“A WOMAN EXISTS SOLELY TO GIVE BIRTH”; AN ETHNOGRAPHIC STUDY
REDUCTION OF MATERNAL MORTALITY AND NEONATAL DEATHS
IN THE DODOMA REGION, TANZANIA

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Educational, Scientific and
Cultural Organization

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TANZANIA
Delivering as One
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My work consists of two parts: the one presented here plus all that I have not written. And it is precisely this second part that is the important one...

Ludwig Wittgenstein
PREFACE

Background and Rationale

The Ethnographic Project was specifically formulated and undertaken for UNESCO for ‘DELIVERING AS ONE’ UN Joint Programme 2 to produce a reliable, gender-sensitive social cultural blueprint aimed to reduce maternal mortality and neonatal deaths. The One Plan brought together six UN agencies: UNFPA, UNICEF, WHO, WFP, ILO and UNESCO, in a joint contribution in partnership with the MOHSW to support Tanzania’s efforts to reduce maternal and newborn mortality integral to the Second Health Sector Strategic Plan and the Reduction of Poverty MKUKUTA/MKUZA, made operational through the National Road Map Strategic Plan from 2006-2015 to “Accelerate Reduction of Maternal and Newborn Deaths in Tanzania”, for full implementation of the UN reform at country level guided by ICPD + 5: to move beyond rhetoric to define reproductive health, including sexual health, in the context of primary health care and to provide countries with specific goals, objectives, and targets, in order to provide quality sexual and reproductive health information and services. This programme builds on the UN’s role to provide support to achieve national outcomes through the provision of technical expertise to support capacity development and evidence-based information to guide policymaking, programming and resource mobilisation. The Road Map has advocated a ten year strategy that provides a prioritisation of intentions and a situation analysis to guide national efforts in addressing Maternal and Newborn Care interventions into an integrated, wide-ranging, effective Reproductive Health strategy anchored in a Human rights approach.

“When a woman undertakes her biological role of becoming pregnant and undergoing childbirth, the society has an obligation to fulfil her basic human rights, which include the right to life, liberty, social security, maternity, protection and non-discrimination.”

This Ethnographic Report seeks to elucidate the diverse social and cultural influences that inform the lives of women, men, girls and boys. It examines in-depth all aspects of women’s health and status associated with pregnancy and childbirth and, neonatal care with a view to informing stakeholders both in communities and, among health practitioners about what local populations are doing, thinking and saying on maternal and neonatal care whilst recording the experiences of government health personnel, the condition of the health services and the interactions between the communities. It also explores the practice of medical care and, the training of health workers’ and their education. Thus, based on these scientific findings, this study proposes the prioritization of specific interventions and guidelines to develop action plans for implementation in selected localities in the Dodoma region which was selected to pilot the One Plan.

There are worrying health trends in Tanzania. It is one of the ten countries in the world where maternal mortality and neonatal deaths account for 61% of maternal deaths and 66% of neonatal deaths. The major direct causes of maternal mortality include obstetric haemorrhages, obstructed labour, pregnancy induced hypertension, sepsis, abortion complications. In addition to HIV/AIDS, Malaria and other communicable and non communicable diseases, Trachoma has been recognised as a major problem in Dodoma. What is clear is these additional burdens on health care systems have repercussions on maternal and neonatal health, indeed, reproductive health. Current figures calculate infant mortality rate per 1000 births being 58 and maternal mortality ratio rate per 100,000 births being 578 in 2004-05 for Tanzania. The figures for Dodoma note infant mortality rate to be 22 per 1000 births in 2008 and maternal mortality 216 per 100,000 for 2007. The facility based progress indicators report that while 97% women received ANC in 2004-05 only 47% chose to deliver at the health facility, while in Dodoma, only 39% attended ANC – thus, one of the central concerns of this study was to investigate

1 Road Map
2 UNICEF/MOHSW Baseline Study 2007
whilst a significant percentage of pregnant mothers attend ANC, why did they choose not deliver at the health facility, an anxiety that the Ministry of Health is extremely keen to redress.

This Report is based on the ethnographic findings in the six districts of the Dodoma region: Mpwapwa, Kongwa, Bahi, Chamwino, Dodoma Municipal and, Kondoa. It also refers to published and unpublished literature that can be found in the footnotes and the Bibliography. As far as possible, widely utilised local terms will be applied in this Report such as mng’hunga (local midwife) to assist readers to identify with the description and languages of this region. The project took almost two years, with the field work comprising in total fifteen months with three research assistants at any given time, four translators and I working continuously until July 2009. Based on a study of the regional reports, seventeen principal sites were selected, and additional sites in the interior surrounding the principal sites were also included, wherever the RAs resided. In total, we gathered information from fifty-one sites – which include those which were located in the interior of the principal sites. In Kondoa, Mahungo–Att, Potea,Kisese and Bambuta; Kwamatoro–Banguma, Masera, Kurio and the District hospital; in Chamwino, Mvumi–Fufu, Manzase,Ivondo, Miowa Barabarani, Iringa Hospital; in Kongwa, Zoissa–Leganga, Wangazi, Ngutoto, Mgoloka and Ndebesi; Mlali–Ngumbi,Pemba Moto, Chitula,Isagara and Kongwa District Hospital; in Dodoma,Dodoma town, Regional Hospital, Chibelela, Kikombo–Chololo; in Mpwapwa, Rud–Ihumwa, Ikuyu,Chogola and, Mpwapwa district hospital; in Bahi, Huzi–Mwapayungu, Mtkira; Maya Maya – Zanka, Chenene; Bahi–Bahi Sokoni and Haneti-Hiso.

Image 1: Field work sites

The Report draws from the narratives and fieldwork by the midwives/male nurses turned 'ethnographers', Joyce Misesemo, Catharine Masalu, Gasper Kaale, Aramika Mangi, Aidan Lubeleje, Beatrice Mwilike, Adellah Hugo and briefly, Ernstine Ndejembi. All the RA's completed the work on the selected sites but in some cases could not extend their contract to continue in fresh sites. I also undertook fieldwork in Dodoma Municipal, Bahi and Kondoa. I am particularly grateful to Adellah, Aramika and Beatrice for their excellent work, integrity and commitment to the project.

We are thankful to our local advisor, Dr GJB Mtey, the Regional Medical Officer of Dodoma for his thoughtful advice and discreet assistance. He supported our endeavours to make possible this independent study of the health facilities and, this opened the way for us to negotiate many levels of interactions with the health facilities, as we lived and worked in the communities. I am deeply indebted to Mr Charles J Nguya, Mr Daudi Hungu and, to Mrs Cathleen Sekwao for the valuable assistance with translations of the transcripts from Kirangi, Kigogo, Kimaasai, Kikaguru, and Kisandawe into Kiswahili and English. I undertook fieldwork in Kondoa and Bahi and, am particularly obliged to Mr Edward J. Kabanya, a retired magistrate who accompanied me and, assisted me with the translations during fieldwork explaining alongside the local understandings of the law and, accountability. We are grateful to Mr Habibu Makubeli, our erstwhile driver for his presence of mind and, driving expertise during our perilous journeys along truncated, muddy tracks. And,
finally, I express my special appreciation to Ms Stella Rwechungura and Mr Al-Amin Yusuph at our Dar-es-Salaam office for their invaluable facilitation.

The choice of Dodoma by the Ministry of Health is justifiable. Unlike most parts of Tanzania, Dodoma is one of the poorer regions in the country with an inadequate infrastructure, very low per capita income. The semi-arid environment makes for unreliable agricultural yields, chronic malnutrition and, impoverished livelihoods. It is not surprising since the last century the punishing memories of sixteen killing famines are richly woven in their oral history, the fear of hunger is a palpable reality as indeed, the spectre of death.

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4 Appendix II
Methodology

Objectives

The Ethnographic Method explicitly prepared for UNJP2 is integral to the contribution by UNESCO within the framework of the ONE UN Pilot in Tanzania. The One Plan adopts a synergistic approach that exploits the comparative advantages of the partner UN agencies, recognizing that the reduction of maternal and newborn death requires multi-sectoral efforts to improve access to quality reproductive services, increase individual and community demand for maternal and newborn health, and to build a policy environment that promotes reproductive health and rights.

The purpose of this Pilot Study has been to produce a reliable, tested, workable, culture and gender-sensitive blue print that will significantly reduce maternal mortality and neonatal deaths. It was essential to explore in-depth, the social and cultural aspects covering all aspects of women’s health and status associated with reproductive health -- puberty, the processes of pregnancy, childbirth and lactation; the control of sexually transmitted diseases; aspects of women's health status associated indirectly with any part of the cycle of pregnancy, childbirth, lactation; other aspects of the health and function of the organs of the reproductive tract in either sex and illness caused by communicable and non communicable diseases particularly focusing on maternal and neonatal deaths.

The principal gaze of this study has been to connect with the experiential weight of human understandings, in particular, those voiced by pregnant women, their families and, the various problems they encounter in their environments, as also their access to and, treatment at the health facilities as indeed, the anxieties and understandings of the health workers – all grades on levels of professional training, nature of health care – on what is possible and what is not possible in their administration of medical assistance.

Summary of the Literature Review

In addition to the official publications, an exhaustive literature review was undertaken on the east Africa region -- and, Tanzania in particular-- the important scholarly findings which emphasised the predominance of the biomedical and epidemiological approaches to research and interventions. Other studies by demographers and other social scientists were also included as indeed, local histories and newspaper articles were also consulted.

In addition to the well-documented biomedical conditions that cause maternal deaths -- such as retained placenta, postpartum haemorrhage, vaginal fistulae, hypertension, abortions by young girls, as also neonatal deaths by birth asphyxia, ANC care has been written about extensively and much of the literature on Tanzania and Sub-Saharan Africa expressed the serious shortcomings in prenatal, antenatal and post partum care and, indeed, the general state of reproductive health. Conclusions from these and other studies can be thus summarised: – Pregnant women expressed reluctance to deliver at the facility: the high costs pregnant mothers incurred included exorbitant unofficial costs and the transport problems and, fear of injections causing sterility and ill-treatment by staff. Diagnosis for conditions such as hypertension, anaemia or tuberculosis as indeed, puerperal psychosis was not done adequately; the prevalence of induced abortions by schoolgirls is reported as widespread; privatisation of health care and difficulties in legal redress was compounded by pregnant mothers and neonates contracting cerebral malaria and tuberculosis as the facilities were not clean – thus many pregnant women mistrusted the facility. Other findings concur with the principal

5 Bibliography
admissions made by the government in the Road Map for example, under-staffed health facilities, lack of medical equipment and so forth. In general, findings reflect on the acute marginalization of the poor and their inability to access health care with increasing privatization, poor governance and accountability mechanisms.

In many of the demographic and sociological surveys it appeared that the sisterhood method remains influential. Through the classic questionnaire method taken from random population samples, siblings are questioned. Based on these findings the lifetime risk (LTR), that is the risk of a woman dying from maternal causes during the whole of her reproductive life is calculated using this formula. The shortcomings are obvious in that it is wholly dependent on the questionnaires and does not take into account, the human factor- how these questions are perceived by the people questioned. Further, it overlooks entirely why maternal mortality happens as it does and measuring risk ratios without any knowledge of a mother's physical or mental health under such circumstances is at best a hazardous venture. However, a sisterhood approach can be integrated within an ethnographic approach – while learning about a family and its tragedies.

An enduring influence from the vast colonial library, and a conspicuous theme in several accounts was to state that “cultural barriers” were a major hindrance to social progress in maternal and child care. However, this study maintains that human beings are always in culture: culture is what enables and makes possible social progress and holds within it the possibilities for dialogues, discussions, cooperation – and empowerment.

It is necessary to mention the relevant studies by ethnographers which have discussed rituals, beliefs and polygamy as indeed, circumcision in east Africa, as important contributions. These descriptive studies have been useful in illustrating colonial politics, cultural belief systems influenced social behaviour. For example, Mathias Mny'mpala's descriptive study of the Wagogo which provided an invaluable introduction. Nevertheless, the findings from these studies have not been included in the information network of policy making.

Definitions:
Maternal Deaths
A maternal death as "the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or, aggravated by the pregnancy or its management, but not from accidental or incidental causes". In addition, recognising that some women die as a consequence of Direct or Indirect obstetric causes after this period and, a category for late maternal deaths defined as "those deaths occurring between 42 days and one year after abortion, miscarriage or delivery.

Neonatal Deaths
- Stillbirth is defined as the birth of a death foetus after twenty-eight weeks of gestation.
- Early neonatal death is the death of an infant before seven days after childbirth
- Late neonatal death is the death of an infant after seven days but before twenty-eight days.

Currently, the official statistics are compiled on the basis of figures submitted by the health facilities - maternal and neonatal deaths to the district and subsequently the RHMT. Often it was noted that maternal deaths were not always recorded, nor were these records updated. Further, such figures are not accurate as they do not take into account preterm pregnancy related deaths, nor indeed, deaths of mothers and their infants who deliver with the assistance of mng'hunga or those who suffer late maternal deaths as also maternal morbidity. It is important to note that in this region, as indeed, most parts of the country, women and men are unaccustomed to direct questioning and tend to be reticent about their personal tragedies. Thus record keeping needs to begin at the village level.

Recently, the very important study by UNICEF Baseline study of the six districts of
Dodoma region has recorded extensively, critical and valuable information on the state of the health facilities and the nature of health care, highlighting the need for several important interventions, the findings which concur with the findings in this study. Based as it was largely on the records of the facilities, the scope of its findings was partially circumscribed by the inaccurate nature of the statistics as also the questionnaire method that will be discussed later.

Beyond Biology

We need to comprehend the health of ‘biological’ individuals in the context of their environments and indeed, social and cultural relationships therein- such details have thus far, often, been overlooked in biomedical research but, inevitably have a critical bearing on all forms of health; research and intervention need to be recognised as social and cultural processes. Thus, pre-specified objectives with selected variables focusing on testing pre-constructed individuals and pre-arranged patterns to gauge numerical estimations and statistical inferences from standard samples that can be used again for a larger "true" population of interest, are not by themselves, reliable. Nevertheless, the continued dependence on statistical and, data constructed by the questionnaire method as being scientific and ‘objective’ has remained a trademark for policy making; global and regional programmes on health have abided these formulae. Clearly, ‘objectivity’ is rooted in culture, language, selective perception, and ideology – which permeate scientific activity. Many aspects of human life such as beliefs and values are subjective and resist quantitative measurement-such subjective phenomena may nevertheless determine certain critical patterns of behaviour and practice and need to be assessed- subjectivity of the research does not necessarily mean subjectivity of the method.

In formulating this pilot project we have sought to broaden the insights from these scholarly researches, as also, reflected upon the lessons from the many national and international agencies committed to community-based participatory programmes for over three decades - because maternal and neonatal deaths have continued to rise. Hence, the exclusive reliance on statistical and demographical principles for measuring the human condition is not adequate. After all, human beings are not effects of molecular and neuronal causes of genetic determinism with fixed traits but, are formed from relationships which in their activities they create anew. Also, it must be borne in mind that human beings the subjects of statistical measurements are never cognitively imprisoned by pre-ordained, predetermining schemata especially, when operating in a world without guarantees.

Another major cause has been a visible dearth of ethnographic gender sensitive micro-level analysis resulting in the formulation of policies determined by broad aggregates, and generalizations, more often than not, excluding cultural specificities and, the poor. Thus, cultural meanings indispensable to understanding maternal mortality have not been addressed. This project has incorporated the findings as also the lessons learnt and provide the much needed Ethnographic analysis.

The Ethnographic Method

The Ethnographic method is scientific integrating both qualitative and quantitative approaches. Field work is fundamental to “the doing of ethnography” by anthropologists of all descriptions. Traditionally, anthropologists have identified with peoples amongst whom they reside and, inevitably this identification is reflected in ethnographic methods which primarily seeks to privilege the world views of people and their life experiences. It involves an in-depth study of human behaviour, the choices and values that guide people’s everyday lives in their natural settings; how they interact within economic, religious, political, geographic worlds that is expressed through their cultural repertoires, in their own words.
Nature of field work:

Participant observation is not so much a method but an approach to collecting information by means of the presence and participation of the researcher. There are many degrees of participant observation—the fundamental approach that informed this ethnographic research was the method of immersion. The process of ‘immersion’ in the field by the researchers indicates committed long-term residence and polite engagement with the local communities—forming sets of relationships and activities, which are connected to the wider society. Participation is seen as an apprenticeship, as a learning process through which the researchers and their personal relationships serve as primary vehicles for eliciting findings and thoughts; relationships of intimacy and familiarity between researcher and subject are envisioned as a fundamental medium of investigation rather than as an extraneous by-product or even as an impediment.

The first step was done by establishing rapport, a relationship of mutual trust. Building rapport is a critical step in research because what informants say or are willing to divulge is affected by their relationship to the researcher and by their understanding of who the researcher is and what he or she is doing. Therefore, the construction of the ethnographic field involves efforts to accommodate and interweave sets of relationships and engagements developed in one context with those arising in another. Thus, field-work meant living with the communities being studied, getting into their ‘time’ speaking their language, being particularly sensitive to the use of metaphors and the way language is used, taking in the environment, learning appropriate greetings, listening to conversations, gossip, quarrels, and discussions as well as asking questions. Often, direct questioning may not be an accurate guide to what people do and, may even bias the answer—while unobtrusive observation can provide a greater depth of understanding of the results obtained by other methods particularly with regard to the range and direction of their concern with the world around them and their own way of life for the purpose of describing the social context, relationships and processes relevant to the issues being examined—in this case all matters related to maternal mortality and neonatal deaths, often needed to go beyond reproductive health.

The phases of research are a gentle process; they are iterative, buildby slowly, step by step from the perspectives of the people and necessitated long-term relationships between the researcher and research participants. Information was gathered through open-ended conversations—bearing in mind the societal rules for interaction including the proper way to ask questions for various groups of elders/women/girls/boys/men. The training assisted the RAs on how to proceed using the fieldwork methods to gather information effectively and politely.

Research Assistants

In order to enable successful intervention measures, one of the critical targets of this pilot was to train Tanzanian health workers on how to gather social and cultural ethnographic information and, thus to learn how to facilitate the successful intervention of civic and health matters by individuals within the communities and, how to establish listening posts with the health facilities. At any given time three mature health workers ‘turned ethnographers’ were engaged in the fieldwork. With their medical training they would be accepted, be familiar with the health administration, and be more sensitive to the health concerns of women and men. They sought to fit into their environment and, to identify with the general livelihood and social concerns that people faced. And, they would be able to recognise and learn the languages—such as Kigogo, Kirangi as also Kikaguru, Kimaasai—and be able to reside and work without causing any disruption or anxiety to the local people.

6 Annex, A Manual for the training health workers on the Ethnographic method which was developed to train the RAs’ is attached at the end of the Report.
It was vital that they were accepted by the local people and not seen as arrogant or
disseminate of them. They sometimes resided in Tembe accommodation with the families
and participated in everyday activities and, also assisted in the health facilities if
required. Thus, the emphasis on RAs being Tanzanians was critical to this study. Not
only did RAs get the requisite training to contribute towards the long-term goals of
this programme as enunciated in the Road Map, but also, they were able to move about
confidently, have greater opportunities to interact and gain acceptance without
caus ing suspicion or drawing unnecessary attention upon themselves.

We could not specify in advance what kind of information the RAs' were likely to get—
respondents will think of problems in a different way. Thus, it was incumbent to

- Specify at the start what we intended to do, why and to what end and how
- Examine not just the current state or ask evaluate conditions but also look at
  how we could improve those conditions—participate in interventions and evaluate
  its outcome.

Description of the fieldwork:

The fieldwork undertaken by the RAs' followed the methodology, whilst they remained in
residence in the selected villages with the local communities and, therein examined
the health facilities which as providers of maternal and neonatal care supplied
valuable information to them. While they observed the interactions at both levels,
that between pregnant mothers and their families, and, entered into separate
discussions with men and boys in the communities as indeed, the health workers and
the examination of the health services, the perspectives from within and beyond, those
of the communities and health workers came to light.

They spent on an average of two months at each site and travelled to the villages near
their main site of residence, sometimes taking up residence in the neighbouring
village depending on the circumstances and material to be gathered. As they were seen
to be midwives and nurses they could establish relationships of trust with the
participants who spoke to them about very deep, painful and personal issues. Great
patience was required throughout to facilitate the process. Culturally, in most parts
people do not talk about their feelings or their lives and take time to open up:

“We do not reveal our feelings even when we suffer pain”

Ase kwetu sicukulonga ng'ani hamba uwe ukugatzika munhumbula ukunyamala du na kutya
nicina ng'ani yono ikungatza - Kigogo

Hatuonyeshi hisia zetu hata kama tuko kweny shida au tabu
- Kiswahili

The sites they lived in were not densely populated - and it was never “rushed”
research - their main focus remained on pregnant women, their experiences of
childbirth and, the survival of neonates as much as on the health facilities and
health workers and the interminable interactions therein. Thus, they followed the
conversations and made their own daily written observations and, they began to learn
about circumstances that women experienced first hand and recorded their
interpretations, values, and beliefs. Men and boys interpretations were deemed to be
equally important and, as they explained their research to them, the female RAs'
enjoyed a special status as health workers and thus were accepted when they stated the
goals of the project.

And, thus, health workers, women and men in the communities began to confide in them
and spoke about their lives to them, their reproductive histories, their experiences
of pain and wretchedness; and how their lives were affected by poverty and the
measures they took to alleviate it to earn a living. And, also asked the local boys
and men – whether they would welcome the idea of assisting in primary health care, in
advocacy and also, involving themselves in discussion groups of men and boys reviewing
their roles in society and assisting women and girls. They grew very interested and keenly offered us suggestions, a promising start towards 'community' participation towards local ownership.

Collecting Information

The nature of ethnographic practices throughout this process of fieldwork did not follow prescriptive, authoritarian codes—thus verbal, visual and, other methods such as drawings were also used to ask them various questions. Women and girls, men and boys—all of varying reproductive ages—were studied separately. They were not asked to participate in focus group discussions if it constitutes a breach on their privacy. They were allowed to choose their method of participation without any interference and develop at their own pace to come to their own decisions. The male researchers interviewed men and boys. The female health workers spoke to women and girls but also to men and boys when they found it possible to do so. Very detailed information was elicited, lines of enquiry ranged from female/male interactions, anatomy, personal physiology to sexual and emotional questions and practices. Women and girls, boys and men were treated as active participants in the whole development process to find what their specific needs addressed. Otherwise, actions that seek to assist them would prove counterproductive and could affect the quality of their lives, adversely.

At no stage of the research were formal or written questionnaires employed—as they are not in keeping with the Ethnographic method under these circumstances. Further, in any formal interview questionnaires be they structured or unstructured both the respondent and the researcher know the goal—that affects communication as they are locked by a regimen, a fixed sequence of questions whereby the interviewer-informant dialogue is controlled to a degree and thus, the interviewee is under a degree of pressure and his or her response options can be restrictive. We needed to get information that was spontaneous and heartfelt as experienced by the informants, which they wish to communicate to us under no pressure. And, our informants rewarded us with deep cooperation and trust and divulged many secrets which affected their health, loves and lives. As the field work progressed, the reticence that people felt slowly disappeared.

Information was elicited indirectly, primarily through relaxed, premeditated conversations over an undefined lengthy period of time. While no questionnaires were used, observations on the ground guided the research. That is the women and men provided us with the nature of the questions that need to be asked and explored. Most interviews with the women took place in the privacy of their homes while group discussions took place in public place. In other instances, the conversations with health workers were done in or at the vicinity of the health facilities.

Note on Ethics

Great care was taken to gather as much information as possible on various matters—we did not know at the start what to expect and, what to find—but allowed ourselves to be guided by informal conversations. We have learnt from the women themselves what factors allowed or obstructed their access to proper MNCH care. Thus, questions were open-ended, non-threatening, culture, religion and language sensitive. They sought to be not intrusive, nor included elements of mockery or loss of dignity and within the physical capacity of all participants.

Ethical issues of research and action remained paramount in research design. Ethical obligations included:

- To avoid harm or wrong, to respect the well being of the humans and nonhuman primates
- To consult actively with the individuals or groups and communities and establish working relationships

There is always a moral obligation to take every culture seriously. It was also seen
as imperative to discuss how the research would provide benefits that the recipients could recognise or value as beneficial. Thus, making local concerns a primary criterion in decision making was seen as important to contribute to this project success.

The core principles were adhered to and all interviews were conducted through informed consent-- the confidentiality and anonymity of the participants has been ensured. Conversations about painful and difficult issues and subjects were performed in accordance with the principle of least harm. Great care was taken to avoid exploiting the power imbalance inherent in all relationships: status, age, gender and class.

Days were planned with maximum flexibility in order to respond to the needs of the participants. The informants/ participants are not simply providers of information but were encouraged to enter into reciprocal relations with the researchers and become active in the whole research process. Simultaneously, they were through their active participation learning and reflecting about their experiences, problems and strengths: developing communication skills and organisational capacities that empower them to act on the results generated even as the process of research unfolded.

Also in keeping with the methodology, the open-ended, rummaging nature of the ethnographic method highlighted and threw up significant, impossible-to-avoid socio-cultural interconnections, opening important areas of enquiry that make happen maternal, neonatal mortality and morbidity. It was thus imperative to extend the field sites beyond the communities and health facilities into cultures of the health administration and, education of health personnel at all levels as these require critical assessment to reduce maternal mortality and neonatal deaths. It was deemed critical to cast the net as wide as possible and cover in-depth, different communities, accommodate varying lifestyles and beliefs, as indeed, locations to make the ethnography, exhaustive and comprehensive for its successful application.

Our ethnography has sought to demonstrate the practical utility of such knowledge to public health personnel. While we study selected communities in Dodoma-- and gather information, we also sought equally in-depth information about the premises, values and practices, which inform and condition the health administration. Such an approach to work in health and medical fields allows policies to develop indigenously which will have both theoretical and methodological advantages as they will be done respecting and accommodating local sensitivities and help establish the much needed dialogues with the health professionals and, to learn about the existing health programmes and their own concerns. Thus, by being providing deeper insights, it was our constant endeavour to initiate active, sustainable, community participation with the health administration and, by such rigorous micro-level analysis at the grassroots, successful medical intervention is not just probable, but possible.

Thus the Ethnographic fieldwork did the following:

Documented the need to communicate by respecting oral traditions and, to understand how social and cultural beliefs, as indeed, livelihoods, civic facilities and the environment affected local health concerns, self-treatment practices and patterns of seeking health care in reproductive and sexual health; Provided baseline data on how ordinary women and men experienced government health services and how the health services functioned and, what health workers felt about their professional lives; Gathered data on the primary health care programmes and how they should be implemented; Traditional birth attendants and belief systems; Advice on how listening posts can be created capable of monitoring community response to Community health work and local health work programmes. And what interventions are required for reducing maternal mortality and neonatal deaths and, this meant going beyond reproductive health covering interrelated MDGs being undertaken by other Joint Programmes in Tanzania.

Information has been shared with Joint Programme partners on a quarterly basis and
three reports were circulated and formal presented. The findings were discussed and specific interventions were prioritised for the development of action plans for their immediate implementation. UNJP2 aims to inform and align with government policies, systems and processes consistent with the Paris Declaration 2005, while ensuring that there is a focus on performance, accountability and results within UN support.

