely remains intact to the present day, including the hierarchical organization of medical offices and administration (Crozier 2007:77). From the start, the British placed a great deal of emphasis on medical services as a fundamental avenue for accomplishing their goals in Africa. As Crozier (2007:3) writes, “In Africa especially, where health problems loomed large, successful medical colonization was recognized as one of the fundamental springboards by which to establish political objectives.” In 1895, with the appointment of Joseph Chamberlain as Secretary of State, the British Colonial Service underwent reorganization and streamlining in order to increase its efficacy. At this time, nearly one third of the Colonial Service was made up of the Medical Service (Crozier 2007:3). Each colony’s Medical Service was run independently, though the services in West Africa were consolidated under one regional administration in 1902. The British government did finally create a unified East African Medical Service in 1921 (Crozier 2007:5). Further reorganization followed throughout the 1920s, 30s, and 40s.

Under British colonial administration there were four types of medical care: government, missionary, industrial, and private¹ (Turshen 1984:141). This list, of course, does not include any sort of indigenous system of healing though the colonial healthcare system was imposed on top of a long-standing local healing system. Missionaries and colonial doctors worked actively to suppress traditional healing throughout Tanzania (Turshen 1984:145). The result of colonists’

¹ Because my research exclusively focused on government healthcare facilities, I will be limiting my discussion in this chapter to public sector/government healthcare services.

efforts to eradicate traditional healing was simply the denial of any sort of healing services to a majority of the population; available biomedical services did not begin to fill the resultant void and the general population most likely continued to utilize multiple methods to fill this gap (Turshen 1984:146). Due to continued poor coverage of primary healthcare facilities, people still sought care from multiple, concurrent healing systems while I was in the field². The national healthcare system consisted of three levels: central, provincial, and district administration (Turshen 1984:141), which would today be roughly equivalent to the national, regional, and district levels of management, respectively (United Republic of Tanzania 2003).

The Colonial Service directly recruited candidates for service in East Africa. Crozier (2007a) writes of the ways in which many British medical personnel viewed service in Africa as a route to adventure and a chance to play hero in a land sensationally portrayed as being full of danger and mystery. As healthcare expanded in British East Africa, there were increasing demands for skilled personnel, including medical officers and nurses. Unable to keep up with the demand solely with those European providers coming directly from the metropole, the Colonial Medical Service began to implement strategies for training locals for work in a variety of medical positions, including as health aids, ayahs (mostly working as cleaners), and eventually as nurses or nurse assistants. Sub-Assistant Surgeons (SAS) oversaw posts in areas not serviced by a European Medical Officer and reported to the Provincial Medical Officer. Sub-Assistant Surgeons were very often Indian and were recruited to the Colonial Medical Service in India. Until I was looking through the colonial records in the Tanzania National Archives in 2015 and repeatedly came across Indian surnames in the correspondence related to healthcare in Ufipa, I had not realized there had been so many Indian medical personnel working in British East

² Stacy Langwick has written extensively about traditional and biomedical systems within Tanzania.

Africa. Greenwood and Topiwala (2015:13) write that there has been very little acknowledgement of this population of medical professionals and “it is a little known fact that there were actually almost twice as many Indian doctors working for the Colonial Medical Service as Europeans” in the post-WWI era. Indian medical personnel were vital contributors to the healthcare system in East Africa well into the 1930s and 1940s.

The central government in the territory was responsible for preventive health services and these services were wholly independent from the curative services offered at all levels (Turshen 1984:143). Maternal and child healthcare fell under public health services, in addition to other services such as nutrition and health education and general sanitation. In 1961, just before independence, the central government was responsible for 71 prenatal care clinics, while local authorities were responsible for 204 such clinics and voluntary agencies controlled another 137 (Titmuss as cited in Turshen 1984:144). However, these prenatal maternal/child health (MCH) clinics were such a low priority that they did not even receive a separate line in the health budget (Turshen 1984:150).

3.3 Colonial Medical Service in Ufipa

The Ufipa plateau refers to what is now known as Sumbawanga town. Ufipa more generally connotes the lands of the Wafipa people, the predominate ethnic group in the area. Ufipa was part of the Western Province which was administered from Tabora. The Germans had left a research outpost and rudimentary port in the area in the vicinity of Kasanga, on the shores of Lake Tanganyika, which remains a village to this day. In the Ufipa District book vol. 2 from the Tanzania National Archives, the District Officer kept an account of the major happenings in the district throughout the 1920s. He writes that in 1922 the district headquarters were transferred from Kasanga to Namanyere and Kasanga subsequently became a sub-station. Of

note, also in 1922, “after many requests, a European Medical Officer was posted to Kasanga in January but was transferred again four months later.” The district book details the many challenges of working in this remote area of the country, including accounts of years in which those in the district had no access to mail or telegraph services for several weeks or even months at a time. Their best connection to the Provincial Offices in Tabora was via boat service on Lake Tanganyika. Whenever the steamer was out of commission for repairs, or due to other problems, the district could be effectively cut off from the rest of the territory. For example, in 1923, “When it became apparent that the Mwanza could no longer undertake carriage of mails, application was made for a regular overland service from Tabora. The postal authorities however were either unwilling or unable to arrange this and in consequence Ufipa was frequently several weeks without mail" (no page number).

In 1928, headquarters were once again moved, this time to Sumbawanga where they remained; the town is still the center of administration in the region to this day. However, the move did not coincide with an increase in communication or infrastructure for some time and in a 1929 report the District Officer wrote,

No steps have yet been taken to connect the new district headquarters at Sumbawanga with the telegraph line and it is understood that no proposals to this end are to be considered during the financial year 1930/31. The Postal Agency at Kasanga was closed. The posts and telegraphs office remains at Namanyere with an agency at Sumbawanga. (no page number)

These changes and the lack of coinciding improvements in infrastructure seem a harbinger of the region’s future; the area has faced many challenges in the area of financing and infrastructure. The region’s location on the country’s periphery made it particularly hard to access and this continued to be the case well past the turn of the 21st century, with nurses telling me stories of

walking for days in order to reach Mbeya to the east because buses were infrequent and regularly could not traverse the roads during the rainy season, and this was in the late 1990s.

In the late 1920s, the colonial government first began building and expanding the government health facilities in Ufipa. The records in the District Book from 1930 mention that, "Native Administration Tribal Dispensaries were set up during the year at Namanyere, Mpui, and Maji Moto (Mpimbwe) and proved a great benefit to the people." The Native Administration was expanded beginning in the mid 1920s as part of the increase in indirect rule in the Tanganyika territory led by the Governor, Sir Donald Cameron. Native Authority courts and dispensaries were run under the administrative oversight of local chiefs.

In 1929, the colonial government first built a hospital in Sumbawanga. Though it is referred to as a hospital in colonial correspondence, the descriptions of the buildings and services that were available do not conjure up an image of a hospital as might have been found in less peripheral outposts. In fact, just a matter of a few years after it was established, the hospital was already in need of repairs and expansion.

Memo from 20th February 1930

"The Honourable, the Director of Medical and Sanitary Services, Dar es Salaam

... I have the honor to draw your attention to the fact that a Native Hospital has already been constructed at Sumbawanga in 1929 out of the funds originally voted for building the new station. The District Officer's letter 2/H/219 of 31.8.29 addressed to your office refers.

2. The present hospital consists of wards, dispensary offices, kitchen, stores, etc. consist for the most part of thick green brick walls erected on ant proof course and with cement floors, thatched roofs, good wooden doors, and glazed windows.

3. Neither the District Officer nor myself had any idea that a further allocation for a Native Hospital was likely to be voted.

4. The present buildings if roofed with iron would last for years and it is submitted that instead of pulling down the present hospital and building again on the same site the money now voted should be used in roofing the present hospital and in erecting quarters for the hospital orderlies, native sanitary inspectors, and in adding such cement floors as may be required. If you require further information I will ask the District Officer Ufipa to

submit a ground plan showing the layout of the hospital and the size etc., of the buildings which were erected in 1929.

C.J. Bagenal, provincial Commissioner, Kigoma Province

(Tanganyika Secretariat TNA file 23853)

Unfortunately, the requests to finish the already-started hospital took many years to be approved and the initial amount of money needed was reduced further and further. Meanwhile, the weather conditions in the area, including a very long rainy season, continued to wreak havoc on the mud brick buildings. In a memo from October 12, 1932, the Provincial Commissioner wrote that the hospital had been built in semi-permanent style, meaning with sun-dried bricks and thatched roofs. The memo continues: "The erection of the new ward was also commenced; the construction being of sundried brick. The outmost walls reached the height of about 4ft and there the work stopped and the allocation lapsed." There were no funds for continuing the work on the hospital and the district officials were requesting permission to use the remaining supplies to repair the district officers house, "It will be necessary to reroof the district officer's house at once. The hospital is not in urgent need of a new ward, the work already commenced for that building may gradually be completed by tax labor and covered by thatch as the other wards." The memo circulated to various officials, one of whom commented, "Who asked for the new ward at Sumbawanga and why was it not built but left with 4 feet walls? And what is to become of the remaining £135 of material. F.J.D." The file (Tanganyika Secretariat TNA file 23853) continues in this manner with correspondence from the rest of the year about the mismanagement of funds, waste of supplies, and the general poor administration of the building projects in Sumbawanga, including the hospital and roads. The writers explained that the rainy season in 1930 had stopped work on the construction at the hospital and during that period, the monies lapsed, which meant they had not recommenced building in 1931, and needed renewed funds. Bureaucratic procedures prevented the quick completion of the buildings and they continued to deteriorate.

Despite these issues, the hospital was able to provide care for the local population and, as early as 1930, the Sub-Assistant Surgeon felt the district could benefit from maternal and child welfare services. However, he did not have enough staff members to support the expansion of services:

Ref. No. 39/N/30
The Hon. The Director,
Medical and Sanitary Services,
Dar es Salaam.
u.f.s. The District Officer,
Sumbawanga.

29th May 1930

Sir,

Estimates, 1931/32.

With reference to my No.38/N/30 of to-day's date submitting estimated requirements for 1931/32, I have the honour to request your consideration of the following matter.

