The maternity ward as mirror

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

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Chapter 4: “Pregnancy is Poison:” Logics of risk and care in the community

4.1 Introduction

At the end of the rainy season, as I navigated mud-slick roads with the windshield wipers on their highest setting, white knuckles gripping the steering wheel, on the way to Kizi village, the district ambulance sped by in the opposite direction, taking a patient to the Namanyere District Hospital. When Rebeca and I arrived in Kizi, we first went to the dispensary and there, once we began talking with the staff members, discovered they had called the ambulance a couple hours earlier. They had been trying to help a woman in labor since the middle of the night, around 3am, when she had arrived from home complaining of problems. When the nurses examined her, they found Pieta’s baby was transverse and the baby’s arm was the presenting part; she would need a C-section in order to give birth. She was 25 years old and pregnant with her third child. Pieta’s relatives had taken her back home, refusing help from the nurses, but insisting her father-in-law would be able to “say some words” to resolve the social conflict in the family, and the malpresentation, making it so she could give birth without an operation. After they refused to let the nurses call the ambulance, Pieta and her family insisted on returning home with her in the hopes she might still give birth. Eventually, the nurses from the dispensary went with the village executive officer to her house and were able to convince the woman’s family to bring her back to the dispensary again several hours later, now around 9am, so that they could finally call the ambulance. Though they had called for the ambulance from the district medical office around 9 or 10am, the car did not finally arrive until 1:30pm because of the trip to another village and then back to Namanyere, which was when we had passed it, and then back again to Kizi.
While we were waiting for the ambulance to arrive, I looked in on Pieta and saw she had a full bladder and the nurses were trying to keep her hydrated with IV fluids. I asked if she had been able to urinate and the nurses said no but that they did not have any catheters. At any rate, the baby was compressing the urethra, which would have made it difficult to insert a catheter even if they’d had one. Pieta was confused, exhausted, and barely able to answer questions. When the ambulance arrived they loaded her into the back, along with two male relatives to donate blood, in case she would need it, and two of her female relatives. Her husband planned to go ahead on a motorcycle. As we waited for Pieta and the relatives to settle into the ambulance, and for the nurses to hurriedly fill out a make-shift referral form, I spoke with her husband. He told me that Pieta herself had asked to go back home, refusing to let them call the ambulance. When I pressed for further details about the family problems the nurses had mentioned, he was noncommittal and vague. After they left in the ambulance, I talked with the nurses about the situation again and they accused Pieta of lying about when her contractions had started. They were saying that maybe this lying was because Pieta had planned to give birth at home and didn’t want the nurses to know she’d been in labor for some time already before arriving at the dispensary. The nurses told us that it was not uncommon in their village for women to report having had fewer pregnancies so that they would not be told to give birth at the district hospital. People in Kizi believed any referral to the hospital meant the woman would always have a C-section.

Before heading back to town, Rebeca and I stopped at the district hospital in Namanyere, where Pieta had had her operation, to see her. She’d had a C-section, and she had baby boy, weighing 3.0kg but he was stillborn. She also had received a blood transfusion and drugs were in such short supply that she and her relatives were told she had to buy them but, they didn’t have
any money. In the end, the family had to go to the District Nursing Officer herself to get the money for Pieta’s medications (facilitated by the hospital), which was exactly what a lot of people feared when they were told to go to someplace other than their village dispensary—having to spend a lot of money on supplies or medications. Pieta also told me multiple times that she was glad we had been there because she felt that the nurses at the dispensary “walinishangaa tu” (they were just shocked by me). She told me she felt the nurses had not known what to do with her case and she said she had been confused and so tired. Pieta’s case illustrated many of the ways in which community and biomedical perspectives could come into conflict; she was but one woman who experienced delays during an obstetric emergency due to complex interactions of clinical, social, and infrastructural factors. When we received women like Pieta at the Mawingu Hospital maternity ward in town, we rarely saw, or even heard about, all the events preceding the woman’s arrival but, all these events, and the woman’s prior life, indelibly influenced her decisions, conceptions of risk (biomedical and social), and, ultimately, whether she (and her baby) lived or died.

While most women and healthcare providers with whom I spoke did not necessarily view pregnancy as an illness, it was an inherently risky time in a woman’s life. Following after a spate of maternal deaths at the regional hospital, one nurse said, “Who said pregnancy is not an illness? Pregnancy is poison!” expressing her opinion of the dangers inherent in this period of a woman’s life. However, the global public health constructions of the problem of maternal mortality have been built on logics of risk and care that sometimes differ from those logics that circulate and guide actions and practices within communities. The World Health Organization’s recommendations, which permeate policy making at national and local levels, are based in a particular version of the world in which pregnant women are rational neoliberal subjects who,
with the right amount of information and health education, will make choices during pregnancy and while giving birth that will help them to be healthy and safe. However, in this chapter, I demonstrate the ways in which those logics differ from the gendered, social logics operating within communities that work to guide and influence women and their larger networks through more complex decisions related to care, medical pluralism, and the sociality involved in reproduction. Women did not arrive at the Mawingu Hospital from a vacuum but, instead, after having already navigated and experienced life events that influenced their opinions of and trust in the biomedical system. Within public health generally, and at Mawingu Hospital, maternal mortality has often been reduced causally to women coming from villages and lacking trained assistance. While I disagree with this reductionism, social relations, meanings of pregnancy and risk, and expectations for local midwives within communities did shape the strategies and decisions of pregnant women and their families. With this in mind, I present some of the underlying experiences and logics that influence women’s lives before they arrive at Mawingu Regional Hospital pregnant or in the midst of an obstetric emergency in order to better understand how a woman might come to die at the hospital. I start the chapter with a brief summary of the ideas and worldview that drive biomedical and public health discourse on maternal health and maternal risk in order to argue that the logics structuring public health and biomedical programs were intertwined with those logics working at the local level in Tanzania in much more complex ways than presented by those bodies and officials designing programs meant to reduce maternal deaths. This insight, then, complicates and informs the interpretation of the events I relate in Part III within Mawingu Hospital.

This chapter is based on participant observation in communities in both the Rukwa region, as well as my earlier experiences in villages in the Singida region of the country.
Additionally, I draw on the community group discussions my research assistant, Rebeca, and I conducted in eleven different villages in the Rukwa region with women, men, community leaders, and local midwives or *wakunga wa jadi*. I have organized the chapter to follow, more or less, the way in which a woman’s route to Mawingu Regional Hospital might unfold, broadly speaking, over her life course—childhood, marriage and domestic work, pregnancy, and care seeking.

### 4.2 A View from Above: The WHO’s definition of maternal mortality and risk

The WHO, public health practitioners, clinicians, and policy makers generally divide the causes of maternal mortality into direct and indirect causes (Ronsmans and Graham 2006). The direct causes are those clinical conditions responsible for the majority (though certainly not all) of maternal deaths worldwide and include hemorrhage, complications from abortion (or attempted abortion), hypertensive diseases (such as eclampsia and pre-eclampsia), sepsis/infection, and obstructed labor (Maine and Rosenfield 1999; Ronsmans and Graham 2006). Despite years of efforts to reduce deaths from these conditions, they continue to be the most common causes of maternal mortality. Often these clinical problems are caused or exacerbated by a lifetime of poor nutrition, repeated malaria infections, anemia, and STIs, in addition to tetanus (Merchant and Kurz in Koblinsky, Timyan and Gay 1996). Clinically, other deaths are the result of the pregnancy exacerbating an underlying health condition such as diabetes, HIV, malaria, obesity, or heart problems (WHO 2015). Clinicians and public health practitioners classify those women whose deaths occur during pregnancy, but are caused by these pre-existing conditions, as indirect maternal deaths.

Clinically, one of the greatest challenges in providing emergency obstetric care is the fact that many women do not exhibit any signs of problems or experience any complications during
their pregnancy. But, they can suddenly develop a life-threatening emergency at the time of giving birth or immediately after. Being unable to predict with complete accuracy (Majoko, Nystrom, Munjanja and Lindmark 2002; Yuster 2005) who may or may not develop problems presents a challenge to healthcare workers and women alike and is, strictly speaking, impossible. By the 1990s, after a decade of the Safe Motherhood Initiative, the policy and public health 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 with clinically determined high risk for developing a serious problem in pregnancy or while giving birth (Yuster 1995). The global health tactic of choice became a more aggressive move to institutionalize birth in order to monitor all women—those with known risks factors and those without—in an attempt to save more women’s lives.