FIVE STAGES OF THE ETHNOGRAPHY WORK PLAN

1. July to End of August 2007 - Literature review and Methodology submitted to the National Institute of Medical Research for Ethical Clearance


5. August- November 2009: Validation:- Report for Validation

6. Dissemination: 2009-2010

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The Setting

The Dodoma region is an upland plateau 3000 feet above sea level with an area of 41,217 square kilometres and a population of 2,004,544 people. It has a semi-arid landscape with 200–400 mm annual rainfall. The months of the year hold great significance for the people of this region, mainly farmers and pastoralists who carry out distinct activities to define each of the months in the year as they engage in specific rituals to measure time by the rising sun, the waxing and waning of the moon, whilst paying solemn attention to the constellations in the night skies, thus when the constellation Pleiades appears in the sky during November, it is time to hoe.7

Noticeably, most people living here recognise two seasons, cifuku the rainy season and, the dry season, cibahu. Clearing and cultivation is done by all members of the household although it is usually the women and children who work. The main crops are a variety of sorghum, uhemba, and a variety of hardy millet, uwele, that survives erratic rainfall, matching the types of the grain to the soil, potatoes, gourds, peanuts and maize. Shifting cultivation is common here and every two to four years, the land is left fallow.

Although the pastoralist way of life is not as important as it used to be its ideals continue to orient their environment at a profound level and measurements of wealth continue to be made with cows and goats being exchanged: it is held to be greater value than TSH. The sacred value attached to cattle cannot be underestimated, although other livestock are important. Customs dictate that sacrifices must be made to keep their cattle alive. Prosperity is defined by the number of cows and bulls a man can call his own and, it is this alone, which determines his status and family size in the community. Usually, the Waganga as healers and, circumcisers have more livestock than others. One such healer informed us that his redoubtable father who had fifty-six wives and three hundred children had double that many cattle. Bride price usually involves giving cattle, usually three cows, maybe five depending on the groom.

In order to comprehend how the social practices and cultural beliefs of the inhabitants of this region comprising mostly of the Wagogo people influence maternal and neonatal health, it is indispensable to learn and, to ascertain what are the values and ways of being which determine every day life in this region. It is also critical to appreciate that these 'common sets' of customs and beliefs cover a much larger region than often acknowledged; findings in this region have a wider applicability. Indeed, recent ethnographic findings are averse to classifying tribes and tribal identity as definitive, distinct ethnic entities. Such understandings remain entrenched from colonial classifications as British policy was guided by the assumption that every African belonged to a tribe, just as every European belonged to a nation. Tribes became an invented concept as they were seen as autonomous, separate, cultural units, “possessing a common language, a single social system, and an established customary law”, incessantly in conflict with other tribes.

The concept of Wagogo itself is a relatively modern one. As late as 1927, British colonial officers doubted any tribal authority in central Tanganyika, “whether any outline of the composition of the Gogo tribe or any exposition of its original constitution” was possible but, nevertheless, codified Laws to this effect.8 Prior to

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8 Mathias Mn’ymapala, Historia Mila na Desturi za Wagogo, 1954 translated by Maddox, The Gogo, history and customs, ME Sharp 1992;Rigby P, Cattle and Kinship among the Gogo, Cornell University, 1969,
colonisation among the people, an indigenous concept of race, tribe or people did not exist, other than a vague perception of a common language and culture. Social interactions between individual and within communities of people did not recognise tribe, but rather, strangers identified each other as belonging to clans', mbeyu and not their tribe, kabila. As noted by the eminent Mn’yampala, in this region, for six hundred years the movement of peoples eventuated in intermarriage, a common practice. As is typical of every syncretism, the patterns to adapt, to assimilate and to accept, meant that those who came here were accepted and, sought to accommodate themselves to the local cosmologies, customs they encountered and, even changed their names.

The Wagogo know themselves as Wanyambwa, Wanya-Ugogo, or Wanya-Takama, Wetumba and so forth in accordance with the area they live in – the main form of personal identification is based on their particular location and, thus, dialectical differences in the choice of words used needs to be acknowledged for unambiguous communication. Thus, for example there are broadly two kinds of Kigogo- Wanyambwa spoken in Bahi, Kitinku and Manyoni and, Nyanugogo spoken in Mpwapwa and Dodoma. And, this is important to note: for example – Mbukwenyi is a common greeting for Good morning – the reply in Wanyambwa is “tzaugono wenyu” and, in Nyanugogo, it is “mbukwa, AA welaa or kumekucha.” In Kondoa district, there are mainly the Warangi people who are similar to the Maasai in their preference for pastoralism. There are also the Wasandawe speak a click language which is quite different from the Bantu languages. Nevertheless, there remains a tacit understanding of what it means to be Tanzanian, people understand one another and make explicit this knowledge, re-affirming the egalitarian principles that govern social interactions at all levels.

Historical Background

The east Africa region was occupied by the Germans, Deutsch-Ostafrika from 1885-1919 and subsequently by the British until 1961. Contrary to indigenous understandings, the colonial governments in east Africa, as in other parts of the continent, most often worked through routine biological determinism, Using anthropometric patterning of physical characteristics – measuring height, skin colour, the nasal index, skull shapes – and attributing rationale, marital, religious and political identities in predictable forms with identity cards, passbooks and marriage registers, officials thus organised shifting conjugal, social and, what they believed to be distinct' ethnic' identities derived from Anglo-Saxon understandings, in order to regulate the control of labour and required resources from the land.

Colonial labour demands took men out of the rural economy for extended periods, upsetting established household divisions of labour, patterns of land use and crop production. In the past, the man used to go to the farm first to cut down the bushes and uproot the tree stumps, the wife's job was to collect the strewn wood with a rake, ikusiliilo. The man always did all the hard work and the wife performed lighter tasks. She left the farm first and went ahead to prepare the evening meal – kuligantiza izindigwa – and prepared water for him to bathe. With the removal of men from the households for conscripted labour elsewhere in the country, women were forced to fend for themselves through the forcible institution of new patterns of settlement which critically altered domestic arrangements, and as it appears, irreversibly.

Such structural changes brought about the severe impoverishment of livelihoods, without the presence and support of the men many valuable customs were wiped out. For example, earlier, in pre-colonial times, elders recount tales of adult brothers' coordinating pastoral and farming activities and held a common wealth fund to pay for food in times of famine to perform rituals and, thus, women and children were protected. While the strong moral obligations to help each other remains, there are no

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such funds that exist any more that used to act as a safety net for families.

Importantly, it has been argued by colonial scientists such as Ford that for centuries, local populations had a sophisticated knowledge and awareness of indigenous ecology. They practiced effective ecological control by isolating the most dangerous areas such as grenzwildnisse in east Africa which existed at the borders of populated territory and arranged lifestyles so that people and their livestock, particularly cattle, were isolated from, for instance, trypanosomiases, knowledgeable as they were of the diversity of their ecosystems—“to tame and exploit the natural ecosystem...by cultural and physiological adjustments both in themselves and their domestic animals.” The associated ecological degradation that accompanied the Germans and, later the British on account of untrammelled authoritarianism which followed the occupation of lands caused profound changes in food production, the landscape and, Ford et al argue, was consequent in the spread of diseases. The colonial disregard of the rich, valuable indigenous knowledge on ecological controls, inadvertently unleashed a plague which decimated the human population and destroyed cattle from the 1890s onwards led by the spread of the rinderpest panzootic, smallpox, and the tsetse belts never stopped advancing.

The loss of autonomy of the local societies with the advent of colonial rule is reflected in their worst memories—particularly of the Mtunya famine of 1917-21. Their food and cattle were forcibly taken away and the Wagogo were forced to beg for food and, since come to be regarded as beggars by other people in east Africa. Further, they were denied food: “Ondokeni Wagogo! Ondokeni! Hanna chakula”. Famines disrupted their social relationships and all that was forbidden, all that was uncivilised took place and, people say, it could never be the same again, people died like animals—“hivyo walikuwa wakifa kama wanyama tu.” According to a conservative estimate, over fifty thousand people died and there were corpses strewn everywhere. As substantiated, changes in colonial policy during the 1930s led to the direct exploitation of each household effectively completed the process of structural impoverishment. It also marked the end of their ability to reproduce their own society from their own resources to protect their families, livestock and the land, and, marked the end of certainty.

The onset of famines from which they no longer had any immunity was followed by the spread of trypanosomiasis, schistosomiasis, influenza and, wasting conditions such as cholera, typhoid and malaria—thus, it is not surprising that the colonial and later, western presence came to be identified by local peoples as mumiyani or chinja chinja, vampires or blood suckers, waging a form biological warfare against them. Such beliefs continue as in recent decades, and are expressed as part of the resistance to family planning, as also local understandings of pandemics such as HIV/AIDS which locals define as an extra-local sickness of foreign origin.

Oral Traditions

The commanding influence of oral traditions, regarded as their precious heritage, communicating as it does, the wisdom of human experience is what people rely on above all other kinds of knowing. And, as we noted, particularly in matters concerning reproductive health it appeared there remains great mistrust of foreign presence and, certainly of foreign initiatives. And, they also are not prepared to be told what they should do especially with regard to sexual activity and reproduction as having babies is highly valued. Local people fear that their social freedoms are being curtailed and mistrust ‘western’ medicines As they say, “we do not want to know about family planning.”

Hatutaki kujua kuhusu mpangilio wa watoto

Part of their misgivings at various sites lies in the difficult memories of the not so distant colonial past, the legacy which lives on. "When the muzungu (white person) enter the Wagogo village we deeply fear he has come to discover what is special from us and steal what we have and take it away... that is their habit, they cannot change...our most precious gifts are our babies, they do not want us to have babies and then we will no longer exist...the contraceptives they push into us are causing cancer because when our wives stop giving birth also you develop cancer and intrauterine tumours. "ukiacha kuzaa mayai yatakusumbua tumboni unapata vimbe za ajabu ajabu, kwenye kizaz"

A theme that echoes through this text was the fear of kufunga or sterilisation is deep rooted, while kufunga kwa muda – child spacing was acceptable, kufunga–closing the womb was abhorred. And, understandably, as there exists deep uncertainty of what each day may bring as immeasurable tragedies surround their lives, living as they do under the shadow of death.

In the course of many conversations, the received wisdom from the past is frequently evoked, a reminder of its critical weight in understanding the present. We were reminded time and again, "We all remember it is important to remember, we know what it means not to forget, to forget means to suffer, to die."

"Kilamuntu muhim. Kumbuchila kusahau, kumbuchila vana kufa."(Kirangi)

And, common explanations not just by elders but even the young --that are offered, tend to elaborate –

Seche tusirimirwa vintu vyene vakoloni vaboya, vakoloni vulaa vala tata, valaiyo vondomeriwa laa novo, da naiwa sitwhewa, na nyumba jachimikwa; vondomeriwa vasinga. (Kirangi)

"We cannot forget what the foreigners did to us and how we were punished. They sent our grandparents to build their roads/railways without food and our grandmothers were forced to have sex with them; our houses were burnt and we experienced deep hunger".

Relevant to our discussion, is that in east Africa and beyond, within the corridors from north to the south, the timing and performance of critical traditional customs and practices derive from the same symbolic systems. For example, the cults of ancestral spirits, burying the chief of a tribe at midnight, divining for rain; social beliefs about the rearing of babies, rites of initiation during puberty, customs such as bride wealth, marriage, pregnancy taboos, dietary regulations, childbirth, postpartum ceremonies, as indeed, ideas about sacrality, the nature of gendered relationships remain the same. Importantly, people's explicit recognition of all human conditions and the intimacy with their environment, their beliefs and their existence are woven into physiological associations–with sex and food, with birth, maturation, and death, as indeed, with all forms of bodily emissions are governed by these strictures.

This Ethnographic study relies heavily upon oral traditions and narratives. We were made to recognise from the start that interpretations of time and space in various locales as indeed, social and cultural information was communicated principally medium of their oral traditions intertwined as it is with the realities of everyday existence, as indeed, extending beyond physiological and reproductive health conditions.

For millennia, oral traditions have been the principal medium for informal education; instructions are narrated through ballads, songs, proverbs, folklore and stories, affirming the deep connections of human experience over time. As informal education they provide the trust and understanding that people seek in dealing with various eventualities. People rely on the wisdom of their oral traditions above all other forms of learning, and, as we found at a profoundly unconscious level in the
construction of realities and rationales which explained their positions and roles in society, their likes and dislikes recounting ancient wisdom through proverbs methali or angwee, riddles dtaandtabule (Kisandawe) or kitendawili in the form of parables. That is why oral traditions need to be incorporated into programme considerations on public health and beyond – their emotional weight in human consciousness cannot be discounted.

Impoverishment of Livelihoods

The profound fear of hunger and famine haunts this semi-arid region. Few people can claim to have any resources, the probability of drought accompanied by widespread food insecurity accounts for the chronic malnutrition. Thus, the locals know it is imperative to be careful with food, storage of food for the dry season forms part of this arrangement. Gourd and other vegetables are dried at the top of the hut over the grass then stored as is the maize and millet. This following couplet illustrates the anticipation of hunger:

Gwe izala lya nyamawaka chimalika gwee haiya
Nyee waya haiya
Nyee wadodod haiya (Kisandawe)
“You, all the famine of this year is going to kill us all
You the women,
You the children”
That is to say, be vigilant, do not waste and be careful with the small amount of food they have.

Wages are never sufficient to meet the needs of the family although both women and men work in the shambas from dawn to dusk. The following couplets taken from another song sung at the kilabuni or at a gathering reflects their plight:

Lead singer: Nobita ku mbago ng’halondole nyeX 4
Chorus: Nakwama x 6
LS: I will go into the bush to find it
Ch: I am stuck (I am without any food)
LS: Ng’halilondola ng’halilondola masawo makamu masawo makamu x 4
Ch: Masawo makamu masawo makamu x 6
LS: I am still searching, I am still searching to get money, and it is a hard job.
Ch: It is hard to get money, it is hard to get money.

The severe nature of poverty -- of depleted cash incomes cannot be underestimated. As Mr Magige a VEO told us,

“Sisi WaTanzania katika maisha yatu ya kila siku watu hujitahidi bila mafaniikio; wala matarajio, hukosa kujiamini na matumaini.”

“For us, Tanzanians, life each day portends a struggle, full of hardships without certainty, which takes away from every individual, the possibility of confidence and hope.”

Here, thus, to make ends meet, the brewing of alcohol in plastic buckets is taken up by women as a necessity using food crops such as millet, sorghum, sugarcane and maize. And, thus they are ensured a steady income of 500 TSH a day as half a litre in a plastic jug costs 100-150 TSH. The story of Paula below reflects the plight of nearly all the families in this region--

Paula, in her thirties and a mother of seven talking to the RA notes, “I fail to walk properly because of the pains I get, and actually I think my body is not at its best... sometimes I feel very weak but I don’t know what kind of disease attacks me, but I am

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11 WFP have done several studies of the region. Report on 2008.
sure I am sick and I need help from you, the experts. You know having a big number of children is a big problem if you can't manage to give them necessary needs such as food, accommodation, school fees etc. Just imagine, I bought this small bottle of body lotion for Tshs. 300/= and that small piece of washing soap for my sons who are coming from shamba and they both want to use that small piece of soap to wash their clothes which is not enough even. Last Monday I prepared local brew and I got a profit of Tshs. 8000/= and I went to buy two buckets of millet which I am now fermenting it for another mkorogo. Now from that profit, I buy kerosene for Tshs. 150/= and tomatoes for 100/= and cooking oil for Tshs. 150/= daily how long do you think the money can last? You have seen I sent my son to go to the shop to buy groundnuts to add in our green vegetables. Can you really say this, that people are enjoying life? The only job I am doing since last June is this job of preparing local brew from millet and selling it."

Mama Amina a young mother of two in her early twenties said that she has a very tough life because life at Kondoa is very expensive—they have to buy food and pay the house rent. She said, "Tukivuna mume wangu anauza chakula chote na haleti hela, hatoi hela ya chakula na kodi ya nyumba nalipita mimi, yani hata sijui watoto wakianza kusoma itakuwaje na nyumbani wazazi wanantegemewa mimi. Kwa hiyo inanibidi nifanye biashara ndogondogo kama kuwa maandazi na vitumbua ili nipate hela"

“When we harvest our food my husband goes to sell all the food and he doesn’t bring the money as he keeps the money for himself. I really don't know what will happen when my children will start going to school because my husband doesn't buy food for the family and he doesn't pay the house rent. I have to do small business such as selling maandazi and vitumbua and you can imagine my parents at the village also depend on me.” She did not want to make alcohol but was considering it as she found other women being paid for it.

Various concoctions of alcohol made from millet and additions are given different names. Mostly, in this region they are known as uwele, ujimbi, pombe kangala, komoni, choya though many other varieties exist — as also distillates such as gongo and chang’aa. Traditional alcoholic beverages play an important role in the daily social, economic, nutritional and cultural life of the people. A study in Tanzania that collected and analysed 15 homemade but commercially available alcoholic beverages showed that ethanol concentrations of the brewed samples ranged from 2.2 to 8.5% to 24.2 and 29.3%. The same survey also found the rate of lifetime prevalence of alcohol use to be 8.7% among males and 9.9% among females. The distilled samples contained Aflatoxin B1. The results suggested that impurities and contaminants possibly associated with severe health risks, including carcinogens, are often found in traditional alcoholic beverages.

In addition to the health risks, alcohol induced deaths are known locally as maziko saa nane, it is the women who bear the brunt of alcohol induced violence which is widespread and needs to be acknowledged. A closely related and noticeably widespread condition is that of gradual blindness, caused by methanol which is naturally produced in the distillation process and damages the optic nerve. This needs to be highlighted and, safer and hygienic procedures need to be introduced in the consumption and brewing of alcohol.

Habitation

Currently, the drive to build schools and new health centres is underway but these initiatives need to be preceded by the construction of reliable facilities for clean water and, electricity which urgently need to be established within the immediate environs. In most of the sites, water was located at a distance of five to ten, even fifteen kilometres and sometimes further. Women and girls were the water bearers carrying the water in plastic buckets mostly by foot but in some cases by bicycle. In

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the north in Kondoa, men carried water in bicycles along with women who usually walk several kilometres accompanied by their daughters who had to climb rocks and descend several feet to collect water.

Image 2: Shallow well

And, in other parts of the region, it was only after a long trek, that a shallow well was found where one had to wait for two hours for a mug of water to come out. It was white in colour, very muddy containing worms and insects, requiring that it is boiled and treated before consumption. In all the sites, people did not boil the water but drank it straight away. Animals such as cows, goats and donkeys also drank from the same source.

The absence of minimum standards of sanitation and hygiene are life-threatening issues. For example, nearly all the latrines are pit latrines which are dug and periodically filled at the back of the houses and cleaned by the girls or women but cannot be cleaned after each use. Also it is dangerous as young children can slip in. Dogs are also seen inside these latrines. Conditions of living are thus far from hygienic as rats, termites, and a variety of insects are allowed to breed in these enclosed spaces.

Image 3: Pit Latrine

It is also seen as the place where refuse can be dumped. After childbirth, the midwife also may dump the tlimama - placenta - into the closest pit latrines. The frequency of diarrhoea and also urinary tract and related infections is not surprising. People also tend to bathe in these enclosed spaces. Eye infections such as Trachoma and conjunctivitis are very common. To combat these infections, the locals use 1 TSH or a piece of tree to make an ndonya and burn it on one side and place it on the child's forehead making a burnt circular mark. It is believed that this will prevent the discharge from the eyes, red eyes, loss of vision and irritation. Discussions need to take place and clean water must be made available.

Thus, such lifestyles could improve by simple preventive health measures if introduced. Current health teachings exist in government programmes but they need to reform their modes of communication with the local communities by initiating ‘community participation’ for civic facilities to be successful. Fitting these latrines with pipes connected to a community biogas plant would address these issues in a cost effective manner. Thus, sanitation and hygiene practices demand imperative attention.

Also, there is little or no provision for electricity and this is worrying as health centres have to use fuel such as kerosene or oil. They sometimes deliver babies in the dark and this is dangerous. The clinical officer noted, further, that it was difficult to keep vaccines for neonates and children or refrigerate at set temperatures.

Another significant and often unacknowledged source of mortality and morbidity is the disease caused by *Spirochete borrelia dutionii* and transmitted by ornithodorous
moubata tick vectors; in Dodoma the most prevalent are the variety called *porcinus domesticus*. Traditional Tembe houses are frequently infested with tick vector and the disease affects particularly young children and pregnant women resulting in foetal loss and neonatal deaths. Many women and men admit that at night they are attacked by ticks – *kunguni* – and they do not think about that much, it happens so frequently. This factor needs to be looked into and studied in greater depth to allow investigations on possible intervention strategies that would implement greater civic awareness.

**Image 4: Tembe**

At any one time, eight to twelve individuals reside in a Tembe and it can get very crowded. Sometimes animals such as goats and chicken are placed inside if there is fear of theft at night. The local health centres have a list of tick borne infections carried by livestock such as these listed in the health facility-- anaplasomiasis, bubesiosis, contagious bovine pneumonia, and from goats who are easily susceptible to the contagious capiri pneumonia. During the rift valley fever, despite all the propaganda, their cherished cattle continued to remain in proximity. Health facilities have pasted the warning signs on their walls with drawings—and also report the need for testing for tuberculosis which affects livestock. But most people living here do not attach much importance to such instructions – they would rather not lose their livestock and income.

**Image 4 Deforestation**

To block the wind (*mbeho*), which blows from the east, (*kucilima*) to the west, (*kwumweetzi*) bringing sand and dust, traditional tembe houses have an architectural uniformity, mostly built along from the north to south direction with the door opening to the west. Towards the east, small holes in the wall become windows which at night are stuffed with old clothes known as *saambi*. There are usually three or four rooms but, always inadequate ventilation. Succeeding houses follow the same direction and are built at right angles – forming a courtyard. A polygamous household, and there are many such households in this region, has a fourth wing forming a *mapitima* or a square. Thus, most habitats form rectangular settlements.

Nearly all the people the RAs' spoke to say that the houses built are in danger of collapsing. The strong winds damage their homes and they have to live with leaky roofs and termites. There is no electricity in any of the sites – most people use small burners *vibatari* and *kandiri* as the only source of light. There is very little furniture inside a Tembe – a few small stools at the most- *kigodas* as they are called. People sleep on donkeys' or cows' skins which are spread over the floor and some use their kangas or kitenges as sheets. Sanitation within the house is personal – floors are cleaned and, the rooms look acceptable but tembes are poorly ventilated and, mosquitoes, other insects and rats abound.

The extensive deforestation adds to the environmental decay. In many parts the masource of fuel is charcoal and trees are burnt for fuel, in particular the Acacias and *Mkungugu* – the rapid degradation of the landscape is extremely worrying. We drove
through many burnt forests and witnessed the smoking of wood and large trees, chopped down. Most households use firewood as the main cooking fuel, traditional tripod-style stoves or the three-stone stoves are used. These stoves emit smoke into the cooking environment and fill the homes. Besides the heat radiation form the stove is dangerous for children and pregnant women in particular. Smoke contains tiny particles of soot, which clogs and irritates the airways, causing disease, and damage that can be irreversible. Smoke also contains a cocktail of poisonous gases, including aldehydes, benzene, and carbon monoxide, which cause headaches, dizziness, and in extreme cases death; it damages the eyes and, can cause premature births. Another result is a high incidence of chest and respiratory diseases facing women and children in rural areas who use firewood for cooking needs to be addressed immediately.

Image 5: Cooking in a Tembe

There are few roads to the sites where field work was undertaken in the interior. Even to the main towns such as Kondo there are hardly any pucca roads in existence and most of these truncated paths are those that have been traversed by foot over a period of time. The paths that exist are stony or muddy. Pregnant mothers make perilous journeys to the health centre or dispensary that is the closest either by bicycle or by mkokoteni, an all purpose cow cart that is used to transport pregnant mothers and, also used for heavy loads such as bricks. A journey takes a minimum of six hours, maybe more to reach a health facility under such conditions. The only vehicle that is effective is a 4WD. Thus, ambulances are unable to go through most of the countryside and public transport is non existent- building roads is another paramount consideration that needs to be prioritised.

An essential intervention is the immediate provision of basic civic requirements such as clean water. Also, electricity, good roads and transport to strengthen preventive health care. These measures would lighten the burdens to the health system considerably.

Image 6: Bad Roads

Local Administration

The offices of the VEO and the Bwana Shamba are of great importance. Not only are they aware of what is going on in their village, they also are expected to maintain records. Record keeping by these officials is extremely useful in gauging the lifestyle and requirements of the people. It was noted that in most cases the VEOs' had basic Standard Seven or Form Four education but could not converse in the local languages "lugha za Kienyeji". All conversations were done in Kiswahili. In most cases we found records of the population, number of men and women, streets, households, latrines, under-fives, schools going children. But in five sites we found no records- as the VEO was not appointed or he was too busy to attend to all these tasks.

At another remote village we found the VEO was also the main clergyman and conducted church ceremonies. He told us that he had been here since 1980 and managed both the jobs. He was thus a justice of peace and a clergyman and had little time to attend to the village duties as he was so busy attending to so many things. The shelves in the office were empty; there were no chairs and we sat on an old wooden table. The Ward
executive officer, Mr Emmanuel, told us that he could assist us. He had no books however and, he recited from memory, there were 5583 people, out of which 1107 are men and 1123 are women and, we calculate to note the remaining were the watoto.”

Image 7: Common mode of transport

The other important person in the village is undoubtedly, the Bwana Shamba. They are usually trained in livestock keeping and, often, have studied crop sciences. They examine and vaccinate livestock and are aware of crop production. They keep records for each season. In one site, the Bwana Shamba, Mr Motoga, told the RA, “for 2007-2008, we expected to harvest 3636 metric tonnes of food crops but we managed only 1951 metric tonnes. Cash crops are also recorded. We keep bees and last season we anticipated six metric tonnes but it was only 1.8 metric tonnes.”

Animal husbandry is also taken care of by them. Mr Abu-Bakr at another site said, “I advise the people on their animals - sheep, goats, cows, pigs - and, can give vaccinations to prevent tuberculosis. It costs 300 TSH per year.” They advise on boiling the milk but few pay heed to such advice believing it to remove the nutrients from the milk and also in some cases to cause the cows to give less or no milk. All the Bwana Shambas we met lamented that people sold most of the milk and hardly added the valuable food crops to their diets, thus pregnant mothers and children could not benefit. The vegetables found are nyamusa, safwe, mkotogoba and isunzi. We watched Admara cooking, it was as many women do in this region; the vegetables are dried in the following way and prepared: she takes the turnip or other vegetable leaves from farm and boils them at low temperature. Then she picks boiled leaves and puts at the top of the roof so that direct sunlight can dry them. After the vegetables are dried she stores them inside the house in a dry bag. But before that she spills the water that was used to boil vegetables as she doesn't know that she is throwing away the nutrients. Thus, the bwana shambas are extremely useful in advising people on nutrition and keeping a balanced diet.

For effectual community participation in health, it is the offices of the VEO and the Bwana Shamba that we need to work with to set up and establish links with the populace, local midwives as indeed, also to encourage the workers in health facilities.