2. It is felt that this district offers excellent scope for Maternity and Child Welfare work and an effort is being made to increase the usefulness of the local medical services in this direction. Situated as I am at present however I find myself handicapped through lack of staff. My own time and that of my two hospital orderlies is fully occupied with the daily routine of attendance upon inpatients and outpatients at the Sumbawanga Hospital.
3. If I were myself able to devote more time to this particular work I am certain that there would be a considerable increase in the number of women attending the hospital. As it is however the women show a natural disinclination to being attended to by my hospital orderlies and I am sure in my own mind that the possibility of this often deters women from taking advantage of hospital treatment.
4. It was at one time believed that there was a possibility of a Nursing Sister being posted to Ufipa but I understand that no such steps are proposed at present.
5. In this district it would be possible to obtain the services of native women, partially trained by the Sisters of the White Fathers Mission. If funds could be obtained for the employment of two such women, whose training could be completed at the Sumbawanga hospital, their services would be most valuable. The knowledge that such "nurses" were always available for the examination and care of women patients would do much towards achieving our object.
6. I therefore have the honour to solicit your favorable consideration of our needs in this direction and to ask that if possible a grant of Shs. 700/- may be made for this purpose, with under Sub-head, Maternity and Child Welfare, or alternatively by an increase in the allocation for Upkeep of Hospitals. The sum asked for would be sufficient to cover the salaries of the two women and the construction of suitable quarters.

I have the honour to be,

Sir,

Your obedient servant,
L. Coro, Sub. Assist. Surgeon.

The above letter was forwarded with strong recommendation from District Officer J.E.S. Lamb, who also referred, in his accompanying letter (Ref. No. 7/F/255 from May 30, 1930) to a previous discussion regarding the suitability of Ufipa for Maternity and Child Welfare work but acknowledging that it would be some time before a European Nursing Sister might be able to be appointed. In all other files available in the National Archives, it does not appear this ever came to pass. The letter from Lamb ends with:

It may not be found possible for some time to appoint an European Nursing Sister to Ufipa but I think it would be a great pity if existing conditions were allowed to continue longer than is really necessary. The appointment of two native nurses would go far towards improving matters and their employment would not involve any great expenditure.

However, there was no evidence in the archives that the station was provided with any of the staff requested. For many years, there are no further available records which indicate maternal healthcare was ever a priority in Ufipa.

In June 1933, one O.T. Hamilton stated he felt a new ward for the Sumbawanga hospital was now necessary because there were more inpatients needing accommodation than accommodation available. In December 1933, a Sleeping Sickness Officer corroborated this view and reported on the state of the Sumbawanga hospital:

Excerpt from letter No. s/12/3/1 dated 3 December 1933 from Sleeping Sickness Officer, Kahama, to D.M.S.S., Dar es Salaam
Sumbawanga Station and Hospital

The Hospital wards, six in number, have a total floor area of about 1350 sq. feet (two with 375 sq. feet each and four with 150 sq. feet each), a height of about nine feet and a bed accommodation at present of 32. The buildings are in poor repair but I understand than [sic] an estimate for current repairs is to be submitted to your office.

There is an insufficiency of blankets. Sumbawanga is an exceptionally cold station and I should suggest that heavy woollen [sic] blankets be provided.

At the time of my visit the number of in-patients was 32, but I am assured that there would be more if more accommodation and funds for Upkeep were available.

(TNA Acc. No. 450, Medical Dept. File 55)

Through these letters it is possible to see the environmental challenges that were particular to Ufipa and still exist, particularly problematic for building projects of any sort, which often must cease entirely during the rains. Additionally, nurses told me that the cold weather, still a characteristic of the region, led to poor hygiene because people did not like to bathe in cold water. Despite the weather and infrastructure challenges, the hospital continued to function and the next correspondence in TNA Acc. No. 450, Medical Department File 55 concerns the hospital a couple of years later in 1935.

November 9th, 1935
Remarks by Inspecting Officer

I went over the hospital with the District Officer yesterday. I am quite satisfied that Dr. Ghanekar is doing excellent work with the means at his disposal. I am glad to see that at last a new building has been approved, and that sufficient funds have been provided. I told the [District Officer] that I would arrange that a [Public Works Department] foreman comes down, or that, alternatively, the Prisons Dept. undertakes the work with trained staff. An operating table and certain other equipment seems necessary & I agreed to try to get this sent down. The sub-ordinate staff seems to be sufficient. The importance of keeping a first class S.A.S [Sub-Assistant Surgeon] with full equipment here must not be overlooked, as Ufipa generally & Sumbawanga in particular are beyond reach in any emergency.

Sd/F.J. Bagshaw
P.C.
Western Province
(TNA Acc. No. 450, Medical Department File 55/231)

As in past correspondence, it is plain to see that the colonial administration was concerned with the remoteness of the Ufipa district and this was a clear barrier to the expansion of medical services and providers in the area. In July 1936, the Sub-Assistant Surgeon, V.M. Ghanekar, wrote a letter to the Sleeping Sickness Officer in Tabora, outlining the repairs and infrastructure problems with the existing hospital in Sumbawanga. He said several walls were nearly hollowed out by white ants, the thatching needed replacing, and other floors and walls were in bad condition. He also stated that it was very cold in Sumbawanga and the in-patients needed fires

inside but, because the buildings were thatch, he wasn't sure if this would be possible even if proper fireplaces might be built. However, a few months later, it seems no progress had yet been made in addressing these issues and a subsequent letter vividly describes the shortage of appropriate medical supplies and equipment in these meager facilities:

Oct. 22nd 1936

Provincial Commissioner.

I inspected the hospital today and am sorry to find that the buildings proposed and arranged for last year are still in the air. I observe also that the S.A.S. Dr. Ghanekar must still operate on a kitchen table. The hospital generally does excellent work with the means at his disposal, but I wish that these could be improved. Dr. Ghanekar reports that Tribal dressers were sent down with Microscopes, but insufficient Microscopic equipment.

Sd/ F.J. Bagshawe

P.C. (TNA Acc. No. 450, Medical Department File 55/255)

These infrastructure and funding issues seem to not be simply a colonial administrative problem but continue to plague the current Tanzanian government. As demonstrated in the colonial records, what was once called Ufipa has long been an administrative challenge due to its isolation, geography, and weather. The area's peripheral location also made it a very difficult place to live for any person not from the area and continues to be a barrier to the recruitment and retention of highly skilled medical personnel:

Saving Telegram

To Primed, Dar es Salaam

From Tryps, Tabora

Saving No. 16/4/893

Ag. S.S.O.

25/7/1944

As you may remember it has been laid down that no Sub-Assistant Surgeon stays at Sumbawanga longer than one year. Mr. Shevade has nearly finished that period and I wish to move him. I should like to move Mr. Desai from Kahama, where a new broom is needed, to Sumbawanga. The move will take about a month as Liemba sailings govern these movements. Can you provide me with a relief S.A.S. for one month in the near future or must I make my own arrangements from my provincial staff? In that case would you object to my stationing a senior Hospital Assistant at Sumbawanga during the movement period.

Mr. Desai will probably try to refuse the transfer, everyone does, so do you approve of my arrangements or can you suggest any other arrangement.

Tryps. (TNA Acc. No. 450, Medical Department File 55/321)

The above correspondence from July 1944 marked the beginning of a period in which the district struggled to maintain sufficient senior staff at the hospital, with a high turnover rate for the Indian Sub-Assistant Surgeons. In order to try to prevent the absence of medical personnel entirely, the administration discussed other options, including downgrading the station so that it could be under the charge of a lower ranking, less skilled Hospital Assistant or African Assistant Medical Officer. The isolation, remote location, and lack of additional income generating possibilities all deterred more highly skilled people from accepting posts in the region:

TNA Acc. No. 450, Medical Department File 55/336

Saving Telegram

To Primed, Dar es Salaam

From Senmed, Tabora

Saving No. 16/4/973

Date 28 February 46

S.M.O.

Following the recent difficulties experienced by you in posting Sub-Assistant Surgeons to Sumbawanga I wrote to Dr. Cane for his opinion as to whether it should be reduced to a Hospital Assistant Station or possibly held by an African Assistant Medical Officer.

The difficulty for Asians there is lack of Asian society combined with lack of private practice, as you probably well know.

Dr. Cane's reply, recommending the maintenance of Sumbawanga's existing status, is attached for your information.

SENMED.

55/337

Memo (handwritten, some parts illegible)

From M.O. Kigoma

To SMO W.P. [Western Province]

23.2. 1946

Dear Wilkin,

In reply to your memo about Sumbawanga I should have been very happy simply to have been stationed there.

I am, however, possibly --- gregarious than some others, enjoy the more bracing climate of the highlands and have no special desire to supplement my pay by private practice.

If these Indians, who enjoy considerably higher pay and social position than in their own country (where I've had experience of them) are not prepared to serve in whatever station they are posted, it is preferable in my opinion to deal with them as with – and –in –of any temporary inconvenience-to let them return home.

...

I do not approve of your suggestions that Sumbawanga Hospital be put in charge – of a Hospital Assistant (or practitioner if available). This is a most responsible post-Europeans there also- and no hospital for serious cases or British nearer than Abercorn 100 miles distant. Communications and transport for patients to Kigoma only once in 3 weeks by Liemba.

Yours sincerely, Cane.

Cane emphasizes that the hospital was the only source of any medical care for many miles and therefore provided important services for both Europeans and the local population. The Rukwa region continues to cover a vast amount of land area and the hospital still continues to be a vital source of services in this remote area.

In July 1947, the Tabora Medical Officer wrote to headquarters in Dar es Salaam suggesting they no longer try to force Indian Sub-Assistant Surgeons to work in the Sumbawanga hospital because they were often unhappy and left. As a result, the Medical Office suggested they could 1) elevate the station at Sumbawanga, making the hospital a [European] Medical Officers' station, 2) make it an African Assistant Medical Officers' station, which would have decreased the hospital's capacities and services provided or 3) close the hospital entirely, opening a new facility nearer to Mpanda in the northwest. The reply came just four days later and suggested that closing the Sumbawanga hospital would be an untenable solution and posting a Medical Officer was not feasible due to shortages of staff throughout the territory. A month later, faced with further staffing complications, an African Assistant Medical Officer who was supposed to report to Sumbawanga was instead rerouted to another location and the district missed out on much needed reinforcements (TNA Acc. No. 450, Medical Dept. File 55/345,

55/347). The District Commissioner of Ufipa expressed great consternation in response to these decisions:

Western Province
Ref. No. 17/15/65
The Senior Medical Officer,
Tabora

District Office, Sumbawanga, Ufipa

Sumbawanga Hospital

I note with regret your decision to admit defeat over the staffing of Sumbawanga Hospital.

