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"Pregnancy Is Poison"

The Road to Maternal Death

Within public health generally, and at Mawingu Hospital, maternal mortality has often been reduced causally to women coming from villages and lacking trained assistance, or to a lack of women's empowerment and vague attributions to harmful "culture." While I disagree with this reductionism—both biomedical and cultural—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. However, as many others have suggested within medical anthropology, some public health practitioners and policy makers use culturalist explanations of increased morbidity and mortality to deftly mask entrenched political economic forces, which are extraordinarily hard to address.[1] Likewise, culturalism often views culture as bounded, static, and homogenous.[2] In contrast to deep structural problems, perceived harmful, static cultural practices are easy to address through education campaigns, just as the maternal death audit action plans attempt to do. Both cultural and biomedical reductionism conceal a number of other important questions such as: What factors might cause a woman to arrive at Mawingu Regional Hospital "already dead"? What might lead her, through either choice or circumstance, to give birth with a local, nonbiomedical birth attendant? Are there really only three delays? The following story of Pieta involves more than the gaze of biomedicine can reveal. Her story complicates the dominant global health model of the three delays and its attendant logic of risk and care for pregnant women by showing the complexities of local logics of reproduction, care, and risk in pregnancy in Tanzania.

After Pieta's story, I present some of the underlying experiences, logics, and structural forces that shape women's lives before they arrive at Mawingu Regional Hospital pregnant or in the midst of an obstetric emergency in order to demonstrate how a woman might come to die at the hospital. Ultimately, women's

previous interactions with biomedicine work to erode community members' trust in the health sector's ability to actually mitigate risk for pregnant women using an ethic of care that matches their desires.

PIETA'S MALPRESENTATION

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 Namanyere District Hospital. When my research assistant, Rebeca, and I arrived in Kizi, we first went to the dispensary (figure 13) and, once we began talking with the staff members, discovered they had called the ambulance a couple of hours earlier. They had been trying to help a woman in labor since the middle of the night, around 3 a.m., when she had arrived from home complaining of problems. When the nurses had 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 twenty-five years old and pregnant with her third child. Pieta's relatives had taken her back home from the dispensary, refusing help from the nurses but asserting that 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. They refused to let the nurses call the ambulance. 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 9 a.m., so they could finally call the ambulance. Though they wasted no time calling for the district's one ambulance, the car did not finally arrive until 1:30 p.m. because of the trip to another village and then back to Namanyere, the district seat and home to the district hospital, which was when we had passed it, and then back again to Kizi, many miles to the north of the district hospital.

While we were waiting for the ambulance to arrive, I looked in on Pieta and saw that she had a full bladder and that 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 had had one. Pieta was confused, exhausted, and barely able to answer questions. She was also in pain and extremely uncomfortable as the baby's now-bluish arm protruded from her vagina. When the ambulance arrived, the dispensary nurses, and those who had arrived with the ambulance, 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 makeshift referral form, I spoke with her husband. He told me

FIGURE 13. The exterior of Kizi dispensary. Photo by author, 2015.

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 did not want the nurses to know she had 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.[3] People in Kizi believed any referral to the hospital meant the woman would have a C-section.

Before returning to Sumbawanga Town that evening, Rebeca and I stopped at the district hospital in Namanyere to see Pieta. She had had a C-section, and she'd had a baby boy, weighing 3.0 kilograms, but he was stillborn. She also had received a blood transfusion, and drugs were in such short supply in the hospital that she and her relatives were told she had to buy them, but they had not brought enough money. In the end, the family's financial circumstance forced them to go to the district nursing officer herself to request the money for her medications (facilitated by the hospital), which was exactly what many people in the surrounding communities feared when they were told to go to a hospital for surgery—having to spend 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.

Despite what Pieta thought, the nurses had known the proper procedures, for the most part, but, again, circumstances brought on by a lack of supplies (a catheter, for example) and only one district ambulance forced delays in Pieta's care and referral. Faced with caring for a patient with a complicated case and without immediate referral support, the nurses at the Kizi dispensary had quickly run out of the techniques with which they were familiar and, in the end, could only watch Pieta, which she had perceived as the nurses being shocked by her condition. Pieta's case illustrated many of the ways in which community and biomedical perspectives could come into conflict; she was just one woman of many who experienced delays during an obstetric emergency because of 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 health care 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 a spate of maternal deaths at the regional hospital, one nurse said, "Who said pregnancy is not an illness? Pregnancy is poison!"