The public health literature often attributes indirect causes of maternal death, as one article from 1985 states, “to the patient, the environment, cultural beliefs or to defects in the health services” (Rossiter 1985:100). Within public health, the three delays model continues to structure analyses of maternal death. The delays include: 1) deciding to seek appropriate medical help for an obstetric emergency; 2) reaching an appropriate obstetric facility; and 3) receiving adequate care once at a facility (Thaddeus and Maine 1994). This model constituted an

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1 However, prenatal care continues to be many women’s first introduction to the biomedical healthcare system and, therefore, continues to play an important role in influencing their perceptions of what the system can offer. Additionally, the WHO released new antenatal care guidelines in November 2016 which now recommend 8 prenatal visits, double the previously suggested number (WHO 2016a). In Tanzania, nearly 95% of women attend prenatal care at least once, a number that has remained very consistent for several years.

2 Public health practitioners and clinicians often include factors such as women’s autonomy and status within a society, delays in deciding to seek care, failure to recognize the severity of an obstetric problem, or family issues that cause a delay in seeking care, which can also be related to delays associated with lack of transportation and poor infrastructure, as indirect causes of death (Danforth et al. 2009; Gabrysch and Campbell 2009; Mrisho et al. 2007; Pembe et al. 2008; Prevention of Maternal Mortality Network 1992).
underlying logic for clinicians, policy makers, and public health practitioners and continued to influence discussions of maternal mortality in the Rukwa region. The pervasive influence of this mode of thinking was particularly apparent in discussions during maternal death audit meetings when providers had to decide when delays occurred, with blanks on the form for each of Thaddeus and Maine’s three delays (see chapter 9). Both the broader public health literature, and the healthcare workers with whom I worked, blamed women’s decisions to seek care from a local midwife or other indigenous healing expert for delays in reaching biomedical healthcare services when an obstetric emergency was underway.

Since the global policy recommendations shifted away from training traditional birth attendants in the 1990s, the WHO’s primary approach to reducing maternal deaths has been encouraging women to give birth with the assistance of a skilled provider, preferably in a biomedical health facility equipped with adequate supplies and staffed by providers trained in (minimally) Basic Emergency Obstetric and Neonatal Care (BEmONC) (Koblinsky et al. 2006; Ronssmans et al. 2003; Scott and Ronssmans 2009). The Tanzanian Ministry of Health also followed this global trend and it, as well as other organizations, ceased training TBAs. A skilled attendant or healthcare worker is defined as “an accredited health professional such as a nurse, midwife, or doctor who has been educated and trained to proficiency in the skills needed to

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3 Many countries found training TBAs to have little effect on institutional delivery rates, while sometimes encouraging more women to stay at home due to the TBA’s increased knowledge. With the realization that more women preferred TBAs, national policies reversed course and moved away from training them.

4 BEmONC training includes instruction on the identification of danger signs indicating possible serious complications, management of normal labor and delivery, as well as treatment of problems such as pre-eclampsia, hemorrhage, or retained placenta, appropriate referral procedures, neonatal resuscitation techniques, and maintenance of necessary supplies and equipment needed for a safe and healthy delivery, including gauze, sterile gloves, cord ligature, scissors or surgical blade to cut the umbilical cord, oxytocin to help the uterus contract, a method of sterilization, and neonatal resuscitation equipment, to a name a few items. Additionally, BEmONC trainings include information on postpartum care and techniques for culturally appropriate, respectful communication with clients and their family members.
manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period, and in the identification, management, and referral of complications in women and newborns” (DRHR WHO 2008). While the WHO makes this definition sound clear cut, there continues to exist a great deal of grey area, particularly apparent through women’s stories, and my observations, of prenatal and delivery care in both local dispensaries and larger health facilities. If an enrolled nurse went to school and was present in classrooms and during clinical rotations related to maternity care but cannot actually describe the signs of eclampsia when asked, is she skilled or unskilled? Technically, she would be grouped with skilled providers because she has an EN diploma but, functionally, she is unskilled in providing maternal healthcare.

For many women in low and low middle-income countries, especially those living in rural areas, logistical (e.g. distance, transportation) and economic (e.g. user fees, travel costs) constraints are obvious barriers to the use of those biomedical health care services that are available (Campbell and Graham 2006; Koblinsky et al. 2006; Lubbock and Stephenson 2008). Improving the social status of women and girls remains a key Sustainable Development Goal (SDGs) and the global community sees this goal as an integral piece of a broader approach to decreasing maternal and reproductive health problems in lower income countries.

One global effort, reflected in the SDGs and MDGs, to increase women’s empowerment centers on improving girls’ access to education. Education for girls, even just through the

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5 A number of public health studies have suggested a lack of female autonomy in decision-making as a limiting factor in the utilization of healthcare services (Gage 2007; Koblinsky et al. 2006; Lubbock and Stephenson 2008; WHO 2015).

6 It is virtually impossible to extricate education from several other indicators of women’s empowerment, including decision-making autonomy and access to household resources (McTavish, Moore, Harper and Lynch 2010). Levels of girls’ education in a country can also be reflective of a broader political and social environment that encourages and supports women’s empowerment and social status through means such as legal protections upholding the rights of women to inherit and/or own land, to have greater access to loans, and labor market rights (McTavish, Moore, Harper and Lynch 2010).
completion of primary school, has been shown in several studies to be a predictor of lower maternal mortality levels (McAlister and Baskett 2006; Ahmed, Creanga, Gillespie and Tsui 2010). It is not so much the book knowledge girls gain in school but “the knowledge to demand and seek proper healthcare” (McAlister and Baskett 2006), through more general empowerment, confidence and skills needed to navigate information or bureaucratic systems. Women who have been to school may also have access to better employment or income generating activities in both the formal and informal sectors, which can strengthen their position within their families.

According to public health practitioners, exposure to health messaging and formal education both increase the likelihood that a woman will be more aware of the biomedical risks involved in pregnancy and that can occur while giving birth. Waiswa et al. (2008) in their Ugandan study, suggest women’s poor understanding of the risk factors for poor pregnancy outcomes and labor complications, as well as a poor understanding of the benefits of prenatal care and the presence of a trained assistant at the time of delivery have led to lower use of biomedical services. In the eyes of public health practitioners and policy makers, more exposure to health information does not always prove effective because it “doesn’t change the social context of maternal health seeking behavior” (Hawkins, Newman, Thomas and Carlson 2005:17).

This is a clear example of how the underlying logics operating in two different registers may be in conflict. Women and their relatives do not necessarily change their behavior due to information about clinical, biomedical risk, particularly if the social risks associated with not having children are greater. In Tanzania, total fertility in rural areas was still 6.1 children, as of 2010 (NBS and ICF Macro 2011:57). The slow decline in the fertility rate is reflective of a number of issues including the continued desire for large families in rural areas. Childbearing
still has a number of important implications for a woman’s position in her, or her husband’s family. Communities may view marriages as insecure until the couple has had their first child, which proves their fertility and concretizes the marriage (van der Sijpt and Notermans 2010). For women who are able to successfully become pregnant and carry their pregnancies to term, they enter into a new status in their families, their husbands’ families, and their communities.

Oftentimes, even if women can reach care, they complain that biomedical facilities do not provide the same services and giving birth there does not accomplish the same sociocultural ends as giving birth at home. Many women are harassed or otherwise abused and subjected to disrespectful treatment in the healthcare setting (Allen 2004; Amooti-Kaguna and Nuwaha 2000; Bohren et al. 2015; Kruk et al. 2014; Mrisho et al. 2007; Van Hollen 2003; and my own research). In places where these abuses are common, women and their family members may decide to avail themselves of local healers instead, reasoning that such care will cost less than the hospital and may indeed be more effective, socially appropriate, and take place in a more dignified setting than the hospital can provide (Amooti-Kaguna and Nuwaha 2000; Danforth et al. 2009; Kyomuhendo 2003; Lubbock and Stephenson 2008; Mrisho et al. 2007). Conflicts between local beliefs and the practices of biomedicine are also an important factor affecting women’s decisions regarding the use of biomedical healthcare services (Bazzano et al. 2008; Kyomuhendo 2003; Okafor and Rizzuto 1994). Guidelines such as those of the WHO do not often take into account the extent to which women and their families still value plural forms of care.