The handing over of the medical work of the District to an African Hospital Assistant is to complete the ruination of this already moribund hospital, while it is a serious set back to the native administration dispensaries which depend on the hospital for their supplies and technical advice.

Fortunately, there is one bright spot in the picture, Dr. Trant, now employed by the International Red Locust Control Service, is making her headquarters at Sumbawanga and has volunteered to supervise medical work at the hospital.

I have allocated to her the unused housing previously occupied by the Sub-Assistant Surgeon and she has already taken up her quarters there.

The arrangement, which I hope will meet with your approval, is that seriously ill patients from the International Red Locust Control Service labour force of 1,500 Tanganyika Territory natives will be treated in the Government Hospital by Dr. Trant who will use her own drugs when possible, but if forced to use any Government Stores will return them at the end of the Campaign.

Rations for International Red Locust Control Service patients will be provided by their supply organization, as will all necessary transport.

One room of the house occupied by Dr. Trant will be used as a ward for European patients if required.

Cooperation between the International Red Locust Control Service medical service and Government will be to the advantage of all concerned.

I shall be grateful for your approval of these arrangements.

Sgd. G.M. Martin
District Commissioner, Ufipa
(TNA Acc. No. 450, Medical Department File 55/354)

I have included Martin's entire letter here as an illustration of the complicated negotiations and the difficulties involved in staffing and maintaining the Sumbawanga hospital. Despite the passage of nearly seventy years, many of these challenges are still present in the Rukwa region. In this letter, too, it is possible to see the ways in which the District Commissioner of this remote outpost circumvented bureaucratic protocols in order to cover the staffing needs at the hospital,

by inviting the Red Locust Control Service doctor, Dr. Trant, to provide services and welcoming her to live in housing provided for government employees, which she was not. There are a number of letters which follow and in which others complain about Dr. Trant's presence, however the Senior Medical Officer in Tabora replied,

I have no information to give. No doubt it was a bright idea of the local District Commissioner; or else his way of trying to make the administration of our department difficult in order to take revenge on us, because we reduced his station in medical rank. That would reduce, in his view, his 'command'.

Stupid as this may read, it is the kind of thing certain administrators do in this country after being in charge of outstations for several years.

The matter is finished. No action is needed; mainly because the Abercorn office instructed their medical officer [Dr. Trant] to go to the Rukwa swamps and do her work among the personnel there.

(TNA Acc. No. 450, Medical Department File 55/356)

Reading the correspondence, it is also impossible to overlook the fact that Dr. Trant was a woman and, subsequently, it is hard to imagine her gender did not in some way predispose some of the men to dislike her, particularly the person who arrived to take over the Sub-Assistant Surgeon's house in the position of African Assistant Medical Officer and found Dr. Trant living in "his" house (TNA Acc. No. 450, Med. Dept. File 55/350):

Native Hospital,
Sumbawanga,
17/12/47

The Senior Medical Officer,
Western and Central Provinces,
Tabora

Sir,

I have the honour to report that as soon as I got to Sumbawanga I found a certain Locust Woman Doctor who is occupying the S.A.S quarter. When I went to see the D.C. the next morning, he told me that was going to stay for some months. I asked whether she was a Government Doctor, he did refuse and said that she was of the Locust Company. She is also working in the Hospital and she even done one amputation of the right leg of one In-Patient, assisted by me in anaesthetic [sic]. I have no house where to accommodate myself being a stranger here. Beside this, I came with one Hospital Orderly from Kigoma Hospital and instead of him staying into the H.O. John's house whom he came to relieve I had to take that small banda and staying in it where as the dresser has got no where to

keep. They are staying in one house with Harrison another Hospital Orderly. Please let me know, therefore, if this Doctor is entitled to be in the S.A.S. house or as to whether she is a Government M.O. as we have got troubles of houses here.

I have the honour to be,

Sir,

Your obedient servant.

Sgd. Y.K. Harawa.

Hospital Assistant I/C

Sumbawanga

In the correspondence, another writer laments that the Administration seems to be “once again dictating medical policy,” meddling in an area with which they do not have the requisite expertise, and goes on to say that “it is unfortunate that once again the Western Province figures in a clash over medical policy,” (TNA Acc. No. 450 Med. Dept. File 55/353) alluding to the fact that this area was notorious for difficulties related to medical administration, which, I would argue, is a sentiment that might extend to the present day in the western regions of Tanzania.

Records from the Sumbawanga hospital pick up again in the 1950s with descriptions from supervision visits. In 1951, Dr. Davies from Medical Headquarters wrote, “...I think we should be ready to ‘be in on’ this opportunity to get this very isolated station its new hospital which is so badly needed to replace the hovels at present called ‘the hospital’.” However, after this, it appears the hospital did not receive sufficient funds for several years and the new building projects were frequently delayed by the rainy season. Supervision of the hospital was often impossible due to the poor quality of roads and the lack of reliable transportation to the area, in addition to insufficient personnel. Present day district level health administrators in the region continue to use these factors to justify their infrequent visits to village dispensaries.

The following excerpt seems to encapsulate the Sumbawanga hospital and, once again, sounds as if it might have been written much more recently than 1953, because many of the challenges mentioned remained well into the 2010s:

From Safari Report July/August 1953 by Dr. J.S. Meredith- Sumbawanga District
Sumbawanga District

On returning from Lake Rukwa, I went to see Sumbawanga Hospital. This is steadily becoming more and more dilapidated and it must be very trying for any Medical officer to have to work under such conditions.

New wards are being built and the theatre is now in a reasonably satisfactory state. An Autoclave had just arrived and was in the process of being assembled. Drugs supplies had been in a very precarious position until shortly before my visit as there seems to be an inordinate delay in the transport to this outlying station.

At the same time, it is very hard for such a small station-so very far away- to have to bear the cost of transporting all their stores.

Dr. Akim, the A.M.M in charge, was of the opinion that he did not have enough work to do but did not seem to realize that in a station which for so many years has borne a bad reputation in the district, so much depends upon he, himself, making work. He does not inspect the Native Authority Dispensaries and without transport, of course, this is not surprising. However, I do feel that he could arrange to travel around occasionally with the District Commissioner or some other local person. (Original 1554/2C)

The cost of transportation has, naturally, decreased in recent years, particularly with better infrastructure, however the burden of transportation costs often continues to fall on district or regional health budgets due to decentralization. Additionally, as will become clear in later chapters, the bad reputation of facilities providing poor quality care (or no care), for a variety of reasons, continued to be a barrier to the expansion of the uptake of services in the Rukwa region for many years³. Supply chain problems can rapidly create severe shortages of medications and equipment in the region and were often caused by the cost and logistics involved in transporting goods so far away from more centrally located distribution centers.

A great deal of building work was completed in the 1950s, including a modest operating theatre and it seems as though the hospital continues to be located in the same spot in Sumbawanga town, though it has gone through several updates and rebuilding projects. When I

³ However, starting in 2012, with the arrival of a new Regional Medical Officer and several physicians, care began to improve and the hospital's services have been increasingly in demand ever since.

first visited the hospital, I was told that the hospital had been built in the 1970s but these letters would appear to indicate the hospital has been at the same location since at least the 1950s. On the map, the road labeled “To Abercorn” is the same as the road leading to Mbeya and the road “to Boma” is still the direction of the road to the administrative offices for the districts, which are, most likely, also still located in the same place.

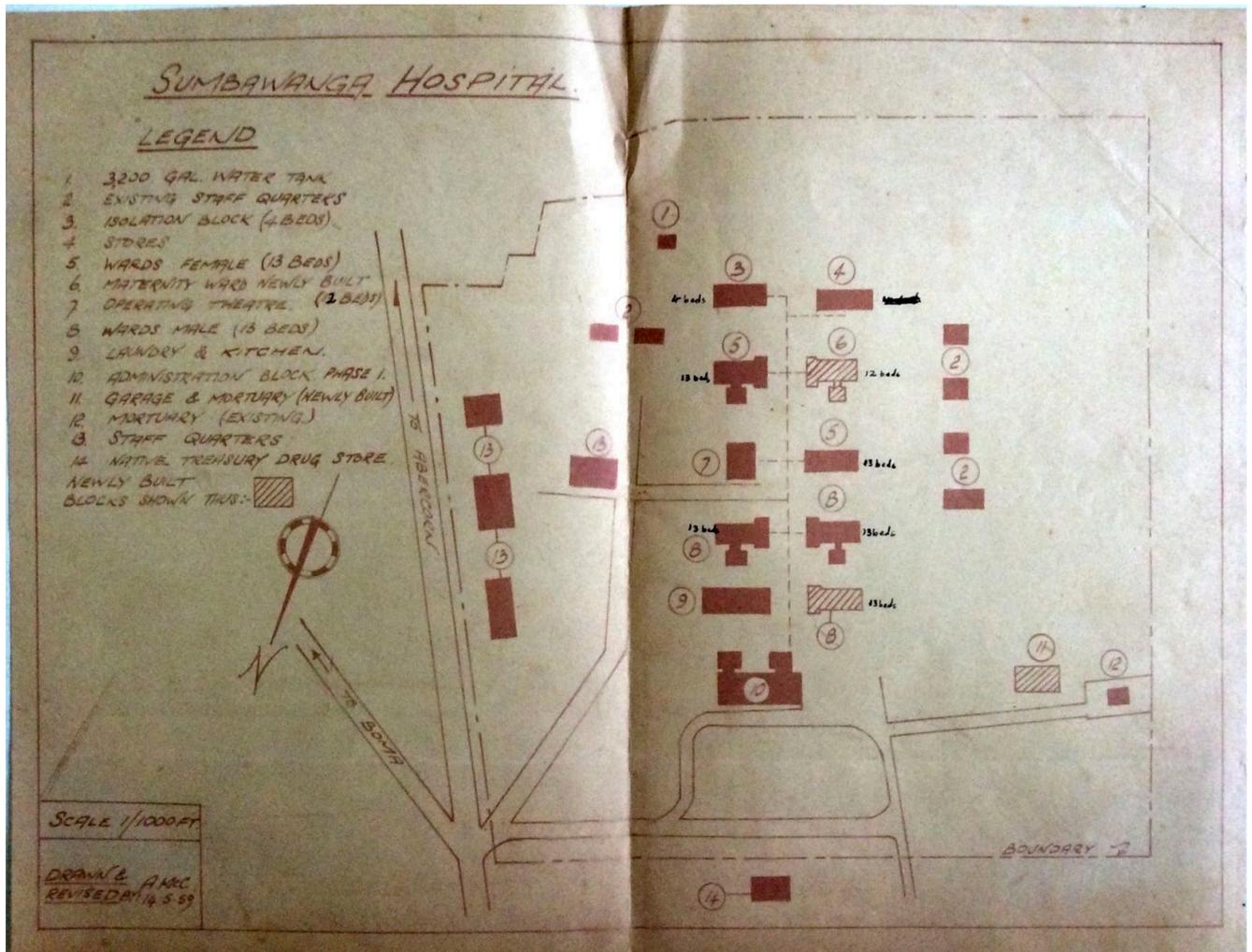


Fig. 3.1 Map of Sumbawanga Hospital plans, 14 May 1959, TNA Acc. No. 450, Medical Department File 55 inserts