Health facilities

The region has seven hospitals, twenty five health centres with 277 dispensaries. Most of the facilities are government owned. The aforementioned study by UNICEF has documented the conditions of the existing health facilities and the health workers and the findings of that survey complement this study, for example, the acute shortage of essential medical supplies such as Ringer's lactate, birthing kits, and in addition, health facilities being woefully understaffed with inadequate in-service training of medical staff, as indeed the lack of emergency obstetric care. In one site there was only a clinical officer, Mr Onanaka, and he had no help at all. He was running about frantically attending to the many pregnant women who were waiting. The midwife was away sorting out why her four months' salary arrears had not been paid - she had been away for over two months as bureaucracy was slow - and, there was no other health attendant with him. We also worked in areas where there were no health facilities such as Maya Maya, Ivundo, Mahungo and, in several of the villages neighbouring the principal sites, there were no health facilities. These problems will be elaborated upon in the section on health later in this Report. The health centres that are built are of good size but the severe shortage of water and lack of electricity cripple their service capabilities thus cannot fulfil the basic demands for primary health
care.
Gender Imagery

Defining Personhood

The social processes that influence the reproductive health and well-being of people are rooted in gender relationships and sexualities, central to the making of personhoods and self-identities and, derive from specific environments as indeed, belief systems. Culturally, men and women, girls and boys are conscious that they are composed of substances from kin and constituted by relationships which they need to respect and need to fulfil the requisite moral obligations or face censure.

Ancestor worship

Integral to social etiquette, all forms of interaction and social order are guided by the rule of obeisance towards seniors and ritual elders. They alone as the genealogically senior males, sometimes, senior women could prevent the estrangement from 'the most potent source of effectiveness in everyday life'. Here it is important to respect that the system of beliefs derive from the powerful status accorded to the sky, in particular, as expressed among the Sandawe -- the moon la"oso and the Sun ll'akasu and the earth are tied with ancestor worship. The phases of the moon are particularly noted and seen to be directly associated with the fertility of the female and the menstrual cycles and, the fertility of the earth. The metaphor of the sky is evident in the chanting of sophisticated maxims which are used every day, during the rituals to pay homage to the ancestors, to safeguard an individual’s health; vitality and safety affirm their beliefs. Also, conception, marriage and death are seen to be tied to the goodwill of the ancestors who are seen to continue to empower the lives of people.

Tchi gkgoko galama q-posets’ë, xoo (Kisandawe)

“Grandfather’s rope now tore apart.”
That is grandfather and one’s ancestors were always correct in their wisdom and direction and continue to be so.

Doro mpanda mikesetchë

“Zebras always inherit the paths of their ancestors”

Thus, elders in the communities command great influence and are important arbitrators to initiate social change for community participation.

“Sisi WaTanzania tunapenda kuongea na bibi,baba,mama, mjomba,shangazi kaka, dada na wadogo zangu wote pamoja na ndugu, wote Ndiyo kwa maana, amani inadumu, pia tunapenda wagani wote waige mifano ya amani Tanzania Karibuni Tanzania.”

“Here in Tanzania we love to talk nicely to our grandmother, father, mother, uncle, aunt, brother, sister and our Family clan. We love all visitors to imitate the good example of peace here. Welcome to Tanzania.”

Prevailing appreciations of personhoods are, in reality, fostered primarily through family relationships, friendships that are informed by gender sensitive, ritual processes through which “a person is a person through other persons and a person becomes human through other persons.” As people value and, are seen to be bound by social relationships and clan interests, moral obligations appear often go well beyond personal choice. For example, although initially girls refused circumcision, they cooperated to get circumcised when told that it is de rigueur, and are expected by their family and community for them to undergo the rite; or, in other instances, women
wanted to have one or two babies but they acquiesced to the expectations to bear as many babies as possible until menopause sets in, regardless of their own health requirements.

While individual identities and needs are respected, achieving personhood is seen as gradual, in stages, and is regarded as a lifelong process making continual allusions to the physical and conceptual positions through different scales of time symbolised during the ritual processes of birth, circumcision, exchange, marriage, procreation, senescence and death. Such events are crucial for shaping individual destinies of both women and men; people derive a sense of identity from those to whom they are related and adhere to traditions upholding inter-generational continuity, rituals that will be described later in the report.

Thus, implementing a health strategy which works on the assumption of individuals as autonomous, propertied, self-interested, and accumulative; and, as having independent agency in terms of power of control over others, i.e. the imposition of generic individualism, is not helpful as it cannot relate to local understandings. For example, to uphold brazen individualistic behaviour is ubinafsi – selfishness that does one harm, bringing disrepute and, almost certainly, social ostracism. An experience in point: when missionaries sought to convert and discipline individuals they also introduced an individualised morality that conflicted with the values and customs that people cherished and continue to practice. An individual is formed through relationships and obligations to the wider family wherever they might be, Eva, a midwife said, “If you go somewhere and marry the child of others, then all her or his relatives become your relatives, because you have married the child, and so you will love even them as your own and they become part of you.”

It is also important to take into consideration the observations of an eminent anthropologist, Thomas Beidelmann:

“Most assumed that missionaries, planters, and colonial administrators were like the people who remained at home simply because the expatriates also spoke European languages, wore Western dress, and proclaimed the clichés of Western ideologies. Few appreciated that such groups were often profoundly different from those in the metropolitan countries that behind commonly used words and manners were meanings and values sometimes considerably different from those at home. Of these colonial types, missionaries were perhaps the most alien of all since the depth, totality, and length of their commitment were the greatest. Furthermore, missionaries sought to change not only the ways of work and politics of native peoples but their innermost beliefs, feelings, and deepest held values as well; and because of these missionaries may be considered the most ambitious and culturally pervasive of all colonialists, attempting social change and domination in their most radical forms.”

As missionaries upheld that the bond between husband and wife took precedence over all other relationships, no polygamist could be admitted into the catechumenate unless he separated from his wives except the one whom he first married. In spite of such apparently non-negotiable strictures, it is not surprising that polygamous unions as we discuss later are extremely common and thriving among those men, who see themselves as devout Christians.

Livelihood Strategies

13 Peterson DR, Morality Plays, American Historical Review, October 2006
14 Pels, P. A politics of Presence, Late Colonial Tanganyika, Amsterdam 1999
16 Interesting to note that, although polygamy is widespread practice in this region, the Wasandawe, in general, are extremely intolerant of such unions and practice monogamy.
That the nature of livelihoods and nutrition are consequential in evaluating the differences in the health experiences between men and women is well known. The daily work load of women and energy expenditure far exceeds that of men and this has a critical impact on their health and that of their children.

**Daily Work**

Almost everywhere in the rural, semi urban and, in part, urban areas of the Dodoma region, women and girls appear to keep the home fires burning almost single handed. Each day a woman (and girl) wakes up at 0400 or 0500 hours, *matzogolo/majogoo yanapowika*, “when the cock is crowing.” She rarely washes her face and dashes out to collect firewood and water; depending on what is available she prepares a meal of *millet kukuzura* and then prepares some *corn porridge* for the children. Alternatively, in the morning there is no tea and some people eat *chipolo cha ugali* (previous day’s food). The food is not warmed properly and sometimes a portion of *ugali* is kept on top of fire directly. The woman tidies up after the man has eaten and she sweeps the outside and, outside of her home. She begins cooking for the farm at 0600 hours; she is ready to leave and works until sunset. When she returns she collects more firewood which carries on her head with a hoe in her hand and, often, a baby on her back. She then prepares to start cooking the evening meal. Often there is never enough food. Upon arriving home she fetches water and makes a start on their daily menu, which is *ugali and mlenda* also known as a meal of *mgalu*. And even though the food is not protected, it is not boiled. The men and boys always eat first at all meals, and girls and women serve them and eat later. In most families women and children eat together in one pot *'chombo cimonga or, 'nyungu monga'* This is not hygienic at all as there is sharing of saliva and, as the RA noted, it was very dirty. The husband eats alone and he is given a lion's share of the food. After his evening meal the husband may stay or could also trot off to the local kilabuni and converse with other men or, seek a woman there for sex.

His wife and the women in his household are expected to continue with the work. She washes the dishes with the help of her daughters – girls as young as three are made to work and then goes to bed at nine or ten p.m.--- any slackness on her part or refusal to work is likely to invite his censure. In addition, most women say that they spend their lives doing work as hired labour - *kibarua or miraba*, on other people’s shambas so that they can have good crops and get paid money/crops for consumption at home. Often that is not enough and brewing local alcohol is a common task many women undertake as noted earlier - it is vital to their finances as it guarantees them a steady and reliable income.

Men appear to believe that women must do all the farm work as also to shoulder all the burdens in the household. After all, men elaborate

“The woman is capable of everything like cooking the food, cleanliness of the house and fetching the water.”

*Kina mama wanafanya kila kitu wenyewe wanapika chakula na kufanya usafi wa nyumba na hata kuchota maji.*

Thus, boys and men’s contributions to the household chores are minimal. Boys think that *shamba* work is for elders and prefer to work in *dukas* or, do business while they study girls and women. Men go with their wives in the *shamba* and spend the whole day working in the *shambas* taking breaks when it suits them and resting. The wives do not rest as their husbands may scold them and they fear their husbands. As a pregnant mother, Zainab recounted that when she rested, her husband shouted, “Is the pregnancy in your hands?” Whether their wives are pregnant or with children, men do not participate in any household chores or, even participate in the early upbringing of their children. But they are always present and welcome proposals of marriage as it means getting cows and the birth of a girl spells bride wealth and they can demand what they wish to receive and, to control.
The evenings and late afternoons are spent in the company of fellowmen with whom they share an easy-going relationship of trust discussing politics or crops or sharing woes. Usually they sit opposite each other while the others watch them playing bao, usoro or simbi which are local games. Even whilst the women are pregnant and have no time to rest, men do not assist them; they are content to sit down and drink each evening and entertain themselves with other men or women. And they rarely provide for the family.

Clearly, from all accounts the energy expenditure of women and the demands made upon them in mutual resource management throughout their lives is consistently greater than those made upon men. Girls from early childhood and women during childbearing ages are expected to engage in heavy manual work and the general physical exertion has dire consequences on their nutritional status and energy levels, particularly lactating mothers. Often, each pregnancy and lactation accompanied by heavy work and responsibilities makes them thinner and less healthy. Breast feeding during postpartum leaves them exhausted, and being undernourished they are unable to feed the baby or bring up their children. Women are not given any assistance or protection at home and their plight is ignored by the men. Men, just simply put, are not expected to assist.

This needs to be addressed as it seems to be the main cause of women's morbidity and their tendency not to rest before delivery, the expectations that they work until the very end – they alone are expected to shoulder work responsibilities and bear children.

The responsibilities and burdens endured by women need to be brought to the open in community participation workshops by local leaders and elders.

Women and Men

Throughout the fieldwork, recurring sentiments from women and men reverberated in this region expressing their anxieties and expectations, exposing the cultural repertoire on how they related to each other.

Narratives by women

When asked at several sites how women defined womanhood, often without hesitation, women replied that the purpose of being born a woman was to become a mother and, to have a child. Mama Dorice elaborated -

*Ni lazima uwe na mtoto ili uitwe mwanamke hatu kama uwe unamjali vipi mumeo kama huna mtoto uutaonekana ni mwanamke usiyefaa katika jamii,*

“One must have a child in order to call oneself a woman. It does not matter how you care for your husband – if you do not have a child you have not fulfilled your duty to society and your destiny as a woman.”

Women who have no children, and we did not meet many such women are seen as bad spirits and of no use to society.
The woman who cannot bear children, the sperm rots in her vagina.”

As the following well-known song illustrates;

“Ng’hujenda ng’ilangalanga nina mwana yali ku mgongo
Ng’hujenda ng’ilangalanga nina mwana yali ku mgongo × 5

“I am walking and looking at my back to look at my baby boy who is on my back...
“I am walking and looking at my back to look at my baby boy who is on my back…”

It is the story of a woman who lost hope of having a baby and to her own and everyone’s surprise she became pregnant and gave birth to a baby boy, and to contain her disbelief she looks at her baby boy on her back from time to time.

On the whole, pregnancy confers pride and motherhood inspires respect; a woman who delivers many babies commands the greatest respect.

“Ukiza watoto wengi kwene jamii ya kigogo unapata heshima sana’

The Sandawe have an interesting turn of phrase when they describe their pregnancy. A woman who was pregnant told the RA:

“Be’ne goowe behedtae manaatche

“I have received a pocket, I do not know what is inside.”

Although pregnancy is to be cherished it is also a time of great vulnerability. One of the main grievances expressed by women and girls is the experience of embitterment – of being cheated in love, marriage and noticeably after conception, during pregnancy. Motherhood is largely a lonely experience as they have to cope with all the responsibilities, single-handedly. Their own mothers are their only source of comfort. Life is hard at the best of times but being loved makes it bearable. While they feel deep joy in their children, the men who make them pregnant are rarely present to assist them.

Infidelity

“How can we know sister what a man is? And, how he will be to you? He speaks sweet words but does he mean it?” Asked Irene,

“When a bad man comes to you, you cannot know he is bad”

“Si udahile manya hono mlume mswanu hono, yakutza kwako kukupogotza”

Thus, she continued,

“Siwendile walume soko wakubita na wacekulu wanji sinyendile hamba, umwende nhaule mwene siyakukutondowaza”

“I do not like men because they go to other woman even if you love him and take care of him.”

When some women are asked what they need the most – the common reply is

“I need a man to be with me as I have no money to buy clothes for my baby. My man made me pregnant and then cheated on me.”
Women seek monogamous relationships with men and, a man as the head of the household remains their ideal. But the irony is that a man almost always never stays with the woman after making her pregnant and rarely will he marry her but he will continue to exercise the right to impregnate her, to reproduce his children.

“what can we say about men? Just look at us Dada”. Cren, a pregnant mother who is on her ninth pregnancy notes that “my husband, he does not care for me and is waiting for “usunau” labour pains. That is all he does. Wait for my labour pains each time I am pregnant. Then when I deliver, I get a kanga as a gift from him.”

“Really sister”, said Jestina, “We have so much anxiety and worry and the only happiness is when we look at our babies”

“A woman exists solely to give birth.”

The common term used is mfumodume. In general, women have no power in this society over their childbearing capacity. The lifecycle of women revolves around their reproductive capacity which is what men obtain for the exchange of bride wealth in marriage negotiations. A woman is not fully adult until she has produced a child. The most important organising principle behind a woman's social status is her reproductive status.

As women are valued and relegated to being primarily bearers of children, consequent attitudes towards reproduction and sexualities hinder women from seeking help and often this translates into a variety of reproductive health problems that have a critical bearing on maternal morbidity and mortality rates. Furthermore, the husband very rarely hardly brings in an income – it is the woman who works and makes ends meet and then, more often than not, the man takes her money or earnings for alcohol and seeks companionship with another woman, mbuya to be seen to be his concubine. A man simply does not take his wife/wives out for entertainment – they remain at home and look after the children. Men can actively seek and have liaisons and relationships with women outside marriage even if they have three or more wives.

Mwadawa, a woman in her late twenties, said, “my husband likes to have sex with young girls and he goes to find a girl and he comes with her in our home, and told me go out I want to sex with the girl, and he uses the same bed to sex with another woman.”

Thus, she continued in a despondent tone,

"Men do not care or value women's feelings. My husband does not care for my feelings or that of our children."

Wanaume hawajali hisia za wanawake.mume wangu hajali hisia zangu na watoto pia.

“My two children, Bosco and Augustine, aged three years and one and a half years old observe this and they cannot say anything to the father Leonard as he is the head of household. We just do not talk about that."

She noted further,
“The girl who is sleeping with my husband told me that I do not know how to care for a man...you cannot satisfy your man that is why he comes to me to give him good care.”

Huyu msichana akija na mume wangu huwa ananiambia huwezi kumtunza ndiyo maana amenifata mimi na pia huwezi kumpa michezo mizuri kwa hiyo nipishe nilale.

Wakutamicila mgati mu nhumbula. Siwakwenda ninga siwakulajila vyono siwakwenda nghani yijo ya walume vyono wakunotza

The women feel deep pain due to the domination by men on all important matters in their families. But they have no courage to show their husbands that they hate this situation.

The experience of Mwadawa is shared by nearly all the women we spoke to in this region.

“Men do not help women.”

Msina msaada wowose kulawa kwa wecilume

“Women love men but men do not love women.”

Wecicekulu wawendile walume zawo ninga wecilume siwawendile wacekulu zawo.

“The only time a man shows his love is during love making.”

Mulume wa cigogo hono wone yakuseka na wa cicekulu yakuseka hono yakumgonya du! Indeed, extramarital liaisons were prevalent in the local administration as indeed, in some of the health facilities.

At one site where I was doing research, the school teacher noted that the VEO, the Village Chairman, the Clinical officer, as also himself were polygamous with the number of co-habiting wives ranging from two to four and that did not exclude the possibility of additional sexual relationships or liaisons. The RA also noted in another site that the VEO in her village was in a sexual relationship with the village Chairman and he spent his time with his mistress and gave her gifts much to the despair of his wife and children with whom the RA lived. The wife noted,

Wakutamicila mgati mu nhumbula. Si wakwenda ninga si wakulajila vyono siwakwenda nghani yijo ya walume vyono wakunotza

Thus, “women suffer inside. They do not like it but they do not show jealously or anger even if the husband is hurting them by taking another woman.”

She continued to talk with philosophic resignation,

“Only men and boys have the power to do exactly as they wish.”

Walume wakuchiwonela ase chisina lya kuwanotza nase sichidahile lajila vyono chikomaye

“They do not feel responsible for anything and, women do not make them feel responsible either.”

Wanaume wanawaonea wanawake na wanafanya wanavyojisikia na wala hawawajibishwi na mtu yeyote hata wanawake wenyewe hawaoneshi kama wamekosewa

Jamila's husband left her while she was pregnant and stays with another woman in the same village. She said that ‘tulichukuona tukaishi pamoja akanipa mimba’ - they just met at the village. Her man just charmed her when he approached her and she accepted him. He told her that she was special and, no one else. She believed in him and they started living together. While she was pregnant she found out that he had a co-wife
who was also pregnant. She could not accept him having a co-wife – msanj myagwe – in her heart. Sadly, it was too late and she feels cheated and is unable to cope with impending motherhood on her own.

In Kondoa, an Mrangi health worker whose husband had abandoned her after she gave him five children that most of Warangi women complained to me about the harsh existence. “They do not care, if it's his wife or sister, men believe that women are their slaves...if it is his wife he can decide to take care of her or not— women are for serving them -- in food by farming and sex only; women can never lead or advise a man”:

Vantu valume teas vantu vaki, vantu vaki nikwajili ya kuvyala na kurima, muntu muki sikontumshauri muntu mulume. (Kirangi)

In fact, they expect the woman to take care of both his families:

Muntu muki kona alorriwe siyo ikale vi lazima adome kwavo na kwanyu. (Kirangi)

It is common for women to say --- “we do not trust other women and are wary of them. And, we cannot like women who sleep with our husband/man.”

Wanawake hatuaminiani ndio maana huwa tunachangia wanaume. Na huwa hatuwapendi wanawake wanaolala na waume wetu.

Women everywhere we resided expressed their insecurities and fears of other women – and, their particular contempt and anger was directed at women who tempt their men away from them. They defined such women/girls as 'prostitutes' which was expressed by the term, kusenhya. Young girls or an unmarried woman with children is regarded as available -- Malaya (Kiswahili) or msenyha (Kigogo), and can be taken by any man as she is seen to be married to many men -- yanamhile mitala minji. As livelihoods are hard to come by, no matter whether a man is single or married, or even in love with his wife, girls and women will solicit men and offer themselves for a price, one of the self-surviving strategies. Thus, men can always get a woman – depending on her age – old ones are happy with a glass of pombe while, depending on the location – for a young woman a man has to pay between 1500—3000 TSH for sex without condom and much less with a condom.

Image 10: “Uwele, Choya" Local alcoholic beverages

A common pattern is to take the girl out for a meal or a drink, and the conversation tends to run this way as men initiate the sexual invitation—

A man approaches a girl he fancies or she is within easy reach and, from various narratives we were told a common request follows shortly after,

Unaweza kucheza bila soxi? (Kiswahili)

Or, udahile jenda na mgosi nhiayo bila mpira? (Kigogo)

Ukudaha kugenda na mgosi nneifo bila mpira (Kikaguru)

“Will you have sex without a condom?”
Girls and women also, despite the hazards, appear to prefer to have sex without a condom; it makes them appear chaste. Women who use condoms are seen to have many men and are paid less. Usually the young girls will do it almost for free – 150-200 TSH as they are satisfied by male interest or a soda, and wish to be loved and, to belong.

Polygamy is widespread. Even if men do not formalise their sexual liaisons, the marital status of a man is of no consequence. He does as he pleases and women also believe that he is available to other women.

“Your husband may be like a ‘husband’ in the house – but outside he is for every woman”

Mume wako akiwa ndani akitoka wa wote

Mgosi wako yang’owa kugati, lakini yanghalawa kunje du ni wawose (Kikaguru) Agatha a nurse at a hospital told us,

“Men do not feel any guilt when they are sexually aroused – by even a schoolgirl. Once a girl has finished primary school they try and seduce her. They say, “We cannot be responsible for our actions”.

Wanawone hawaoni vibaya kuwataka wasichana wa shule kimapenzi. Wanasema hawahusiki kwa matendo yao.

What is worrying is that many young schoolgirls are often not ready for sex and are taken advantage of. For instance, when girls dress for themselves – to feel good and not to attract a man – men interpret it as if they are inviting male attention. Any expression of sexuality by a young girl is seen as her ‘being ready” and soliciting for sex. Said Husna a young girl of sixteen who was at school,

“I feel bad when a married man makes a sexual pass at me. I think when I marry will my husband be like that also?”

Ninajisikia vibaya pale mwanaume aliyoea akinitaka kimapenzi, Huwa nafikiri nitakapoolewa na mume wangu atakuwa hivyo?

A girl is made of aware of her sexuality very early in life and, she has also an awareness of her lower status compared to the boys. She has to work hard and assist her mother or the women in the family.

Despite the saying, Mtoto wa mwenzio ni mwanao; “treat another’s child as your own”, men do not hesitate albeit being married; “and they can feel that even your girl child is not a child but your age mate” (i.e. she can have sex with me like you do) said Monica a middle aged mother of six.

Mtoto wa mwenzio mkubwa mwenzio

The RAs were told of many such incidents and we narrate two cases that were quite typical. Pendo, now 18 years old and a single mother was only 14 years old and a man who was quite old and whose name she does not wish to remember told her,

Panua miguu yako nizame ndani na utapata utamu"

“Spread your legs and I am coming inside, you will enjoy it”

She is still very young, very shy and cheerless; she feels she cannot be otherwise. She was forced to leave school and is in despair as she cannot return. In another site, Esther who said she was 18 was poorly. She was asked to leave school when she was in STD 5 as she was impregnated by a man aged 28 years old; her teacher she reluctantly added after some time. She said, ‘nilitumuliwa nikaacha shule’ she was impregnated and had to drop out from school. She didn’t know that she was pregnant
until two months later when she found out her menstrual flow had stopped.

Here, girls are brought up to serve men and, be willing to please -- and, this meant that if a girl got pregnant she had to leave the school. Sometimes, the boy is blamed for her pregnancy and suspended though he may not actually be responsible. Teachers are very powerful and people revere and also, fear them. While men are allowed to be sexually promiscuous, women remain insecure about their future and that of their children. And, women often are complicit and covet another’s woman’s good fortune.

Note the conversation below which we heard unobserved, whilst sitting in the shadows of a guest house, being privy to an extraordinary interaction, between Geoffrey, the village ironsmith (who was newly married) accompanied by his wife’s brother and, two young women one evening just before dusk. We could not record the conversation as we had not asked their permission. Mr Kabanya who was present noted the exchange and translated it from the colloquial Kigogo:

Helen: Gwee Geoffy ta utzee!
Hey Geoffy come!

Dafrosa: Wamtuga kwihi mlume mswanu ayo?
Where did you get that attractive man?

Geoffrey: Wime, nimceme yatze mlongane ne mwenecho.
Wait, and I will call him and you can talk to him.

Helen: Lece mcema!
Don’t call him!

Dafrosa: Nhaule ukidodoha? Mcemaje duu!
To Helen--Why are you so scared? Call him!

Geoffrey: Hono yatze muutze gomweneco.
When he comes ask him yourself

Helen: Taah citzilekaje tzitzo! Utinke mwi basi?
Oh bother! Leave it! Have you got off the bus?

Geoffrey: (carrying clothes) Aah! Ndawile kanza myenda.
No, I have just washed the clothes

Dafrosa: Haa! ulawile kanza? mcekulu wako yali hayii?
Shocked expression - you washing clothes? Where is your wife?

Geoffrey: Yaliya baho duu!
She is around.

Helen: Yena mlimio ci?
What is she doing?

Geoffrey: Yasina mlimo!
She is not doing anything.

Dafrosa: Nhaule ubitile kanza gwegwe?
How come you are washing clothes?

Geoffrey: Ni m’boceye du.
I just help her

Helen: Nhaule ukumleceleza? Nagwe wamtola yakukanzile myende na milimo minji.
Why are you letting her have her own way so much? How come you wash the clothes when you married her to do the work and other duties for you?

We have to help each other. I did not marry her to work only


You Geoffy! Nowadays men need to be protected! Does she not know that we are always looking for the men and don't get them? If she is tired of you we shall use guile and take you, then we will wash your clothes and fulfil all your needs!

Geoffrey: Gwe yakwakanza. Ane nambocela du zuali (smiling) she is always doing it- and I am now helping that is all.

Helen: Alu yakumbucilee wacheku baha wenji kuliko walume: kwa hiyo walume wa kwaha wa wakupepelezaa.

You remind her that now women here are so many that men are so few they need to be guarded!

As they were leaving, we introduced ourselves and told the women that the population of men and women was roughly the same and it was wrong to assume otherwise. It seems a widespread common belief despite census figures that there are too many women and very few men.

It was acknowledged time and again, that this was in the culture and women were used to it: that “men exercise power and they decide what can and cannot happen at home and outside the home--they cannot be challenged by women at any time. Women are not allowed to make decisions because they are not intelligent like men”, ‘wachekulu wasina mahala’ - a commonly echoed refrains by men and tacitly accepted by women.

Polygamy continues to be rife and thus the burdens on women are much greater than otherwise as they have to not only take care of their children but are expected also to care for the children of their co-wives. Here “Wagogo and Warangi women are powerless they cannot care even if the husband goes to another woman as he has the last say in the family”

Wacekulu wa Wagogo na Warangi siwakuona vibi, Walume wao Wakubita na wachekulu wanji na walume wao wo wena nonga ya mwisho.

It is not just about being a woman from a certain area – most women agree that, “women in Tanzania are living in very difficult conditions. When we smile we do not always mean it, we carry a lot of jealousy, anger and resentment. It is very tough to live as a woman here.”

Wanawake wa Tanzania wanaishi kwenye mazingira magumu sana. Tunapocheka mara nyingi huwa hatumaanishi. Tunabeba mizigo mingi ya matatizo na mahangaiko, hasira. Ni vigumu kuwa mwanamke hapa.

Relationships between women

Thus it is not surprising that more often than not relationships between women cannot be easy-going or comfortable-- there exists jealousies caused by tensions as competition for male attention and care --and use of the scarce resources-- can be overwhelming. Gender needs to be understood in this context as indeed in every other context, relationally: How men and women relate to each other and what it means to be masculine in relation to what it means to be feminine. Gender needs to be seen as a process not as a category, not the ‘being’ of gender but, the ‘doing’ of it.
Joyna, a newly married girl of twenty said, “I just want him to be mine only. I don’t want to share him with other women except me only. . . He should perform his duties as usual and whatever he earns (limbawata) he should bring it to me – example if he earns 1800 shillings he must come and give it all to me.” This is the truth that most women feel sister, which is what we seek from our man.”