Kyomuhendo (2003), in a study in Uganda, found that women preferred the help of close relatives, traditional birth attendants, and friends during childbirth over that of health workers who were viewed as outsiders and thus not part of the local birth culture. Berry (2010) explains how giving birth at home in Guatemala solidifies a woman’s place in her husband’s family.
4.3 A View from the Ground: Local logics of Gender, Care, and Reproduction

4.3.1 Access to education and the road to early pregnancy

Upon arriving in each village in the Rukwa region, I always asked the village chairman to give me a brief tour, walking by the market, the health facility (either health center or dispensary) and by the school. In most villages, we passed by the school as a couple hundred primary-level children ran about in the school yard, with the smallest children running home with cups of uji, which, I was told, marked the end of their school day, around 10am. Often, on these tours, we would stop in the school headmaster’s office so I could introduce myself. In several villages, my research assistant and I held our group discussions in available school rooms. It was clear, more or less, from the state of the blackboards, the number of desks, and the number of teachers’ names on the headmaster’s list pinned up in the office how each school was faring. In discussions with community members, my research assistant and I started with general questions about challenges facing the village. Often participants brought up education in this context. If they did not, we asked specific questions about primary and secondary education: how many teachers and students? Was there a secondary school and if not, how far away was the nearest one? Was the community satisfied with the quality of education the students were receiving and, if not, why not? Often, the community members told me their schools were under-resourced:

The challenges that are there in our school there, first is that there aren’t any houses for the teachers. Then, the second thing, our school is just like an environment for keeping children because the classrooms that are there aren’t enough, again they really aren’t enough. Then, third, toilets, the toilets aren’t sufficient. Fourth, supplies for learning and for teaching still are a problem. (Kizi village, men’s meeting)

These types of comments were pervasive, though some communities we visited did tell us that they had recently gotten more teachers or the number of students who passed their primary school leaving exam and gotten a spot in a local government primary school had increased.
In Songambele Azimio, the parents complained that the quality of education available at the village’s primary school meant that most children did not get the opportunity to go to secondary school. Therefore, starting around the age of thirteen or fourteen, children were done with school:

RM: That means children that remain because they lack a spot to continue their studies, it’s always a lot of them, so now what do you all usually do, I mean what happens? Like if she’s a girl, does she get married or how is it?

1: This remains the responsibility of the parent, to see my child, how can I help her according to our economic means. If you have good finances, you can find a place for her at another school so she can continue. If your finances aren’t good, well, she stays and she farms.

RM: Here, in your community, there isn’t any child marriage? 8

2: It’s there, again a lot.

RM: What usually happens?

2: You find like that ability to take her to another school, you don’t have, so she just stays at home and the results are that she gets married. I mean, she doesn’t have anything else to do therefore even if you forbid her, it just is that way, or she gives birth at home.

3: I mean, you find you are all there at home, you are eating dinner, you all go to sleep. Now, you think your child has also gone to bed but really, she has gone to the videos. In the morning, if you wake up, you find she’s in her room like she was there the whole time but really she has gone to see the bad movies therefore they [the movies] are ruining children. (Songambele, women’s group)

The women suggested the movies included graphic sexual content which youth then went to try with each other, resulting in early pregnancies leading to early marriages. These comments were particularly significant in light of the fact that one of the first things I had noticed at Mawingu Hospital in 2012 was the high number of very young girls giving birth at the facility. At that time, I had asked one of the doctors working on the maternity ward if women in the region commonly gave birth at a young age, from his observations. He confirmed that the hospital did see large numbers of very young girls coming to give birth. Clinically, girls who have not finished growing have a higher chance of developing severe complications, such as

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8 In Swahili, the term is “ndoa katika umri mmdogo” which literally translates to marriage at a young age, but was often glossed as child marriage by Tanzanians with whom I spoke.
cephalopelvic disproportion, necessitating surgical birth. However, on a social level, oftentimes these young pregnant women were not married, or the father of their baby had agreed to marry her only as a direct result of the pregnancy.

These unintended, early pregnancies put young women in a more socially precarious position. For example, one young woman whose case I followed at Mawingu came to give birth only to discover she had a phantom pregnancy\(^9\). Instead of waiting for further test results or counseling, she absconded from the ward without discharge. When Dr. Charles and I had spoken to her, she told us her family had been unhappy with the news of her pregnancy, and conflict had ensued between her family and that of the man who had gotten her pregnant. They had only resolved the dispute when he agreed to marry her. Now, in light of the nonexistent pregnancy, her status was once again uncertain. This uncertain social position could also severely limit the support a woman would have available to call upon should she develop a complication during her pregnancy or while giving birth. In my immediate social circle, two families had their housegirl (domestic helper) run away from the home after becoming pregnant. Young women who did not attend secondary school sometimes took up positions as house help and, in their free time, engaged in sexual relations with men in the neighborhood.

In describing the effects of early marriage and pregnancy on families, a woman from Songambele explained, “Really, this has a lot of effects because your child, if she gets a child, OK, it’s your grandchild, but both are children and the burden of raising them is yours, as the mother, because a time will come when she will be defeated by life there where she has gone [to the father of the baby] and she will return home.” This comment also illustrates the ways in

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\(^9\) When a woman displays all the outward signs of pregnancy including weight gain in the abdomen, amenorrhea, and even morning sickness. The phantom pregnancy might be caused psychologically, such as due to pressure or desire for a pregnancy. Other physiological abnormalities, particularly with the endocrine system may be a cause.
which these early pregnancies could result in decreased social support. In this case, if a young woman returned to her parents, she might be unable to draw on the baby’s father’s family for financial or other support, particularly for needs requiring cash, such as healthcare services.

The men in Songambele also mentioned the problematic issue of the sexually explicit movies being shown in their community. In their focus group they said children were hard to control these days, and it was hard to control what they saw or learned about sex because of the availability of these videos. One of the villager leaders who was present in the discussion said, “A child these days is a child of the state,” which prompted other participants to talk about the idea of human rights and one said, “Parents’ strength has decreased these days because of these human rights.” When I asked for further explanation, the men suggested parents were no longer able to discipline their children, particularly with corporal punishment, because this would be considered violating the child’s human rights. This comment clearly demonstrates the ways in which local and more global logics were in conflict in communities in the Rukwa region. As conceived of by policy makers and global health advocates, a rights-based approach to health is meant to empower individuals and keep states accountable for providing for their citizens. However, these comments from men in Songambele Azimio call into question the universality of this framework. The WHO and UN use a rights-based discourse in both the Sustainable Development Goals and the new strategies for Ending Preventable Maternal Mortality (EPMM). In light of men’s comments, I challenge the idea that this WHO and state rhetoric would be successful in this community, and others in the region, as a way to promote women’s health interventions when it so clearly failed to resonate in relation to children, perceived, instead, as an affront to parents and local forms of intergenerational control.

There is much more that could be said here in terms of analyzing the implications of the man’s statement about children being children of the state. This implies a conflict over autonomy and the state,
In several communities, we discussed sexual education. While one community said students got some health education in school from the local dispensary healthcare providers, most communities did not have a formal mechanism for sex education. When we expressly asked parents if they spoke with their children about how to avoid pregnancy or how to not get someone pregnant, the responses usually fell into two categories. Either parents said they talked with their children but the children did not listen, or they told us that it was not a subject that was easy for parents to bring up and, so, many things were left unexplained. Also, several community members felt it was inappropriate to discuss something such as birth control with an unmarried daughter, instead hoping she would simply abstain from sexual relations. These local logics that guided intergenerational relations served to further illustrate the gaps in the global, WHO-led constructions of maternal health and death. The norms and values which led parents to not discuss sexual education and contraception with their children followed rational decision making, to be sure, but in a form that the WHO, clinicians, and public health experts in offices might not recognize as such. In turn, the lack of sexual education increased the chances of early pregnancy, leading to increased clinical risks for the young woman, which could be further exacerbated by the halving of social and financial support to which a women suffering from an obstetric emergency could turn, all resulting from the unrecognized or unplanned nature of a pregnancy.

4.3.2 Bridewealth, Marriage, and Decision Making

In talking about educating girls, one man in Kizi village observed that, while working to register children for school, he had noticed the Sukuma people purposefully kept some girls at

as well as over what forms of discipline are acceptable and who should carry them out- State agents? Kin? Elders?
home, away from school, so they could marry her off at an earlier age, anticipating a high bridewealth payment. Among healthcare providers throughout Rukwa, the Sukuma women were rumored to be the least educated, often not speaking Swahili, still ascribing to indigenous religious beliefs, and often not giving birth in health facilities. Some providers had a clear prejudice against these women and would often address them, while in the health facility, simply as “the Sukuma.” The aforementioned tendency to keep some girls out of school could have also added to providers’ perceptions of the group overall as being uneducated.

As in the conversation referenced above, in speaking about education, the conversation among community members in our groups often drifted into the topic of bridewealth, marriage, and women’s subordination within marriage. In Kizi, the men said:

4: I should just say, you know the basis of the difficulty is that you find you have educated your daughter, she has gone there and gotten married. Now the motive is always bridewealth, I mean that is the problem because, for example, a Sukuma, he always gives really a lot of cows. Now, he is believing that, ‘Her, I have bought her.’