3.4 Development of Maternity Services in Tanganyika

The primary debate surrounding maternal healthcare that is reflected in the archival record centers on whether pregnant women should be giving birth in hospitals or at home. This debate was framed in terms of institutional versus domiciliary birth and the colonial administration appears to have reversed opinion a number of times between the 1930s and the end of colonial rule in 1961. Parallel systems of services developed during this time. On the one side were services for European woman during their pregnancies and births, which even extended so far as to include conversations about reimbursing them for travel expenses to hospitals for “lying-in” close to the time of giving birth (TNA 108/9 Vol. II). Services for local women were not nearly as robust and were founded with fundamentally different goals, more related to educating locals in “mothercraft” and using medical services to bring the local population in closer contact with the colonial authorities.

One of the earliest mentions of maternal and child healthcare services in the territory dates to November 6th, 1926 and is part of a general accounting of the expansion of services in the territory. The document indicates that between 1921 and 1926, the number of Nursing Sisters in Tanganyika increased from 16 to 28; Native Hospital staff from 297 to 464; Hospitals from 31 to 52; and Maternity and Child Welfare Centers increased from zero in 1921 to 8 in 1926 (TNA Acc. No. 450, File No. 189/34). The issue of training personnel to provide maternity services became a pressing issue in the late 1920s. In the archival record, there are a number of documents related to the training of indigenous midwives, as well as those discussing the difficulties involved in finding and recruiting suitable candidates to train as domiciliary birth attendants. According to Allen (2004:27)⁴, the training of indigenous midwives in Tanganyika

⁴ Allen cites TNA file no. 10409 which may be one of the files that I repeatedly requested and was told the Archives staff were unable to find. In the intervening 20 years since Allen made use of the archives it

received a great deal of attention from colonial administrators in the late 1920s. There was some difficulty in finding suitable candidates to train as domiciliary birth attendants and there were no established training facilities during this period (Allen 2004:27). Due to these and other issues, the government decided to place the emphasis on moving births to the hospital so trained providers could oversee them in a more concentrated form; it was simply impossible to cover all the women if they continued to be dispersed throughout the community. However, this increased the workload in the hospitals and more healthcare providers were desperately needed. The district officer of the Shinyanga region recommended the administration train young women (ages 15 to 18) to provide help in the maternity wings of hospitals and clinics in order to augment the workforce (Allen 2004:27-28). Allen also cites further archival documents in TNA file no. 10409, which relate colonial officer's descriptions of "native" women giving birth at home, including suggestions that these women did not need the assistance of midwives as such (Allen 2004:28).

The archival documents Allen cites also include a great deal of discussion about the reluctance of families to allow their daughters to undergo midwifery or other training away from home (Allen 2004:27). This issue of training candidates and removing local girls from their homes continued to be a challenge even after training centers were formalized. Well into the 1940s and 1950s there are documents lamenting the difficulties surrounding recruitment of "suitable" young women for training programs. One file (TNA Acc. No. 450, file no. 314) includes many years' worth of documents assessing the suitability of candidates for training. The earliest documents are lists of "ayahs for training in domiciliary midwifery" and, in addition to listing their education and marital status, there are comments about the women's personalities

is not inconceivable that this file has been irretrievably lost, at least until some future time when the archives perhaps are moved to a new located and/or digitization occurs.

and perceived suitability for the job. Some comments include: “I think she is too old.” “Very careless.” “Very good practical worker. Don’t think she could do the lecture.” “Fairly intelligent, (inclined to be lazy) and cheeky. Unsuitable.” “Fairly intelligent-quiet manner. Fairly suitable.” “Very good worker.” The most suitable students were those women who were intelligent, but not too much so as to be defiant or “cheeky,” and hard workers who complied with orders and were generally clean (see chapter 7 for more on the idealized nurse).

3.5 Home or Hospital: The Start of an 80-year Conflict

In 1936, Dr. Mary Blacklock wrote a report entitled “Certain Aspects of the Welfare of Women and Children in the Colonies,” a copy of which was circulated among the Colonial Medical Service in Tanganyika. The original contained comments on native women’s education and their roles as mothers, describing baby shows and other training fora. In the responses to Dr. Blacklock’s report, the Governor of Tanganyika, Harold MacMichael wrote (TNA J/24840/15), in part:

4. The difficulty of obtaining suitable African candidates for training either in general nursing or midwifery has given much concern. Literate candidates for these duties have not in the past been available and many attempts to obtain them from missions have failed through the calls of matrimony or owing to the lack of suitable boarding accommodation and supervision of the girls when off duty. The female native staff of the medical department, whose members cannot yet be dignified by the name of nurses, are therefore mostly illiterate, though attempts have been made in some cases to teach them to read and write during training; but it will readily be appreciated that the technical training of native women of such a low educational standard cannot proceed very far. The difficulties are greater in the towns than in the country where serious efforts to train literate midwives have been made in Government institutions, unfortunately without a large measure of success. In certain missions, however, where the permanency of the staff and resulting personal influence with parents and girls render moral control and discipline effective, better results have been achieved, though even there the number of girls who carry on their work after completion of their training is negligible when the effort expended on teaching them is taken into account. For these reasons the training of health visitors has not been attempted.

Better results are appearing in the training of colored girls not of pure African descent. A small number of these girls is under training and they promise well; and provision has been made for expansion of this service during the present year. But I fear

it will be some years before the supply of even moderately competent native midwives and nurses can meet the great need throughout the Territory for work of this nature.

Maternity and child welfare work is carried on by women at twelve special clinics maintained by the Government and by missionary societies, some of which receive financial assistance for this work from the Government.

...

5. In short, while agreeing in principle with most of what Dr. Blacklock writes, it will, I fear, be several years before substantial progress in the education or employment of native women can be made in this Territory.

Harold MacMichael
Governor

It is clear that the territory's administrators were still struggling to generate an effective means of recruiting, training, and retaining local midwifery staff. Fundamentally, it was difficult to find candidates with the requisite levels of formal education. The recruitment of high quality, i.e. academically successful nursing school candidates continues to be difficult in present-day Tanzania. At the same time, local women were utilizing the services of the government's health facilities more and more, even for uncomplicated births (Allen 2004:29).

In the late 1940s, one of the medical officers stationed in Tabora, in Western Province began to propose a number of changes to the provision of maternity care in her province, as well as for the territory as a whole. Dr. Jackson extensively reviewed the state of medical services in her province, particularly focusing on maternal and child health services. Some of the relevant parts are included here:

Present Government Maternity Services

I. Aims and Methods. The first maternity services appear to have been instituted as one of the instruments for fact finding in a survey made from 1927-31 in Kahama- this place being chosen as a typical section of the native population. Women were encouraged to use the lying-in facilities provided; it was realized that institutional delivery of all women in Tanganyika would probably never be possible but the contact with the Africans at lying-in wards could reasonably be expected to be a valuable source of information as to beliefs and practices connected with women's and children's lives. Also it was considered that if large numbers of midwives were trained (and this can be undertaken only where an institution offers material for demonstration practice) the loss of lives in childbirth would be greatly reduced.

...

With the exception of the Sewa Haji Hospital, where proper attention is given to female out-patients, I consider that the plight of sick women and children is hopeless, even Hospital Assistants don't seem interested in them, and firmly as I am convinced that prevention of disease in children is of infinitely more value than patching up sick children and mothers, I consider that *it is essential to find some compromise in order that we may not alienate the familiarity and beginning of trust which Africans are starting to have in Western medicine*. This compromise can only be devised by people with experience of modern Western welfare clinics combined with a real knowledge of Africans among whom they work. With my English background I am more impatient of the practice of giving a dose of medicine of some kind to every woman and child attending the clinic, but most people who have much experience of African woman consider that to be necessary and the educated Arab and African men with whom I have discussed this feel that the idea of banning medicine from welfare work is too advanced for their women folk. (Emphasis in the original, TNA Acc. No. 450 File 108/9/169C)

It is clear through her letters that she, as a representative of the colonial administration, viewed the local women who were giving birth in hospitals as a source of information. She only tangentially mentions the possible outcome of institutional birth, and enough trained midwives, as a reduction in the deaths of pregnant women, the first time maternal death was specifically mentioned in the documents I reviewed. She then goes on to describe the types of services offered by the various religious missions in the area and states that their provision of medical services, particularly maternity care, is largely related to evangelism because "meeting mother at an impressionable time in her life, perhaps getting a response to evangelism as an act of gratitude so that mother, and through her, the family will be converted." Dr. Jackson noted,

Present delivery centers- Medical Department, Native Authority and Missions. None of these at present can be closed down for the resultant confusion and sense of frustration in the Africans who have been taught to value these centers for their medical and political and probably other unknown social values would make the Africans suspicious and uncooperative for years in any more useful service we may offer. I have discussed this eagerness to come to a clinic for delivery with all the Missionary workers I have met, with some members of the Administration and with some educated Africans and most of them consider that the main reason for women liking institutional delivery is that it is the only way in which they can evade traditional rites and practices. This is itself important as a beginning of throwing out old practices, but its importance is enhanced by the fact that among most tribes it is customary for people to go for advice regarding the care and upbringing of the child to the person who has had charge of the delivery. Some mothers are prepared to go for advice to the person who has given ante-natal supervision, but these are the people coming from homes in which they are allowed to be delivered in a

manner advised during pre-natal supervisor is ousted and supplanted by the traditional assistants and the care of the child is then directed by these traditionalists and the mothers are only allowed to take their infants to hospital when they become really ill.