But as we witnessed time and again, the reality is sadly otherwise.

A popular song in Kigogo runs like this- and it is sung at all festivities and celebrations including male circumcision-

Nalekwa yee x 6  
Mlume wangu yahamila kwa mcekulu wa kejete x 5  
Alu namulecela Mulungu yanhatze x 8

“My husband left me, he has gone to his second wife, and I left it upon God to help me. I believe God will save me.”

Many ballads are sung at ceremonies – rather than celebratory tales they are messages of betrayal, of pain, of feeling aggrieved, anger or revenge inevitably centring around a man abandoning his wife and children for another woman.

When asked why they performed such songs on joyful occasions, they tend to favour a stoic reply, “well this is life sister and, we sing about the truth of our lives and of love.”

One popular ballad has the following stanzas,

Lead Singer: Neza temanga muwondo cikale wose wigane x 2  
Chorus: Neza temanga muwondo cikale wose wigane x 3

“As you abandon me without remorse......”, ( a ballad of heart-broken woman)“I am going to pull out all the pillars (Muwondo tree) and tear up and demolish our house so that it is not just we both suffer”. That is, she is saying, “I am to live without a husband and you, husband, without the home I made for you and what we had together.”

Neza nyanya inhuli cikale wose wigane x 2  
Chorus: Neza nyanya inhuli cikale wose wigane x 3

“I am going to burn the wood grinder so that no cooking is possible for you or for me.” That is you also cannot fulfil your needs as you have deprived me of mine.

Women echo what men say, “When a man sees a woman his sexual feelings predominate.”

Chikolo chawona ng’ombe chaduma

Men are greedy and, can never feel satisfied with one woman,

Tamaa na ubabe, usulumizi na itanha

Such taken-for-granted beliefs are transmitted from one generation to the next.

Note the message in the following song sung at circumcision and marriages ceremonies:

Majibile yakulonga mwanangu nha wilumbaje  
Nhumbula ye wayago uhame uuhe gwe hono  
Ng’huuya nhumbula ihememula wanyaso weyangalila  
Agano mawine gakwihemula

Majibile, the father says to his son, “You my son, you should satisfy the heart of a girl but leave by the time I return. I am burning for the body of this beautiful girl
and, I should fulfil the lust that is consuming my body as my body is searing with pain."

That is the father is consumed by the lust of sexual desire for his son’s girl and can express his wish to consummate his lust without any consideration for anything else.

Such songs are instruments of instruction as indeed, affirmation --for boys who learn from listening and observing men, on male sexuality and masculinity. And, women and young girls also listen to such songs. They are taught that faithfulness, cannot be expected from men. While boys understand that to be a real man, one must have many women and express masculine power.

_Uaminifu sio kitu cha kawaida na kizuri kwa mwanaume. Ili kuonekana mwanaume rijali ni lazima uwe na wanawake wengi_

Fear of Witchcraft:

Another immeasurably deep fear both men and women experience is that of uchawi or witchcraft. Pregnant women are particularly vulnerable and they go to desperate lengths to protect themselves against it and usually the spells are cast by another woman, possibly jealous of them or covetous of their husbands with whom they may be having a sexual relationship in secret. In most of the villages and cities, there exist those who are seen to have the power to cast spells. It could be some disgruntled woman who cast spells and she known as mchawi and she instructs those who wish to be assisted _kumwachiya mikoba_. Throwing out blood stained items is dangerous as those that want to cast spells will use these items and harm will come to the woman to whom the item belonged.

As Kassim, who had just come out of the mosque told us:

_Valnagi konee vaptire mwana vavina sana vinenga sana lakini kone vapatire mwana haha kulanga mwana vyafafa sana kwatite usave sana. Vantu vosakwa walange vanasana so tamika. (Kirangi)_

“It is important to guard one's infants and children against witches because they could harm and destroy their lives by bewitching her."

_Mwasu urufuma ufume no mwasu urukutumira ukutumira no mboja asaluswane (Kirangi)_

“Thus, a man should take care of himself from dawn to dusk so that no one can bewitch him."

This is where the powers of the _mng’hunga_ and the traditional healers are evident. They are seen to be able to make potions and by divination drive out the evil spirits as will be discussed later. Even the nurse attendant at one health centre who was pregnant rushed to Dodoma as she feared meeting the 'witch' who was reputed to cause still births and, other kinds of neonatal deaths.

Sexual and Domestic Violence

The theme of violence and wife beating are recognisably issues that affect women's well-being and that of their children. Regardless of whether a woman is pregnant or not, or has recently delivered a baby, we noted alarming levels of women being beaten. It is seen as a private matter between the man and woman. On the five occasions when we met the men we noted that they often felt justified and argue roundly in defence of their actions; they rarely apologised. In one case at one site, the girl had been punched in her eyes by the man and was unable to open an eye. She said she did not love her husband anymore and did not want to go back to him. When we met him he justified beating her and argued fiercely defending his actions – and, he said he wanted her back. She had also suffered several bruises on her body and was in shock. Her wishes were not respected as the clinical officer said he would get them back together.
Agnes a mother of four in her early thirties, expresses her feelings towards being beaten by her husband. She said that ‘nikihulika vibi mulume yang’anowa’ -- she feels very frightened each time her husband beats her. He beats her using a huge stick, slaps her and boxes her as if she were a wall. She said that she is beaten when her husband is drunk “since he is so stubborn”. However, she still remains with him, he has fathered her children.

Jesca, a young mother in her late teens said, “I gave birth in 2006 and I continued to lactate because I did not want to conceive again. I gave birth because my husband was forceful... I was not ready, not even happy about this and once I mentioned family planning, my husband beat me every night because he gets jealous when he drinks – afa kungwa ujimbi. If he sees me with a girl or other woman talking together, he is thinking that maybe they will bring other men to me with information and they teach me bad behaviour. He believes that men want to take me away from him always and I must stay alone! That's why he was beating me. I want to go to Mpwapwa where my parents are, by foot as I have no money for transport as he does not give me money. Therefore it is a matter of escaping him.”

In rare instances women cope rather bravely under trying circumstances and care for their children. They are also strong minded and leave their husbands. Take the case of Vumila whom the RA stayed with for two nights talking to her. Almost thirty, she is a mother of two children but with different fathers. She studied up to STD VII and she got pregnant, by her school teacher, and was forced to leave, ‘alitumuliwa’. She gave birth to her first child, a male, in one site at the dispensary. She said that there was no problem during childbirth. But what followed was excessive bleeding (postpartum haemorrhage) until she felt faint. Her brother was told to go to the health centre to ask for ‘dawa ya sindano’ (could be oxytocin or ergometrine). She remembered that she woke up and ‘maji ya diripu’ - and IVY fluid drip was inserted (could be ringers lactate or normal saline). She said that she stayed at hospital for a day and on next day she was discharged as she said that she was feeling well. She married later.

During her second pregnancy she said she was doing well to start with but her husband began to beat her. She was beaten until she fainted. Her husband beat her on stomach and everywhere using hands and legs. She woke up and he was not around, her friend helped her and gave her some food. After a week she gave birth to her baby but he doesn't care. She had no food and she said she stayed for 7 days without food as she was tired and she wanted to die. She left him and went back to her family. On the night the RA stayed with her, she told her not to worry if her husband would come and disturb her. Sure enough, at the wee morning hours the man came to the house very drunk and asked her to open the door. The RA woke up in shock as Vumila's husband shouted ‘naingia na mlango’. He berated Vumila and use abusive language, telling her that she is a msenhya, a prostitute, and if she were to marry another man, he would kill her and the man. Vumila continued to refuse him entry. At which point, he broke the door and entered in with a bush knife ‘panga’. When he saw the RA he retreated but not without giving Vumila another warning. In spite of these frequent visitations and violent exchanges, Vumila has set up a small shop and educates her son.

More often than not, such levels of violence centred around alcoholism and poverty and women often bore the brunt of male frustration. During quarrels with men, women feel they wish he was dead, then they could be freed, ‘chibufwee chilejele.’

The AMO in one site said that after harvest there is not much for men to do and they get frustrated and drink. They then come home and beat their wives. “Beating is commonplace,” noted one VEO, “but we cannot interfere in the family matters, maybe the wife was sleeping with another man? Who knows?” Such attitudes by the medical staff and local officers are harmful to the health and wellbeing not just of women but indeed, Amos, Sospeter, Juma and Augustino who belonged to different sites were among the many men who said that wife beating happened because women refused to have sex with the husband or lover and thus it was justified. They interpreted the many reasons why
women refused sex and justified wife beating and rape which they did not see as a criminal act; men here are seen to own their wives almost as chattels.

“A woman cannot agree to have sex with her husband since her husband doesn’t buy her new clothes. A woman loves a man when a man is responsible for her. But mostly they argue it is because she has another lover and that is why she refuses sex and thus it is right to beat her, as also to rape her if she refuses sex.”

Elsewhere, the arguments ran thus: Men own things in the family - land, house and furniture. Even if the woman cultivates crops and sells them, he is the one who has the right and can take all the money.

And, some men say, “We cannot give money to our wives as she will spend all the money on another man!”

Living without sex is seen as unhealthy in a man or woman. This is a widespread belief. Celibacy is not good for the well-being of a man and also not for a woman, to the extent that women must also fulfil men’s sexual needs and are not expected to refuse a man.

“A man has to exercise his sexual needs or he is seen to fall ill.”

Tunguri ikijaa lazima imwage takataka jalalani

That is, if a man stays for a long time without having sex, the scrotum gets loaded and the rubbish should be emptied at the pit -- inside the vagina. That it is important to have sex every night was a view also echoed by many men.

As one RA found to her terror, whilst working in the field, late one evening without any notice, a local businessman entered her lodgings without her consent and locked the door. He used to harass her with sexual innuendos and she used to ignore him. In addition he was already married with two wives and six children. As he held her by her shoulders, she asked if he was going to rape her. He said,” Oh no, but you are going to give me sex.”

Ubongo wako una matatizo na mwili wako pia kwanini ukae siku zote miezi miwili bila kufanya mapenzi?ni muhimu kufanya mapenzi kila siku kama inawezekana.

“You have fallen sick in body as you have abstained from sex for two months - you must have sex every day.” The RA used her presence of mind and asked him if he had a condom and, fortunately, he did not- she then told him to buy one and he asked her to go out and get one. At which point she escaped and went to the VEO and informed him about the incident. The businessman responded thus, “It is not I but the devil in me who took over,” and he was let off.

In general, culturally, men expect gratitude and reassurance and they do not wish at any level for their authority to be questioned. Women are expected to constantly attend to them. As Grace and many women time and again remarked, “men need to know what is going on all the time with us especially in our relationships with other people.” As Grace noted, “even if I talk to my women relative or friend, my husband thinks that she is going to get me a man!”

Strangely, remarked Jane a nurse, “men have all the power but still are very jealous of their wives and do not give women any freedom.”

Wanaume wote wana nguvu ila cha kushangaza wana wivu sana kwa wake zao na hawawapi uhuru wake zao.

“In my job I am also asked for sex by my male colleagues who are senior to me as also
important men. Once a Clinical officer rubbed my breasts and I was upset. He asked me, “why as I was talking and inviting many men. I had to just tell him, talking to many men doesn’t mean that I want to have a sexual relationship with them and in my job I have deal with all kinds of people including you.”

Kuongea na wanaume wengi hakumaanishi ya kwamba unawahitaji kimpenzi na katika kazi yangu nahitaji kuhusiana na watu wa aina nyingi akiwepo wewe.

“How did he react?”, asked the RA. Jane replied, “What could he do? We are so few here that they need to keep us here.”

It is not that men do not know the problems women experience. Although they want to father many babies, they are not prepared to take any responsibilities and vent out their frustrations. Discussions need to take place through community participation.

Narratives from Men
It is, undeniably, a much easier life for boys and men, although they believe otherwise. It is not that men do not work “but we do not contribute in any domestic activities. The workplace for a man from childhood is in the field. A young boy in a pastoral or in a settlement grazes cattle and, is engaged outdoors. After that he comes home to play. In an agricultural society a boy is given his own part of shamba to dig from the age of seven years old and he must contribute to the harvest. This is a training to prepare him becoming a good man in the society.” These descriptions are commonly accepted as the norm not just in the communities but also at the health facilities - various grades of male hospital staff said that they do not participate in any kind of domestic activities, and certainly do not enter the kitchen, “it is simply not what men do”. Only women and girls are used to that kind of work. Boys are not allowed to perform domestic activities such as cooking or fetching water.

‘mwana wa chilume siya kwituma milimo ye chidaladala’(Kigogo)

Image 11: At the “Kilabu”

Mtoto wa kiume siyo wa kutuma kazi za kike keke (Kiswahili)

A male child is brought up in a way that he is of a greater value than a female child and he should be respected by women. Having a boy also raises the status of the father and his family.

Note the following song sung at various ceremonies:

Lead singer: Wono wena wana wa chilume wayefu mhola baba
Chorus: Wono wena wana wa chilume wayefu mhola baba mhola gwee

Lead singer: “Our fathers who are blessed to have male children, God bless them...ooh God ooh
Chorus: “Our fathers who are blessed to have male children, God bless them...ooh God ooh

Fathers give priority to boys rather than to girls. Although boys enjoy distinct priorities such as being able to go to school and play, still they complain about their lives, “to get a good woman as a wife is tough business and requires exertion. One has to impress her and make her interested, or her parents and give them cattle.”

Of course, one has to be careful and get the good girl first,
If you chase two partridges at a go, you will miss both of them.”

Most boys begin sexual intercourse after circumcision - ages of twelve onwards. And, in conversations with them, it was clear that they enjoyed having sex with girls and women. Some boasted about their sexual prowess,

“Nilikiwa kiwembe, nilikuwa natiyagia

“I used to be hard and do it at every opportunity.”

The symbolic power of fatherhood

In east African culture, the role of the father is extremely important. His word is law and cannot be overruled. He also cannot be criticised and is always fed first and given the lion’s share of the meal. Quite simply, he remains in charge and his sons and daughters cannot speak against him at any time even when he brings another woman to their home or staggers in drunk. Also, as he derives his authority from his father, it is said to rile against the father means to invoke the curse of the ancestors and the power of their curse is enough to destroy one’s life.

Masculine identity and the authority of manhood revolve around the celebration of the power of fatherhood and a man’s desire to be identified by many offspring. Not surprisingly, it is he who receives the bride price of four to seven cows. Traditionally, Omary notes, “we used to give even twenty or forty cows but the hard times have pressed us down.”

Men are expected to be strong

Kusakata! Muntu mulume amanyire kusakata (Kirangi)

A good hunter is one who hunts alone.

Chikwasukwasu chipala cha ng’amu hamba chikwasu sicikulama uwongo

Mawanaume hatia akizeeka bado ana uwezo wa kuzaa bado ana mbegu za kiume (Kiswahili)

A man’s sperm is always strong and active and he can father babies always, no matter his age and in this engagement, the woman’s participation is taken for granted, bearing as many of his progeny as she possibly can.

Ase hono catola mudala cikumulongola ciyo mwenecho yacilongole are we

During various discussions at various sites, we brought up the subject of fidelity - Why should a woman be faithful to man and not a man be faithful to a woman? Why are men unfaithful?

Men say about themselves, ‘tamaa na ubabe’ in Kigogo ‘usulumitzi na itanha’- “men are greedy and seek variety.”

Kwanini ule ugali kila siku wakati kuna chakula cha kubadilisha

“Why eat Ugali each day when you can change your food--- one’s sexual partner need not be the same woman.”

What was conveyed to us was the unashamed, open expression of the self-interested regard that men and boys had for women and girls and it was done in a taken-for-granted manner.
The worth of a woman lies in her providing sexual intercourse, men say, “Ane Nhangeye manyile kola’

What was emphasised by men and also accepted in principle by women –

*Mchekulu ni munhu wa kulela du (Kigogo)*

*Mwanamke ni mtu wa kulea tu (Kiswahili)*

A woman exists solely to give birth

*Si wagosi wose wanaweza kuleleka wajawazito chibitali. Wagosi wengine wanafanya mambo yao na si kuwa karibu na wajawazito.*

Men mostly look after their own business and do not care for their wives and their problems.

“We love women during hard times and when we are empty in our pockets. After we harvest crops and get money we spend do not spend time with our wife until we finish all the money spending it with other women.” Such answers were typically found in this region in over four thousand or more conversations, be it on the bus, at the tembe, the shop, the homestead, *kilabuni* in the city or at the health facility. However, in contradiction to their way of being, boys and men in general, agree that faithfulness in a woman is non-negotiable. A woman is the caretaker of the home and must protect it. The persistent and widespread logic behind such opinions is that,

“A woman is always weaker” -- *dhaifu* -- than a man and, she should not have another man as it would diminish her strength and she would be simply unable to cope, is a common answer.

Joshua, aged 16, and his group of male friends agreed in unison, “a woman should be faithful to man since he paid bride price and also woman is not allowed to be a her own person but she should take care of a house.” He added, ‘*akiwa mapepe sisi tunamwita mhuni au malaya*’ If a woman has another man she is a *malaya* or *mhuni* - a prostitute.

*Chilume. Mamulaka ga koungolela nene kumwande soko nene yo nintolile yo nowa mulongozi we kaya*

“Once we marry automatically we take control of everything and, never permit the woman because it is I who has married her and not her who has married me, so I am the head of the house in all matters.”

To justify their dissatisfaction, men complain about the poverty and hardships in their lives which prevented them from feeding their families. This was the starting point of all discussions. certainly, in all the interactions we had with the men and women in this region:

*Shida kubwa zinazawakabili wakinamama -- magonjwa na umaskin matamwa na utoka*

The expression of male sexuality, thus, is inseparable from their social status when understood through such definitions of maleness and by derivation, femaleness. There is a political mythology that governs all bodily experiences: the male is centrifugal while the female must remain centripetal. Thus, men seek re-affirmation of their potency in repetition rather than the prolongation of the sexual act. The sexual potency of a man is tied to his social status and his masculinity is expressed in his virility.

They boast that it is very easy to get a girl for sex. Chastity is not a virtue and with 200 TSH or 500 TSH and a soda, boys say, “a girl is willing to spread her legs, ‘vodafasta’ and it is easy to have sex anytime, any place, even the bush, or behind
the trees. But that can be boring. It would be much nicer to get married.” But to them, that requires hard work and a fancy they cannot pursue without the approval and help of their father; having a wife means “getting warm meals and, the guarantee of being taken care of every night.”

Often the resounding of male voices echoes the refrain

Inze magayo chono uliye chochako
Dunia ina shida ulicho nacho ndio chako
“Life is tough, what you have is yours”

Women agree with them on this, one of the few areas where there is consensus.

Ideals of Feminine beauty

Boys and men vary in their ideals of beauty. Boys say, The ideal girl is black beauty – mtitu – with a beautiful face, sula swanu, with a thin – msisili – figure like an eight. But the girl they want to marry must have good behaviour – she must talk sweetly and nicely to the boy always -chihuliko in a girl.” And, to marry, men and boys want a well-spoken girl.

Hono Nghutola nghusaka mhinza mono yena cihuliko, muswanu.
“When I am ready to marry, I want an understanding girl with bouncing breasts.”

They elaborated further,

yetze yena sula swanu,yetze yena matombo gemajile, yowe msisili, ye yamanyile towa ciwino

“She must have a beautiful face with bouncing breasts ninety degrees. She should be slim, she should know how to use her waist and roll during sexual intercourse.”

Studying the family tells you about their character and that is important” say the boys, “To have sex, a woman can be a prostitute, ai mila yetu kuwa na mbuya, mafigwa madatu gogakupisa ugali

“A woman must have big buttocks and a pretty face, her character is not important, but to marry we look for a good character from family.”

Ase hono catola mudala cikumulongolela siyo mwenecho yacilongolele.
Nene nowa kumwande soko nene yo nimtolile, nowa mulongotzi we kaya

“Once we marry automatically we take control of everything and never a woman because it is I who has married her and not she who has married me, so I am the head of the house in all matters.”

Sex before marriage is necessary to experience love-making; it is not hard to have sex. A girl will give herself for a soda or 200 TSH in the hope that she can get the boy forever. Boys say the problem is that girls just love the boys – when they have sex. Boys are not so serious about girls but girls always get serious so it is a problem.

Hono Nghukola nzila nghusaka mhinza mono yena madako mawaha, msanu, sula swanu

Older men’s ideals of beauty are defined by the buttocks as ideal for good sex,
One of the main considerations in marriage is that the woman should be able to excel in domestic chores and be strong enough to cope with life. Practical realities dictate choices. For example, the typical value of a woman – as noted by a Mrangi – depends on her efficiency and work capacity, as he advised: "If you want to marry, you look for a (family) house where there is a woman who can toil in the farm, fetch water, collect firewood and, perform all other activities. Long ago the elders used to have three or four wives as they knew they would help them with farm work. However, if you marry 'mstaarabu' - the civilised woman from town, 'umechemsha'- you have failed! There was the man who had married mstaarabu, his relatives everyday used to chide him to get another wife, "mstaarabu, she can just about cook, but she cannot go to the farm or do hard work. So you must marry a woman who is able to do hard work.” Such values extend in rural areas all over the region.

Another consideration is that she should have a sweet tongue, no matter what and know when to shut up. One of the married men remarked, “When women use abusive language, it is a problem as a woman doesn't take care and respect her husband." For example, Julius said to his wife 'nipe maji nikaoge' his wife said that 'kachukue nje kwenyu dumu'. He said only this reason prompts him to find another woman. His male companions nodded in agreement. And, men never consider assisting their tired wives while the wife is expected to assist and serve him all the time.

She is also expected to cook all his meals and even if she has home help she needs to cook and serve him his meals according to tradition. In another site, the RA found the mother of eight Veronika cooking, “Our staple diet is millet, and side we have mlenda, ng’hanya walume or the delicious dabule ng’huniese, the celebrated dish of our tribe which we cook on important occasions and, to increase love in the house. Well I want to please my husband and thus I am cooking this she said with a smile.” Women do whatever they can within their capacity to keep the family together while men enjoy the fruit of their labour of love.

At a meeting of Maasai men in Kongwa we were accompanied by the elder Maasai and told that women in Maasai culture build the houses and men are aware and they take cognizance of this as they seek to rest at home. The group of thirty or more young boys were more vocal, especially Saamueli, Batulemayo, Kuya and Oodeli. “There are many shared values between the various groups of people – in terms of how we see women and men.” Noticeably, differences stem from traditional forms of livelihoods – for example, between Maasai and Wagogo people. But for the Maasai people like the Wa' mangati and the Wasukuma –“we can live in the forests far away from human contact for any length of time, and enjoy the herbs and know what to eat in the forest, while Wagogo prefer to be close to settlements, they cannot cope like us.” “Our women build the homes and we know how important they are, we value them. Only the Wagogo men build homes and their women are not seen as important as Maasai women,” said Joseph who later joined us. He is in his early thirties and married with three children.”

Said 15 year old Batul, whose wife had already been chosen by the father -- it is the father who finds a suitable bride. “We as young Maasai, we are brought up to believe that boys are superior.”

Ore iyole nekera ibarto lar Irmasa’e ore taata iyole iyde e’ngabila ang’aa nr iyde o’bong’e e’nganga nekira sapukini te enga ng’i
What was an ideal girl? “We cannot say about Maasai girls – we cannot think like that– they did not think themselves or they will be disappointed. Parents decide about marriage and choose their brides. But they could think about other girls- she must have a pretty face, good behaviour, way she speaks is very important (that is not so much her voice) but the words she uses must have meaning" and thus intelligence and purpose are valued--"not too big breasts but, firm and standing – body should be as light as she walks and like a feather-Slim girls – “big bottoms are not nice. But if our father chooses a girl for us to marry with big bottoms we will accept that.”
Sexual imagery -- The Female Body

The imagery of a woman's sexuality is far from flattering. Some descriptions of the vagina emerge in Kigogo:

'Mbuda kotya ndigwa yawachuluwe yono yakulya bila kuheka chocheka hamba mafupa; udazi waye zomo mtwe wa hasikanyi kotya chisima, chono siciwuema kotya mmpula ya ng'omba, mbuda yamachichekulu ili yaudeche udeche, na yonoikondizye'.

"A vagina is like a man eater that leaves nothing, not even bones; it is gaping like the head of a leopard/big cat; it is like a well, it never fills up; like the nose of a cow, a woman's vagina is always moist and ready".

And in Kirangi: Kuma ya muntu muki ni ja molomo wa Ndakwi daukivika maji siyomema tuku, kira siku iri chweechwe.

"A vagina is like a donkey's mouth, even if you put water inside it, it does not fill up, it is always wet."

Such descriptions appear to exist in all languages within this region where women are seen to be out of control. Female sexuality is seen as insatiable and disruptive. Women are viewed as inherently licentious and troublesome, a theme that runs through the cultures and is reflected in the way men behave with women. This is not just specific to East Africa but prevalent in many parts of the world. In West Africa, for example among the Hausa, it is said that, "A man's wife is his grave"-- matar mutum kubarinsa; or "He who falls in love with a woman is a fool, for he never knows if she hates him or not"-- "Matar na tuba bata rasi miji." Troublesome women are called hot pepper -- yaji, zamanke kai kadai ya fi zama da mugunyar mace-- living alone is better than living with an evil woman; in contrast, a submissive woman will not lack for a husband, matar na tuba bata rasi miji.

Such descriptions lend credence to beliefs that women are always ready for sex and thus are always available when men need to have sex as also dictating how women must be. In contrast to the damaging descriptions of the vagina, the penis has been described with positive connotations. Note this well-known song:

Nzoka nyamuhando yenjila mu kaya ikalonga gwee liyaya heya x 4
Nzoka nyamuhando yenjila mu kaya ikalonga gwee liyaya heya x 10

“A black mamba has entered the house and it said, with pleasure and ecstasy...oooh I am inside the house... x 4

A black mamba has entered the house and it said with pleasure and ecstasy...oooh I am inside the house"

The mamba is the penis and the house is the vagina – such metaphors are common in this region.

In these sites, girls giggle and women twitch when asked about these descriptions but remain reticent when asked about men. When pressed, what about sexual relationships with men? Rosa sitting in her tembe said, “Traditionally we do not kiss as white people do. It is shameful. In Kigogo, our sexual invitation is to receive a husband when he returns from the shamba and, take from whatever he is carrying and then we welcome him and say, milimonyi that is how was your work? Then we give him water to drink and, rest and then bathe him and give him millet, chimhombogo and while preparing ugali and mlenda, we also add fried meat or kande na njugu cooked maize
mixed with bambara nuts. Men initiate all sexual activities, we do not show interest in that as a man grows suspicious.” She did not talk further and the conversation ended as soon as her husband appeared at the doorway; the RA greeted him and took leave.

Knowledge about the Body

Discussions on the bodily functions and the body for both men and women are seen as a taboo. With reference to issues revolving around sex and sexual initiation, instructions were given during circumcision as it was in the past for girls. But nowadays, neither the mother nor the women in the family speak to the young girls about such subjects – thus as there is no sex education and very few can go to school, most girls are taken aback by shock by their first experiences of menarche; and in some instances it happens after marriage.

Very few women and girls are aware of their menstrual cycle or have knowledge about their bodies, the bodily functions and orifices are not discussed. Everything they know is by observation and experience. Lily a young girl said, “It is regarded as shameful to talk about these subjects, we just watch animals and learn”

They do not learn about menarche as it is not taught to them; they remain ignorant until they experience it.