…

4: I mean, it would always be just like a person is giving [bridewealth] like a gift. But the question of this bridewealth, it makes people feel like they have bought other people, again like me, maybe I take ten cows to them [in-laws] then today you have done something at your home place without asking me, weee! It will all erode.

3: You know, we Africans, the question of giving bridewealth, there is something there in between. First, it brings a good relationship between two sides, then it brings respect, I mean even you married [someone], you say yes.

(Kizi, men’s group)

In this conversation about bridewealth, the men in Kizi note that bridewealth can be an instrument used to keep women in a subordinate position within a marriage, if that is how a man chooses to use it. A Sukuma man went on to say:

2: At our place, us, our relatives, Sukuma women are very forbearing, friends, I mean to quarrel with each other, it’s really rare and it’s possible it never happens.
RM: A person just closes it in their heart.
2: Yes, I mean our women are patient, forbearing every day. If it happens that they have gone to their place, I mean it is difficult, because first it’s like the army- everything
is ‘yes,’ she can’t add a word, even one. For example, if you tell her, ‘Go to the field.’ She will go running.

RM: What contributes to women appearing to be low people such that everything is just yes, is it the bridewealth or?

1: I mean, if I give a bridewealth for a light skinned girl, I mean it can be 60 or 40 cows therefore she must submit to me a great deal because you have given for her a large bridewealth. (Kizi, men’s group)

It was clear that for this man, as he spoke on behalf of his Sukuma community, that women whose families had received a large bridewealth payment were not supposed to disobey their husband nor, in fact, contribute much to any sort of decision making in the extended household. This mode of thinking had ramifications for healthcare, particularly for pregnant women, because their position in their marital home could make it difficult, or impossible, for them to choose when to seek biomedical (or other forms) of care during their pregnancy or at the time of giving birth.

Despite national and global health efforts aimed at increasing men’s participation in women’s reproductive health, local communities and individuals took up their participation in these schemes unevenly. Many men still lacked information about pregnancy and childbirth which meant they were not as well informed as their partners about danger signs or obstetric emergencies. When women could not voice their need or desire to access biomedical services because they were not the primary decision makers and were subordinate to men who felt they “owned” them, women could suffer from life-threatening delays, reaching Mawingu Hospital, for example, only in time to die on the hospital’s doorstep. In Mkamba village a Sukuma man told me that even if there was an emergency in the family, a Sukuma woman would not sell a cow or anything else in order to raise money for emergency transportation to medical care. Instead, she would have to wait for her husband or another male relative to carry out those procedures, thereby possibly resulting in delays.
Among the Wafipa, there was not as much consensus on these issues of bridewealth, and men generally put forth a range of thoughts on the topic of women’s roles in the family, some saying they involved their wives in decisions. In Songambele, women said that men often refused to listen to their opinions or input because men feared listening or submitting to women would make them look weak or like they had allowed themselves to be dominated by a woman, which was socially undesirable. One woman said, “They will always say this, men, I mean [they say], ‘Me, I should give bridewealth then you make yourself to answer me, isn’t it that I have married you?’” In Swahili, men marry (kuoa) and women are married (kuolewa). For women, it is always a passive verb and for men it is an active verb, which was reflective of the ways in which men saw their roles. They often used this linguistic difference to remind their wives that they, as the husband, were in charge. Therefore, these dynamics, influenced by bridewealth and socially constructed gender roles, also contributed to what men were willing to do and to what degree women were able to make decisions, particularly about their own healthcare needs.

In Kalumbaleza village, the topic of decision making came up directly in relation to health education, pregnancy, and the prenatal clinic. One of the healthcare providers in the village had told me that he was frustrated because he often advised women to plan ahead in order to give birth at Mawingu Hospital, for example if they were in their first pregnancy or very young, very short, or had had many previous pregnancies, all risk factors for various complications. I wanted to know if or why women did not follow his advice, as he had suggested to me, so in the women’s discussion group, I asked:

AS: Why do you all think that the doctor advises women to go to another place [to give birth]?
1: He has already recognized your problem.
AS: So why do people refuse to go?
2: Others of us are unable to understand, we have hard heads.
3: And also, it can be economics. Because men, if they were attending the antenatal clinic, they would know a lot of things. But now, because they don’t attend, that’s the reason they don’t know that there is an importance to going to give birth in Sumbawanga. If you tell them, they become argumentative. For example, if you leave the clinic, if you tell him, your husband, that you are supposed to go to give birth in town, he doesn’t understand you at all. Now, as a woman, you don’t have any way out, you just have to stay quiet.

Here, in these village settings, if a woman did not have any access to cash herself, there was no way for her to arrange for travel to the hospital in Sumbawanga, or even to the relatively close by health center. She was dependent on her husband for the financial resources, as well as, in some cases, permission to travel. Because men did not attend the prenatal clinics with their wives, they did not learn about danger signs in pregnancy or the reasons why the dispensary workers might refer a woman to a higher level of care. Instead, they might assume their partners were simply angling for a trip to town or just preferred to not give birth in the small, under-resourced dispensary.

4.3.3 Pronatalism and the Value of Reproduction

While women in more urban areas in Tanzania appear to be verbalizing a desire for smaller family sizes (my own interviews 2009-11; NBS and ICF Macro 2011:57), women in rural areas often still expressed a desire for larger families, for a number of reasons. One of these reasons is simply the fact that under-five mortality rates are still quite high in the country (though have dropped quickly, Afnan-Holmes et al. 2015) and many families still expect to lose at least one child. In June 2012, I was in a maternal-child health clinic in Singida, Tanzania when a woman came in with her three-year-old daughter. The girl had been having difficulty breathing at home and the mother had rushed her to the hospital. Despite the woman’s haste, the girl had already died, having choked on something she had swallowed while playing in their yard. The woman was distraught about the death of her youngest child. In addition to her grief over the loss
of her daughter, the woman kept repeating that she had just had a tubal ligation, having made the
decision to have no further children, and now she would be unable to have another child in place
of this one who had tragically died. Such instances weighed heavily on the minds of women
whose health and that of their children remained perilous.

At Mawingu Hospital, the pediatric ward experienced more deaths than the majority of
other wards, though I never counted these. In the rainy season in 2015, as I rushed to the
hospital, late for the morning meeting, I passed a woman who was walking down the road near
the hospital gates crying and saying over and over, “Bring back my child, bring back my child.” I
went into the meeting to hear the report of another death on the pediatric ward. With these fears,
it is no wonder couples continued to value large families, despite health education efforts aimed
at reducing the national fertility rate.

Against this pronatalist11 background, I examined women’s roles in their communities and
in their families, both nuclear and extended, in order to better understand the ways in which
marriage and bridewealth contributed to this social imperative to reproduce. Understanding
decision making within a household can lead to insights into how couples make the decision to
have children, how many to have, the timing of pregnancies, or whether or not to use any of the
available forms of birth control. All of these decisions have implications for a woman’s health
throughout her pregnancy, as well as her risks of morbidity and mortality.

A woman told me while she, as the wife, might prefer to stop having more children, her
husband did not know about the potential dangers of having many children and simply saw a
large family as an expression of his masculinity and a societal ideal. In every focus group
discussion, women complained to us that their husbands did not support them through the

11 Pronatalist means beliefs, practices, or policies that encourage reproduction and childbearing,
particularly supporting a higher birthrate.
difficulties or complications associated with using various forms of contraception and, as such, they often felt alone in shouldering the burden of limiting family size. In this context, I asked men in Songambele village about family planning and who decided when or how many children to have. One participant told me,

“This decision making is there between the husband and wife. Now, another problem, you find, inside the home, that there is another wife, she can say, ‘Let’s use family planning’ and instead that is her strategy to find a lot of men so that she starts to annoy me, saying that that family planning is a really good idea but many [women] use it for another purpose. (Participant 3, Men’s group, Songambele)"

If there was this lack of trust between the woman and her partner, it became exceptionally difficult for her to negotiate the use of contraceptives in order to limit the number of children they would have. While this man from Songambele started out by making it sound as though the man and woman both have equal say, an inherent suspicion about women being unfaithful colored his view of contraception, a detrimental barrier which could lead to maternal depletion and increased danger of developing severe obstetric complications if his wife were to carry more than five pregnancies. High birth rates increased women’s chances of experiencing complications during pregnancy or while giving birth but, more generally, the lingering desire for larger family sizes reflected a sense that reproduction, and life in rural areas, in particular, was still precarious and could not be assured.