(TNA Acc. No. 450 File 108/9/169C)

It is here that we can see the beginnings of what was to be a very long-lasting problem. Since the beginning, medicine had formed a central route to the good will of the local population. By bringing people to these services, it was easier to learn about their thoughts and practices, but also to track and surveil them. By changing the recommendations about giving birth in hospitals to refusing to serve women without complications or abnormalities, the colonial administration risked incurring the ill will of the local population. Just as Dr. Jackson feared in the 1940s, repeated changes in Tanzanian policy related to the roles of local, indigenous midwives and the roles of biomedical institutions have reduced people's trust in these facilities (chapter 4). Dr.

Jackson's recommendations included,

1. Institutional delivery should however be permitted. This compromise with the status quo is necessary in order that we may not alienate the familiarity and confidence already gained. It may even be necessary as one of the steps in development when we are in a position to expand Maternity and Child Welfare work in areas of the territory which have not yet come into contact with any such work. It is important however that the work of Maternity and Child Welfare clinics should not be judged by the number of institutional deliveries and that lying-in wards such as the present remote Native Authority "Clinics" in the Tabora and Nzega districts be avoided. European supervision and adequate ante-natal and infant welfare facilities are essential in any "clinic."
2. Institutional delivery of women should not be encouraged except for (a) abnormal conditions which should be treated in a maternity ward of a general Hospital which alone has adequate and Staff for surgical obstetrics and (b) a training school where nurses with general training are trained to staff maternity wards, and young women are trained before marriage i.e. a general training in hygiene and child care.

(TNA Acc. No. 450 File 108/9/169C)

Importantly, Dr. Jackson suggests that the overall success of maternal child health services should not be determined by the number of institutional deliveries. She also emphasizes the importance of facilities that have surgical capabilities. In these recommendations, she was well ahead of her time. She was highlighting quality of care over numbers, a concept which, in the

current era of randomized control trials and metrics, continues to highlight important tensions within biomedicine and at the policy level. Dr. Jackson's letter generated a great deal of interest and response, with some respondents accusing her of not being familiar with "the natives" and others very much in favor of her views and propositions. She was eventually moved to Dar es Salaam to run a training school and help direct the reinvention of maternal and child welfare services in the territory.

In February 1947, the Director of Medical Services wrote,

A survey of the existing maternity clinics is now in progress to determine how it may be possible to ensure that these objectives are attained. In the meantime, as a matter of policy, the establishment of new maternity clinics will not be encouraged, unless it is made clear to this Headquarters that:

- Personnel, time and facilities are available to allow for the full program
- This program is fully developed on record and understood by the Officers concerned
- The assumption of such additional duties as may be entailed, is without detriment to existing departmental commitments.
- Additional fiscal and building requirements are fully foreseen and within reasonable prospect of attainment either from public or private funds. (TNA 108/9/177)

The Director's letter draws attention to the need to ensure well-functioning facilities by not initiating their creation if their sustained support and access to funds and facilities could not be guaranteed. Unfortunately, this holistic approach to the expansion of medical services was not sustained as the demand far outpaced the available funds, facilities, and trained providers. From this point forward in the file there is a great deal of confusion about what Dr. Jackson's report, and the Director of Medical Services' response to it, meant for the actual provision of care for pregnant women. One representative letter reads:

TNA No. 108/9/178
11/1/369
The Provincial Commissioner,
Western Province,
Tabora.

10th February 47

Maternity Clinics, your No. 1550/9 dates 6th February 1947, refers.

No written instruction has been received from the Director of Medical Services, nor has any written instruction been issued from this office excluding normal confinements from the Clinics. It is possible that Dr. Jackson, whilst on safari, has issued such an order to individual clinics during her visit.

Such an order would be in line with the policy discussed with the Honourable, the Director of Medical Services during his visit here. The future policy would be aimed at encouraging ante-natal and child welfare work with the object of reducing maternal and infant mortality. To do this, it would be necessary to reduce the number of admissions of normal confinements, which do not benefit the country as a whole.

The object of ante-natal work is to ascertain whether the case will be normal or not, and to attempt to correct, before confinement, irregularities which may cause a difficult birth.

If you wish, I will ask Dr. Jackson, on her return from leave about the end of this month, whether she has in fact issued any such order. I have no doubt she has done so, and if that is the case I should agree with it.

Senior Medical Officer.

Later in February 1947, the Director of Medical Services again intervenes in the correspondence in an attempt to raise some concerns as well as to clarify directions for maternity care.

Your 11/1/369 of 10 February copied to me for reference: I do not of course know what action has in fact been undertaken by Dr. Jackson, but my only apprehension rests upon the question of timing. The judiciousness of the pace of change must rest upon you and the person on the spot. I do not advocate timidity but I do suggest that sudden revolution is not sound tactics.

- The general principle that the interests of the abnormal pregnancy are paramount to those of the normal is reasonable, but to refuse midwifery attention to the normal with the hope that the abnormal will occupy full time attention is in my opinion, unsound. I would be prepared to support the criterion of all "comers" within a specified radius from a clinic to which you could expect the resultant infant to be brought in weekly or fortnightly, or at such other interval as may be appropriate. Those mothers who fail without good reason to collaborate, should be listed and in future pregnancies, if normal, should be penalized to the extent of offering ante-natal services only; not delivery services. As for normal from distances beyond the practical "follow-up" required for infant welfare services, they might have the lowest priority for delivery services. Abnormals from a distance should have the same priority as any other abnormal. (TNA No. 108/9/180)

I include the above excerpt also in order to illustrate the tactics the colonial administration was trying to use in order to incentivize antenatal care and to limit institutional births. While Tanzanian women now nearly all attend the antenatal clinic at least once in their pregnancy (NBS and ICF Macro 2011), only around half give birth in health facilities. It is plain to see that inconsistency and reversal of course have long plagued maternal and child healthcare efforts.

3.6 Village Midwives, Home Births, and Transportation

The debate picked up once again in the 1950s. In 1950, the Provincial Medical Officer of the Lake Province refers to suggestions to train “village midwives” in order to increase the services available to women giving birth at home and to expand the rural midwifery services:

The “village midwife” should therefore combine the functions of assisting in delivery with those of the “health visitor”. If she is to do her two jobs properly her sphere of activity must be strictly limited. She must be acceptable to the local population, which implies that she should be a local resident of mature age. She will therefore probably be married or a widow and have a family of her own to look after. Such a person is unlikely to be able/supply the needs of more than 100 families. (TNA No. 314/127)

In addition to not having the space and trained staff to support institutional deliveries, the Provincial Medical Officer and others, including Dr. Jackson in her earlier letters, saw domiciliary births as a way to gain entry to local women’s homes and thus provide them further education on topics such as hygiene and child rearing. The full text of the above letter is included in Appendix F, item A. In other areas of the territory, including Tanga on the east coast, there were other ongoing efforts in 1950 to encourage domiciliary birth and provide women with someone to check on them during their births or shortly afterwards (TNA 314/131 text included in Appendix F, item B). One of the most important aspects of the schemes designed to support home birth was appropriate transportation for the nurses, aids, or others who were meant to be providing these services. Without an ability to reach the women in their homes, the whole scheme would be for naught.

The challenge of providing transportation for the purposes of helping women give birth at home proved to be a serious limiting factor. I was once relating to a Tanzanian colleague this idea of nurses in villages visiting women in their homes, possibly going by bicycle, and the person with whom I was speaking began laughing. The thought of a Tanzanian nurse mounting a bicycle in order to visit women in their homes was unthinkable. Needless to say, this model did not last into the post-Independence era. The Regional Assistant Director of Medical Services in Tabora, Dr. Keevill, wrote a lengthy response to the original letter outlining the rural midwifery expansion plans (Appendix F, item C) and several of his main concerns were related to the fact that many local women had come to prefer institutional delivery. He did not imagine there would be any objection from the local Native Authorities:

There is no doubt that the Native Authorities would welcome a “Midwifery Service.” The local members of Barazas always know what to ask for in order to be regarded as “progressive;” it is not at all so certain that the rural African women are at present making much demand for domiciliary midwifery. That the need exists there is no doubt at all. That it is a tough fight to get the women to accept what we think is good for them is also without doubt. (TNA 314/133 and 133A)

In later correspondence, the same Regional Assistant Director of Medical Services, mentions the fact that many of the Native Authorities take pride in constructing the buildings for clinics but then are unable and/or uninterested in maintaining them once, “Their prestige has gone up, they are now regarded as ‘progressive,’ so why worry if the place is falling down or if the dresser is openly taking bribes or indulging in malpraxis [sic].” This short excerpt from the Assistant Director’s letter ties biomedicine to “modern” or “developed” identity construction, which continues to figure into biomedicine’s role in Tanzania to this day. Additionally, he writes of bribes and malpractice, topics which repeatedly arose in community focus groups in 2015 (chapter 4). This evidence suggests these problems may consistently ride the coattails of

biobureaucratic expansion in whatever era, particularly when the expansion occurs in a haphazard, erratic way without the necessary supervision, supplies, and support.

The Regional Assistant Director of Medical Services cites the government's ability to assist in running these facilities as being limited by a lack of sufficient funds, tutorial staff, supervisory staff, and communications and writes,

Some comparatively wealthy Native Authorities have funds available for the erection of dispensaries and clinics and do not seem to understand why the Medical Department does not welcome the multiplication of buildings. It needs to be explained to them that the provision of a building is usually the easiest and least important part of a medical service (TNA 314/136A).

Once again, here Dr. Keevill seems to be presaging the future problems that would follow the Tanzanian government for years to come, well into the time when I conducted my fieldwork. Empty buildings do not qualify as biomedical facilities.