As Bahati noted, “Most of our mothers do not tell daughters about menstruation or how to take care during menstruation.”

Valamama sivawira vantu vaki njole sakami ya mweri ivaa. Da vintu chee vaboyee kuzuira sakamii. (Kirangi)

Doubtless, menarche is regarded as a critical rite of passage. Celebrations occur so that boys and men become aware that the girl has experienced menarche and thenceforth can bear children. But the girls are secluded during such celebrations.

As Majimbi notes, “when a girl menstruates for the first time, she is kept inside, she is taught how to clean herself for all those days when she completes her periods then she is allowed to go out. But during her stay inside she must be bathed by a fine soil called iswagumbi. She must clean or wash the towels she uses and is taught not to sleep with boys because she would be pregnant. When she completes her periods she is bathed and all the dried; iswagumbi is cleaned off and it makes her skin shine and soft.”

In some cases they are married before menarche and thus their mothers-in-law tell them about it. They believe it is difficult to know about their cycle because they do not know how to read and write.

“Kwakweli inakuwa ngumu sana kwetu kina mama hasa ambao hatujasoma. Lakini kwa waliosoma inakuwa ni nafuu maana shuleni walijifunza sayansi hivyo wanajua mzunguko wa siku”

Eliza, early twenties(?) asks, “Is that important? Why? It is difficult for us, because I didn't go to school but for those who went to school they understand because they learn science.”

Mimi binafsi sijasoma hata wazazi wangu hawakwenda shule hivyo nilikuwa najiendea tu, mpaka nilipoolewa na kuanza kuhudhuria clinic ya wazazi ndipo tulifundishwa, Lakini bso sikuelewa vizuri mzunguko mzima unakuwaje.

Lucy, aged about 35 said “I didn't go to school even my parent they didn't go as well. And I didn't know anything till I got married and start attending ANC where I was asked that and some quick explanations. But I did not understand well what the
Catherine, about 45 said, “My parents did not see the importance of taking me to school simply because I am a woman, so my brothers were taken to school and I was left at home with my mother to help her with housework.”

Wazazi wangu hawakuona umuhimu wa mimi kwenda shule kwa sababu mimi ni mwanamke, kaka zangu ndio waliopelekwa shule na mimi nilibaki kumsaidia mama kazi kama kupika, kufua, na kuokota kuni.

Aziza, a young mother of three in her twenties does not know her menstrual cycle and doesn't feel bad about it; she says, “vana kufuma kwa mulungu, venE arukumpera no vavo, tuku si lazima sindri tanga mzunguko wane wa mweri. Watoto ni zawadi kutoka kwa mungu kwa hiyo atakaonipa ndio haohao si lazima sana nijue mzunguko wangu wa mwezi.

“Babies are gifts from God so he may give me the number of babies he wants I don't really have to know my menstrual cycle.”

The common name they use to express menstrual flow is ‘kutumia’ and if a woman is bleeding then they use pieces of old kanga or kitenge; in the evening she washes the pieces and uses them for the next day. Maasai and Warangi women use pieces of animal skin, ngozi, during menstrual flow instead of pieces of kanga. During menstruation, they also tend to use pieces of goat or sheep's skin which is soft as a sanitary towel called ‘elandana’. The piece is used at the start of the day and in the evening, washed and left to dry and re-used the next day. Dispensaries should provide free sanitary towels to the women each month and, also advice on hygienic disposal. They could thus, also monitor pregnancy and advice on childbirth as indeed, fertility.

However, as is the case in many parts of the world, menstruating women are told to observe taboos. They cannot go to church or offer prayers at the mosque. They are instructed not to go to the fields as they could poison the field and there would be no harvest. Also, if the man returned from the field they should not touch the hoe as it would split into two. Everything they do in the public sphere is seen to be dirty and polluting. For example:

Cililikwekwe chila lye liniamba, lingomale ng’hubita kululenga

“A menstruating girl or woman must return home and wash herself if she intends to fetch water and not pollute the river or well.”

But on the whole positive connotations are attached to menstruation as a girl can now be seen to bear children

On her first menstruation, referred to politely as hono yatema thamha, 'when she has cut the leaf', a girl immediately informs her mother. She is now said to be 'grown up', or to have 'just grown up'. Sometimes in playful conversation this is also said about the girl by young boys.

Oie chipela chagwa wadodo
Oie chipela chagwa wadodo

“A small Boabab fruit has fallen down
A small Boabab fruit has fallen down”

That is, a girl has started menstruating, (she is ripe and has come into seed)

But many girls remain ignorant of the knowledge of the body and bodily functions.
There is a need to initiate informal education by story telling, dance and songs and employ the medium of film in Kigogo and all other local dialects. These gatherings should focus on education of the body for men and women, boys and girls of all ages followed by a discussion chaired by a village elder or traditional healer.

On Conception and Pregnancy

Many men and women were asked about the development of their baby and, it was interesting to note the repetition as the following answers illustrate:
Knowledge of foetus development is very scanty and inaccurate. Some excerpts: “after mapenzi (sex) conception took place if the womb was warm, what develops in the womb is a clot of blood. The baby starts as a clotted blood; then later at 4 months turns into a lizard and slowly it develops other parts. It is mature at nine months,” said Jeremiah an excited father aged about eighteen, who was waiting to meet his first born at Kondoa. Another remarked, “This clot of blood keeps on increasing in size until four months when the body parts start to grow. It is a baby at 6 months when it has physical baby parts with hair, legs, and arms and can easily swim in the womb. At 8 months it turns to face downwards and this time it mainly kicks. It is a mature baby at 9 months and that is when it is delivered. My sister had a baby and we heard this on the radio,” said Leila, a shy, fifteen year old school-girl. Her sister added, “From the 1st to 4th month the head of the baby faces upwards then from there on to the 8th month it develops while facing downwards.” Asia the mng’hunga noted, “The baby starts developing when a man plays sex with a woman that is also magic, the eggs meet and at 1st month the egg which was fertilized moves to the womb and at 3rd month the thing is shapeless – it is guided throughout by the malaika (angels). From the 4th-6th month the different parts of the body starts to develop and at 7 months the baby turns upside down. The baby is mature at 9th month and is ready to be born.”

“Were they explained the foetal facts?”, the RAs' often asked the midwife nurses – but even the latter were not conversant with the obvious facts when quizzed. Out of the thirty-eight nurse auxiliaries attending to childbirth whom the RAs' questioned at various sites, only three gave correct answers; it is important to put up charts so that women can also read it or have that explained to them at the ANC. They can also then be able to take appropriate steps to protect themselves and rest before birth.

It is important that women and men are encouraged to gather together and that such discussions take place in an atmosphere of conviviality. Under such circumstances, the men would become much more involved and various issues could be addressed through discussion. Women and girls could be taught these facts and told that the precautions that they need to take so that they gain confidence, are knowledgeable and can take decisions when to rest, so that they do not exhaust themselves working till the end as is now the case, or panic about what is happening.

Knowing one's age is not common. Women remember when they gave birth or when their moved village and sometimes calculated their age when the CCM party was formed or refer to the time when “there was much rain and the rivers were flooded with water and fish.” Those who are younger just say I am this age or that age, but the truth is they do not know.


But what they do acknowledge is that they have undergone the rites of passage and come of age and that is much more important in these societies than maintaining a consciousness about linear time.

Rites of Circumcision
Circumcision

Traditionally, circumcision confers ritual sanction for girls and boys to engage in proper sexual activity, unhindered. No sexual activity can be undertaken by girls or boys without circumcision, *sona za cigotogolo, sona tza cigotogoto, or sona za calama*, or *kugotola, or kulawa*, literally meaning 'to come out'. It is a matter of great shame for the families concerned if a girl or a boy do not remain virgins until they are circumcised; they could be driven away from the village, and penalised. It is seen to be impossible to get married without being circumcised.

While much secrecy surrounds a girl’s circumcision although it is widely practiced - as it is banned by law, male circumcision is a public event and after initiation, a Gogo, Mrangi, Maasai youth begins to have legitimate heterosexual relations and to prepare himself for marriage. Thus, the inception of a boy's search for a spouse and sexual activity is marked by the 'public' act of initiation. In the ceremonies, certain definite categories of kinsmen are involved. A boy and a girl come of age regardless of whether they have reached puberty or not.

Female circumcision

For women, perhaps the momentous rite of passage that has a critical bearing on sexual activity and childbirth is *kugotola* or clitorodectomy. The traumatic experiences that girls have to undergo illustrate the degree of ritual control that defines her future status: it is believed that if a girl survives circumcision, she can survive childbirth.

A girl it is believed at this deeply significant transitional stage of her life-cycle is called *munyacipale* or *munyacinga*; after her puberty rituals, she becomes a 'marriageable girl', *muhitzza*. While there are three or four different kinds of circumcision, the removal of the clitoris, or clitorodectomy, is the most common circumcision that is practised. Among the Somalis depending on the families, it is pharoahnic circumcision but clearly it is only a small number who practice that level of circumcision and they are a minority in this region.

A girl's initiation, however, comes two or more years before puberty and, as we witnessed, after puberty. It is conducted with the utmost secrecy as it has been a punishable crime. Many girls are reported to be “away on safari” when quizzed about their whereabouts - to conceal the circumcision as the RA found in Dodoma municipal when she wished to meet a certain girl. And she met with the same response from other girls who attended school.

She is secluded, as she was after initiation, in the inside room of her mother's house in the homestead. The seclusion lasts for varying periods of two weeks to three months. Traditionally, during this period she is given instruction in exclusively feminine matters, such as childbirth, behaviour towards her future husband, and the techniques of sexual intercourse. The instructress can be any married woman of the grandparental generation, the girl's grandmother (*Mama'ye* in Kigogo and *Loo llo* in Kisandawe), she may be still sexually active, or beyond the menopause. The term for these secret lessons is *mizimu*, although nowadays it is not done that much. However, appeasing the 'spirits of the dead' *milungu* by performing the ceremony is regarded as important by all religious denominations.

Despite the knowledge that female circumcision is banned by law, it continues to be widely practised in this region. Sometimes, the fathers from poor families desire an early marriage for their daughters as they would get cows as bride price. Early circumcision often leads to girls being married even before menarche. Sexuality and sexual activity is linked to motherhood and, the social value of motherhood rather than sexual pleasure.

From the narratives, most circumcisions are performed when girls are two to 15 years of age and are deemed ready for marriage after menarche. “Kutema lininii - we, Wagogo,
call it *kugotola* and it has to be done... a girl comes of age only after such an operation that will reduce her sexual desire and make her clean or else she remains a prostitute, dirty and, interminably cursed." These are commonly echoed sentiments in these sites. Health workers say that in many of the cases of childbirth, women have prolonged labour, and often suffer from anaemia caused by excessive bleeding, and poor nutrition in their daily diets does not help. Further the psychological and sexual problems that girls are forced to undergo rob them of their vitality and optimism.

Nearly all the health workers spoke of the frequency of these problems blocked menstruation and related problems during childbirth with pregnancy complications as women were mostly circumcised. They have to perform episiotomy or refer the woman to the hospital for Caesarian section, as vaginal tears and obstructed birth is a life-threatening danger. Medically, it has been recorded that serious complications in childbirth infections caused by circumcision are vulvae abscess – swelling of the vaginal area; urine retention – pain at micturition, urinary infection; Keloid scars; inclusion; clitorodial scars; tubal factor infertility, and dyspareunia. The most worrying are obstructed labour and heavy haemorrhaging and septicaemia; prolonged labour and post partum Haemorrhage; these are the leading causes of maternal morbidity and deaths, and constitute a danger to neonates in this region.

It is well known that female circumcision of any degree narrows the birth canal. Although the vagina is extremely flexible and babies can be born and are born, the pain and suffering circumcised girls and women have to endure cannot be measured – and certainly among undernourished women, as is often the case here, the danger is alarming. Said Greta, a German doctor working as a medical volunteer, “Women take well over the normal time of ten or twelve hours -- that is because obstructed labour and heavy bleeding are quite commonplace features of childbirth...how they can survive, and, we worry for how long.”

A few narratives below illustrate the consequent experiences of being circumcised. Jestina's story

Jestina who was somewhere in her thirties recalled, “Unlike nowadays, when I was circumcised by *Ngariba*, it was a public event and openly celebrated.” She recalled she did not want to be circumcised, “I was ten years old, I think. I told my mother I will not be circumcised and I never want to marry. I just want to be with you. But my grandmother told me that all my friends would think I am dirty and not speak to me and no one would love me, agreed, and she made me go to the *Ngariba*. My mother went with me to a place far away from home. I was very frightened and very sad and cried all the time. My mother cuddled me and told me to be strong. She left me with the woman whom I did not know. The *Ngariba* is the woman who circumcises girls. She looked at me and told me to be still. Then she applied *matope ya hato* (the faeces of the snake) on my face of to prevent anything untoward or bad happening and is supposed to bring good luck in her task as the circumciser she said. Then, I went into a small house and saw a knife with medicinal powders and leaves. She tied me to a tree stump inside the hut. And took everything out and left a small hole. She said this was life – and I had to survive it. After she cut out my organs inside my vagina and applied the medicines. I cried and shouted. I was bleeding continuously. It was so painful that I lost consciousness. When I woke up I was still there and she was applying medicines for a week maybe more I do not know. Then after a long time and many months or so my mother came and took me away and, I was so tired and felt very sad. There was a big ceremony with drums and dancing and I was given many gifts, such as a *kanga* and money about 50,000 which was contributed by the entire community.”

“There was a party and I asked whose party it was. Why it is your marriage party my brother said. Nothing was told to me. I was then married to Wambula my husband, who you see chewing tobacco. I have been with him since. It was very difficult for me to make love and I did not like it but my mother kept encouraging me and told me not to refuse him. I will get used to it. I cried everyday after we had sex. I do not enjoy sex. I got pregnant at about 20 years or so. I delivered at home somehow – it took
such a long, long time the baby to come out that I cannot remember how. When I woke up I saw a baby boy and my husband was happy. Now I am on my ninth pregnancy. I lost three babies at birth, I somehow survived, I always get severe bleeding after every delivery and I feel extremely weak all the time and maybe I will die soon. My only worry is who will take care of my babies, my dear sweet children, who will cook for them”

As Neema, an experienced senior nurse that at Hospital Hospital notes, “The clitoris is removed leaving a smaller hole” and most mothers who come there are circumcised. Almost all the pregnant women have been circumcised and that includes them allowing their young daughters aged two to three years to get circumcised. I have also been circumcised a long time ago, I am a grandmother now”, she explained as beamed proudly. From this and other conversations, we noted that some health personnel appear to support circumcision.

Whilst in conversation with health workers – MCH midwives/nurses and Clinical officers – we were informed that over 96% of the women who attended ANC are circumcised. It was encouraging to note at one health centre, the intrepid clinical officer had created a special column to mark circumcised women with a tick by their names and ‘H’ for hapana.

An extra column needs to be introduced in the MCH registers – at all levels of the health facilities. Also, it would be useful to record STDs and other sexual conditions such as warts and genital herpes in the same register.

**Image 12: Ticks in MCH register showing circumcised women**

There is widespread denial by locals when quizzed whether female circumcision is taking place – many administrators also believe circumcision of females is no longer taking place. Many of the ngharibas who cannot be identified as they practice in secret note that it is well paid and not a full-time activity. They are also engaged in farming and work as mng’hungas. Certainly, the two who spoke to the RA’s said that it was a moral practice and the community depended on them to carry it out. They used knives and kept them wrapped in leaves of Morabaini-Azarichita Indica. They had no formal clinic training to prepare them for their practice but had watched their relatives doing it and learnt that way. In the young girls only the stem of the clitoris is cut with a blunt knife while the older girl, a large part is cut from the stem of the clitoris (lisami) to the labia minora. A black powder was applied on the wound. In the morning the wound is washed with warm water mixed with salt and a black powder applied and after some weeks maybe a month or so the wound heals slowly.

Although the women stated that excessive bleeding and infections happen as potential sequelae of clitorodectomy, they attributed these complications to curses, bad omens, or broken taboos which pregnant women must individually take precautions against once they get pregnant and they often advised them to do so.

**Witnessing clitorodectomy**

One of the RA’s who cannot be named for ethical reasons witnessed a circumcision ceremony – confirming its very pervasive influence. She walked to the area dressed as a local woman and was accompanied by a local woman who was known to the nghariba. There are no beaten tracks to the destination and even bicycles are not seen. In this remote area there was no one living as it was over ten kilometres from the nearest
village, there were no houses, just one tembe with a room. The circumcision was performed under a tree and a kanga was used as a screen.

The nghariba named Miriam was told by the RA that she wanted to learn about it and was allowed to watch. By the time the RA arrived the ceremony was being prepared. Five women pinned the frightened fourteen-year-old girl, young Mwanaidi, to the ground.

Mdala Miriam said, “Kutahiri ni mila na desturi na sifa kwa mwanamke kutahiriwa. Chikugotola mwezi wa 6, ili chilonda chihone haraka kwa sababu ya mbeho. Wasanake wakwija wane auinategemea. Kulawa serikali ilemese, kugotola mwana yumwedu basi au nikaidoke mwaka sinikufina mwana, baada ya kugotola kikuwafundisha ukulu. Foo kufunigwa hung’adende namgosi yeyose mpaka chilonda chihone, chimgomtali fookuwa mwali diselo naka uitse lo mpaka mga yamgale okaya akalafe mali noalutanye. Kwa sababu ya matamu kilawmana yakutumia chiwembe chake, tofauti na katali achitumiga kiwembe chimwedu kwa wanu wose. Baada ya kufunigwa chikubakala mitichikuzuia sakame ing’alawe, baada ya siku7 chilonda chikwachihona kabisa, “Circumcision is our tradition and I am proud to practice it and safeguard our values. I perform circumcisions during the months of June and July. The cold helps a wound to heal quickly.” In the past, she used to circumcise four to six girls each year but after the legal ban by the government – (although this was doubtful given local gossip – she was a bit worried about the RA’s credentials) she may circumcise one girl, or, she added she could pass a year without any work. After circumcision she taught a girl about maturity and values and instructed the girl not to have sexual intercourse until menstruation. If a girl got a man she should bring him home for introduction and man should marry her. She said, as there are many diseases, she uses a different blade for each girl. In the past, they used to use one blade for all girls. After circumcision they apply local herbs on the wound to control bleeding and after seven days a wound heals well.

The RA watched in concealed horror as Miriam held a clean blade. She was not wearing gloves. Three women held the young girl tightly by the shoulders and the other two held her by the knees and she had her feet wide apart. They pressed her down while Miriam held the clitoris and removed it with a clean cut. Bleeding profusely the girl cried in pain. Miriam took some prepared local herbs and she applied the paste on the wound and the bleeding stopped and the girl stopped crying as the herbs numbed the pain. After that they gave her rice, meat and milk. The shape of the vagina had changed.

After it was over, the girl just sat inside the tembe looking pale and exhausted. She was crying in shock when the RA spoke to her. She said she was in Standard 7 and really against all of this. She said “my mother forced me to do this and I refused! My grandmother then came home and brought me here.”

The girl was very sad and she looked forlorn. She had not wanted to undergo this experience. She would now remain indoors for about six weeks and then return home and keep to herself. A ceremonial party was awaiting her and she was not keen on that.

These songs were supposed to be sung by the girl and those accompanying her home,

*Munda yaya x 2*
*Munda mutamile*
“Stomach is paining”

*Ayu mwana yali sungu gwee*
“This pregnant girl is tough/strong, she can withstand the pain”

That is to say she has undergone circumcision and that is why she will be okay.

*Munda Mutamile*
“Stomach is paining”
Ayu Mwanma yakulia gwee
“The infant is crying...ooh”

Munda mutamile
“Stomach is paining”

The song is sung to their mothers who do not attend the ceremony. When the mother hears this sad song she is also in tears. These songs are in marked contrast to those that are sung at the male circumcision ceremonies.

Amina’s story
In another instance, Amina a mother of three notes, her husband has three wives. She recalled, “I am the first wife to this man I got circumcised when I was twelve. It was ilikuntama very painful and she bled severely: damu ilitoka, waliniwekea kipande cha mti kukata damu. She cannot recall the name of the herbs but it slowly made her stop bleeding,

tunapofanya mapenzi na mume wangu sisikii raha kabisa na kuna wakati nakuwa na maumivu.

During sexual intercourse she experiences pain and cannot feel any pleasure whatsoever. She was thirteen when she first got pregnant and it was very painful childbirth.

Image 13: circumcised woman giving birth

What is clear from the experiences of women who have undergone circumcision is that most women cannot experience sexual pleasure and often feel pain during sexual intercourse. This is medically diagnosed as dyspareunia – women’s genital pain experienced during intercourse.

Vumila noted that like Mwadaila and many other women, she was circumcised between eleven and fourteen years of age. In most cases circumcision took place just before menstruation but, as we found, in many cases girls were also circumcised after menstruation. Like the majority of the girls and women we spoke to, she has not experienced any feeling of joy and feels pain during sex – she does not like it and has been married for a year. Having sex is a duty, being forced to do something that is not enjoyable for most of them. Sometimes the repetitive nature of the sexual act exhausts the women but they feel that they need to please the man and just perform it with a wooden feeling inside and, when questioned, many men seem to be impervious to women’s emotions and, seeking their own self pleasure.

tunapofanya mapenzi na mume wangu, sisikii raha kabisa na kuna wakati nakuwa na maumivu.

In some interpretations, it has been argued that the removing of genitalia is seen as an external way of enhancing their femininity – an assertive and symbolic act controlled by women emphasising the power and essence of sexual beauty, morally appropriate fertility, and the potential to reproduce the lineage by connecting to the ancestors and being guided by their wisdom. Yet in these articles, there are no dialogues with girls and women who have undergone circumcision thus we do not get to the heart of the matter.
In addition to excessive bleeding, blocked menstrual flow, pain during sex, scars, vaginal tears and obstructed births remain a primary concern from the innumerable accounts we got from various health facilities. Fistula accompanied by morbidity needs to be monitored as related conditions from difficult childbirth experiences.

What is clear is that circumcision is entirely in the domain of women and controlled by them. Thus, suggesting alternative rites of passage by emphasising the medical dangers to women’s sexual and reproductive health and well-being needs to be urgently addressed by the women themselves with assistance from the men.

What were men’s opinions on this subject? Most of the men we spoke to were not in favour of circumcision. They also said they knew little about it as it was entirely women's business.

Ore emumurata oontoye naa kijoitoi torro ni rahe ore pee mepali emmuratare kejoito nin ye Orruruak lentimalang emmaa anaa enataaza naiterru rop. (Kimaasai)

Kaka ore mmurtatare oontaye naa embaye naipirita ing’elu akake metii ilewa. (Kimaasai)

“Female circumcision is entirely women's business. We know nothing about it.”

Older men and some middle aged men blame sexual licentiousness on girls. Nowadays, they say that it is common that girls and boys as young as 10 years are having sex. “They know the game and can tempt the boys and men,” they remarked in several sites.

“It is because the young girl is not circumcised (iliji, the clitoris needs to be removed) so to quench her thirsty body she goes out to seek a boy.”

Yakubita saka mulume yatze amgon’ye ny’hilu yakwe. (Kigogo)

Nevertheless, more often than not, men and boys say that the best sex is with uncircumcised girls--

Wachihume wendile wachekulu wadodo wono siwabitele mwikumbi

Men and boys like young girls because the vagina is tight as the girls are not circumcised." They indicated that:

- She can be stimulated easily
- She likes to have sex several times and she enjoys being with a man compared to the one who is circumcised
- Her clitoris brings stimulation to a man and hence stimulate man easily
- She is creative during making love - homoni zake zipo karibu’
- She rolls her body and wraps her legs around the man's body as her vagina is relaxed.

Boys believed that circumcised girls were not sexually exciting as they have no sexual desire and sex is not good. -siykihulika mtzitzi

Sicendile wahinza wono wagotolwe soko wasina mtzitzi

Many myths are circulated – Galus said when they were young they heard that a woman who is not circumcised can have problem during delivery, and she is not sweet during making love with her ‘hana utamu’ and could bewitch him. Therefore, they thought women need to be circumcised.

A few men of varying ages --Luka, Ayubu, Steyne and Joseph said that they prefer circumcised women because:

She is hard to be stimulated and so she can not become ‘mapepe’, she cannot be taken
by other men
She does not get tired easily during having sex

A woman who is circumcised, men agreed, cannot be a cheat or unfaithful since she is likely to have a low sex drive and no sexual desire for another man. She can be then controlled by the husband.

*Mchekulu siyagotoligwe yowa malaya. Mchekulu yono yagotoligwe wakuusa vyose yawe na hamu ndodo ya walume*

Thus, she cannot be vulgar and insatiable.

*Mwanamke anakatwa nyege*

In the Kondo region as elsewhere such beliefs persist--

“If the women are not circumcised it was believed that they would behave as prostitutes,” ‘kaane muuntu muuki siitiwe alakaa saana’

For example, said Daudi a farmer, sitting with a group, “There was the woman here, and men said that she was uncircumcised. She used to arouse every man.”

*Amwaare ija siitiwa aboya mapenzi na kira muuntu vi.*

“An uncircumcised woman has an insatiable sexual appetite, twice that of the man they are with and she would not feel shy especially when she totally falls in love with you.”

*Nateera kwa vaantu viingi, vasesa muntu muki kaane siitiwe, afikira mwisho mara keviri kabla ya muntu mulume, faaamuuwire.*

When told that many of the women who practiced prostitution were circumcised, a silence descended and the men and boys began to think about it. But there was no further response.

Male circumcision

The rite of circumcision is a rite of instruction that teaches young boys what it is to be a Mgogo and what values and customs they need to adhere to in their lives. The young boys are also instructed by older boys how to conduct themselves socially, and how to guide and protect themselves and their families from all harm and how to take care of the old. They are also instructed about sex; how to approach a girl and how to control her. They are instructed to keep their genitalia clean and shave all hair. The parents of the boys incur costs during circumcision. Sex is allowed only after circumcision and they come of age as they become young men.

*Image 14: Boys receiving instructions*

Kaana ujaribwiire kuboya mapenzi na muuntu muuki, ifuuji fyukirariri

Kama ukijaribu kufanya mapenzi na msichana, govi litarudia

If a boy has sex with a girl before being circumcised, the foreskin, ifuuji will return.
“Up there stands three tomatoes – two of them are ripe and one is semi-ripe.”

A young boy is not ripe but after puberty, his penis has developed and he is ready for sex.

*Chibinubinu inhambililo mpeelaa, lamba libinuuche lilagoloka*

or

*Mdala yono yene muda yapindile ilagoloka hono yehohole – mwanamke mjamzito hupinda mgongo, akizaa hunyooka*

*Mwanamke hata awe mkubwa wa umbo au umri au cheo mwanaume aliyekwenda jando anaweza kumwingia kimapenzi.* (Kiswahili)

“It does not matter how old woman is, and how large, a circumcised man can make love with her”

Male circumcision is a much more joyous affair and publicly celebrated, there are various stages in the circumcision ceremony. In Dodoma municipal, a local healer Mitagoh explained to the RA that he performs circumcision ceremonies; he is also, in this instance, a Health Aider at the dispensary.

Traditionally circumcision is done to a family, whereby the family inform their close relatives and neighbours that tomorrow the circumcision ceremony will be held “kumbi” in Kigogo or hambala, jando – umbi – where (place) they circumcise; wanyamuluzi – those who are to be circumcised, that is the boys; wahunga – people who supervise those who have been circumcised and train them.