4.3.4 Gendered Work and Care

Children, especially girls, are often a great asset to their families when it comes to additional labor. Early contribution to the household economy persists and only intensifies throughout a woman’s life. In many societies women bear a “double burden;” they are responsible for household work, as well as a large amount of agricultural labor (WHO 1989:67). Historically, women played an important part in agricultural cultivation of key crops that were
essential for the family’s survival (Gordon and Gordon 2007:33). Colonialism changed the
gendered structure of labor in ways that largely excluded women from involvement with cash
crops, relegating them to kitchen gardens for domestic use. This gendered involvement in cash
crop production had a substantial impact on women because many households did not pool
money and other resources; women could no longer bring in equal resources as subsistence
farming lost its value in the colonial, capitalist economy (Turshen 1984:55-6). Men began to
occupy the position of economic providers for the family. In communities in the Rukwa region,
many men related a common narrative about economic provision as care for their families and
their wives. Women, on the other hand, engaged in large amounts of domestic labor.

Particularly during my time doing research in communities in the Singida region of
Tanzania between 2009 and 2011, I followed women as they went about their daily duties. Many
women in rural areas wake up very early in the morning to start work. When I spent time in one
village, the women in the house awoke as early as 4:30am to begin preparing food for the small
restaurant they ran. Women and girls are often responsible for fetching water, collecting
firewood, and working in the fields. They also must prepare all the meals, which often takes a
great deal of time when cooking on charcoal stoves. The women also must make sure their
children get up and get ready for school. They are responsible for washing clothes and the
general cleanliness of the house and compound, which can mean several hours bent over at the
waist, sweeping the dirt or washing floors in the house and around the compound. As becomes
immediately obvious, while women do incredible amounts of work, very little of it takes place in
the formal economy. Women have very little leisure time and are unable to rest, even when they
are pregnant, because of all their responsibilities. What also becomes clear is that the labor and
economic contributions of women often go overlooked, even by their husbands, “Partly because
so much of their outside labor is unpaid and therefore ‘invisible,’ women are rarely relieved of any of their housekeeping duties by their menfolk” (WHO 1989:68), as true today as in 1989. Many women, over the course of my time in Tanzania, have told me that ideally they would reduce their workloads during pregnancy but only some women were able to do this. Women most often told me they relied upon neighbors or female relatives to help them while they were pregnant (unpublished data from fieldwork in 2010 and 2011).

Once, while on a supervision visit to communities in the Nkasi district, we were riding in the car, past people coming back from the fields. One of the district health administrators commented that you always see women with water or firewood on their heads, babies on their backs, a hoe in one hand, corn in the other, and another baby growing in her belly. And the men are walking behind the women, maybe with a couple ears of corn or a hoe. She said that women are like the donkeys of the community, doing all of the heavy lifting (Fig. 4.1).
Women often told me that, even during pregnancy, if they expressed a need for help with their work, their husbands simply said, “What, are your hands pregnant that you can’t work?” A woman in Songambele had a representative response to my question about what women typically do and whether or not their husbands help with the work,

2: If you wake up, you sweep, you wash dishes, you cook, another time there’s no firewood so you go to collect firewood, you go to the field, and there you are pregnant and there you have a baby on your back and if you tell your husband he tells you, ‘What, is the pregnancy in your hands?’ Even to sleep at night, he says let’s sleep together and there he doesn’t care if you are tired. Honestly, the work exceeds us, women from here. (Songambele women’s group)

Women overwhelmingly explained that men did not help with domestic tasks even if they, the women, were sick or pregnant. Instead, it was most often other women who would help a pregnant neighbor or relative in a communal sharing of tasks. Women could also only rely on
this help if they maintained good social relations within their community and were not, for example, from outside the area or from a minority ethnic group.

Men viewed their own roles as the family providers. While frequently it was only men who were to be found with the leisure time to hang out playing cards, checkers, or the board game bao under shady trees in the afternoon, or drinking and taking meals in bars, they explained how they saw their contributions to their families:

1: Here in Kizi, 99%, searching for money and community development are [the responsibilities of] men. That is the main thing, I mean the man is the finder like if he wants firewood, or charcoal, or I don’t know, he will carry timber, or bricks, that is his responsibility in order to prepare so his wife and family get their daily needs.

3: If he has already returned home it’s not that just because he finds they have already cooked he eats and just sits. No, it’s also his responsibility to know the development there at home, for example if there’s something that is pressing on his wife, he helps her. (Kizi village, men’s group)

Here, these two men describe the ways in which a man is responsible for always searching for the materials or money needed to meet his family’s needs. Ultimately, this searching, the man’s role as the “finder,” was a key responsibility in caring for the family despite the more nebulous form of this work.

4.3.5 Men’s Involvement in Care and Pregnancy

The gendered logics at play in the communities did not cleanly map onto the policies laid out by top-down approaches to interventions meant to involve men in women’s health. Global trends, taken up by the Tanzanian government, and enacted by local village leaders and NGOs often drove policies recommending (or mandating) men attend prenatal visits with their partners, sometimes even causing dispensary workers to fine women or turn them away if they arrived for care unaccompanied. These types of mandates overlooked the ways in which men, to different extents and with vastly differing levels of enthusiasm, were already engaging with their partners’
pregnancies and health through other, less obvious tasks. These tasks were, nonetheless, socially
valued masculine tasks, deviations from which (such as early adoption of other, externally
imposed activities) were socially sanctioned. The men in Kizi went on to explain why a man
might not engage in the same tasks as his wife:

2: Another time you can find that a man, he wants to help his wife. Now, other people, if
they pass by, they say he has been ruled by (tawaliwa) his wife, so to remove that, the
man he decides to change because he is afraid they will tell him he is being ruled by his
wife. So then even if his wife gets sick, he says she has done it to herself and says, ‘Get
up, cook,’ just so to protect against what’s being said on the street.

AS: [What does a husband do if his wife is sick?]
6: Still that legacy of you being seen to have been dominated by your wife enters in
there and that’s the reason you find a man is just brought the news that his wife has given
birth, that she got contractions at what time. He doesn’t even know. His work, if he
returns in the evening, first he is drunk, and he should find food and if not, it’s the stick.
But for those with some understanding, if his wife has been really busy with work, he can
find for her even his sister or a neighbor to help his wife, saying, ‘Watch her, I’m going
out for a bit.’

... 
AS: And if she’s pregnant?
8: I am Mmyamwezi, for us if my wife is pregnant, the responsibility for helping her,
it rests on my parents. I mean, for me, I don’t participate at all until the day I’m told she
has given birth.

... 
RM: Therefore, your mother then does the cooking. What about the responsibility for
bringing necessities there to the house?
8: That I continue to do but not carrying buckets of water!
7: I think when we say the question of helping our wives, it’s not necessary that you
carry a bucket of water on your head, you can even borrow a bicycle from your neighbor
and go to fetch water, eat a little ugali, you and the two children, you just stir it around a
couple time, you all eat it, and you give some to your wife. Because when women are in
that state, they always want to see their children, they want their family to be close.
Because that pregnancy, they share with each other, it’s of both of them so therefore it’s
necessary that the husband also should be pained, he should think about how his wife will
give birth, why should she suffer with work while he is there? But there are also some
women who you find can’t do something but she makes herself do it. (Kizi, men’s group)

In this conversation, men elucidated a number of ways in which they sought to care for their
wives, though they did not explicitly use this term. The act of finding a bicycle and going to
fetch water or looking for relatives and neighbors to help take care of the woman while sick or
pregnant were all forms of care, sets of actions and practices in which these men engaged, directed outwardly for the perceived benefit of their partners. In Mkamba village, the community leaders, primarily men, also described how they would enlist their female relatives to help their wives with household tasks during pregnancy, clearly presenting this as a form of caring for their wives. Men sought to engage in this care in gender specific ways that would be accepted by the broader community. Just as the women in Songambele mentioned, some of the men in Kizi thought they would be ridiculed by others in the community if they were seen helping their wives. The men in Kalumbaleza village also mentioned not wanting to be seen washing their clothes because they would be laughed at and people would think their wives were dominating them, not a desirable impression. Interestingly, in Kalumbaleza, men suggested that if they weren’t married they would cook for themselves and wash their own clothes but once they were married they would not engage in this work again, largely because of this public perception problem. Early in the conversation in Kizi, one of the men mentioned how some men would take up a stick if they did not find food ready at home when they arrived. This subtle mention of the stick also coincides with the honest response from a woman in Songambele village who told me husbands might beat their wives if they came home drunk and did not find food or the other work done.\textsuperscript{12}

In other situations, too, men did not want to be seen to be doing so-called women’s work. In Songambele, we were told that some men would only accompany their wives to the dispensary when she was in labor if it was during the night. Slightly surprised by this, I asked for

\textsuperscript{12} In a survey question in Tanzania’s 2010 Demographic and Health Survey, 42.1% of rural men and 27.4% of urban men agreed a husband would be justified in beating his wife for at least one reason; the most common reasons were if his wife argues with him, if she neglects the children, and if she goes out of the house without telling him (NBS and ICF Macro 2011:254), indicating that many men still commonly view women’s roles as secondary.
further explanation, thinking it might be due to fears of more danger at night. No, in fact, I was told that it was because men were embarrassed to be seen because it was not considered “manly” to go with one’s wife when she was in labor. Pregnancy was still very much women’s business. Engaging in activities that were viewed as women’s work was another way in which a man could show that he had allowed himself to be dominated or controlled by his wife. In these discussions about their wives’ pregnancies, we also discussed who should go with women to their prenatal visits or accompany them to the dispensary, or other health facility, when they were in labor.