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 the logics that circulate and guide actions and practices within communities. These logics, and how they portray women, have likewise shifted since the inception of the Safe Motherhood Initiative.[4] 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 *have the potential* to be agentive, 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. This neoliberal subjectivity then becomes another linchpin in the global health community's quest to continue reducing maternal deaths,[5] and it is embodied locally in Tanzania in the discourse around *maendeleo* or development, which extends to responsible, "modern" personhood, including appropriate, effective, and timely use of biomedicine.[6] An underlying premise here often seems to be that women can become these ideal actors when they overcome their culture, a vague barrier to realizing women's empowerment, gender equality, and ideal use of biomedical institutions. However, these logics of risk, care, and neoliberal subjectivity differ, sometimes drastically, 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.

PATHWAYS TO DEATH

To arrive at Pieta's point, a crisis situation that culminated in the death of her baby and an expensive surgery, women first walked a long road extending back into their childhoods and adolescence.

One global effort, reflected in the SDGs and MDGs, to increase women's empowerment centers on improving girls' access to education.[7] Several studies show that education for girls, even just through the completion of primary school, is a predictor of lower maternal mortality levels.[8] It is not so much the book knowledge girls gain in school as "the knowledge to demand and seek proper healthcare,"[9] 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.[10] Studies have found that health messaging and education alone increase women's knowledge of health problems during pregnancy but are not capable of fundamentally changing women's social environment during pregnancy.[11] This finding suggests there are other structural factors affecting women's "social environments," for which education is not the answer. Globally, more and more girls are entering and staying in school, sometimes even surpassing the number of boys enrolled. However, in Rukwa, many girls ended their education when they were in their early teens. Others, because of the poor quality of instruction, completed primary school but were functionally illiterate.

Though primary school became free to all Tanzanian students starting in 2011, it was not until the very end of 2015 that the government abolished all fees for the lower levels of secondary school, the Ordinary ("O") Levels.[12] At the time of my fieldwork in Rukwa, all children who passed the primary school exams were allowed to continue their schooling, but only those who did very well received low-cost spots in government schools. This meant that many children ended their educational journey after primary school, at around thirteen to fifteen years old. Parents insisted they would educate both their male and female children, but when I pressed them to choose between a son and daughter if they had the resources to educate only one, many people responded they would send their son for further education. Community members said this was because they were concerned a girl would get pregnant while in school. However, this choice was predicated more on economic calculus, in most cases, than on lingering beliefs that it was better to educate boys; in fact, many parents suggested daughters were more likely to take care of their families if they succeeded economically, thereby making them better long-term investments, so long as they escaped early pregnancy.

Despite increasing access to secondary school education by abolishing fees, the Tanzanian state falls short of policies that would support gender equity, or even equality, in education. In June 2017, Tanzanian president John Magufuli announced at a rally that girls who got pregnant while still in school would never be allowed to return, citing them as "bad moral influences" who would teach other girls how to become pregnant.[13] Though the law enabling expulsion of pregnant schoolgirls under "offences against morality" passed in 2002, many teachers allowed girls to continue their studies after giving birth.[14] Now that future for girls is even less certain.[15]

There were few options for a girl who stopped her education after primary school. In Songambele village, as well as many others, parents told us there were no formal mechanisms for teaching sex education. There had, at one point, been rituals surrounding adolescence and marriage that included an element of sex education, but the Wafipa in the villages I visited no longer observed these practices. No other institutions, such as the clinics or schools, had yet picked up this slack in a way that reached a wide population, and the result was young people, out of school but unready to settle down to a life of backbreaking farm work, who sought out amusement in the company of the opposite sex with little knowledge of safe sex practices or how to prevent pregnancy. As Augustina in Songambele told my research assistant, Rebeca, and me, "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 [unmarried]."

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 Dr. Charles if, from his observations women in the region commonly gave birth at a young age. He confirmed, "Yes, even me, I was surprised to see such young girls here. I even once saw a twelve-year-old, you can't believe. Yes, there are young girls coming here to give birth in this region. More than other places." Clinically, girls who have not finished growing have a higher chance of developing severe complications, such as cephalopelvic disproportion, necessitating surgical birth.