Preparing them to become men involves instructions by the scholars, *wang’hungalibadu* or *wang’hungahoni*

*Nyabubibili taga magembe kuno*

*Oooh Nyabubibili taga magembe kuno*

*Chokitang’anyila kwibiki dinyalile*

*Ooh Nyabubibili taga magembe kuno*

(Kikaguru)

In Kigogo,

*Kalibibili taje majembe kulya*

*Ooh kalibibili taje majembe kulya*

*Chitanganila ku muti mkavu*

*Ooh kalibibili taje majembe kulya*

“Boy, you are now to become a man; give up your immaturity and act as a grown man and follow the teachings of the *wang’hunga.*”

The food is prepared by the mothers at home and the mothers bring the food to the circumcised boys; they do not come to the camp, but leave it at a distance of about 50 metres and shout “naza, naza”, stating ‘I have come with the food’. The boys answer, “Na mjeni naza” ‘you are a guest and you have come’. The attendants who are called *wang’hunga* go to the spot and pick up the food. Before eating they wash their hands but after eating, in some cases they do not wash their hands as it is believed that if they do, their wounds will not heal. During the stay they are not allowed to bathe. They are given very good food – a lot of meat, ugali made of millet and maize, and green vegetables

After a week boys are allowed to get out of the *kumbi* to exercise, walking around the village or forest under the supervision of *wang’hunga*. At the next stage, after the boys’ wounds have healed, they apply *limkakame* (white chalky soil) around their bodies
to show that the circumcised boys have healed well, and that they are ready to come out from kumbi. Thereafter, the limkakame is applied to their body and they walk around close relatives singing to greet them and, after this ceremony they return home and prepare for their journey as men.

They are taught many proverbs, riddles, sonnets and stories on human procreation through song and dance celebrating their coming of age. Some of these that are sung today are more than two hundred years old.

These songs were recorded by the RA's.

Sex and Civic Education
Through such ballads and sayings boys are educated on sexual intercourse, what it means to come of age and how to behave with their family members.

Lead singer: Ngadu Gwee

Chorus: Ngadu gwee tnzo ng'hutume tnzo
Lead singer: Kutumwa kwake
Chorus: Kutumwa kwake kwa ngadukule kwa
Ngadule kuli nzila nyinji kuliwasoni
Towelungwangwa ee lungwangwa
Chadali wela chadelima chinguklilinguli
Mzigula aiyee gwee

LS: Hello Ngadu!
Chorus: Hello Ngadu, come along – I have an assignment for you that will ask you to report back to me what you have learnt.
LS: How do I assign him the task?
Chorus: To assign him there are many ways, so that he can be ready to do the tasks, to assign him ritual customs, to lose his shyness, he has been going around through the night without any success.

Story: Ngadu is a story of a boy who has been asked to go into the main house by a wise old man, observe what he finds there and let him know. The boy entered and found a couple making love. He had to wait until they finished and, thus was there the entire night. He found it difficult to tell the old man what he seen.

That is precisely what the wise old man wanted him to do, to overcome his shyness and understand what his coming of age means and to understand what sex was all about.

Kisu changu ni Kidogo chanepanepa x 2
Kilichinja mbuzi mbili ng’ombe watatu x 2
Nilidhania kidogo kumbe ni kikubwa

“My knife is small, and is swinging (penis)
It managed to slaughter two goats and three cows (that is he had three boys and two girls)
I thought it was too small, to my surprise it is big.”

Other examples:

Madale hamba adalape siakutaga sali
Mdale hamba anzehepe siakutaga Sali

“Even an old woman has a vagina” (that is she is sexually useful and has sexual desire)

Kuchany’ha kulya kuli ndeje nhambi hamba

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Itamba muno siyatoga nzoya

“Up there, there is an old bird (old woman), who is so stubborn that she will not
declare she is not menstruating anymore.” – Fertility is to be valued always.

Chibinubinyu tambi lya mplea hamba libinuche

“A pregnant woman is not sick, when she delivers, the stomach comes back to normal position.” – Pregnancy is a natural condition.

The circumcised boys are also taught how to interact with people – respect all elders,
family members and outsiders – above all, to revere their ancestors.

Chifutufutu napumbu ga nyau, hamba gufufwatuche siga kuseka mwana

“A circumcised boy should not laugh whenever he sees an old man who is naked.”

Ane Kongo gwe, sinamliga kaya
“A son should not abuse parents. I will never do it”

Kuliga kaka mwiko sina mliga kaya
“To abuse your brother is strictly prohibited. I will never do it.”

Kuliga dada mwiko sina mliga kaya
“To abuse your sister is strictly prohibited, I will never do it.”

Both the boys and girls used to be taught about sexual intercourse by song and how to
behave and treat girls and, for girls, boys and men. Nowadays these songs are
restricted to boys’ ceremonies which being very public invite musical repertoires and
drumming.

These teachings are sung in the form of sonnets, often lines are added according to
the singer to the main teaching are repeated at all male circumcision ceremonies
followed by drumming and song and by copious amounts of alcohol consumption by the
circumcised boys and the assembled men and women – a festive and enjoyable event that
comes after harvesting. For example:

Chihemuhemu matenga ga nhande galahemula ga nhande sinapya

“Even before sexual penetration of the vagina occurs the penis of a man is already
erect and ready.”

Kiga ng’ haboye mena
“Penis has no bone.”

Chihenyuhenyu tinde ukambala hamba liheyuche sinyo nyanya kaya
“No matter how red hot a vagina is, it can never burn the penis.”

Ifupa-mbuula
“The vagina is a bone.”

Chimsoma chibumbile
“The penis enters the vagina and occupies it.”

Ibumbile-imbolo
“A vagina sucks the penis.”
“Southwards of a woman's body there are two holes and the penis penetrates in second hole.”

“Eastwards is an erect penis which shoots white foam.”

“Westwards, thee is a white snake which spits white foam” educating the boys on man's prowess to ejaculate - even an old man can ejaculate.

“Up there stands three tomatoes – two of them are ripe and one is semi-ripe.”

On incest and sexual relationships:

“I can see very beautiful girls who are very far. When they come closer, I recognized that they were my relatives.”

“Swim in other people's swimming pools and not your own. That is, make love to women from outside your family.”

“Let others come and swim in your pool, that is allow other men to marry and have sexual intercourse with your sisters.”

“Marry the sisters of other people – your sister can be married to another man.”

The wisdom of elders is to be cherished:

“If an old man gives you advice, it is necessary to heed him.”

In essence, the main responsibilities that define what it means to be a man are emphasized with the following strictures: how to understand the body, perform the sexual act, feel confident to be able to impregnate women, to be dominant and, to be able to work. By undergoing circumcision a boy comes of age and proves himself to be all of these, brave and strong, respectful of young and old and to retain control of the woman and his family.

The public re-affirmation and celebration of manhood gives boys and men confidence and power that cannot be underestimated. Thenceforth, he has the privileges of a grown man – and older women regard the circumcised youth with respect. Thus, in stark contrast to the lonely vigil of a girl who remains in isolation, there are many assurances instilled in the boys' passage to manhood and they are able to express their sexual
and emotional needs with ease.

It is only after circumcision that marriages can be permitted for boys and girls.

Marriage

It is interesting to note that rituals of courtship and the traditions that accompany it are elaborate. Most of the marriages that occur happen after an intricate ritualised ceremony.

"Marriage is not something we take lightly." There are elaborate rituals that need to be followed. Ideally, a boy and a girl meet and fall in love with each other; then they talk about loving each other and agree to get married. Thereafter, the boy goes back home and tells his parents that he found the bride to marry.

*Muhitza hoa yena wabanyi wenji. Sogwe yoyakumuhagulila wo kutoligwa nayo.*

'Only the parents decide who the girl should marry'.

Then, the elders go to the girls family and meet the grandmother and parents they say" at your family we found a girl to marry. This custom of *banyilo - posa* is the payment to initiate the process of introduction about marriage after the grandmother confirms with the girl that she is willing and a payment of 2000 TSH to 10,000 TSH, the initial agreement that the girl accepted the “Banyilo” or *Kuomba posa*. Among the Wasandawe, it is known as *pala* or engagement, it is usually a small coin and the sister of the boy ties it on the girl. The sister of the boy says to the bride to be I have tied the pala for my brother. The girl lets her parents know. Thereafter, they return home and inform the family that the posa has been accepted. Following that, the family arrange the date for bride price agreement or *chigumo -- kikao cha kupanga mahali* “the bride price agreement meeting”. Sometimes if there is a delay the boy's family leaves cows in the girl's family home to show that their serious intent to procure the girl as a bride for their son.

The following steps need to be adhered to:
1. **Liso** – Jiicho or a sum constituting a thank you payment from the boy’s family to the girl's for seeing her. It could be about 500 TSH or more.
2. **Luzizi** – This is the process where the boy pays a sum for being the first to make love to the girl.
3. **Songa** – Also to show that the boy will be the first to make love with the girl, therefore another amount of money is given.
4. **Itambi** – The uncle of the boy gives a male or female goat to the girl's uncle as sign of thanking him for giving a wife from his family.
5. **Machenda kejete** – Paying Bride price
   At this stage both families seal the agreement of bride price which is usually three to five cows and exchange an agreed sum that is given to girl's family to arrange the wedding date.

On the day the cattle are delivered, the groom's family sing a song
Kuli wajenzi wenyu, sanga lalaye hoye kuli wajenzi wenyu-
“we are your guests, make us happy, we are only your guests"

6. **CIHOVUGO – KUCHUKUA MKE (MARRIAGE):** It is the preparation for marriage - -when the boy's family prepare to go to the girl's family to celebrate their marriage ceremony, where there is ugimbi (local alcohol) and drums (ngoma) and they dance with each other.
What is interesting are the important messages are conveyed through songs in an atmosphere of merriment:

Lead singer: Haya hiye gwee ng'oma yalila x 10
Chorus: Ng'oma yalila baba gwee x 10

LS: Hurry up your drums are singing
Ch: The drums are singing, ooh father.

And, at this ceremony, the father of the girl may send the following message to the boy:

Lead singer: Mlece nhowela mwanangu mwanangu mpolo gwee huwa x 10
Chorus: Mwanangu mpolo gwee huwa x 20

“Please do not beat my precious daughter, my daughter is very polite and considerate. My daughter is very polite and considerate.”

7. Ulinzi: After the ceremony, the bride stays in a house with her grandmother to receive the training on how to take care of the family into which she is married. She is to be respectful and hard working. Then the groom's family tells the grandmother that they want to go home with the bride and the grandmother prepares for that event by arranging a few girls to escort her.

Procreation

Procreation is seen to be the purpose of life and, it is celebrated with particular fervour. The songs sung during the engagement and marriage ceremonies are particularly noteworthy, as this one from Bahi which has a large swamp:

Ng'hududu mwi ilamba x 2
Ooh mwi ilamba mwi ilamba nagwe mwi ilamba

“The Ng'hududu in the swamp ...ooh in the swamp”

Ng'ududu is a bird which feeds from a swamp, dams or lakes. It attracts creatures by singing, “kududu kududu”, while flying over the water. When the creatures that live underwater and, fish hear this music they come to the surface and the ng'hududu then dives in and takes its prey.

The local people liken this to the sex act- the swamp is the vagina or ilamba and the penis is the Ng'hududu.

After the marriage ceremony, this song below is sung after the first night to the newlyweds.

Main singer: Simbiye cidodo cinya mwitolole gwee haya hee
Cinya mwitolole gwee haya hee x 60
Ane jende gwee x 60

Chorus: simbiye cidodo cinya mwitolole gwee haya hee
Haya hiye hiye haya x 40
Ane jende gwee x 40
Ok haye hiye ok x 40

LS: “To the new bride: Do not cry (pain during her first sexual intercourse/loss of virginity)
A small ring has engulfed the whole finger, ooh it is nice...ooh it is nice...

CH: “A small ring has engulfed the whole finger, ooh it is good, ooh it is nice.”

LS: “Ok walk ahead, you just let yourself go, let go, It is fine – all is well”

It is important to remember that most marriages which occur in poor homes, in reality are arranged. A girl often concedes as she has no right to choose her husband to be but her father is the one who decides upon the groom and sets off to select a husband for his daughter. He looks for a man who is wealthier and receives bride price (Lusona). The highest bride price is 200,000 TSH and could go up to more depending on the family of the bride or, the beauty of the girl.

Some marriages are in truth, ‘forced’ marriages which tend to result in many problems for girls and women. These problems may include upon entering a polygamous household – rape, committing suicide, domestic violence, mental torture from a husband who treats his bride as a slave, and consequent psychological disturbances, lack of confidence in making decision and poor health due to loss of appetite, anger and distress.

Sexual intercourse is not always by consent. As marriages are arranged here, the girl has to accept the man regardless of her feelings. If a girl is married before puberty by a ‘forced’ marriage, which appears to be common in the rural areas – then she has to please her husband and agree to his terms and conditions. Men are free to express their sexual predilections and can get any number of wives as long as they can pay the bride price.

Breast feeding and Taboos on Pregnancy

It is a matter of grave shame that women feel when they become pregnant while they are breast feeding. Frequent pregnancies are common here and although child spacing is attempted by women they are not always successful. Taboos against breast-feeding are taken seriously by women as sexual intercourse is forbidden during that time, but men do not regard these taboos seriously and may voice their complaints publicly. Men usually get a better hearing than women when elders sit together.

As Felista notes,

“I have been lactating after each delivery for one or two years and my husband was not happy about that and called the elders and complained that I delayed making love to him. They just supported him. I told him how can we have sex because how can I feed our baby? One day, at noon, he closed the door in the afternoon and forced me to have sex with him and after that I got pregnant and, imagine I had only just delivered six months ago. He scolds me if I do not have sex with him. Now I worry about my baby, what will happen to him?”

It is feared that a woman who has sex after childbirth will affect the development of her new born infant and destroy his or her chances of a healthy life. In fact, the occurrence of diarrhoea is attributed to the mother and father’s sexual behaviour while the mother is breast feeding afflicts the new born. Breast milk is perceived as an essential source of nutrition, energy, vigour, and strength. Lactation failure does not appear to occur in this society. All infants nurse within a few hours of delivery and receive colostrums. The infant remains with the mother night and day, even when she is working in the fields. Breast feeding is on demand, generally in response to crying, and lasts for two or three years. Any changes in the quality of breast milk are viewed as associated with maternal disease or witchcraft due to jealousy.

Sophia had sex with her husband seven months after giving birth, at his insistence. She said that she was forced to have sex with him against her will -- and now she is pregnant, she cannot breast feed her one year old “as he will get poisoned and will die.” He was already suffering from diahorroea. Bad milk is believed to cause
diarrhoea, and withheld from the infant. In many cases, if milk in one breast is perceived as bad, that breast is no longer used for feeding.

Sexual intercourse is prohibited during lactation, and women who become pregnant before weaning are shamed. The progressive weakening of the child associated with the cessation of breast feeding at the time of a new pregnancy is viewed as a consequence of the breach of sexual taboos: ‘immoral’ behaviour causes her milk to be poisoned and is seen as a violation of postpartum taboos. In east Africa, the devotion to nursing a newborn baby is given the utmost priority and a mother must dedicate herself to the task; there is a strong link between the quality of the breast milk and health. Many mothers and women here interpret such taboos to define what a good mother is, a father is also held responsible for his behaviour. There is a sophisticated indigenous classification of diarrhoeas, their characteristics and treatments.

Many beliefs exist and are adhered to by women in different parts of the region. After childbirth, she and her baby are taken by grandmothers and aunts and she is not supposed to meet with her husband until after 3-4 months. They believe that the baby will be harmed if husband and wife meet and have sexual intercourse: kutima mwana—“harm the baby”.

Elsewhere in the Kongwa, it is believed that a pregnant woman should wear black clothes after being three months pregnant and the reason is that the outcome of that pregnancy is unknown and thus is protected by ‘chikumtumbikiza’. But wearing black is common here and such beliefs extend elsewhere. She also keeps her condition as secret as possible. Also, when a mother is pregnant she ties a cloth around her abdomen to protect her uterus. In Kigogo it is called call isambi it remains tied after giving birth so as to compress the uterus back to normal. Also, the local midwives do not discuss their condition. Warding off the evil eye or bad sentiments from other women seems to be the main reason.

The pressures on women are numerous. They have to behave well. In a woman, fidelity is de rigueur. She stakes her reputation and that of her family on it.

Most women are born into the cycle of deprivation. The physical and social positions that women occupy and are complicit in maintaining need to be dealt with strategically. Undervalued by law and forced into a servile position, they are judged solely by their reproductive capacity. They are often married without choice at an extremely early age and forced to begin childbearing before physical maturity has set in and this has serious consequences. There is little availability of morbidity figures - but the phenomenally high occurrence of obstructed labour and perinatal mortality is a good indicator.
The Culture of Health: Pregnancy and Childbirth

Narratives from the Communities

Having a safe delivery is a paramount concern for all pregnant mothers and their families. It is how they choose to go about it that has been the subject of ministerial concerns – that is, not giving birth in the health facility but only attending the antenatal clinics.

Yet, as the accounts below illustrate, such concerns need to be re-examined and more questions need to be asked on the important role of the health administration in its provision of basic health care not just at the outreach facilities but also at the centre. There is a burning need to re-evaluate, to re-assess and to reformulate the nature of primary health care that is available at various levels of health facilities from dispensary to the referral hospitals.

To improve significantly the safety of pregnant mothers and those of the health workers, a fresh appraisal is imminent, being very much in keeping with the goals of primary health care programmes that the MOHSW is currently initiating with specific focus on maternal and neonatal care.

While most of the pregnant mothers we met and spoke to welcomed the idea of giving birth in clean, cost free, caring surroundings that would guarantee safe childbirth, the realities they encountered at the health facilities discouraged them from delivering their babies there. In addition to the distances that some have to traverse there by foot, there were several other factors as discussed below:

Neonatal deaths we found to be alarmingly high in all the sites and maternal deaths were also recorded in some of the sites by the RAs' but very few of these deaths, while the RAs' were present, were recorded in the dispensary or health centres or at the district hospitals. Certainly not either at the mng'hungas places of work. Thus, statistics and reports are not reliable. And, this needs to be acknowledged. There is an abyss in the maintenance of medical records, particularly concerning what is happening on the ground and what is being noted in quarterly reports.

How do pregnant mothers and their families articulate their experiences? When spoken to they are accusatory of the health facilities and feel that there is no difference whether one delivers at the wang'hunga' or the facility in terms of safety. Poverty and neglect has destroyed the lives of many families here. And, more often than not it was with sad resignation that the mothers or those kin of babies who died at birth said to the RA's at various sites:

“Every baby has his or her own star”,

Kira msinga na nyenyeri yachwe. (Kirangi)

Cila mwana yena nyeleziyakwe. (Kigogo)

Kila mtoto na nyota yake. (Kiswahili)

Kila ontungani atanganyi. (Kimaasai)

However, such explanations cannot in any way prevent them from interminable grief knowing that their baby could have lived had they been cared for and looked after whilst they were pregnant and during childbirth.

Testimonies of Pregnant women
At the Antenatal clinics:

The attendance at antenatal clinics is noticeably high. Women walk great distances to attend and procure a card. That card is for their baby to be vaccinated. But what the RA's found in all the sites was that women waited for long hours and there was no water to drink while they waited – many were extremely exhausted and more often than not anaemic.

Also, the nurses were not cordial or kind to them. Even professionally, the examination was not done as per procedure. For example, it was common to find that examinations were done very fast and the mother sent packing. Martha the nurse at the district hospital summed it up – "when we see these antenatal mothers – we examine them as they come to the clinic and give them hati punguzo receipt for mosquito net once they visit our clinic. We don't do per vagina examination unless a pregnancy mother complain about thing or discharge waste from her vagina. We need to rush as there are so many of them waiting and we need to get home and attend to our chores also!" The RA's asked “what about blood pressure, anaemia, weight and recording the reproductive history and general well being of the mother?” “We cannot do it all can we?” replied Martha, exasperated. “What, they want to know is that we confirm their pregnancy and anyone can tell they are pregnant - look at her big body,” remarked Severina pointing to a young first time pregnant woman.

Most of the antenatal work is done by nurse attendants if nurse mid-wives are busy. And, those we met said unequivocally, that they had to work at least twelve hours a day attending to the pregnant mothers who were at ANC. One MCH aider the RA met, explained that According to the guidelines, a pregnant woman has to visit the anc four times and then she said that these were their instructions:

First visit: Below 16 weeks.
Take history
Haemoglobin level
To know the blood group
To give vaccination
To give health education

Second visit: Between 20-24 weeks;
To know the haemoglobin level
Take blood pressure
To give health education

Third visit: Between 28-32 weeks.
To know the haemoglobin level
Test blood pressure
To give health education

Fourth visit: 36 weeks and above.
To know the Haemoglobin level
To test blood pressure
To give health education

The danger signs for pregnant mothers:
Low Haemoglobin level
Abnormal discharge from the vagina
Bad smell from the vagina
Severe headache
Oedema of the leg, face and arms
Chills and vomiting

The RA's noted that despite the strictures the instructions posted were not followed.
And, on a rare occasion, when a blood test was taken the blood group was not revealed to the usually nervous pregnant mothers. This was contrary to with the MOHSW government regulation supplied to the health facility:

1. All services to the pregnant woman should be free.
2. A nurse should be in the clinic throughout the day to give a pregnant mother care
3. A nurse should give health education to the pregnant woman
4. She should take care of her gently with polite language

The first three procedures, taking and recording temperature, pulse and blood pressure, can have implications for the final outcome of birth, and could therefore influence the management of labour. Thus not following these procedures has very severe consequences in the progress of the mother. The WHO guidelines state unequivocally that risk assessment is not a once-only measure, but a procedure continuing throughout pregnancy and labour. At any moment early complications may become apparent and may induce the decision to refer the woman to a higher level of care.

Trained staff were few and far between. In general, BP was not tested but when it was the RA’s noted that BP was not taken properly and, only two of the many observed performed the procedure correctly. The process of screening for hypertension by measuring the risk factors as outlined by MOHSW was thus found to be woefully inadequate. As they found the health workers underestimated the degree of hypertension and simply did not take the necessary measures to advise the mother, thus eclampsia was not diagnosed properly. Antenatal records were not well maintained. ANC cards were given and the health workers depend on these cards to note the pregnant mother’s attendance and progress but not much attention was paid to proteinuria, oedema and weight gain.

Our study which concurs with the findings of Baseline study note there were critical shortcomings recorded in level of education. It was found that many of the health workers, included nurse attendants with only on-job training, nurse assistants with one year training in elementary or basic nursing, and health assistants with one year community preventive education and health education. The remaining one third were males working as Clinical officers or AMOs.

There was seriously inadequate pre-service training for example, the low standards of knowledge of staff at health facilities was reflected in their lack of knowledge or in using the haemoglobin chart, although guidelines are in place. In another instance, the RA was asked by a nurse: “So how to assess risk factors?” she explained the procedure: “It should start during prenatal care. this can be attained in a relatively simple way by determining maternal age, height and parity, asking for complications in obstetric history such as previous stillbirth or Caesarean section, and searching for abnormalities in the present pregnancy, such as pre-eclampsia, multiple pregnancy, ante partum haemorrhage, abnormal lie or severe anaemia. The risk assessment can also differentiate more extensively between individual risk factors and levels of care.” The nurse midwife and MCHA’s said they had not been taught all this at any time. On the whole, the RA’s recorded a general atmosphere of ignorance, carelessness and professional negligence.

The health workers noted at nearly all the sites:

“We do not usually examine haemoglobin level as we have no lab facilities. And, it takes time and there are so many of them waiting. We also do not have the equipment to do so.’ Another said, And “most of us do not know how to examine or arrive at conclusions.” While another remarked,

“Yes, explanations should be given when any blood test is to be undertaken and if the numbers are large they can be addressed as a group. But we really do not have the energy as there are so many of them and so few of us."
Most of the time the health workers showed irritation and annoyance when they discussed the women attending ANC. "They should come early. But do they do that?" she continued in her irritated tone and as many other health workers also noted, "Hardly ever. They come here after six months sometimes five months and then get confirmed that they are pregnant and they go back home and, then do not return here until after the baby is born." Another said, "When they get a problem they go to the mng'hunga. They come again to the health centre. There is no way we will assist her after that! We give health education about dangers of delivering with the mng'hunga!"

"What is the nature of health education?" the RA's asked, and the reply was that it was dependent on the pregnant mother and her queries on a need-to-know basis. It was also noted that during these antenatal visits, not much information was given to the mothers' questions and replies were brief and often rude. They were not given any explanations. "They are simply not listened to and, remain in fear of the hospital personnel who appear to act as if they are more superior to the women they are dealing with. They also display impatience and use harsh tones and do not show kindness to the women," noted the RA's. They were looked down upon in general by the health workers and usually talked down to, rather than kindly. Many cases were noted but the one below is typical of the treatment a pregnant woman receives:

Three maybe four months pregnant, Devota came in for her first antenatal visit with her mother. They had walked to the clinic which was not far from their home. The mother asked the head attendant to examine her daughter aged about 15-17 years. The girl was very shy. The nurse midwife called her inside and checked her height which was 175cm and weight which was 61 Kgs. She asked her to lie down on the bed and rubbed her abdomen roughly with her hands, and then to check heart beat and palpitation she used a stethoscope. These actions frightened Devota. She ordered Devota to sit on the bed and then looked at her eyelids and then, as the RA noted she could be anaemic, the nurse told her to eat green vegetables. No tests were performed. That is all she did. The midwife asked her to bring her husband on her next visit. She then recorded the visit on her card.

What is clear is that even when distance was not a consideration, women such as Devota did not seek to deliver at the health facility and went to the Mng'hunga for delivery.

Narrative of a neonatal death

Following is a recording of a neonatal death at a health centre – all names have been changed. it was mid morning and the husband of the mother who had just lost their baby was being spoken to by the Clinical officer.

CLINICAL OFFICER: Please tell us is this woman your wife?
MATONYA: Yes this woman is my wife.
CLINICAL OFFICER: How many times has she been pregnant?
MATONYA: This is her fifth pregnancy.
CLINICAL OFFICER: Rehema is it true?
REHEMA: No this is my seventh pregnancy.
CO: She says this is not her fifth as you claim it her seventh... what do you say then?
MAT: Yes, she is right I just forgot, sorry about that.
CO: If so, did you know that she was supposed to go to Hospital Hospital because she has delivered more than five times and she is not powerful enough to deliver without a help of some machines as you were told previously did you know about it?
MAT: No, I had no information about that.
CO: I have seen a book here which shows you signed on it why do you think you signed for
MAT: She told me to accompany her last Monday on arriving I was given a book to sign I have been signing on it whenever she came here since my first born I just
knew that it was to testify that she is my wife.

CO: You, Rehema, were you not told by the nurse last time to inform your husband that any pregnant women who expects to deliver her fifth and above child should go to Hospital? Did you informed your husband?

REH: Yes I told him and he said he had to go to find some money first.

CO: Did you came back to us to say that your husband had no money and seek some advice from us or not?

REH: No I did not do that.

CO: Mr. Matonya your wife claims to have informed you about going to Hospital. Do you comment on that?

MAT: For sure she informed that to me, but I had no money to take her there.

CO: Ok, let us go back, why do you think she took you here to sign in our book?