Significantly, Dr. Keevill's first letter also includes a portion on the local midwives who were already operating in the area,

6. It may not be widely realized that there is already in existence a rural midwifery service. Each small area is served by African women who are recognized as the local midwives and who receive remuneration either in cash or in kind for their services. They are mostly illiterate but they have some accumulated local wisdom (not to be dismissed too contemptuously) and they are accepted. It seems to me that these are the women who should be taught, not midwifery but the elements of cleanliness, e.g. the importance of hot water and soap and the use of a nail-brush, even possibly the use of some harmless antiseptic such as Dettol to add to the hot water and to cleanse, if not to sterilize, the old safety razor blade or the traditional piece of "mtama" stalk with which the cord is cut. Such women would not look to Government or Native Authority for remuneration; they would simply have been helped to do better a job on which they are already employed. (TNA 314/133 and 133A)

Though this letter is from 1950, the wording regarding these "traditional birth attendants," as they would later come to be called, might be from the 1990s, down to the very use of Dettol, still in existence, and the feeling that these women should not expect remuneration from anyone (chapter 4).

3.7 Biobureaucracy and Abnormal Bodies

In 1953, the Colonial Medical Department in Tanganyika began to stress the use of institutional delivery services only in complicated, abnormal cases, in order to stem the increase of women without complications who came to the hospitals to give birth. In its focus on abnormality, the Colonial Medical Department was sanctioning health services, and the subsequent biobureaucratic expansion, on the grounds of a certain, biomedical definitions of deservingness and need, predicated on deviations from the normal, which are notoriously hard to determine in pregnancy. These decisions had repercussions for years to come and fundamentally undergird the approach to maternal health services that still persists and continues to trouble Tanzania today. A representative description of the challenges and decisions, from July 1953:

2. You will see that the doctors are now of the opinion that we have now reached the stage when maternity services should concentrate more on domiciliary visits than what they call "institutional midwifery" and which to us laymen means "maternity clinics."
 3. Probably none of the Assistant Directors of Medical Services will have been on the service long enough to recall that great efforts were made by the Provincial Administration, at the request of the Medical Department, to encourage African women to go into maternity clinics. The success of those "institutions" is a tribute to the work of the administrative officers in the districts concerned. It may not be as easy as the doctors imagine to reverse this teaching and encourage women to stay at home rather than go to the clinics. However, I think we will all be glad that matters have reached this stage and will agree that, if it is practicable, we should adopt this policy.
 4. I should very much like to know your views on the matter.
- M.S.S. (TNA 34300/74)

Local, African women had been disciplined into compliant colonial subjects, trained to attend maternity clinics and give birth in institutions. Reversing the decision to encourage institutional deliveries most likely raised complicated negotiations about the role of care. Additionally, these systems and policy reversals were laying the groundwork, producing the conditions that continue to privilege and disallow certain forms of maternity care throughout Tanzania. In response to the above letter, many of the provincial commissioners responded and most were skeptical of the changes, citing reservations linked to the economy of institutional services, the greater ability to

control services when provided in an institution, and the ongoing lack of enough personnel to adequately undertake home health visiting, particularly in the most remote areas (see Appendix F, item D for further information).

At this point in time, the colonial government proposed five changes in maternity care: 1) an emphasis on prenatal and postnatal care with hospitalization only for complicated maternity cases, 2) a curb on the “uncontrolled expansion” of institutional midwifery services, 3) encouragement of home births for normal cases, 4) development of domiciliary services in rural areas, and 5) the training of “native” midwives for domiciliary work (Tanzania National Archives 34300). This reversal of policy was, in fact, a clear harbinger of the future indecision that would mar both national and international policy recommendations concerning maternal health, extending to the present day. A few years later, the 1957 Annual Report from the Provincial Medical Office in Tabora for the Western Province stated that, despite the change in policy, hospital deliveries continued to increase and, “Deliveries at home unfortunately have not increased, and there are still large numbers who have delivered before the arrival of the Midwife” (TNA Acc. No. 450, File No. 1614/8A). It was clear there would be many challenges on this front for years to come.

3.8 Healthcare Services after Independence⁵

After independence, there was much debate in Tanzania about how best to provide health care services for the population (Turshen 1984:194). The country’s First Five-Year Plan was issued in 1964 and it focused on the achievement of self-sufficiency in health personnel requirements, raising the national life expectancy from 35-40 years to 50 years, and increasing

⁵ At this point in history, starting around the Independence era, there are many fewer documents available at the National Archives. I was told many of these files had not yet been released for the public. One alternative would have been to try to gain access to the Ministry of Health’s archives, which would be a route for future study.

per capita income (Tanzania Ministry of Health [MOH] 1990:1). The First Five-Year Plan also sought to establish a regional hospital with specialist and surgical medical care in all of the regions of the country (Tanzania MOH 1990:1). The emphasis at this time was on improving hygiene, environmental sanitation, and child nutrition (Tanzania MOH 1990:2), which might be seen as an extension of similar efforts by the British and the Germans to “civilize” and “develop” the country. Services initially focused on curative care, which did little to effectively improve the health of the population when what was really needed was a comprehensive approach to preventative services, in addition to the improvement of curative care (Turshen 1984:195). An undated speech (most likely from 1964) given by the Minister for Health, D.N.M. Bryceson, around the time of the launch of this Five-Year Plan starts off thusly:

As we plan how we are to fulfill this in the future, we are fortunate to have the report and recommendations of the Titmuss Committee to guide us. This small expert committee came at the end of 1961 as a result of a request which I had made to the African Research Foundation. The Chairman was Professor Titmuss of the London School of Economics.

This group recommended that we should do a certain reorganization of the health services in order to do two things:

1. to make the maximum possible use of all our available resources-of central government, local government and the voluntary agencies;
2. to ensure that a particular emphasis would be placed on health education and the preventive aspects of medicine. (TNA HE 1172)

Here, the emphasis on preventative services is plain to see. I have included the other excerpts from the speech in Appendix F, item E. In summary, the speech also included plans for financing the medical services portion of the Five Year Development Plan. The Minister covers many topics, including training of personnel, but the primary message is on the move to decentralize services and focus on reorienting attitudes in favor of preventing disease and illness via improving hygiene, vaccination rates, and the like. In a circular on “Training of Nurses” from July 1963, there was a focus on training medical personnel in order to be able to replace the large number of expatriate nursing staff who would soon be leaving Tanganyika. The circular

emphasizes the lack of personnel as well as the lack of information about the number of village midwives and their activities (TNA HE 1172).

In a memo dated May 18, 1964, Minister of Health Bryceson wrote to all healthcare providers to tell them their roles in helping to support Nyerere's Five Year Development Plan (Appendix F, item F):

After explaining a number of policy matters, Mwalimu ended with his call to the Nation- It can be done. Play your part. [Fanya wajibu wako]

Now what does this plan mean to the Health services and what is our part. But before turning to that I should like to make it clear that in the context of this Development Plan, each of us has two roles to play.

One is a personal individual one- for this is a plan of the people, conceived by the people assisted by our planning experts and dependent on the all-out individual effort of each person. So it is the duty of each of us as a member of society to take part in nation building projects which have an important place in the plan. All over the country there are development committees. It is incumbent on each of us to assist in the work of development through discussion on those committees where that is appropriate, through energetic and enthusiastic participation in community development projects as they are started and whatever form they take, and through personal effort and contribution of particular skills or knowledge. Being a laboratory assistant does not relieve you of the duty of cultivating a communal shamba, being a doctor does not mean that you should not help make a new road, being a nurse does not stop you from teaching young or old people to read and write and count. Whatever the development we, as citizens of a progressive society, have our personal parts to play and it is our duty to play our part and, playing, encourage and assist others to do theirs too. (TNA HE 1172/67)

I also include this excerpt to demonstrate the ways in which socialist rhetoric was deployed in this period. While none of the healthcare personnel with whom I spoke had begun their studies or practice in the 1960s, their accounts of their time studying or working under Nyerere reflect the rhetoric used here. The healthcare sector was an important cog in the machine of Ujamaa socialism. Bryceson ends his memo by saying,

We are responsible for the health of the nation. The attainment of the broad aim of an increase in life expectancy is dependent upon our efforts. The very target of an improved standard of living is dependent to a large extent on the success of our teaching. I know that our medical workers, of all grades both in the Ministry and in the Voluntary Agencies are already hard worked. Nevertheless, I am asking for more time, more effort- particularly and specifically in the field of preventive medicine. (TNA HE 1172/67)

Particularly in light of my conversations with providers regarding their memories of working in healthcare during the Nyerere era, I am led to believe that this rhetoric, which invokes providers as key actors in nation building, imbued them with a sense of purpose and responsibility which those currently working do not feel as strongly. The more diffuse 21st century rhetoric of development and human rights simply does not resonate as strongly on the local level and therefore is not the same kind of motivator for working hard under difficult conditions. One of the retired doctors I interviewed told me,

Then now, health, it was- we were very strict. With what? With that knowledge. Truthfully, the knowledge that we got, those of us in the beginning, is totally different than now. The knowledge currently is different, and our attitude and that of those who are leaving school nowadays, it is different. Mmm. And us, that quality, it has declined a bit, if you compare with Nyerere's time.

Another provider who had started her career in healthcare under Nyerere said, "Work accountability, people were really working very hard. People had respect and they had love. That is different than what you see [these days]." There were others who also told me they felt that during Nyerere's time the healthcare facilities had been better stocked with the supplies that were available during that period and, overall, healthcare providers were more focused on providing care as opposed to trying to make money. Enriching oneself for personal, rather than national or community, profit was antithetical to the mission of Nyerere's Ujamaa.

With increasing villagization, and its attendant population density, after the Arusha Declaration in 1967, it became easier for the government to provide rural populations with healthcare services. The Second Five-Year Plan, initiated in 1969, after the Arusha Declaration, emphasized the socialist ideals of equitable distribution of, and access to, social services and resources in the country (Tanzania MOH 1990:2). The Second Plan paid more attention to preventive services aimed at curbing the spread of communicable diseases (Tanzania MOH

1990:2). There was still no targeted focus on maternal or maternal child health at this period in the country's development. However, the ideology of Ujamaa and self-reliance led to government efforts to increase equality and social justice, and to minimize conflicts within the country (Campbell and Stein 1992:5). These efforts took the form of social programs and welfare initiatives, which included providing education, rural health services, and clean, running water in the Ujamaa villages (Campbell and Stein 1992:5).