These unintended, early pregnancies also 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.[16] 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 that 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 pay bridewealth and marry her, solidifying his obligations to the woman and ensuring that the baby would be counted as part of his family. 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 should she develop a complication during her pregnancy, or while giving birth, and need financial resources. In describing the effects of early marriage and pregnancy on families, another woman from Songambele explained, "Really, this has a lot of effects because your child, if she gets a child, okay, 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." 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 health care services.

Tanzania has a law forbidding marriage for anyone under the age of eighteen, but poverty and a lack of other options for their children often pressure parents into accepting or demanding an early marriage so they can collect the bridewealth payment. After our group discussion in Songambele, the village chairman's wife Susanna pulled my research assistant aside, entreating Rebeca to talk to her husband on her behalf because he had agreed to the marriage of their fourteen-year-old daughter as a second wife to a much older man who had impregnated her. In desperation, Susanna had gone to the man's house, breaking the lock on his door, to physically remove her daughter from the situation. There was a court case underway because the man had accused Susanna of destruction of property. Legal recourse against the older man and prospective husband was, however, out of the question; Susanna's husband refused to bring charges against the man because he had already paid for the marriage. While on paper the Tanzanian state protects minors from early marriage, once again the lives and structural constraints on the ground reflected a different reality, one that continued to endanger girls through early childbearing.

BRIDEWEALTH, MARRIAGE, AND DECISION-MAKING

Once a woman of any age enters a marriage, bridewealth, gender dynamics, and household work all affect her health, her decision-making autonomy, and, subsequently, her ability to get lifesaving care at a health facility in the event of an obstetric emergency. Bridewealth is a long-standing institution in many parts of sub-Saharan Africa and includes the exchange of goods between the groom's family and the bride's family. Here the flow of goods is opposite to that in a dowry, when the bride's family must pay the groom's family. For most ethnic groups in Tanzania, bridewealth is paid in cattle or smaller livestock, such as goats or even chickens. Currently, many families will also accept the cash equivalent of the livestock in lieu of the animals themselves. In patrilineal groups like the Wafipa, and the Wasukuma, who make up a sizable minority population in some villages in Rukwa, the woman joins the groom's family. A man in Kizi village during our

group discussion explained, "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.'" The other men in the room listened attentively, waiting for him to finish, "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 [my in-laws], then today you [my wife] have done something at your home place without asking me, weee! It will all erode! [i.e., the marriage relationship will break down]." Several of the men in the room chuckled or nodded, acknowledging that this sometimes happens. Another, though, spoke up thoughtfully: "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" to the man because he can say he officially married a woman and had the financial resources to do so. The men noted that if a man chose to abuse the covenant of bridewealth, used to establish this goodwill between families, he could wield it as a weapon to punish his wife and limit her freedom or autonomy, keeping her in a subordinate position in the family.

From speaking to men in Kizi and other communities, it became clear that women whose families had received a large bridewealth payment were not supposed to disobey their husbands or, in fact, contribute much to any sort of decision-making in the extended household. These large bridewealth payments were more common among the Wasukuma people, who paid sometimes ten times as much in bridewealth as the Wafipa. One Sukuma man said, "I mean, if I give a bridewealth for a light-skinned girl, I mean it can be sixty or forty cows. Therefore, she must submit to me a great deal because you have given for her a large bridewealth." This mode of thinking had ramifications for health care, 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. Yet although this was ostensibly a cultural norm and seemingly monolithic, the practices varied widely depending on individuals and their choices about how to interact with the institution of bridewealth.

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, they 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, to raise money for emergency transportation to medical care. Instead, she would have to wait for

her husband or other 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 village, women said that men often refused to listen to their opinions or input because men feared that listening or submitting to women would make them look weak or seem as if 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 how many 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 health care 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 health care 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, were very young, were very short, or had had many previous pregnancies, all risk factors for various complications. I asked women in a focus group why they might not be able to follow the advice of the clinician if he instructed them to give birth in a larger hospital. One woman responded: "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 villages, if a woman did not have any access to cash herself, there were few options for her to arrange for travel to the hospital in Sumbawanga or even to the relatively nearby health center. She was often dependent on her husband for the financial resources, as well as, in some cases, for 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 that they preferred to not give birth in the small, underresourced dispensary.