MAT: This is not my first time to sign on that book; actually I just knew that I was signing to prove that she is my wife as I have been signing before this incident. She hasn't elaborated to me that the signature was to approve her transfer from here to Hospital.

CO: Now why you lie to us that is her fifth pregnancy?

MAT: No, that happened accidentally it was not my intention to talk lies, sorry about that.

CO: On that clinic day when you came with your wife, there were other men also who had accompanied by their wives. Did you speak to some other men, to see why they were signing it means you just signed and left!

Not all the people who come to sign here, sign to name their wives; some women are getting pregnant without knowing with whom they slept and others with some other problems; some even come with their fathers or mothers just to know who will be responsible in case of a problem. We ask all to sign -- all who come for the first, and fifth deliveries-- and above. But for those who come for the second to fourth we do not request signatures them because we check their birthing records and we allow them to deliver here in the clinic.

RA: How many times she has attended clinic?

CO: She has attended clinic three times.

REH: Yes I attended clinic three times.

CO: She attended clinic in October and then February and the last week and all the times she attended clinic we were reminding her of going to deliver at Hospital when the time comes.

RA: Rehema were you telling your husband about you going to deliver at Hospital?

REH: For sure, I was telling him and he knew all about this.

CO: I think there is some hidden information at home between you and your husband which both of you find difficult to say to us. Any way Mr. Matonya do you mean that you had no information at your entire wife that she was supposed to travel to Hospital for her seventh delivery?

MAT: In actual fact she informed me last Monday after I had come here to sign and I replied to her that we must get something to do in order to get the money for travel to Hospital and since then I have been raising the money to enable her to travel there without much success.

CO: I am sure you know that at Hospital she was to go to Chigonela. Why shouldn't you take her to Chigonela with your mother and you stay back at home continuing with your efforts of getting that amount required for her, and I am sure no one is chased away there at Hospital just because she has no money why didn't you do that?

MAT: I am very sorry that your idea is good but unfortunately I was not aware of that idea. I just concentrated in looking for another way of getting the money.

CO: When were you informed of her labour pains?

MAT: It was this morning.

RA: Rehema, when did you start feeling the labour pains?

REH: It was about midnight.

RA: Which action you took after you were feeling very serious labour pains did you informed your husband?

REH: My husband was not in the house he went to sleep at my co-wife's house nearby.
RA: Did you shout by yourself alone?
REH: No, I went to inform my mother-in-law nearby, she came and proved that it was serious.
CO: Ok now, Mother-in-law said that she came to seek assistance from you, what is your comment?
M/IL: Yaah, she came to awaken me up I went to their house it was before the cocks started crowing.

Aside quietly she indicated to the RA: One cannot awaken a man who is in bed with his wife indicating that the couple maybe enjoying *chimsoma chibumile* or sexual intercourse

CO: Rehema, when did you inform your husband?
REH: This morning when he turned up.
RA: Mr. Matonya which action did you take after seeing your wife this morning and what time was it?
MAT: He did not reply
CO: They arrived here at 10:39 am
CO: It seems you were not serious enough otherwise by 10:30 you could have already been at the Hospital.
MAT: In fact we were coming here just to get your blessings and say it was OK for us to proceed to Hospital.
CO: All in all, still you came very late, by the time when your mother came to call me to go to assist Rehema the face of the infant was almost halfway out there is where the whole problem lies, the infant had some problem of coming out of the womb, was coming out not by the normal procedure and it was impossible for me to abandon her and say go to Hospital because she was on the process of delivery already so how come you say you were just passing here on your way to Hospital and, when I took the blood pressure measurements they had started to change so we took charge of her. Do you understand that?
MAT: Yes I do understand everything you are talking.
CO: I and my colleague (RA) we tried our level best to save your newly born child of yours but all our efforts failed and here is the body of your infant, can you see the bruises on the face and the head was very large at first but now is ok, now whom do you think is to bear the burden, we here as nurses or somebody else?
M/IL: The nurses have nothing to blame at all.
RA: Ok mother-in-law you say the nursing staff should not be blamed because we ignored to make arrangements of going to Hospital as you advised us earlier.
CO: M/IL do you mean that you were also told in advance that we suggested to them to go to Hospital.
M/IL: Yes I was aware of that.
RA: Do you know why we suggested for her to go to Hospital?
M/IL: I know very well I am a mother too, sometimes she may fail to deliver because the body is tired, sometimes they need to add some water through drips, sometimes she may need an operation, in fact I know the importance of your advice to my son and the wife and actually I was asking my son several times when will he take his wife to Hospital because the advice you gave to him was very important but I am sure he ignored.
RA: Mr. Matonya, what is your conclusion on this matter.
MAT: I do agree upon you that I am the one to blame.
CO: Please take it from me; when ever we give you any kind of advice when you come to us is because we want you to be on the safe side on our clinic we don't have enough equipments to do the extra jobs especially for complicated matters such as this one. We had another case, a pregnant woman who was also in the second stage like this one came in earlier, and the hand of the baby was already out, what we did was to take her by motorcycle up to Hospital where she was attended to very nicely, the baby came out alive and the mother was alive too. If you could have been here by 8:00 am that would have been a simple job because she was still in stage one, we could have found transport for her to go to Hospital. The problem here is lack of adequate equipment. Mr. Matonya, could you
please come over here and sign?

MAT: Yes, I agree to sign.

RA: And you as a co-wife do you have any thing to tell us about the pregnancy of Rehemaa?

2nd Wife: Actually I just saw her being pregnant and sometimes I was seeing her coming to clinic.

RA: When she was coming to clinic was she telling you that today I am going to attend clinic?

2nd Wife: No, she used not to tell me, but I remember last Monday it was 25th she told me that she was coming to attend clinic, as I am also pregnant we were planning to come together but afterward I changed my plans and decided to go to the shamba (kumatongo) so I let her go. I came very late so we met the following day, she told me that her days have passed and they have advised him to go to Chigonela at Hospital. I asked her if he has informed our husband, she said yes he knows. So I questioned her to know when she has planned to go, she say at the moment her body is ok so she was not planning to hurry up going to Hospital.

Later on I spoke to my husband about that issue of my fellow wife going to Hospital. He said that he had spoken the issue with his mother and have told them to meet and arrange for the day for them to leave so that he can give his support. But one evening last week when we were about to go to sleep our husband asked her to say when she would be ready to go, the first wife said there is no hurry for her to go, he wanted the husband to just find some money without pressure she would say later on, but don't be in a hurry. So this morning our mother-in-law came to my house it was around 8:00 and told me and my husband that Rehema is in a labour pain. At that time we were just waiting to take our breakfast and leave for shamba. I blame my fellow wife she took this problem just for granted, when I asked her this morning as since when she started to feel the labour pain she said since yesterday when she was getting her supper, so you can see still there was an ample time for the husband to arrange for her going to Hospital. Still she kept quiet until this morning; I think she has nothing to do but to blame herself. No one knows the functioning of the body of the other person except him or herself.

Image 15: Ugali na Mlenda

RA: What kind of food did she eat last night?

2nd Wife: It was ugali and mlenda as usual.

RA: You mean that is the only kind of food you eat everyday?

2nd Wife: Of course yes, sometimes you can eat much better food if you have some small businesses of your own, because don't depend on your husband to give you all the provisions you need for your daily life, especially to us the village people you must be clever enough to make sure at least you and your children have another source of getting money. Mostly our village husbands have no jobs.

CO: Thanks for your good explanation to us, I think now you know that the older women with over five children, they need to be very careful because their placentas are very large that it is not easy sometimes to get labour pain soon and, also it causes the infants to sleep in either way because of the big space they enjoy in the womb.
The narrative above can be regarded as a shared experience that women here encounter more often than not. Men often abandon their pregnant wives and stay with another co-wife. It is seen a woman’s battle to become pregnant and deliver – all by herself. Thus, they are not aware how many times their wives were pregnant. What matters to them is that the babies who remained alive counted and those that die cease to exist in their memory. In contrast the mothers remember the pain and suffer in silence through enforced stoicism. In spite of the common suffering, women do not treat each other well. And, there is considerable rivalry and jealousy amongst themselves. Men are never accorded any blame as seen in this narrative.

In this instance, as the RA was present, the death was recorded with some difficulty. The register that was maintained was empty and soiled.

In many other conversations where mothers recounted the deaths of their new born infants at the health facility we found that deaths were not always recorded at the health centre or district hospital. Records on the whole were maintained very poorly.

LEILA
Leila said she was twenty-three years old and had given birth to two babies; her first was born in 2006 and second born in 2008. It was sad as she gave birth at two different conditions that were dangerous for health of her children and herself. She looked very ill and exhausted when the RA met her. She said she was forced to deliver her first born at home as the nurse was away at a seminar in Dodoma Municipal so there was no nurse and the dispensary was closed. They ask a mng’hunga to help her. The delivery was conducted on ‘kitanda cha milejehe’ (a bed made up of ropes). The mng’hunga received a baby and cut the umbilical cord using a razor blade and tied with uzi. After a week she went to hospital for immunization of her baby. Her second baby arrived after she was sent away from the dispensary and told that her labour pains were false. She gave birth on the way home. Fortunately, “my baby was born under a good star” she smiled with some tears in her eyes.

As her husband abandoned her, she has after 10 days postpartum, started working. She is selling water, a bucket of 20 litres for 200 TSH so as to earn money. She fetches water at a distance of five kilometres in the Chamwino area and more than three times per day. When she goes to fetch water she carries her small newborn baby on her back and a bucket on the head. The money she earned helped her to buy things like cooking oil, salt and kerosene. She can earn 600-1000 TSH per day but it is not enough. She is exhausted and, she suffers from obstetric morbidity like quite a few women here.

FATIMA
She is a young woman and claims to be 16 years old. She has never gone to school. She was married to a young man aged 19 years. He studied up to STD 4 and he dropped out. Fatima is a mother of one male child who is 4 months old. She said she was in labour pain for three days before going to hospital. On the fourth day she went to hospital escorted by her mother. She went to the dispensary at 6 am, and she was told that she is dehydrated and weak and so a nurse referred her to the district hospital. At 7 am an ambulance came from a health centre and collected her and her mother. When she arrived she was infused with fluids (500mls + 300mls =) and she doesn't know the type of fluid and after that she gave birth. She said that, ‘niliwekewa maji chupa moja na ya pili sikumaliza nikazaa. Walinifanyia operesheni kidogo tu’ episiotomy was done and she gave birth to a 3.5 kgs baby. She said she was bleeding a lot after delivery and her relatives gave her juice from grapes to replace the lost blood. She said that, ‘hapo una vidonge vya majira’ meaning she was asking for contraceptive pills since she doesn't want to become pregnant until she is 20 because the pain was very severe during birth.

The RA quizzed her, ‘will you take the pills at the hospital without consulting your husband?’ she replied that, ‘haiwezekani’ meaning that it is not possible for her to make decisions without her husband. She said that, ‘akisema fanya fanya’ if her husband ALLOWS her she will do it and not otherwise. She was taught that she should respect her husband and obey to him on whatever she is told by him.
IRENE
She is young looking and in her early twenties. She was married in 2003. In February 2004 she delivered her first born and she said there was no problem. In October 2007 she carried pregnancy and in June 2008, the baby died during childbirth. She recalled that sad event: When labour pain started she told her aunts and they escorted her at the hospital. At 4 pm she was in second stage of labour but she was not able to push the baby. Her aunts and a nurse made their efforts to help her by pressing her at the fundus so that to help push the baby out. They didn't succeed. She said that, ‘walinikandamiza nizae ikashindikana, mgulu ukasuluka du' mtoto nywele zilionekana akarudi ndani’ – she sustained left hind limb numbness. She was not able to stand walk or support herself with her left leg. They told her to continue sleep in a supine – lithotomic – position. Much later the midwife called an ambulance and the car came at 7 pm in the evening. She said that during that time, ‘tumbo linauma, linauma, linaumaa’ meaning that she had severe pain and she was confused. She thought that she was going to die. They arrived at district hospital three hours later and, a Caesarean section was done at 9 pm at night. The doctor told her that, ‘utapata kidonda lakini hutapata faida’ meaning that she will have a wound but no benefit. She it was very painful to lose her baby. She looks so sad when she talks about her baby.

The main problem was that, the RA noted that the midwife did not identify earlier that she had a problem and she needed urgent help. It was possible that she had a cephalopelvic disproportion as she was short below 150cm and she was weak. Her weakness is apparent and she cannot walk properly due to problems she developed during childbirth, as her left leg is still sore.

Image 16: Jane with her twins

JANE
Jane had twins at Berega hospital. She said she was married in 2003 and had a daughter Jacqueline. She had just delivered twins and returned home to her village when the RA met her. She was lying happily with her babies on a cow skin. She was contented with her experience of childbirth. She said that she had walked from Kilimani village to the dispensary in the next village but she was asked to go to the health centre. She had oedema in her face legs and arms and was tired by the walk. No help was forthcoming. The CO there advised her to go to Kongwa. He also told her that she would have to have a Caesarean. Then, her relatives helped her. She was carried in a bed made of ropes by four men to Kongwa and from there they took a vehicle. Her relatives took her to Berega where she had a normal delivery. She said in the health facilities there was a tendency for the health workers to force interventions and cut the vagina -- and not allow a pregnant mother to give birth normally.

Many women feared this also because their husbands may not desire them anymore and would abandon them.

Sitagutagu mapumbu ga mtzehe hono gataguce si ga kuhona

“If a vagina tears it cannot be sewn back” – that is, it is not as exciting because it cannot become small and tight.

PAULA
Paula claims to be 21 years old. She is living at Kinangali. She is married and is pregnant. She was told to give birth at the district hospital as it was her first pregnancy. The nurse told her that, “all first deliveries should be conducted at the
district hospital." She delivered a baby 3.5 kg through spontaneous vaginal delivery. She sustained a second or third degree tear and nurse Ngaiti stitched her with 3 sutures. She said that ‘alinishona bila ganzi nikaumia sana’. A nurse stitched her without local anaesthesia application and so it was very painful. In December she was discharged from hospital and she returned home. The stitches came off and there was no suture at her dispensary so she was told to go back to district hospital where no apology was tendered and she was just given tablets she said were yellow in colour, and capsules so as to fight infection in the wound. When she returned to her dispensary to attend the ANC they charged her 10,000 TSH. She has to walk seven kilometres each time to the dispensary and she is very unhappy by the way she has been treated and the pain she experiences. She says that she gets a searing pain in her thighs at times and in Kigogo it is called kukuuyejele. She asked the midwife who told her it could be mafisu which is caused by walking long distances and bruises the thighs. She struggles and tries to cope, but weariness and exhaustion make it difficult to carry out her motherly duties.

ASMAH
She is 28 years old and she stays in Wangazi suburb in Leganga village. She is a mother of two babies and she lost one baby during childbirth. During her third pregnancy, she was told that the foetus was under 140cm in height. Nurse Anna told her to give birth at the district hospital. During labour she could not go earlier and the reason she said that she had no money and she delivered at Mng’hunga without any problem. She went to Leganga village to Mng’hunga and she stayed there but the mng’hunga was not able to help her because it was a breech presentation and the baby had a big head. At 10 pm she left her by renting an ox-cart, mkokoteni. By the time she arrived at the dispensary, the membranes had already ruptured (chupa ilipasuka) and the cervix was fully dilated. The foetal heart rate was lower than normal; it was 132 beats/min: all this happened at 1 a.m in the middle of the night as it was that time when she arrived at the dispensary!

Nurse Anna called an ambulance and it came at 5 am early morning. Before that time she was given tea and she vomited and the nurse had nothing to do rather than checking vital signs and foetal heart rate after every 30 minutes. The cost of the ambulance to the district hospital was then 57,200 tsh instead of 20,000 TSH as in the past --as the price of petrol was too high. Her relatives borrowed from many people and paid the money and they arrived at around 7 am in the morning. A Caesarean section was done but the baby was already dead! After the operation she was given a prescription to have antibiotics. The nurse in there told her ‘utaenda kupata hukohuko ulikotoka’ meaning that she will get the drugs at the dispensary where she resided. She went back home but she had pneumonia and after two weeks she went to the dispensary. She was given tablets that were prescribed ‘vidonge vya njano na vya rangi mbili’. The drugs were metronidazole tablets and ciprofloxacin capsules. Also, Mr. Masahai prescribed Procaine Penicillin Fortified (PPF) injections, 1.2 MU intramuscular, for 5 days and paracetamol tablets. The surgical wound had already healed well, the RA noted, but she WAS still weak and traumatised, and likely to experience morbidity.

SANURA
Sanura is approximately in her late twenties – she knows this as she was born when the CCM party was set up in her village. She was seven months pregnant with twins and is unmarried. Her father took a man to court as he impregnated when she was a teenager. Her current pregnancy is on account of a married man who refuses to marry her. This caused considerable tension for her and her labour pains began early. She delivered the first twin, a female baby, at 0830 hours; the birth of second twin was delayed. Thus, the nurse wrote a referral to the hospital. There was no transport to take her to the hospital and the mother was in labour waiting for four hours. Then a friend of clinical officer Chuwa was successfully contacted and he contacted his friend who fetched Sanura and took her to the hospital for 40,000 TSH and she arrived in that state at 1 p.m. The RA accompanied them.

Image 17: RA Beatrice in the field
Whereupon the nurse was extremely rude and demanded that she wait. As the RA watched one of the nurses put on gloves and examined Sanura but did not inform Sanura of the progress although she was undergoing contractions and strong labour pain. The membrane ruptured at 5 pm but the second baby did not show any sign of movement. Meanwhile, the nurses just sat down drinking tea and, making conversation. They took no action to notify the Doctor. It is a miracle that Sanura survived as she was pale and in acute pain. The RA held her hand and went to the nurses and asked them to assist. At 2 a.m. the next day Sanura was exhausted she complained to the nurse that she felt the life was going out of her and finally, she was helped. The nurse notified the doctor who arrived at 3 am and sent her to ultrasound examination and discovered the baby’s position in the womb was transverse. Thus it was impossible to deliver the baby by the natural birthing technique. He, thus, operated on her and the baby was born alive after 21 hours - both babies were sent into a premature baby room and placed in the incubator and, the correct temperature was maintained with light all the time. The RA left them there and on her return found that Sanura had become very weak and her second baby was critical.

**Narrative from the Health Centre and District Hospital**

**RA:** Hallo! How are you?

**MAJIMBI:** I am fine, how are you too.

**RA:** I am fine too, please can you allow me to converse with you as I have been told that you are a mother of eight children, I would like to know the problems which pregnant mothers face before delivery what do you say, and are you ready?

**MAJ:** There is no problem on that you can interview me.

**RA:** I have heard that you were very late when you went to clinic to deliver your last born child, what happened actually.

**MAJ:** The day I got labour pains I went by myself up to our village clinic I remember it was around 1:00 am when I arrived there was no one at the reception desk, but by sheer luck my brother in law followed me at the clinic so when I was just seated at the reception platform he appeared and I told him to go to find the nurses to come to attend me. He got the nurse who is called Mama Rosa. Then Mama Rosa asked him, “She was escorted by how many people?” My brother in law told him that I have just come alone.

Mama Rosa asked him, “Is she really in a labour pain or she is just joking, how comes she is alone?” In fact it took over an hour when she came and saw me through the window, she started shouting, “You woman, why are you here, I don’t want you here what are you doing? Then she entered there and told me to get up and leave the clinic premises as soon as possible. She chased me like and I don’t know what and actually I hate that woman very much I swear to God. I have never seen such a cruel woman like her in my life. Make sure you get transport and go to Hospital, I don’t want troubles here do you think if you cause me problems and make me chased away from my job, who will take care of me and my family, I know you are very poor people, please go to the hospital leave this premise, you go away please. Then I stood up and went outside while my brother-in-law was seeing me going out and, now the vagina had started to release some water. I went and knelt near the bricks behind the clinic building. my brother-in-law went to the village to see the forestry officer who had a motorcycle and agreed to hire it for 12,000 TSH my brother-in-law had 7000 TSH and my brother had 5000 TSH so they contributed and gave the forestry officer Mr. Msagati those 12,000 TSH but before that when Mrs. Msagati knew that it is me who is needing the motorcycle she started ordering his husband to get the cash money before he takes me to the hospital. You know the wife of Mr. Msagati is not a good woman to me and I don’t like her: she is very pompous and boastful. Finally, the trip was arranged and we started the journey Mr. Msagati as a driver, me and another neighbour who sent me to the hospital. Remember that I left there without any kind of extra cloth for me and for a baby if at all the
baby would come out alive. Also remember that the water was still coming out, although at that time it was not much as it was when that cruel nurse chased me. The journey to the hospital was not comfortable to me throughout the journey as you can see a motorcycle for two people was having three people and I was seated in the middle. I can’t forget those tiresome moments of my life but all these are the burdens of being poor.

On reaching at the Hospital it was around 3:00 am it was very difficult for me to come out of the motorcycle, so some people came to help me, my legs were powerless, they took me straight to the hospital bed. I continued to scream on the bed up to around 5:00 p.m. I advised the nurses to take me to the theatre but they just ignored me. Finally labour pains came at last around 6:00 p.m and because there was nobody to help me so I started to use my hands to squeeze my stomach and widened my legs just alone, then the nurse saw me and shouted to me to stop the exercise while she started wearing gloves to come to assist me. By the time she came the head of my son was already out of the vagina, so she came and continued to do from where I had reached and finally the boy came out safely. Also the money which was paid to Mr Msagati for hiring the motorcycle he also returned all the money to me upon reaching the Hospital. I spent some money to buy my baby boy some clothing and also at the hospital if you bear a baby boy you pay 12,000 TSH; if it is a baby girl you pay 7000 TSH or at around those figures because you can bargain if you have less than that. It depends on the facilities you got from them.

For the case of our local clinic we were not charged so much- especially on early deliveries for my case I gave birth to one of my children in 1999. I paid them 2000 TSH, but nowadays we pay 5000 TSH, others up to 10,000 TSH. They demand these monies for washing their bodies and clothes.

I stayed at the hospital few days as there was nobody from home who came soon. Finally, I came back with my son, I call him Julius. One day I met the nurse Mama Rosa - she wanted to know how I managed to give birth there at the hospital. I told her the whole story and I told her that I gave birth very soon after arriving there. I openly blamed her for refusing to attend me. She defended herself by saying they get worried to attend women who have more than five children and aged because their ability to give birth is uncertain. But I also told her they shouldn't worry because all the human being plans are in hand of God and nobody else. If someone dies at the clinic you would not say if we send him to the hospital she can't die, don't do that, it's only God who plans everything. To be frank I hate that woman and it is at least now she is changing to be more human than those years which she came, I mean she has been here for about three years now. There is another nurse called Edina she came two years ago she is very generous to the pregnant woman. Also another nurse Mama Neema she is also kind to mothers, but this nurse Rosa and another one Mode the wife of Richard are not good for the job they are very cruel. I think they joined this job by accident it is not suitable for them. You remember sometime they went for an upgrading course, it is Christina who emerged the best student because of her character and great love she has to the people she attends. For instance, if you were supposed to go to clinic today and you miss to go and you go tomorrow, they chase you away and they won't give you time to defend yourself.

For sure I have no love at all to nurse Rosa and Mode, I hate them due to their bad habits to the mothers going to attend clinic. Finally, I think at least now she has slightly changed a bit. But any way now let us leave them because they were born like that it is up to them.

RA: Is this boy your son.
MAJ: Yes this is the one Julius who gave me all those pains, can you see his head is bigger since he was born.
RA: He is the 6th child?
MAJ: He is the 7th but the eight on the line because I lost one out of eight children.
RA: Who is assisting you with your daily chores in your home?

MAJ: No I don't have any one to be frank, if I get one what can I pay her I have no money. I don't have daughter. The brother to this last son is a male he was born in 1989 the senior brother to them was also a boy he was born in 1986 and died in 1991. In fact he died of measles, you know at first we thought it was degedege and we wasted a lot of time to the local medicine men (waganga wa kienyeji) by the time we took him to the Hospital it was too late.He died the following day upon arriving at the Hospital. Even during the time when his brothers went to circumcision he was there. I think also the husband I am having now ignored the idea of sending the boy to his father because he was not a son of my present husband.

RA: You have said you wasted a lot of time with your dead son going to witch doctors. What kind of treatment did he get there?

MAJ: They used mostly going to bring roots of wild trees boiling them and gave him to drink or sometimes boiling them in a pot and tell him to sit on a kigoda then take a pair of sheet and put it all over his body for sometime, and sometimes washing his body by mixing with water. You know even my Julius sometime was infected with measles but because I hurried him to the Hospital he got proper treatment and improved, shortly afterward.

RA: Since when you started to go to deliver at the Hospital?

MAJ: Since my 6th pregnancy onward.

RA: There at the chigonela do you get any assistance from the Hospital Authorities?

MAJ: Nothing like it is that you buy your own food they provide you an empty kitchen so if you are alone it is a problem but if you accompany a relative then she can go and fetch fire woods, buy food and prepare for you. If you don't have anything sometimes your fellow there, they can help. Life is like that, very uncertain.

In this narrative, the harrowing experience of Majimbi indicates the uncertainty that pregnant women are likely to face at the health centre time and again. We heard many such stories of habitual ill-treatment by nurse-midwives. These nurse-midwives are also nervous of the outcome and do not wish to take any responsibility – as many clinics are poorly equipped. On the whole there appears to be also a lack of professional etiquette and compassion as discussed in the following section giving narratives from health providers.

Representative Case Studies: Conversations inside the Tembe

MARY

Mary is in her early thirties. She has never gone to school. She is married and has five children. She is seven months pregnant and it is the eight pregnancy. She delivered her three babies at home and four at the hospital. During her first delivery, she had primary PPH. She said that ‘mabirika majete ngamelile sakami’, that two bed pans were full of blood! The bleeding was too heavy and the midwife injected her without telling her what was it but the bleeding continued. The hospital midwife took maize flour and mix with water - cold and unboiled. Mary was given a cup to drink and after few minutes the bleeding stops. Her baby was just left by her side without any care.

Image 18: Weighing new born

It was 8 pm and so she slept at the hospital and she was discharged the next morning. Her baby was not weighed. At home her baby was not able to suck milk and she decided to give him tea! The baby died next day and she doesn't know the reason of death but she guessed that it was due to hunger. Also she said that she gave him cow's milk ‘mele ya ng'ombe’ but the baby didn't drink. The same happened to her second born. She gave birth at the hospital but
there was no problem. She came back home and her baby died as he was weak and could not suck milk.

She delivered her three subsequent babies at home and she said she just decided to do that without giving any specific reason but the major reason was that she did not see any difference between a midwife and a mng’hunga since she gave birth two times at the hospital and both times, her babies died. The babies she delivered at home have survived and attend school.

She once used a family planning method: DEPO provera injection. She said that she had heavy bleeding, high grade fever and became pregnant. She stopped and has no plan to use any family planning method. She just accepted to carry pregnancy and she said ‘muda ikuza yenecho’ meaning that she just found herself pregnant while at shamba

SAFIA

Safia is reluctant to go to the hospital to give birth at the hospital. She lives about forty kilometers from the district hospital, and is expecting her third baby. She delivered the first at the hospital and did not wish to return there. “Sister, the nurse uses very abusive language. We walk all the way to get care and no one cares. At the antenatal clinic, the nurse whom they also call midwife is rude.”

Mng’hunga wean iziibi sana, siwalongaga viswanu na wadala wono wean usungu.