Men in Mkamba said,

5: Maybe I should say for us Wafipa, my wife, if she has already started to complain [of contractions], I quickly run to my sister or my mother so that she comes and starts to prepare her to take her to the dispensary and me, as the father, I am behind, I follow-up later. That’s how it is for most.

6: Me, as the Village Chairman, I receive a lot of women whose husbands refuse to accompany them to the clinic and if they arrive there without their husbands, [the dispensary staff] won’t test them. Now, they have to get a letter written for them so that they get care. Therefore, maybe I should say that more education should continue to be given to men. (Mkamba, village leaders group)

In this conversation, it starts to become apparent who might be responsible for ensuring a woman makes it to a healthcare facility during labor and birth. She might have to wait for the arrival of a female relative to help her get to the dispensary, which could cause delays, particularly if her husband happens to not be at home when she realizes she needs to think about reaching a facility. Also in this conversation with the community leaders, it is clear that men often think neighbors or female relatives should be helping their wives, instead of they themselves as the husband. In other communities, men were much more used to attending the prenatal clinic with their partners, demonstrating the uneven responses to these top-down initiatives from NGOs and the Tanzanian government meant to encourage men’s involvement in women’s reproductive health, a nod to the continued importance of men’s decision making powers within the family. These programs also
failed to take into account the ways in which gendered ideals of birth and reproduction were enacted at the community level (see also Brunson 2010). These complicated, gendered interactions and negotiations surrounding care seeking could certainly determine where a woman gave birth and how quickly she reached care during an emergency.

In every community, I asked men and women whether or not men attended the prenatal clinic visits with their wives in order to get a picture of how the community was engaging with the more recent push to involve men. In some places, only a few men could honestly answer that they had gone with their wives; in others, nearly all men said they had been at least one time. In Kizi village, I asked the men if they attended the prenatal clinic with their partners and nearly every single man present had been at least one time, an exception to the more general trend of relatively low participation. I was interested to learn how men felt the healthcare providers were treating them when they came to the prenatal clinic because, in my previous experiences, providers often did not include men in the visit outside of testing them for HIV, as was required. I heard a fair amount of rhetoric about including men in women’s reproductive health but continued to view this as a missed opportunity in most health facilities. Sometimes providers were even derogatory or ridiculed men who attended the clinic. In Kizi, I asked one young man to describe to me, in as much detail as he could remember, what happened when he went with his wife to the antenatal clinic. He started by giving a very detailed account of HIV counseling and testing procedures. I then asked him:

AS: OK, let’s say you’ve already been tested, you don’t have HIV, then what happens?

1: What follows is that they will continue with those things for women. I mean, she will be put on the bed then she will be tested, tested and then later they tell you, ‘You, go’ and then they remain with your wife. Therefore, what goes on inside I don’t know.

2: Me, I like to observe a lot. There was one day, I was at home so we went to the clinic. Now, when we arrived there at the door, the man told me, ‘You, get out.’ Now, me, intellectually I know that there is care that will be done to my wife but if I wonder
why they have removed me outside while they are removing my wife’s clothes, do I know him? Therefore, me, my eyes didn’t move from the window. Truthfully, they looked at her stomach then they took the tape and measured her stomach. Then when he was finished, he talked about a lot of things but he didn’t know that I scandalized because I was asking myself why did he remove me outside?

AS: Did you ask him?

2: Like normal, although I asked him why because there she is my wife and he is the provider he can’t give out someone’s secrets. He told me, professionally, that it’s not good because you can find a woman has [high blood] pressure then it’s not good to have two men surrounding her. But generally, they usually advise her how to take care of the fetus and that maybe she has pressure therefore she shouldn’t be annoyed and she should rest.

(Kizi, men’s group)

This was a common occurrence, from my observations. Men then often did not see any point in returning to the prenatal clinic if they had already been tested for HIV, which happened during the woman’s first visit. The providers generally did not allow the men to remain in the room and rarely engaged in conversation even with the women. When I was in Mao village, we were waiting for the nurses to be done with their work so we could interview them. In order to help them finish with the patients, I conducted the prenatal visits for all the women who were waiting. Nearly all had come to the dispensary with their partners and I welcomed the men to stay in the room for the whole visit. I explained in detail what I was doing at each step and I asked every man if he would like to listen to the fetal heartbeat through the fetoscope, as a way of involving them in the visit and in the pregnancy. This was clearly a novel experience for all of them, several of whom turned away when I lifted up their wife’s shirt to palpate her stomach. I also gave both parties the opportunity to ask questions about the pregnancy or anything else on their minds. I did not use any supplies that were not already available, I simply spent more time with the couple. This is not always possible when a facility is short-staffed, but could improve people’s perceptions of the services biomedical providers offer.
4.3.6 Men as “Finders” and Transportation to Biomedical Facilities

Men, as the “finders,” were the ones responsible for locating transportation if their partner needed to go to a larger health facility. Ilambila village had particular difficulties transporting ill community members and pregnant women to the nearest health center. The dispensary provided only rudimentary services so, many women tried to go to the health center. The dispensary providers also told us that out of all the times they had called for an ambulance from the district health office in order to carry a referral patient to the health center they had never once had the ambulance arrive. Therefore, they no longer even tried to call the ambulance, preferring, instead, to arrange alternate transportation in order to expedite arrival at the health center. It was nearly always the man who was responsible for coordinating the transportation once everyone had agreed his wife needed to be referred. In Ilambila, they explained,

1: Another challenge is transportation. You will find maybe that a patient needs to be taken to Matai [where the health center is], you find that the patient’s husband must sell maybe a cow or a plot of land to get the money for the expenses of the transportation.
RM: Let’s take the example, you have a patient who is a pregnant mother or a regular sick person, but they need to go to Matai for more care, what do you do?
2: I mean there it’s the burden of the patient themselves to see the process of renting a car or motorcycle if they can.
...
RM: Now, if the person doesn’t have any money? Or anything to sell?
8: You just die.
(Ilambila, Men’s group)

Poverty was also a clear contributor to the problems in Ilambila, and throughout the Rukwa region, particularly when the community members had little access to cash before selling the year’s harvest. In the same community, the leaders elaborated on the extent of the transportation problem:

9: I should add another challenge. You find that other people don’t have the means at all even to rent a car, they have to be carried by bicycle and that mother can die on the road. We return the corpse to be buried. If she gets lucky to maybe pay for a motorcycle, then that gets her there…
AS: Has it ever happened that a mother tried to go [to the health center] but then she died on the way?
9: Yeah, by motorcycle.
AS: Mhm do you remember when it was?
9: Three years ago.
3: I transported her by motorcycle... We were on the road and she died. I had to return the body. So, it’s a problem. Yeah, transportation by motorcycle is problematic, I mean if a person has already died on the motorcycle, you have to tie the legs, I don’t know what all, I really got problems. (Ilambila, Leaders group)

Following that comment, we continued to discuss the ways in which the speaker had had to tie the dead woman’s arms and legs to his in order to keep the body from sliding off the motorcycle as he drove back to their village. I saw the same technique used once when I was working on the night shift at the regional hospital and a man arrived with a barely conscious woman on the motorcycle behind him. He had tied her legs to his to try to keep her on the back of the motorcycle on the way to the hospital. In that case, she was barely conscious due to severe hemorrhaging following giving birth earlier in the day. However, because it was late at night, her relative’s motorcycle was the only way to make sure she reached the hospital. Using this mode of transportation meant she arrived without any supplies and without any relatives to help, to donate blood, or to find other supplies for her.