The nurses at Mawingu tended to be from families of higher socioeconomic status than the farming communities in these outlying villages. However, they were not very far removed, in many cases, and several had come from families in the region. This meant the nurses were, on the whole, familiar with what women's lives might look like before they arrived at the hospital. It was easy, then, to point to many of these other social issues, particularly those widely perceived to be due to "backwards thinking" or a lack of education, as the cause of a woman's late arrival and precipitous death at the hospital.

PRONATALISM AND THE VALUE OF REPRODUCTION

Once married, couples face a strong social imperative to reproduce. While women in more urban areas in Tanzania appear to be verbalizing a desire for smaller family sizes, women in rural areas often still express a desire for larger families, for a number of reasons.[17] One of these reasons is simply the fact that under-five mortality is still quite high in the country,[18] and many families expect to lose at least one child. Having children solidifies a woman's place in her marriage and in her husband's family, and being unable to conceive, regardless of which member of the couple might be the source of the infertility, often results in social precarity for women.

Gender relations in Rukwa highly influenced the extent to which women were able to contribute to choices about birth spacing, family size, and family planning. A woman told me that 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 in communities, women complained that their husbands did not support them through the difficulties or complications associated with using various forms of contraception. Women 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 takes place between the husband and wife. Now, a problem, you find, inside the home, a wife can say, 'Let's use family planning' and instead that is her strategy to find a lot of men. . . . She starts to annoy me, saying that that family planning is a really good idea. But many [women] use it for another purpose." 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 to space pregnancies or to limit the number of children she and her husband would have. While this man from Songambele started out by making it sound as though the man and woman both had equal say, an inherent suspicion about women being unfaithful colored his view of contraception. Such opposition could lead to maternal depletion and increased danger of developing severe obstetric complications if a wife were to carry more than five pregnancies.

GENDERED CARE AND WORK DURING PREGNANCY

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.[19] Historically, women played an important part in agricultural cultivation of key crops that were essential for the family's survival.[20] 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.[21] Men began to occupy the position of economic providers for the family, an arrangement that followed models imported by colonial rulers from their own countries and largely continues in Tanzania to the present day. In communities in Rukwa, many men related a common narrative about economic provision as care for their families and their wives and as a man's primary role in the family. Women, on the other hand, engaged in large amounts of domestic labor without being exempt from agricultural labor needed to sustain their families.

As becomes immediately obvious, while women do incredible amounts of work, very little of it takes place in the formal economy. Women in rural areas have very little leisure time and are often unable to rest, even when they are pregnant, because of 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,"[22] a pattern as true today as in 1989, when the WHO published the report quoted. 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 had the resources, social or otherwise, to be able to do this.

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, maize in the other, and another baby growing in their belly. And the men are walking behind the women, maybe with a couple of ears of corn or a hoe. She said that women were like the donkeys of the community, doing all of the heavy lifting (figure 14).

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 described women's typical daily tasks and their husbands' contributions: "If you wake up, you sweep, you wash dishes, you cook. Another time there's no firewood, so you go to collect firewood.

FIGURE 14. Women carrying firewood and water. Photo by author, 2015.

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." 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 rely on this help only 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 about playing cards, checkers, or the board game *bao* under shady trees in the afternoon, or drinking and taking meals in bars, men described how a husband was 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.

The gendered logics at play in the communities did not cleanly map onto the policies laid out by top-down approaches to interventions aiming 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) that 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 how 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. One man, George, in Kizi village explained why a man might not engage in the same tasks as his wife: "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."

After George had finished speaking, Boniface presented a slightly different picture of what some men in the community might do when their wives were pregnant:

> 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 [like a woman], you can even borrow a bicycle from your neighbor and go to fetch water. Cook a little *ugali,* you and the two children, you just stir it around a couple times, 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?

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. 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.

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 accompany their wife to the dispensary when she was in labor only if it was during the night. Slightly surprised by this, I asked for 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. Instead, many men preferred to find a female relative to accompany their wife to the health facility when her contractions began, and the men might follow along later. Men, however, as the "finders," were nearly always responsible for securing transportation when their wives needed to go to a health facility or received a referral to another level of care. Procuring transportation might include selling family

assets, collecting contributions from neighbors and relatives, or negotiating to use a car on credit. Poverty could make these processes painstakingly slow, exacerbating delays and threatening a woman's life even further. These complicated, gendered interactions and negotiations surrounding care seeking often determined where a woman gave birth and how quickly she reached care during an emergency. Sometimes, because of delays in marshaling resources, precipitous labor, or maybe her husband's refusal to accompany her to a health facility, a woman gave birth at home with the help of a local midwife or *mkunga wa jadi*.