Some sources attribute a decline in the healthcare sector to Ujamaa socialism, citing it as an additional obstacle to improving the health of Tanzanians (Turshen 1984:195-201). According to Bech et al. (2013), the socialist era also contributed to deteriorating work ethics in the healthcare sector. Starting with government guidelines issued in 1971, management of the healthcare sector began to fail and managers had only limited power to discipline workers (Bech et al. 2013). The “ndugu” or “brotherhood” concept, popularized by the socialist government in the latter half of the socialist period, had important implications for healthcare. Okema (1996: 36-46) relates corruption, inefficiency, indifference, and lack of necessary authority and discipline in the civil service to this concept, which had dire implications for government healthcare services and provider morale. However, the providers with whom I spoke, as reflected above, did not seem to remember the period in this way. It is true, however, that they would have been young and early in their careers at this time and therefore did not have administrative responsibilities and would be unable to reflect on those aspects of the system.

3.9 Maternal Health in Post-Independence Tanzania

In 1974, the Tanzanian government launched the first coordinated maternal health services. The coordinating team was comprised of the Ministry of Health, the National Family Planning Association (UMATI), and the National Women's Organization (UWT) and was appointed to

formulate a maternal and child health policy to be implemented throughout the country (Family Care International [FCI] 2007:76). This project also established a dedicated unit in the Ministry of Health, which was responsible for planning, organizing, coordinating, and implementing maternal and child health policies throughout the country (FCI 2007:76). At that point, the main policy objective was to provide integrated health services to at least 90% of the population by 1980 via rural dispensaries and clinics (FCI 2007:76).

Donors had long been the primary contributors to funding for national health initiatives in Tanzania, particularly against the background of poor profits from cash crops on the global market due to the economically difficult period of the 1970s. During this period, much of the social services in the country were underwritten by foreign aid because the organization of the economy could not support these services and the material resources they required (Campbell and Stein 1992:5). By the 1980s it became apparent that the country's limited tax base would not be able to support the increasing health needs of the country (Lambert and Sahn 2002:120). The country's second president promptly accepted money from the World Bank and the International Monetary Fund in exchange for implementing structural adjustment plans in the country. Structural adjustment in the 1980s reduced provider wages and the number of new providers hired, and contributed to a general decline in living conditions and social service provision as the country was forced to reduce spending, particularly in these areas (Bech et al. 2013).

Donors had contributed to the failures of the public health sector, particularly in regards to the sustainability of the system. A lack of coordinated programming and communication had resulted in an inability to create a comprehensive national health strategy (Lambert and Sahn 2002:120). In 1988, the Tanzanian Ministry of Health put together a team of experts in order to formulate the country's first, comprehensive national health policy (FCI 2007:76), which it

published in 1990 (FCI 2007:76; TZ Ministry of Health 1990). The policy's first objective was "to reduce maternal and infant morbidity and mortality and increase life expectancy through the provision of adequate and equitable maternal and child health services, promotion of adequate nutrition, control of communicable diseases, and treatment of common conditions" (FCI 2007:76; TZ Ministry of Health 1990).

3.10 Health Sector Reform and Decentralization

Prior to the early 1990s, the people of Tanzania were not required to pay user fees and for-profit, private sector activities in healthcare were limited (Lambert and Sahn 2002:121). In 1996, the government undertook a process of health sector reform, which included decentralizing many aspects of healthcare planning and delivery. The goal was to let each district have the autonomy to identify and address its particular healthcare needs (FCI 2007:78). The central government still played a part in coordinating broader policies and, at that point in time, the private sector started to play a larger role in health care delivery. Importantly, as a result of these reforms, cost sharing of health services was decentralized to health centers and dispensaries, and communities were to assume responsibility for the financing of health services through a range of avenues, such as community health funds (FCI 2007:78-79).

As part of the health care sector reforms that were initiated in 1996, the government of Tanzania and the donor community started to change the way in which funds for the healthcare sector were allocated. Donors established a Health Sector Basket Fund (HSBF), which allowed them to deposit money into a holding account in the Bank of Tanzania that was specifically earmarked for healthcare programs (FCI 2007:79). There is now a Basket Fund Committee comprised of the Ministry of Health, the President's Office, the Ministry of Finance, and Regional Administration and Local Government, which approves funding and releases funds

quarterly (FCI 2007:79). The District Council, roughly the county level of administration, is now the seat of the accounting office for all local and donor resources that go into primary health care, including safe motherhood initiatives (FCI 2007:79). One of the goals of this reorganization was better coordination of the flow of donor resources into safe motherhood and other primary healthcare services (FCI 2007:79).

In 2004-2005, foreign funds made up approximately 55% of the health expenditure in the country (FCI 2007:81). Spending on reproductive health and safe motherhood programs amounted to just 7.7% of the total healthcare budget, which itself was just 9% of the national budget (FCI 2007:82). What all of these data demonstrate is that there has clearly been strong and consistent political commitment to addressing reproductive and maternal health but the implementation of policies has been inconsistent and uneven. A lack of reliable and sufficient funding (or its effective channeling into programs) has also hampered the success of programming and a concomitant decline in maternal morbidity and mortality.

The long-term effects of these structural issues continue to the present day throughout much of the country. I have written elsewhere about the origins and on-going effects of donor involvement and aid dependency in Tanzania, as well as the effects of structural adjustment policies implemented after 1985 (Strong 2017). Training of medical personnel in sufficient numbers to meet the demands for services, particularly in rural areas, also remains a challenge. In the 2010s, the Ministry of Health reduced the time of study for enrolled nurses from four years to three years and, in some cases, even two years, with mixed results; more nurses are working but the general consensus among older nurses was that the new nurses' levels of expertise and knowledge were lower than with previous generations⁶.

⁶ Mhamela (2013) wrote a definitive text on the history of nursing in Tanzania, which is available through the Tanzania Nursing and Midwifery Council. Here, he traces the developments of nursing in the area

3.11 The Evolution of Global Safe Motherhood

AbouZahr (2003) summarizes the entire history of the Safe Motherhood movement so I will not recreate her article here. However, I want to include the main highlights of this movement in order to demonstrate how and why maternal mortality came to be taken up by the global community as a public health problem worthy of time, effort, and financial resources.

The colonial records cited previously in this chapter should make it clear that colonial administration, at least for the British, was concerned with maternal and child welfare as a way to promote progress and “civilization,” as well as functioning as a route to winning the hearts and minds of the local population. The reasons that motivated an interest in maternal health evolved over the course of the 20th century. AbouZahr (2003) notes that concern for maternal and child health was included in the League of Nations’ founding documents in the 1930s and that these health issues are also components of the WHO’s Constitution. With the rise of feminism in the 1960s and 1970s, the United Nations declared 1975 to be the International Woman’s Year and organized a conference in Mexico City, the first World Conference on Women and, at the urging of the conference participants, declared 1976-1985 to be UN Decade for Women (United Nations 1976).

This focused attention on women’s issues, including health, and generated a large quantity of scholarship on so-called women’s issues (Allen 2004:35). It was during this period of increased interest in women’s health issues that scholars and policy makers began to pay more attention to maternal mortality globally. Mahler (1987) explains that maternal mortality had not garnered more attention earlier because the scale of the problem was largely unknown. The

from the colonial period to the present. In this volume, Mhamela also thoroughly reports on the training requirements and programs of study for nurses throughout history, which I will not repeat here. He includes a number of examples of course syllabi from nurse training course, which can also be found in the Tanzania National Archives (Mhamela 2013:86-90).

countries with the largest burden of maternal deaths also had poor infrastructure and were most often lacking vital statistics registry systems that could effectively track deaths and their causes (Mahler 1987). Starting in the mid-1970s, a number of surveys were carried out, which helped to identify the true scope of the problem of maternal death. To this day, measuring maternal deaths continues to be a challenge in many countries (WHO 2015). Rosenfield and Maine (1985) issued a strong call to clinicians and policy makers to rethink their approaches to maternal health, asking “where is the ‘m’ in MCH?” (MCH- maternal and child health). They suggest that too often the services provided under the heading of MCH did little to address maternal morbidity and mortality but, instead, it was assumed that what was good for the health of children would help women (Rosenfield and Maine 1985). Aside from the sheer number of deaths that could now be counted, the global community identified maternal mortality as a health problem that had severe implications for the well-being not only of the woman and her family, but also her community and countries as a whole, on a social and economic level (Mahler 1987).

The Alma Ata conference on Primary Health Care held in 1978 is most often cited as the beginning of the Safe Motherhood movement, though this was not to be an official movement until almost a decade later. Primary healthcare as a global focus was meant to address the needs of the poor, focusing on community-level health problems, which encompassed maternal and child health (AbouZahr 2003). This conference occurred around the same time as researchers were conducting surveys to measure maternal mortality. The emphasis in the late 1970s and early 1980s on women’s health, and improvements in measuring maternal deaths, culminated in the Safe Motherhood Conference, held in Nairobi in February 1987 and jointly sponsored by the WHO, UNFPA, and the World Bank (AbouZahr 2003). The conference gave birth to the Safe Motherhood Initiative, which underwent various transformations throughout the 1990s. The

1990s also saw enormous scholarly effort poured into identifying the causes of maternal death, particularly in low resource settings, both clinical causes and other, more sociocultural factors. With better understand of underlying causes, both proximate and ultimate, there came the push for interventions to address these causes and reduce maternal deaths. The interventions ranged from training so-called traditional birth attendants, to an emphasis on skilled attendance at birth, to what is now called Basic Emergency Obstetric and Neonatal Care (BEmONC) training.

3.12 Tanzania and Safe Motherhood

Tanzania was one of the first countries to sign on to the Safe Motherhood goals, doing so the same year the conference occurred (Tanzania MOH 2008:1). However, despite planning and formulating a national strategic plan to combat maternal mortality, published in 1992, the implementation was inconsistent (FCI 2007:77). Implementation of the policy recommendations was largely vertical and lacked integration among the various stakeholders. One of the best (or worst) examples of these failures was that no moves were made to create the multi-sectoral safe motherhood coordinating committee that had been called for in the original document (FCI 2007:77). In 1993, after an assessment by the WHO, the country significantly revised the strategy, this time with more of a focus on integration of stakeholders and improving the quality of and access to maternal health and emergency obstetric services, and expanding family planning services (FCI 2007:77). The 1994 International Conference for Population and Development prompted Tanzania to establish a Reproductive and Child Health Section within the national Ministry of Health that same year (Tanzania MoH 2008:1). This new section in the MoH went on to develop the National Reproductive and Child Health Strategy. Over the years, the country has made an effort to continually implement comprehensive strategies to improve health indicators, moving away from a reliance on project intermediates (i.e. number of facilities

built, similar to Dr. Keevill's criticism of counting buildings) as measures of success and, instead, focusing on measures of individual outcomes (i.e. a decrease in the number of maternal deaths) (Lambert and Sahn 2002:120).