Many other communities faced similar challenges and many other healthcare providers working in village dispensaries related stories of unreliable district ambulances, long waits, or struggles to find transportation. In some villages, they did not have working cell phone networks or radio call systems and the providers would have to first climb a hill to reach a spot with reception before being able to call for the ambulance. The walk itself could take at least 45 minutes to one hour, further delaying the referral. As one man in Ngorotwa said, “And another thing, you find that maternal deaths and those of children are many because we are told that we have a car for the health center but we haven’t seen it. I mean, a Parliamentarian came, promised
to bring us a car and honestly he did everything, he brought the car but after a while, it was not seen again. Therefore, this promise of transportation for patients is still ongoing.” This lack of reliable transportation or misuse of cars that were provided for the purpose of transporting patients, was a source of frustration for community members and providers alike. There was generally very low ambulance coverage throughout the region, leading to long delays if families were forced to rely on this mode of transport for a pregnant woman.

The ongoing challenges of poor road infrastructure, lack of transportation, and a weak referral chain were all important contributors to maternal and neonatal deaths and formed an important component of women’s experiences before their arrival at the regional hospital when they were referred there for further care. In another instance, a woman had been referred from a dispensary many miles away and had, in the middle of the night, walked for hours in the rain after the car she and her relatives had hired had broken down. She arrived at Mawingu Hospital with mud caked on her legs up to her knees and with the umbilical cord protruding from her vagina—a cord prolapse that most certainly had been the cause of her stillbirth and would have probably been preventable had she reached care sooner.

4.3.7 Local Midwives and Pregnancy

In ten out of the eleven villages in which I conducted focus group discussions, women stated it was now more common to give birth in the village dispensary or another biomedical facility than to use the services of a local midwife at home. Strictly speaking, local midwives did not provide any care for women before the time of labor and delivery, which is why I have placed this discussion here in the chapter. In three villages, I conducted group discussions with women the community identified as *wakunga wa jadi*, or traditional midwives. In Lowe village the *wakunga wa jadi* informed me that they were practicing more than they had in the past
because the village had recently chased out a nurse who had been working at the dispensary and the other providers had been away for some time. The most senior mkunga wa jadi in Lowe was able to describe, in detail, the ways in which she would deal with various obstetric complications. Her level of skill and knowledge was better than that of many so-called skilled personnel working in village dispensaries. She reported that she had never once lost a woman to complications. In Songambele, the wakunga wa jadi described the ways in which they had come to be practicing as birth attendants. In the past, each ukoo, or clan, in the area had had its own midwife. In all three communities, the traditional midwives told me younger women were not interested in learning more about the practice and were not entering this line of work. In Songambele, the wakunga wa jadi also explained the secrecy that historically surrounded childbirth and pregnancy:

AS: And generally, maybe men think these pregnancy things are the work of women or?
I: During that time when we were doing the birth in the streets [at home], one mother was really a coward, if she felt a contraction she made so much noise like, ‘I’m dying!’ Now, the men were asking themselves, ‘Oh, so birth is work!’ But we were afraid to tell them the truth about these things because in our tribe it is shameful for men to know these secret things. But nowadays, they have already started to know after getting this reproductive education.
AS: Therefore, women were giving birth just silently?
I: In the villages, we always give birth just like sheep, I mean it is silent and if you make noise, you are pinched.

It is perhaps partly due to this line of thinking that men were still so little directly involved in pregnancy and childbirth, particularly in a way that would be legible to organizations such as NGOs or the WHO. Women did not often express a desire for their husband to be present at the birth because they felt it was more appropriate to be with a female relative. These are the sorts of issues to which public health practitioners or politicians are referring when they mention “cultural” barriers to the increased use of biomedical services. However, it is critically important
to take into account these ideals and historical practices in order to plan and provide care that speaks to the needs and desires of women and their communities.

Community members and *wakunga wa jadi* often stated they believed women had had fewer pregnancy related problems in the past. Though this is not necessarily likely to be true, the veracity of the statement is not as significant as what it might connate in terms of the perceptions of the current biomedical system. This discourse might be read as a form of resistance to the biomedical system which disempowers women and discounts, or even criminalizes, the knowledge of *wakunga wa jadi* by locating control and knowledge in institutions of specialized, cosmopolitan expertise which often reduce bodies and obstetric complications to biology, ignoring the local realities of the social milieu of pregnancy and reproduction.

In Mao village, the *wakunga wa jadi* told me that nowadays, because of the fine for anyone who gave birth at home, or helped a woman at home, their main role was just to accompany women to the dispensary when it was time to give birth. They lamented the loss of any sort of remuneration for this kind of work though, even in the past, they hadn’t received much. In conversation, the *wakunga wa jadi* told me about the ways in which they used to receive some appreciation from families via goats, soap, flour, or other small gifts that helped the *mkunga wa jadi* run her household. In contrast, nowadays families rarely continued this form of remuneration. While public health practitioners and biomedical providers construct the use of TBA’s services as due to supposedly harmful “traditional practices” or beliefs, I would argue that TBAs do not have an incentive to stop practicing if they have been viewing their role as a profession like any other, needed for economic support. A woman working as an *mkunga wa jadi* in Kasanga village told me in 2013 that she was losing her source of income as more and more women went to the village dispensary.
The people in the Rukwa region were still widely relying on the *wakunga wa jadi* until relatively recently due to the slow development of healthcare services and facilities in the region. Sometimes women would go first to their local *mkunga wa jadi* before heading to a biomedical facility because there were certain aspects of care that the biomedical system could not provide. For example, as in the story that opened this chapter about the woman with the arm prolapse, sometimes people believed that prolonged labor was caused by social problems within the family and biomedical personnel could not address those causes.

In other instances, the *wakunga wa jadi* provided herbal medicines that women and their families believed would increase the contractions and result in a fast birth. Many of the biomedical personnel complained about the use of these herbal medicines because they were convinced large numbers of women in the region used them and the medicines caused problems such as ruptured uterus or stillbirth. The Regional Reproductive and Child Health Coordinator told me, “And they use a lot of those local herbal medicines. Up to right now, here where I am talking, even there in the labor ward a lot of times they are confiscating those herbal medicines.” Providers in villages often complained women arrived at their facilities late, in the second stage of labor, ready to give birth nearly immediately after reaching the dispensary. On the other hand, women suggested they did not like to stay at the dispensary for long periods because usually there were not enough beds and the surroundings were uncomfortable and lacked privacy. These factors all may have contributed to a higher desire to limit the time in the facility through the use of these herbal medicines. But, the use, or even suspected use, of these herbs led to repeated conflicts between women and the biomedical providers, particularly at the regional hospital. In the lack of privacy and the prohibition of herbal medicines, the biomedical facilities did not generally meet some of the locally valued requirements of a good place for giving birth.
However, most women did prefer to have a biomedical provider deliver their baby while, at the same time, limiting the length of their stay in the facility. Many villages in the Rukwa region had implemented a system of fines for women who gave birth someplace other than in a biomedical facility. One man in Ngorotwa village explained, “Also you find other [women] who give birth at home then even they don’t go to the facility. Her outcome, if she gets problems, is a challenge and others are afraid to go [after giving birth at home] because they are afraid of the 10,000 shilling fine [for giving birth at home].” This fine had been instituted in many communities I visited and it is yet another example of biobureaucracy, meant to curb what is constructed as the deviant, dangerous, or abnormal use of the wakunga wa jadi, regardless of the circumstances surrounding the need to resort to non-biomedical assistance or a woman’s prior plans to do otherwise.

The amount of the fine differed but, in most communities, they told us usually the woman had to pay, sometimes also her husband, and sometimes even the person who had attended her at home, be it a relative or an mkunga wa jadi. To avoid these fines, and in order to be ensured service in the future when they took their newborn to the dispensary for vaccines or when women later sought contraceptive advice, many women allowed themselves to be integrated into the biomedical system. In fact, this integration was inevitable if women wanted other care or benefits in the future, such as the legitimacy provided by documents such as a child’s clinic card or the paperwork necessary for a birth certificate application.

4.3.7 Interactions, Neglect, and the Quality of Biomedical Care

Once a woman arrived at a biomedical facility, the quality of services provided, and the appearance of the facility itself, became of the utmost importance, influencing her future decisions about where to give birth in subsequent pregnancies. In Songambele, they had a
common problem of not enough beds for mothers in labor or after giving birth. Women were most often told to return home almost immediately after delivery:

AS: Has it ever happened that a woman got a problem on the way home [after giving birth]?
E: Yeah
AS: Who can remember what happened?
K: I myself I remember, it happened to me. When we were on the road a lot of blood started coming out and I had to lie down at a neighbor’s.
AS: Who helped you?
K: We were with my in-law and she made the preparations to return me to the dispensary and there they gave me a shot. I was admitted and later they came to get me.
F: Even my daughter, it happened to her too just like that.