LOCAL MIDWIVES AND PREGNANCY

Speaking in Kifipa, a wizened old woman surely at least in her eighties, Bibi Mbalazi, spoke slowly and with authority, explaining, "Me, I always know, by looking at the umbilical cord, that this mother, she was bound by some person so that she would die from her pregnancy. You find the umbilical cord has already been tied, tied like this, but God helped her, and the midwife delivers her safely." I had asked her about the rumors I had heard about powers traditional midwives had had in the past either to use witchcraft to bind women to them or to detect the malicious intentions of others toward a pregnant woman. In this case, Bibi Mbalazi explained, the knotted umbilical cord could be evidence of witchcraft. The rest of the room was silent until one of the other women translated the response into Swahili for me. After this, Bibi Mbalazi resumed, telling me how, in the past, women had brought gifts of flour and beans to their midwife, entering into a contract with her to deliver the baby when the time came. But sometimes a woman would end up going to a different midwife for the birth and then not pay or not finish paying the original one. Then, Bibi Mbalazi said, the two midwives might fight over the right to deliver the woman, and the midwife who felt cheated of payment might interfere with the birth through witchcraft and harm the woman or her baby, thereby corrupting the goals and reputation of midwifery. She continued: "People are fighting over the mother, therefore they are doing everything top to bottom [in their power], so she doesn't give birth, [thinking] 'For this one, [I will do this] so she knows to come to my place.' Therefore, another time, there is a death of a pregnant mother or even one midwife among them." Women and local midwives all used to know who would help the woman give birth, entering into a relationship with that person early on. These relationships no longer existed with the local midwives and often were not possible with biomedical health care workers. Such contemporary distancing between pregnant mother and (biomedical) midwife might reduce the potential for jealousy and witchcraft, but it also limited the social embeddedness of giving birth. Unlike the *mkunga wa jadi,* who could diagnose malevolent witchcraft intentions by looking at an umbilical cord, biomedical nurses tended to operate in a different world. Though often products of a similar environment, nurses, through training and practice, came to inhabit

a slightly different ontological world, in which knotted umbilical cords held biomedical meaning first, before becoming signifiers of witchcraft.

Though local midwives, who conduct deliveries at women's homes, continue to practice in many communities, most women, particularly younger ones, now express a desire to give birth in biomedical facilities. 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, in these communities local midwives did not provide any care for women before the time of labor and delivery, in the past or present.

These *wakunga wa jadi,* called traditional birth attendants or TBAs in public health literature, often fill gaps in the biomedical system. In the maternal death audit meetings and other biomedical spaces, administrators often blamed TBAs for delaying women's arrival at a biomedical facility. They imagined that these TBAs detained women in their homes, allowing them to labor for long hours before referring them to facilities. Likewise, in the biomedical imagination in Rukwa, administrators and providers, drawing on culturalist reasoning, often envisioned women seeking out TBAs, actively avoiding facilities out of *imani potofu,* or backward beliefs. However, this is much too straightforward an explanation for how women sought to patch together care when they went into labor early, or in the middle of the night, when in the fields farming, or when their husbands or other relatives were far away. *Wakunga wa jadi* stepped into these gaps and assisted women, often in ways women found to be more comforting and supportive than in hospitals, though both women and the *wakunga* themselves acknowledged it was preferable to go to a facility where emergency care was available. Most commonly, women and *wakunga* gave the example of blood transfusion and IV fluids or oxytocin to augment labor as care that was unavailable at home but could be lifesaving and desirable. Often, if a woman gave birth at home with an *mkunga wa jadi* it was because she lacked the resources or transportation to go to a biomedical facility.