3.13 Shifts in Direction

In the years immediately following the conference in Nairobi, policy makers and public health specialists, against the background of the Alma Ata conference, and an increasing emphasis on preventive and community care, focused on improving prenatal care and training traditional birth attendants (Starrs 2006). Prenatal care came to take on a significant role in the plan to reduce maternal mortality. Routine prenatal visits play an important role in monitoring maternal and fetal health and act as a means for "establishing a good relationship between women and their healthcare providers," which can lead to a reduction in maternal mortality (Magadi, Madise, and Rodrigues 2000:551). In the Democratic Republic of the Congo, for example, studies showed a 17-fold decrease in maternal deaths with the implementation of standardized prenatal care (McDonagh 1996). Based on such findings, the WHO began recommending at least four prenatal visits with the first visit occurring at the end of the first trimester (WHO 1996). Unfortunately, many women in lower income regions of the world have been unable to follow this recommendation (WHO 1996). By the late 1990s, the focus on increasing prenatal care attendance had waned as health officials came to acknowledge the fact that prenatal care is, in fact, a very ineffective mechanism for identifying women at high risk for developing a serious problem in pregnancy or while giving birth (Yuster 1995). Prenatal care came to be seen by many as a costly and inefficient way to identify women who might develop a problem when many of those who had gone through their pregnancies free of problems suddenly developed a life-threatening condition at the time of birth with little or no warning (Yuster 1995).

In the wake of research bring produced about the complicated and multiple factors contributing to maternal deaths, ranging from clinical problems to gender inequality, the Safe Motherhood Initiative often manifested as complicated and expensive multi-sectoral schemes that were nearly impossible to implement (Starrs 2006). At the end of the movement's first decade, the global community recognized the failure of the primary care interventions, the large scale training of traditional birth attendants, and the diffuse, complex programming; organizations and governments shifted their approaches to focus more on health sector interventions designed to increase women's access to skilled, professional care, particularly when they faced obstetric complications (Starrs 2006). In 2001, the Tanzania Ministry of Health issued a report on the country's progress in the first decade of attempts aimed at reducing maternal deaths (MoH 2001). The report elaborates the country's efforts to create and implement a national sentinel system for tracing cause-specific mortality, allowing them to collect more accurate information on the causes of death (MoH 2001:3). The primary outcome of the report is that the country had succeeded in reducing maternal mortality but only in urban areas; declines outside of the urban center of Dar es Salaam were not statistically significant for the period under review (MoH 2001:5). This reflects broader global trends that persist to the present day; inequity in the burden and distribution of these deaths can be tied to wealth, education, and access to other resources including health facilities, all of which are relatively more available in urban areas as compared to rural ones. Interestingly, this report also suggests that in real numbers, maternal death was comparatively rare, even in resource poor settings, and was therefore not a cost-effective measurement of results achieved under the Safe Motherhood Initiative, though it suggests no alternative measures (MoHSW 2001:8).

3.14 Doomed to Repeat History

The policy reversals and the extension of services only to withdraw or drastically change them later mirror debates happening in the Colonial Medical Service fifty years earlier. One of the ongoing challenges appears to be overextension; the aspirations nearly always seem to extend beyond the actual capacity of the government (and affiliated organizations) to live up to the plans, which then creates a vicious cycle of poor progress and dissatisfaction with the outcomes. Unfocused efforts to improve care, lacking consistency in different places, and lacking singularity of purpose, not to mention the financial and human resources, have long delayed further improvements of maternal health in Tanzania, and many other countries. Without attending to the successes, failures, and key debates of the past, the Tanzanian government repeated many of the mistakes that occurred in the colonial era and, perhaps unknowingly, continues to grapple with the systems established many years ago. Biomedicine and biobureaucratic expansion continue to determine which pregnant bodies deserve biomedical assistance or where these same bodies should be allowed to give birth and with access to what personnel and what resources. The bounds, limits, and acceptable forms of caring for pregnant women were long ago determined and continue to produce many challenges and conflicts both within communities and biomedical institutions.

3.15 The Era of the Millennium Development Goals

From the 1990s, a number of policy shifts occurred. Perhaps the most relevant and important was the creation of the Millennium Development Goals (MDGs) in 2000. A set of eight goals designed to focus poverty reduction efforts globally, the MDGs were established with an end date of 2015. Several conversations in the Rukwa region and among NGOs and the Ministry of Health and Social Welfare in Tanzania at the time of my fieldwork revolved around the end of the MDG timeline. MDG 5 was to improve maternal health, with a sub-goal to reduce

maternal mortality by three quarters from the 1990 level (UN 2015). At the close of 2015, the WHO and partners issued a report on maternal death at the end of the MDG period, stating that globally maternal mortality had declined by an estimated 44% since 1990, missing the mark of a 75% decrease (WHO 2015:16). In the lead up to 2015, global health policy makers and practitioners worked to redesign the efforts to reduce maternal death for the post-MDG landscape, producing a new set of development goals terms the Sustainable Development Goals, which include 17 comprehensive target areas. Goal 3 is related to health and wellbeing and the first target listed under this goal is “By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births,” emphasizing the ongoing importance of this goal which the world failed to reach under the MDGs (UN 2016). For those organizations focused on maternal health more specifically, they have created the “strategies toward ending preventable maternal mortality” or the EPMMs (WHO 2015a). The EPMM guiding principles include empowering women, girls, families and communities, integrating maternal and newborn care, prioritizing country ownership, leadership and supportive legal, regulatory and financial mechanisms, and applying a human rights framework “to ensure that high-quality sexual, reproductive, maternal and newborn healthcare is available, accessible and acceptable to all who need it” (WHO 2015a:14).

An integral “cross-cutting action” for EPMM is cited as “improving metrics, measurement systems and data quality” (WHO 2015a:14). This focus on data collection and utilization builds on a trend that began under the MDGs but, the argument could be made, extends to the period in the 1970s which paved the way for the Safe Motherhood Initiative⁷. The thought seems to have long been if we can measure it, we can solve it. Indeed, the WHO report on maternal mortality

⁷ Data collection extends to a much earlier time, see Adams 2016 for a brief history of the uses of statistical data in health projects.

always includes many pages in the beginning of the document which explain how the organization arrived at its estimates, the statistical analyses involved, and the ways in which degree of uncertainty is measured, and how they interpolate data in the absence of robust vital statistic and civil registry systems. Policy makers, politicians, global regulatory institutions, and others often put these data on health indicators to use much more broadly as proxies for state efficacy, stability, legitimacy, and deservingness of aid or investment (Davis, Fisher, Kingsbury, and Merry 2012; Merry 2011).

In a recent edited volume Vincanne Adams and her co-authors (Adams 2016) explore the myriad ways in which metrics are taken up and used for a variety of purposes. Metrics, better evidence via better data, were touted as the panacea to all the global health problems, bringing these health issues out of politics and into the ostensibly less biased arena of science and statistics (Adams 2016:23). However, the chapters in the volume all emphasize the dangers inherent in this thinking. Adams (2016:27; also Erikson 2012) argues that the rise of metrics, and the emphasis placed on them, is in part linked to a call for greater accountability in global health interventions; to know if a project or aid money is effective, there must be a way to measure the outcomes, without these measurements, who was to say that aid money was being utilized effectively? Cost-effectiveness helped to drive the increased focus on data and metrics. Despite this link with calls for greater (fiscal) accountability, Adams (2016:37) suggests data are often fabricated and care, treatments, or diagnoses manipulated in order to correspond with expected outcomes. Additionally, organizations and regulatory bodies circulate and return numbers and statistics, producing globalized renderings of local phenomena (Erikson 2012). Finally, just because some diseases or other phenomena cannot easily be studied via random control trials,

does not mean that they are any less important, nor does it mean data collected in other ways are not valid and useful (Adams 2016:36).

3.16 Conclusion

Oni-Orisan (in Adams 2016) and Wendland (in Adams 2016), each describe in detail the ways in which statistics can be manipulated in calculations of maternal mortality ratios in order to skew numbers in ways that are favorable to politicians, as well as highlighting the uncertainty still built into these calculations. It is with these critiques and warnings in mind that I proceed with the following chapters. The question, the problem, of maternal mortality is one that is inextricably linked to global inequity between high and low income countries and between groups within a country. If nothing else, the archival data demonstrate some of the ways in which reproduction has long been a site of governance and has been tied to shifting political goals. Additionally, these documents demonstrate the ways in which maternity care stubbornly defies standardization and violates the norms of other healthcare service provision. The colonial era, and subsequent policy changes and health sector restructuring produced the current environment in which healthcare providers acted when trying to save women's lives. Certain forms of care (technology-based biomedicine) achieve primacy through metrics, data collection, and the reduction of bodies to numbers and tick boxes. Other forms of care, more affective and relational, were effectively quashed within the biomedical system due to institutional scarcity, which has often been the result of biomedical and biobureaucratic expansion that sought to accomplish too much, too quickly.

Maternal health, and reproduction more generally, can never be separated from state making and perpetuation. In countries that have undergone a demographic transition and now have low fertility rates such as Italy, for example, or during the Ceausescu era in Romania, the

state has actively promoted pronatalist policies. During the colonial period, bodies were a valuable source of labor to be exploited and biomedicine was introduced for practical and ideological purpose; to keep productive subjects healthy and to win the allegiance of the local populations, goals inextricably linked to the expansion of the British empire in the 19th and 20th centuries. Because of the complex and unpredictable nature of obstetric complications that can lead to maternal death, maternal mortality ratios are often used as a sort of litmus test for the overall functioning of healthcare systems (Wendland in Adams 2016:62). What follows, then, is an analysis of some factors that contribute to maternal deaths, while being attuned to the perils of biological reductionism. The chapters present the varying discourses surrounding this ongoing, and sometimes seemingly intractable health problem, as well as an analysis, centered on healthcare facilities and providers, of how maternal risk is shaped across the various levels of individuals, community, district, region, and state in light of these historical precedents.