Such were the dangers of sending mothers home too soon. In other cases, a woman could have started experiencing eclamptic seizures or other severe complications. Most often, the 24-hour observation period is suggested in order to make sure the woman’s uterus has contracted and she will not hemorrhage. This is also a crucial time period to monitor the woman to make sure she has not developed a problem such as pregnancy-induced cardiomyopathy, eclampsia, infection, or severe blood loss.

In addition to a lack of biomedical supplies or decrepit biomedical infrastructure, some villages experienced difficulties and conflicts with their healthcare providers. In Lowe, one of the nurses, in particular, gave the community a great deal of problems, until they refused to allow her to continue working there. In an act of resistance, and in an effort to demand the healthcare services they felt were their right, the community finally decided to report the offending nurse and kick her out when people died due to her negligence. Villagers reported that this nurse also allowed women to give birth unattended. This was a rather extreme example of the ways in which community members could be dissatisfied with the services available. In most other instances, the transgressions were not so overtly negligent. In other villages, people seeking care
often went through similar experiences when the village’s healthcare providers were all out of the community for various reasons. The reasons for their absence ranged from annual vacation leave, to participation in seminars, to three of four nurses in one village all being out on maternity leave, to providers being away while they traveled four days, roundtrip, to collect either supplies or their salary from the district medical offices. Besides all of these reasons, there were numerous occasions on which providers were not available or only one was present. In nearly all of the villages I visited as part of the random sample for group discussions, as well as all those I visited while shadowing supportive supervision visits, we found at least one provider absent, often without notice or explanation.

Social interactions were particularly important to community members during prenatal care visits but, I argue, these interactions during the woman’s pregnancy helped to determine whether or not she would seek biomedical care or follow a provider’s recommendation to give birth in a larger facility if she had a potential complication. The interactions between women and biomedical providers in the prenatal period helped to build or erode trust in the system as a whole. Community members also cited a lack of supplies and suspected corruption as deterrents to the increased use of the facilities in their villages. In terms of provider understanding and compassion, one of the village leaders in Mkamba had the following thoughts:

1: Then another thing, women are embarrassed, I mean if she is told then for example that she should go to town, right away she knows she is going to be operated on. Really the goal is for her to get the best care that she needs but she remains there at home, embarrassed...But, on the other hand, care should be improved and these providers of ours should be given training. (Mkamba, Village Leaders’ group)

Here, the leader suggests that a women might be afraid of having a C-section and therefore not follow a provider’s recommendation to go to Mawingu Hospital in town. Sometimes this was merely a misunderstanding borne of lack of information or lack of trust in the biomedical system.
The women in Ngorotwa outlined some of the problems in their community health center which deterred attendance. They complained that if a woman did not have any money, she would not get her prenatal clinic card (which, legally, was always supposed to be free) or medication and she might be charged a bed fee after giving birth there, which was also an illegal practice:

1: If you don’t have money, you won’t get medicine.
AS: But the medicines are there?
2: The medicines are there but they tell you you have to buy them. For example, you have a pregnant child, now while taking her there maybe she gives birth on the way. Now, if you take her there to the facility you are charged money.

3: Another challenge is a mother, if she has already given birth, to let her get out of the bed, you have to give money.
AS: Even for a pregnant mother?
3: Yeah, 12,000 they ask for, for soap or something, I don’t know.
AS: Me, I don’t understand because healthcare for pregnant mothers is supposed to be free.
2: Even us we know that it’s free but if you go there, if you ask them they will tell you that not even one day have they ever charge a pregnant woman. Even if you call them to a public meeting, they refuse, they say they have never done that. If they say to ask the women, the mothers are afraid so there isn’t even one who says because she is thinking, ‘If I say, then the day I go to the health center they will chase me out,’ so that is what is restraining the women. (Ngorotwa, women’s group)

These types of abuses and attempts by providers to make more money were common causes of complaints and could certainly erode community trust in their facilities and providers, making it less likely they would choose these facilities for care. The women in Ngorotwa clearly were unable to report their healthcare providers for bad behavior or for imposing illegal fees for fear of retribution the next time they needed healthcare services. These accounts of extortion in village biomedical facilities illustrate the reasons women often decided to seek care in other, higher level facilities, thereby increasing the burden on the regional hospital due to the poor care in these lower level dispensaries or health centers. On the other side, rural healthcare providers reported that they charged small fees for antenatal clinic cards or other services sometimes as a
way of raising funds to pay for a security guard at the dispensary or other such initiatives. This is not to say that sometimes they were not also charging women in order to line their own pockets, but only to acknowledge the fact that providers sometimes were either unaware they were engaged in an illegal practice or found ways to justify the fees they imposed with rhetoric about using the money to improve services.

4.4 Conclusion

Women did not arrive at Mawingu hospital from a vacuum, instead, before their arrival, they might have already been subjected to a number of factors that could predispose them to poor health and biomedical risk during pregnancy and the postpartum. Starting from a young age, girls may not have equal access to education, may be married or get pregnant at a young age in order to meet the financial needs of their families (through bridewealth payments) or because they lack other activities to fill their time (attending sexually-explicit movies with men), bear the largest burden of work in the family, and may not be involved in family decision making, in addition to being victims of intimate partner violence. What I have presented in this chapter can be considered representative of the lives of women living in rural areas. The experiences of women in urban and peri-urban areas, as well as those employed in professional fields such as teaching or nursing, would be different than for the majority of the women with whom I spoke in group discussions. However, these rural women represent the vast majority of the Tanzanian population.

When women were able to access care in biomedical facilities, there was the potential for numerous other conflicts between the local and global maternal health logics. Understaffed dispensaries with providers concerned with sustaining their own families on low salaries and working in remote areas with little support, often led to poor quality of care and interactions in
the care setting that left much to be desired. It is no surprise then that many women with economic means and the money for transportation sought to bypass their village facilities, or even the district hospitals, in favor of the Mawingu Regional Hospital.

Both at the community level and within healthcare facilities, women experienced varied forms of care and, often, a lack of it. This lack of care often came from their partners who expected women to continue working through sickness and pregnancy. A man might not even consider involving his wife in decisions about their family or even her own health, instead justifying his unilateral approach by saying he paid bridewealth, or because he was seeking to avoid looking as though he had been dominated or controlled by a woman. Women however, often did provide each other with care through relations with neighbors or family members, both close and extended, sharing work and bringing water or food to women who were ill or nearing the end of their pregnancies. Communities expressed dismay, frustration, and feelings of betrayal when they perceived a lack of healthcare resources and poor quality. Often this was because they expressed the view that the state had a responsibility to provide medications and healthcare to its citizens. Even a lack of infrastructure could be viewed as a lack of state care, as when women died on the back of motorcycles on the way to a health facility due to lack of transportation or impassable roads.

These experiences all formed the background of the decisions women and their relatives made to seek medical care at the regional hospital during pregnancy or at the time of giving birth. Negligent, abusive, or corrupt care in their communities conditioned women and their relatives to mistrust the biomedical system even before they arrived at Mawingu Hospital. Their locally constructed, gendered logics of care and ideas of risk (social or, less often, biological)
informed their comportment and interactions in the hospital setting. These views, combined with past life events, sometimes paved the road to medical complications or even death.

To conclude this second part of the dissertation, I want to emphasize once again the ways in which the growth of biomedicine has come to disallow other forms of caring during pregnancy and childbirth. This outcome has been accomplished, in part, through the expansion of biobureaucracy across levels. Chapter 3 demonstrates the development of biomedicine as a system to monitor and control local populations under colonial rule and, in a new form, through the Safe Motherhood Initiative meant to empower women and help them to access their right to a safe and healthy pregnancy and delivery. Chapter 4, in turn, shows how the top-down, WHO-led logics of rational actors and rights may, at times, conflict with the goals, needs, and conceptions of risk that are present at the local level in Rukwa, Tanzania. Biobureaucracy continues to expand through fines, forms, referral procedures, and guidelines of best practice that structure what biomedical healthcare providers view as compliant health-seekers, men and women both, when they go to biomedical facilities during a woman’s pregnancy or when she is about to give birth. The biobureaucracy has also expanded in a way that made it difficult for village dispensaries to maintain supplies and provide the high quality care that women desired instead, leading providers who were underpaid and left without support, to resort to negligence or extortion to make ends meet in their own lives. Part III carries these themes over into the regional hospital setting of Mawingu’s maternity ward.