As biomedicine continues to reach into ever-further corners of the world, biomedical knowledge has become the proverbial gold standard in many locations. However, the arrival of biomedicine did not preclude the continued utilization of alternative forms of healing or health care. The ongoing presence of coexisting systems proved time and again to be at the root of contestations over "truth" and "lies" on the maternity ward, as when nurses accused women of killing their babies by drinking local herbal medicines or using other nonbiomedical treatments. Nurses might look down on a woman as being uneducated and "from the village," in a derogatory sense if they thought she was resisting biomedical interventions, authority, or methods. By extension, biomedical health care workers largely scoffed at the methods and knowledge of "traditional" healers and birth attendants, at least in public settings.[23] At their heart, these were contestations related to power and authoritative knowledge within the walls of the regional hospital. As

certain ways of knowing, and the attendant practices, are discounted, others gain ascendance and are thereafter sustained and reproduced.[24] The WHO and the Safe Motherhood's shifting targets and priorities throughout the 1980s and 1990s also helped to create and perpetuate the power of biomedicine in many low-resource settings, as these organizations and programs first created the category of "traditional birth attendants,"[25] invested in training them, and then reversed course, recommending only "skilled" (as these women were not) attendants at birth in biomedical facilities.

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 one of the government dispensary nurses and because the other providers had been away for some time. Villagers reported that this nurse had allowed women to give birth unattended, alone on the dispensary doorstep in the middle of the night. In an act of resistance, and in an effort to demand the health care services that they felt were their right, the community finally reported one of the nurses and kicked her out of the village after people died on account of her negligence. In the absence of biomedical providers, women had once again turned to *wakunga wa jadi* for care. The most senior *mkunga wa jadi,* Bibi Mbalazi, was able to describe, in detail, how she would deal with various obstetric complications. Her level of skill and knowledge surpassed that of many so-called skilled personnel employed in village dispensaries. She reported that she had never once lost a woman to complications. Traditional midwives throughout the region told me younger women were not interested in learning more about the practice and were not entering this line of work. Even though women with whom I spoke were expressing stronger and stronger preferences for biomedical care, this preference was also shaped by the foreclosing of alternatives.

Many villages in Rukwa 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 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 nonbiomedical assistance or a woman's prior plans to do otherwise. Instead of encouraging the use of biomedicine, the fine became, for the poorest women, a structural impediment to achieving biomedical care. Knowing she did not have cash to pay the fine, a woman who was unable to reach a facility delayed visiting the facility even if she experienced a postpartum complication or wanted to have her newborn checked and given vaccines.[26] Such bureaucratic technologies do not prevent "culture" from leading women to TBAs but instead further entrench existing inequalities in access to care. 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 like a child's clinic card or the paperwork necessary for a birth certificate application.

The people in the Rukwa region were still widely relying on the *wakunga wa jadi* until relatively recently because of the slow development of health care 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 Pieta's story that opened this chapter, sometimes people believed that prolonged labor was caused by social problems within the family and that 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 that large numbers of women in the region used them and that 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." The use, or even suspected use, of these herbs led to repeated conflicts between women and biomedical providers, particularly at the regional hospital. Because of the lack of privacy, no option for having a relative remain with the woman in labor, 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.

Home birth fines and the complicated paper-based procedures for proving an accidental delivery outside the local biomedical facility served to deteriorate relationships between some *wakunga wa jadi* and the biomedical facilities even further. But the ones most often caught in the middle, bearing the brunt of these struggles for legitimacy and control over birth, were pregnant women themselves. These are not new concerns; this conflict has deep roots and a long history in Tanzania. There have been policy debates about the merits of home versus hospital or institutional births since the colonial period, representing a deep agnosticism related to the relative cost/benefit of each location in this low-resource setting.

TRANSPORTATION TRAVAILS

When women did try to access biomedical services, transportation was one of the most frequent impediments to timely arrival at a facility because of poor roads

and a lack of public transportation. Ilambila village had particular difficulties transporting ill community members and pregnant women to the nearest health center. The dispensary providers told us that the district government ambulance had never once arrived when they had called it; they no longer even tried. Now they preferred to arrange alternate transportation to expedite arrival at the health center. The result was, as one of the village leaders explained, "You will find maybe that a patient needs to be taken to [the health center], 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." Rebeca asked the assembled group of leaders what would happen if a woman and her family didn't have any resources to hire a car. Another man in the group responded, "You just die."

One of the village chairmen, Jobu, continued, "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." Curious about the specificity of his answer, I asked, "Has it ever happened that a mother tried to go [to the health center] but then she died on the way?" Jobu replied, "Yes, it was by motorcycle, three years ago." I prompted the group further, wanting to know what had happened. Danieli cleared his throat and began to speak: "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." Danieli had tied the dead woman's arms and legs to his in order to keep the body from sliding off the motorcycle as he painstakingly drove back to their village.

Many other communities faced similar challenges, and health care providers working in village dispensaries related stories of very sparse and 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 climb a hill to reach a spot with reception before being able to call for the ambulance. The walk itself could take at least forty-five minutes, 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. Therefore, this promise of transportation for patients is still ongoing."

In several of the communities Rebeca and I visited, the community members described how Parliamentarians swept through the area during campaign season. They would make grandiose promises of new ambulances as they acknowledged the dire need for better emergency medical transportation in the region. And yet these ambulances rarely materialized. The district and regional medical offices did not have the capital needed to purchase appropriate vehicles that were equipped as ambulances either. In one case, I saw the ambulance for Ngorotwa

Health Center, donated by one of the aforementioned Parliamentarians, driving around Sumbawanga Town and could not help but wonder to myself why it was there instead of parked at the health center several hours distant.

In another instance, I was on the maternity ward at Mawingu when we received a woman had been referred from a dispensary many miles away, close to a neighboring region. She arrived exhausted and dirty, telling us that in the middle of the night she had walked for hours in the rain after the car that she and her relatives had hired had broken down. She collapsed onto a bed in the maternity ward with mud caked on her legs up to her knees and with the umbilical cord protruding from her vagina—a cord prolapse that caused her stillbirth, which probably would have been preventable had she reached care sooner. She had arrived without a formal referral letter or an accompanying nurse, making it easy for the harried nurses at Mawingu to assume she had arrived from home and did not have a serious condition. 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 powerfully shaped women's experiences before their arrival at the regional hospital when they were referred there for further care. These challenges, too, were all highly visible reminders of how the state failed to care for its citizens and allowed pregnant women and others to die while in the throes of a medical emergency.

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. Both in women's minds and in guidelines, quality care required material goods and physical infrastructure but also respectful, responsive health care providers. Breakdowns or deficiencies in any of these areas eroded women's trust in their local biomedical services. Even if she chose to return to her nearest biomedical facility after a bad experience, a woman might no longer honestly share with nurses her medical history, her previous attempts to access various forms of care, or her desires. Secrecy was often a result of past instances in which nurses had accused a woman of lying or of being noncompliant, a problem patient. In other cases, a woman had seen that no matter what she said or did, the nurses ignored her and, in moments of need, demanded money for supplies, a bed, or documentation to which, legally, the mother had a right for free.

These types of past experiences could then create a cycle in which women no longer trusted the recommendations of their providers. Poor relations between village health care workers and their pregnant clients could mean women did not receive adequate explanations for referrals. Bennet, a village leader in Mkamba,

FIGURE 15. Foundation of an unfinished addition to the dispensary in Songambele village, March 2015. Photo by author.

told me, "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." He felt that women misunderstood the reasons for their referrals while, at the same time, acknowledging that the quality of care in their dispensary needed to be improved.

In Songambele village, located high on the Ufipa Plateau, the dispensary had a common problem of not enough beds for mothers in labor or after giving birth. The foundation of an expanded maternal-child health building stood uncompleted near the existing dispensary building, which remained unfinished in 2019 (figure 15). Nurses often told women to return home almost immediately after delivery to save space. In this community, I asked women if they knew of anyone who had developed complications after giving birth, while on the way back home from the health facility. Mama Rajabu told me, "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. 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 [to take me back home]." Another woman jumped in and said, "Even my daughter, it happened to her, too, just like that!" Bleeding after giving birth is relatively common and can sometimes be severe,

requiring additional oxytocin to help the uterus contract or, in other instances, may entail manual removal of retained portions of the placenta that broke off during the birth. Most often, protocols for best practice recommend a twenty-four-hour observation period 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, or infection. Poor infrastructure combined with low levels of provider knowledge or a lack of communication could cause some women to begin viewing biomedical facilities as places that caused problems instead of solving them.

In nearly all of the villages I visited in Rukwa, we found at least one provider absent, often without notice or explanation. The reasons for the 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, round trip, to collect either supplies or their salary from the district medical offices. Other times providers simply left work to engage in other income-generating activities or had worked overnight, in the case of births, and were resting at home. Finding their providers led to delays in care for people in many communities.

Even when providers were present, community members cited a lack of supplies and suspected corruption as deterrents to the increased use of the facilities in their villages. The women in Ngorotwa outlined some of the problems in their community health center. 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 might be charged a bed fee after giving birth there, also an illegal practice. In a group conversation, Mama Malaika told me, "If you don't have any money, you won't get medicine!" Interjecting, Mama Grace explained, "The medicines are there, but they tell you you have to buy them. For example, you have a pregnant child. Now, while you are taking her there, maybe she gives birth on the way. Now, if you take her there to the facility, you are charged money," the home birth fine. Mama Noel picked up the thread and continued: "Another challenge is a mother, if she has already given birth, to let her get out of the bed, you have to give money. Even for a pregnant mother. They ask for 12,000 shillings, for soap or something, they say. I don't know." Surprised, I told the women, "Me, I don't understand, because health care for pregnant mothers is supposed to be free." Mama Grace explained that they knew care was supposed to be free. But it was difficult to hold health care workers accountable. She explained, "If you ask them, they will tell you that not even one day have they ever charged a pregnant woman. Even if you call [the nurses] 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."

The women in Ngorotwa were unable to report their health care providers for bad behavior or for imposing illegal fees for fear of retribution the next time they needed health care services. These accounts 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. On the other side, rural health care 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 to line their own pockets, but only to acknowledge the fact that providers sometimes were 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.

Seeking better-quality, more comprehensive care through either self or health care provider referral, women often arrived at Mawingu Regional Hospital after days, months, or years of struggle, trying to extract sufficient care from a reluctant and overburdened, undersupported system. Sometimes they did indeed arrive from distant locations, in bad condition, exhausted and physically depleted, hoping beyond hope that the regional hospital would be able to save them where others had failed.

BROKEN PROMISES OF CARE

Both at the community level and within health care facilities, women experienced varied forms of care and, often, a lack of it. Just as policy makers suspected, some of this lack of care was rooted in gender inequities or cultural practices like the exchange of bridewealth or beliefs in the value of herbal medicines. However, as becomes clear from talking with groups of men and women, culture is not static nor homogenous; men and women make space for care during pregnancy within and beyond the bounds of existing practices or "traditions." Just as cultural practices could not explain away the structural factors shaping high rates of maternal death, neither could biomedicine solve all of a pregnant woman's problems, even when she arrived early to a facility. Communities expressed dismay, frustration, and feelings of betrayal when they perceived a lack of health care resources and poor quality care. In rural areas of Rukwa, village leaders told me with pride about how Nyerere had once visited their community to look out over the Ufipa Plateau. Nyerere presented Songambele village with a certificate for their excellent collective farming practices as a model Ujamaa village. While, to outsiders, Tanzania's socialist era feels like the distant past, many community members hold on to an expectation of collectivity and support extending to the state level. People often expressed disappointment in health care services because they thought the state had a responsibility to provide medications and health care to its citizens, a vestige of the socialist era and a testament to its enduring legacy.

Negligent, abusive, or corrupt care in their communities conditioned women and their relatives to mistrust the biomedical system even before they arrived at Mawingu. 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 late arrivals, medical complications, or even death.

I want to emphasize once again how 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. WHO-led logics of rational actors and rights may, at times, conflict with the goals, needs, and conceptions of risk present at the local level in Rukwa. Biobureaucracy continues to expand through fines, forms, referral procedures, and guidelines of best practice that structure whom biomedical health care 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 makes it difficult for village dispensaries to maintain supplies and to provide the high-quality care that women desire. Instead providers who are underpaid and left without support sometimes resort to negligence or extortion to make ends meet in their own lives.

Just as biomedicine obscures a large portion of women's experiences leading to maternal death, a focus on something uncritically and homogenously deemed culture leads to the same result. Culturalism obscures how enormous systems—the biobureaucracies of safe motherhood, global policies, national budgetary problems and priorities, and poverty—affect women's and health care workers' decisions, actions, and experiences. In the end, long histories of fraught interactions, persistent supply shortages, rumors of corruption, and extractive biomedical practices all reduced the trust between women or their relatives and biomedical institutions. Because of an intricate combination of these factors and failed promises of state care rooted in Tanzania's socialist past, the death of a pregnant woman comes to contain much more meaning than the death of an individual.