“When we go there, the nurse midwife says woman we did not make you pregnant, so do not disturb us”

Nyinyi kina mama hizo mimba zenu hatujawapa sisi kwa nini mnatusumbua?

And, sometimes they are rough when they examine us said Rosa so if we make any sounds while we are being examined they say

“You woman be quiet, why do you disturb us? Keep your buttocks down!”

Wewe mama tulia kwa nini hutaki kutulia? Tuliza matakao yako chini.

FARIDA

Farida, in her late twenties, was pregnant four times and gave birth four times; two of her babies died during delivery. She said that there was no dispensary and the local mng’hunga was unskilled, “during delivery she said the baby’s hind limb was seen first instead of the head so it was footling presentation.” The mng’hunga was not able to conduct that type of delivery and, the mother struggled until the baby came out – but he was already dead. She sustained a tear that could be third or fourth degree and the mng’hunga applied black powder on the wound until the next day. She cleaned the wound with unsterilized water everyday and applied the black powder. She doesn’t remember what was used to prepare the powder. It was very painful to lose a baby.

During her third delivery, she was rushing to hospital and the transport was by ox-cart. She felt labour pain and she decided to go to the dispensary but she was late as she gave birth on the way! The baby didn’t cry, she slapped him but there was no improvement. The baby was weak and turned bluish (cyanosis). Her aunt helped her to cut the cord and tie with uzi from cloth. Few minutes later the baby died. She told the RA- “Ikutama, Dada, Ikutama sana-- “It was painful sister, very painful”. She cried a lot and when she reached at the dispensary she found out that there was no nurse. She waited and the nurse came later. The nurse assessed the baby and confirmed her baby had died, gave her some tablets and she went back home. She was quite unsympathetic towards her and just walked away while Farida sobbed.

And, upon her return home, her husband did not share her pain. He asked her, ‘Where is the baby?’ she replied, ‘The baby died on the way’ He scolded her and said she was bad
luck. She remains very sad and goes about her activities as if in a daze.

SOPHIA

Sophia is in her early twenties. She gave birth to two babies, first was born in 2006 and the second was born in 2008. She delivered her first-born at home. The reason was that the nurse had gone to a seminar in Dodoma Municipal so there was no nurse and the dispensary was closed. She went to Mr. Masahai to ask for help but unfortunately he said he was not able to conduct delivery. He gave her ‘magroceri’ (gloves) and she went back home. They ask a mng’hunga to help her. The delivery was conducted on ‘kitanda cha milejehe’ (a bed made up of ropes). The mng’hunga received a baby and cut the umbilical cord using a razor blade, tie with uzi. After a week she went to hospital for immunization of her baby who was born safely. She delivered her second-born just outside the dispensary. She felt labour pain at 7 am and she stayed at home till 7 pm. She said, she thought that the time was not ready that is why she didn't go to the health facility early as she did not want to be accused of false labour pains ‘rikupitula’, a matter of shame.

Thus, she went to health facility at 7 pm when the pains were strong, escorted by her neighbours. At the dispensary there was no nurse. They called the nurse (Anna) and before she arrived, Sophia delivered the baby outside the dispensary. She said also ‘limama’ (placenta) was out when the nurse arrived. The nurse took the razor blade and cut the cord, and then she told them that ‘kazi imeshamalizika mnaweza kurudi nyumbani’. “The work is done and she can go home.” She left Sophia outside and just went away - the neighbours cleaned Sophia with unsterilized water.

Meleya

Meleya appears to be still in her teens, she is not sure of her age. During my conversation with her she said she has two babies, her second-born attended the clinic after a week. Basically, Meleya said, “she always likes to deliver at home by the help of her grandmother and her mother, she said always her mother do help her with the delivery or grandmother both of whom are Wang’hunga. They always charge them about 3000-6000 TSH only as “thanks God for good conduct.” When the RA asked her why she delivers at home rather than going to hospital Meleya said, “Once a pregnant mother comes to dispensary the midwife does not treat them in a polite way”.

Wakati mnafanya mapenzi na mume wako mimi sikuwepo kwa nini mnatusumbua; Sukuma acha ujinga wako.

“Woman, we didn't give you this pregnancy so do not disturb us. While you have sex with your husband I am not with you, so let me rest”

SINARAH

“I am glad to have delivered my three babies at home”, Sinaraha remarked after giving birth to her fourth baby; the fourth was delivered at the health centre, “Even to stay with the mother in labour ward is difficult. Many of them deliver along the labour ward and the nurse midwife arrived just to cut the cord only.

In District hospitals some cruel practices were witnessed by the RA’s. Safia was in the process of delivering the baby, she was screaming with pain – she was barely twenty it seemed and this was her first delivery – the nurse barked at her, “While you have sex with your husband do you call me to assist you in sex? Why do you make so much noise; keep quiet.” The Nurse used forceps and pinched her thighs as Safia cried in pain.

At another hospital, a mother of eight was told,
“Wewe ni muuaji unataka kuua mtoto eeh!”

“Do you want to kill your baby?”

“Therefore, why should we trust people who do not care for us? We had better deliver with those who care for us. I was ordered to push and they moved me in a rough way and left me.”

Unadeka nini, nitakupiga nakanwambia sukuma.

“I will beat you; push!” while she was ordering me, the nurse said, “let your baby die and we will see if your husband can still love you.”

Ngoja umuue huyo mtoto alafu utajijua natuone kama huyo mume wako atakupenda.

“They are very cruel to us. That is why I never will go to deliver there. My expectation is the government health sector to supervise nurses in the villages and pay them good salary, also train them why mothers do receive free service, because they just ignore us due to free service we get. They use harsh language during labour pain and delivery. The mng’hunga is always polite.”

“My last deliveries - all of them were successful at home by local mng’hunga and as this is the first time and this will be the last time that I will deliver at the hospital,” said Sinarah, a mother of three.

Nali nesumile nali saka hono nghubita sawa mwanangu nitze ne mng’hunga wa cigogo mmonga no mng’hunga wa kusibitali mmonga ninga manyile awano siwolumba.

JESCA

Jesca said she is fearful to mention that she is experiencing labour pains to others--Because her neighbour did that and was taken to hospital where she remained for almost a week without giving birth. The labour pains disappeared and the staff mocked her and considered her to be mdodi – mwoga, being afraid to give birth. “That why I do not because I might be sent to hospital and the labour pain disappears there. I have to wait for strong labour pains and then I just call mng’hunga to help and there is no problem.”

“We trust the mng’hunga much more than the nurses because the mng’hunga are patient and stay with us until we deliver the baby; nurses leave us alone in labour ward and cannot know of the progress of our labour.”

Chihemuhemu malenga ga nhande, gahemulaga nhande sinapya.

HALIMA

Halima is married and she has ten children. She delivered all her nine babies with the mng’hunga because they use polite language than the nurse. She notes, “I know that as a mother I will face complications but as we say, we must bear that and be strong.”

Chihemuhemu malenga ga nhande, gahemulaga nhande, sinapya.

Mama mjamzito mimba humsumbua kabla hata miezi tisa kufika.

It is believed that a pregnancy that has complications before the due date has to be borne by the pregnant mother. “Also, I am circumcised, and that is why I fear the health workers as I have experience of them making fun of me.”

Another noted, “When I go to the midwife she examines me and sometimes sings and comforts me. She is circumcised and she knows what to do. The nurse is not circumcised and very harsh to me.”
Nevertheless, the RA was told that for her tenth delivery she went to the centre. The nurses were careless and do not treat her well. Also medical procedures were not undertaken according to the guidelines. For example, the nurse performed episiotomy without specific reason but also they did not use lignocaine to minimize pain.

Muuguzi anaongeza njia pasipo sababu na huwa hatumii ganzi kupunguza maumivu.

“I was bleeding and the nurse just looked at me and scolded me and told me to pack up and leave and not cause her trouble.”

At the Health facility

MAMA JUMA

At one hospital, Mama Juma, sitting with her pregnant companions waiting to be attended to, spoke quietly, “We are told the antenatal and labour and delivery services are provided free of charge... but the nurse can ask you to give her some money secretly so that you may get quick services, otherwise it can take you the whole day to get the service you need.”

Mama Juma who is eight months pregnant claimed to be 35 years. She has been admitted at the antenatal ward for the past three weeks, she complains that the nurses who are responsible for the antenatal services are very harsh, and they pretend to be polite whenever they see a visitor or District Medical Officer. Mama Juma is with 58 other pregnant women in ward number 2 which is the antenatal ward where they wait for their days of delivery to come because they come from villages which are very far from the hospital.

She also added, ‘Kwa kweli hiki chakula tunachopewa wala hakituutoshelezi na pia hakina virutibisho mihimu na hivyo inatulazimu kwenda kununua mboga za majini nje ya hospitalai na kama huna hela basi hamna jinsi utakula hicho hicho.’

“For sure the food which the hospital provides for us, is not enough and LACKS some important nutrients (unbalanced diet) so we have to buy cooked vegetables outside the hospital and if you don’t have money, there is no other alternative; you have to eat the small quantity of food provided by the hospital.”

Aziza added, ‘nimechoka sana kukaa hapa sipati chakula cha kutosha na kila siku tunapewa ugali na maharage, sina ndugu wa kuniletea chakula na mume wangu yupo mashambani. Sina hela ya kununua matunda na mboga za majani. Tunalala watu wawili kitanda kimoja na wakati mwingine tunalala chini kwani vitanda havitoshi.’

“I am very tired of staying at the hospital. I don’t get enough meals and we are daily given stiff porridge with boiled beans. I also don’t have any relative who lives near by that can bring food and my husband is busy with farm work. I don’t have money to buy fruits and vegetables. As you can see we sleep two people on one bed and sometimes I sleep on the floor as the beds are not enough.”

EMMY

Emmy, aged 19, had come from a distance of 59 kilometres with her mother. It was her first delivery. At the hospital, the RA noted the ward was not clean, the beds had no bed sheets or blankets and it had lot of flies and mosquitoes. women shared beds and waited for their delivery.

Her mother was asked to wait outside while Emmy was taken in. She screamed while in labour. A nurse slapped her and told her, “If a woman is in labour pain she is not supposed to shout.”

Mwanamke hutakiwi kulia ukiwa na uchungu
The RA heard the nurse as did the mother of Emmy, and the RA observed that the effects of such abusive language traumatised Emmy and she could not speak for several hours. Her delivery also went very badly.

PENDO

Whilst the RA was in the field she witnessed Pendo aged thirty (maybe less) suffering the loss of her baby after a few hours of giving birth. Pendo had been pregnant five times but lost three babies. She told her that she had been pregnant five times and delivered all the five times but only two survived childbirth. She delivered the first two babies in the health centre and they died. In 1999 she went to hospital at night but unfortunately during the night she was weak, as she suffered from severe anaemia. At 4 pm she was referred to Dodoma Hospital for further management. She said there was no ambulance and so they should catch a bus. They had no money and they borrowed money from relatives at night. There was no bus and so at 7 am in the morning she and her relatives got a bus and arrived in Dodoma at 8 pm.

At the hospital Pendo was transfused with 1 unit of blood and she gave birth at 6 pm in the evening. The baby was very weak and unable to suck. She said the baby tries to suck just once and at 9 pm the baby died. Till today she is not sure what was the real cause of death but she guessed may be because the baby was so tired. It was so sad but she said it was God’s plan for such a thing to happen and my baby swallowed the muceum.

Uchungu kuuma muda mrefu (prolonged labour) na kama mtoto atameza maji ya uchungu wang’hunga.

She will not be coming here again. Nurses do not speak politely with patients = more examples:

If a pregnant mother does not answer immediately, they shout,” mshenzi wewe? “Are you stupid?” Ulimokuwa unalala na mumeo uliforahia – “When you were with your husband you enjoyed and now you make trouble”; or, usipige kelele nyamaza kimya – “do not shout and be quiet; or mchafu wewe- you are dirty

They also charge between 5000–15,000 TSH.

“Don’t come here without preparing yourself at home- come here with gloves, cord tie, syringe and sometimes ergometrine drug to prevent bleeding after delivery.”

Thus, the low cash incomes and absence of financial support from The husband makes it impossible for the mother to prepare the items demanded by the nurses at the health facilities-- that are required during delivery. Veronika was told to prepare kerosene (2000 TSH a litre), sugar (1400 TSH per kg), lamp glass (1000 TSH), razor blade (50–100 TSH) and clothes. She cannot afford since she does not have any money and thus she will go to the Mng’hunga, she said to the RA.

JEMIMA

She is a woman claims to be 22 years. She is married to Kilongano who works as a farmer. She was pregnant four times and she delivered four times but sadly two of her babies died. She said that in 2002. She delivered at home and she said that her mother told her to deliver at home since there was a mng’hunga near her home who was inexpensive and who could help her without any problem to deliver at home. At the age of a week, her son died due to a disease she doesn't know. She said that, ‘mng’hunga sikuhulika agwe’ meaning she didn't identify the disease but baby’s belly protruded and on the next day he died. It was a saddest experience for her. In 2004 she delivered another baby who is alive and she delivered him at home also due to the same reason as above. After a week she took the baby to hospital for immunization for nine
months when she stopped taking him to the clinic.

In 2006 she shifted from Banyibanyi to another town and she was pregnant. She delivered at the dispensary and she said there was no problem during childbirth. When the baby was a month old he had convulsions, and she went to hospital to seek medical treatment at the health centre. She was given tablets ‘vidonje’ and she was not told what kind of tablets they were. The baby's condition worsened as he had high-grade fever and at 4 pm the baby collapsed. She cried a lot and it was very painful to lose a second child. In February 2008 she delivered another male baby at the dispensary. She said there was no problem during delivery. She said that her husband forced her to have sex and she didn't accept since she planned to have sex after she had stopped breastfeeding her baby. Sometimes she slept on a different bed with her husband so that he didn't touch her. Her husband asked her to use a contraceptive method but she declined since she thought she would harm the baby. She also believe that, 'ukiwa na mlume unatumia, lakini usipokuwa nae hutumii' meaning that if she makes love she will start menstruating and if she doesn't have sex she will not menstruate. She is in lactation amenorrhea as she has been breastfeeding for six months now and she didn't see any menses.

During delivery of her last born she had labour pain at 8 am and her neighbours helped her and took her to hospital at 12 pm. She gave birth at 3 pm and then she was back at home at 5 pm. When the RA visited her she was told she had been discharged! Normally a woman should stay 8 hours after delivery so that a midwife can observe if she had any problem, especially excessive bleeding. She stayed at the hospital for 2 hours after delivery and the nurse told her that since she was doing well there was no need to stay at the hospital.

Being discharged early at the dispensary, health centre or the hospital is another worrying observation we found to be practiced in a majority of cases.

Jemima said it is better to deliver at the hospital rather than at the mng'hunga since there is no bed at mng'hunga, instead a woman delivers on the nyingo. She said ‘kwa mng'hunga kule la ye nyingo’.

The Maasai way:

FELISTA

Some customs are followed by certain tribes such as the Maasai. Felista is a Maasai woman. She doesn't know her age. She was able to speak Swahili and so make communication easier. She is a mother of two children. She had a black animal skin belt around her waist, and The RA asked her why every Maasai woman carried her young baby had that belt? She said that it is sign that she is not ready to have sex with any man until she stops breast-feeding her baby. Also the belt helped to shape the belly so that it won't become big. The black belt is made up of hard animal skin and it is called ‘ngirarii’. The Maasai women do not use artificial family planning but use natural family planning. Usually, they do not have sexual intercourse until the baby starts to walk.

The RA also asked her why Maasai women do not deliver at the hospital while they attended antenatal clinic and she said, “at the hospital there is no homemade ghee which a woman drinks after delivery. The oil helps to loosen the abdominal wall after giving birth”. Oil is also applied around baby’s body after birth and they feed their baby using ‘kibuyu’. They value such customs.

Pendare, another Maasai also has no formal education. She said that a Maasai woman stops eating after seven months of pregnancy; she is not allowed to eat or drink anything except water and dry maize that are burned on a fire ‘likyalata’. She eats two meals per day and she is not allowed to take milk. The reason for doing this is to avoid the baby growing big so that a woman does not get problems during childbirth.
When the baby is born, she/he is given homemade ghee so as to gain energy. The mucus from the baby's nose is removed using a thin piece of animal skin, 'oluchoni'. The woman is also given homemade ghee to drink so that she gains energy and to replace the blood lost during childbirth.

After the day of delivery the woman has a special diet. She is given ‘motorii’, made up of fat from a goat and, pieces of meat. The mixture is boiled with water and she eats/drinks this for five days. Then she is given 'uji' porridge for next 5 days and 'supu' for five days. This diet is for a period of two months.

The woman who has delivered stays in separate houses from her husband for a period of two months and after that she can stay with her husband again but they must sleep on separate beds. They believe that if they sleep together and the woman become pregnant they will harm the baby, as do other people in this region. A woman is also supposed to cut her hair and remain with a bald head so that she looks ugly and other men can not be attracted to her.

Many women complained about the deeply unpleasant way the nurse-midwives treated them because they were poor in comparison with other better off pregnant women who could buy them a soda as they had money. Also, these poor women were subjected to rile and mockery within hearing distance and, they felt very ashamed and unhappy; they also lost their confidence. The common opinion was that “The health facility nurses simply do not care about them.”

Wang’hunga we cigogo wafundigwe walece tambula imalema ga wanhu wono wakusawa niga wang’hunga wa musibitali za cizungu siyo wanhu waswanu hono wamuwone munhu yena imalema mu muwili wakwe wakubita walonjela wanhu wono wawamanyile yo leka wanhu wenji siwendile kubita sawila mu zisibitali.

“The wang’hunga respects our privacy and our confidences and, does not discuss us. But at the health centres the midwives are very harsh and they do not keep secrets if they find you have defects in your body, they make fun of us and we hate them.”

Conduct of the Health staff:

Most shocking was that in four health centres, on more than five instances, the RA's found the attending clinical officers to be drunk and, while attending to the patients, they smoked cigarettes in the health facility. Such harmful behaviour does not help women who are discouraged but have no choice but to be attended by them. There is no electricity and water supply is not on tap - thus dark birthing rooms are lit by candles and kerosene. Mothers must pay for the kerosene to get discharged. On the whole, such commonly occurring situations are very dismal. The RA's used their torches given to them for field work to light the rooms.

In general, in most of these sites, neonatal deaths were not recorded and certainly there were no records of maternal deaths.

Wanafanya siri kwa sababu ya vifo vya kinamama wajawazito.kwsababu wanaogopa adhabu kutoka wizara ya afya.

A constant reply was that they feared keeping records as they get blamed -- because if a nurse has more than three 'punishment' letters, she is likely to be terminated from her job in the Ministry of Health.

Another problem, two of the RAs' noted, was that out of the fifteen Clinical Officers with whom they had worked, thirteen of them were alcoholic and came into work as they pleased.

Mganga Mtiga yeye hajari wakati wote amelewa Na anavuta sigara si unamuona alivyotayose wkana mwanaume mzee.wakati anakuhudumia atakwambia subiri kidogo nipate nguvu, atawasha sigara yake na kuanza kuvuta.Akimaliza mnaendelea na huduma hivyo ndivyo alivyotayose.
The local people say, “Clinical Officer Mtiga yeye hajari, all the time he is drunk and he smokes...he is young but he looks like an old man...while he attends to the patient he can say ‘Just wait’. He takes his cigarette and he starts to smoke, this is the way he is.”

Another of the RA’s found that the clinical officer was having sex with one of his patients. And, she noted that he gave her favours such as aspirins and other medicines. But on account of their status they are not censured. Furthermore, it is seen as all right, as a man needs to fulfil his sexual desires.

Kezia, a young woman, complained that at a health centre the Clinical Officers do not treat patients well. For example, one day she went to hospital because her newborn was ill. When she entered the clinical officer’s room she greeted him and he replied ‘taja una tatizo gani sio kunisalimia’ that she was just supposed to tell her problem without greeting him. There are no good therapeutic communication skills among staff and the patients and this is a big problem even at higher-level health facilities. A poor relationship between health care workers and patients creates more problems than can be imagined. Shouting by nurses can be heard from outside the maternity wards. An old man, a grandfather, Mzee Omary who had accompanied his son to the hospital embarrassed and saddened, noted:

Ase wanhu wa Tanzania siciyendile sese weneco kwa weneco.Cikuwona ciba cimutate muzungu yatuje nunga umuyago yajendelele gatzika

“We Tanzanians, we put each other down. We feel it is better and right to assist a foreigner rather than helping fellow citizens.”

Such an observation was remarked upon at other occasions.

Politeness must be made mandatory and communication skills need to be improved. Also, it is vital that health workers, as indeed VEO’s and village and district officials, be sensitive to local languages – lugha ya wakienji – and keep a translator to assist them to speak the local languages. At many of the health facilities, also the staff do not speak the local languages and are often unable to communicate with their patients. They also insist that the local women can speak Kiswahili which is not the truth. And, they say the local women and men must speak Kiswahili. Many people are unable to go to school and in addition, communicate only in their mother tongue. They respect the fact that Kiswahili is the national language and to them, the language of business, not the language of the heart.

Several themes emerge, but what was clear from our findings in many sites that were witnessed by the RA’s, nurse-midwives were not competent in their work – and ignorant of what needed to be done. This is an extremely grave problem, as on account of the lack of technical expertise by health staff identification and management of hypertension in pregnancy and pre-eclampsia or birth asphyxia and preterm births could not be handled. Also, many infections such as the common neonatal sepsis, pneumonia, diahorrea and neonatal tetanus go undetected. They state cause of deaths to be macerated births or fresh births, but that is not always the case. The knowledge base of established practitioners and awareness of what constitutes best practice should be updated regularly through continuing medical education of all health personnel.

The Chigonela
A chigonela which is in Kigogo is a place provided by the hospital for women to rest. Most of the women who come to chigonela do so as they want to have a safe delivery under clean medical conditions. The RA noted that all pregnant women at chigonela were coming from very far off villages and most of them travel by foot from their home to hospital walking all day and sleeping at night by some village. The RA spoke to pregnant women from Chitemo Mpwapwa, Iwondo, Fufu, Igendu, Manzase, Nghahelezi, Mkanana Kongwa, Mgunga Chiboli, Seluka, Mlowa Barabarani, Chipogoro Nhinihi and Kisima Mtera. Some of these stories are recorded below:
Tabu from Chipogoro travelled by foot from Mlowa and took two days as it was over twenty kilometres. She was able to manage a bus ride from Chipogoro with some difficulty. She was welcomed by other pregnant women there and like them she had walked alone. It costs 1000 TSH to stay for a month and 1500 TSH for a laboratory test. So she had to be careful with her money.

Victoria walked from Loje village over 40 kms away. She is about 25 years old. She came on account of multiparity and the advice of the midwife, for safe delivery. She took about three days to come to the chigonela by walking from Loje to Manzase, from Manzase to Iringa hospital then from Iringa hospital to the hospital. It is a very long safari but she had to walk. She did not have money to hire even mkokoteni. She said she was not given any care there at home, so she decided to attend this antenatal clinic where she got a check-up and laboratory for investigation where she paid 1500 TSH. She then went back to the waiting house where she paid 1000 tsh for accommodation.

There were other women, who did not wish to be named, some of whom had walked from Kongwa as far-off villages and Mtamba in Mpwapwa. They came because they had to find a safe place for delivery. But the chigonela was packed with beds, each with three women. By the bed on the ground the women kept their rations of dried vegetables and millet flour. The beds were very dirty, with soiled mattresses and no mosquito nets, as the ones there were in tatters. The women had informed the hospital but no one attended to their complaints. There was also no nurse in the chigonela to attend to them in the case of emergency at night for instance. But then as some women remarked with an air of resignation, they were not considered worthy of such help by the authorities and would not be treated well anyway.

HAZILA

She is one of the women who had lost a baby a few hours after delivery when the RA met her. She claims to be 33 years old. She was pregnant five times but she has only two babies who are alive. She gave birth to her first-born in 1995 and her second born in 1997 and both at the hospital. In 1999 she was pregnant and the time she expected to deliver was at home. However, she went to the hospital during the night and unfortunately she was weak with severe anaemia. At 4 pm she was referred to Dodoma Hospital for further management. She said there was no ambulance and so they should catch a bus. They had no money and they borrowed money from relatives at night. There was no bus and so at 7 am in the morning she and her relatives got a bus and arrived in Dodoma at 8 pm.

At the hospital Hazila was transfused with 1 unit of blood and she gave birth at 6 pm in the evening. The baby was so weak and unable to suck. She said the baby tries to suck just once and at 9 pm the baby died. She is not sure what the real cause of death was but she guessed maybe because the baby was so tired. It was so sad but she said it
was God’s plan for such a thing to happen, “Every baby has its own star and my dear baby was cursed.” Since then as before, life was too tough; her husband a drunkard was not responsible to take care of the family. She said that, ‘alikuwa hahemu, nilikuwa nahemea pekeangu’ meaning that he was not responsible for the family. In 2003 she was pregnant and her husband used to beat her several times and the baby died. She had an abortion. But she said she doesn’t want to remember and explain the real situation as she said she will cry. Her husband continued to beat her using a stick and in late 2007 she divorced him and went back with her two children. Her last baby was born was conceived after her divorce and was born dead and she does not know why. No one at any of the hospitals gave her any reason or showed sympathy.

“Men are responsible for their wives' medical care and if they do not give them money how can they pay for delivery?”, said the nurses and let slip that fees were being taken. In general, pregnant mothers and their children are given priority and there is no charge that is openly recorded. However, payment was done be it in cash or kind more often than not. At a referral centre all pregnant mothers had to bring a log of wood, or kerosene to augment the fuel supply. While fees were not taken in the presence of the RA’s, it was clear that fees are taken as women who cannot pay are turned away. No records of fees are maintained – it is not permitted by law to charge for childbirth in government hospitals. The general attitude was one of arrogance, impatience and even hostility to the local women. Also, in all the sites the pregnant women said to the RA, “Sister, there are so many hidden charges that we end up paying 5,000--10,000 TSH and that does not include the costs we and our relatives incur to get here.”

Whether it is at the dispensary, the health centre or the hospital, women are expected to pay. Furthermore, in most cases the poor women are abused and ill-treated by the health workers. These workers recount that they are all overworked and underpaid and thus feel hard done by.

The severe shortage of essential birthing kits and the shortage of intravenous fluids and resuscitation equipment that are essential requirements in these districts does not help the pregnant mothers, most of who have journeyed by foot. The widespread practice of early discharge of mothers is also extremely worrying. Interventions are required; for example, a notice could be sent to all health facilities and during re-training, advising against such steps.

Most of the neonatal deaths can be prevented – it seems that maternal mortality and neonatal deaths ratios that are measured are one aspect of obstetric outcome. Another urgent matter is that of obstetric morbidity which must be addressed as a principal factor in all studies on maternal mortality. Ill-health across generations results from the interplay of economic, social and biological factors. Interventions suggested below seek to put an end to the passage of ill-health across generations.

Testimony from Amina

Amina, about 30 or a bit more, is married to Mr Juma, and she is his second wife and has borne him six children; sadly, two babies died at birth after being delivered in the health centre. That is why she will only give birth with the mng’hunga in attendance.

“During my marriage I managed to deliver six babies, four are alive and two died. My fifth pregnancy had been a normal delivery but my sixth pregnancy my stomach was too tight. I could not sleep well or even sit so I was always just changing position. I could not eat well, even if I attend to Ant-Natal Clinic they just say this happens because I have big baby and I accepted this explanation. then after labour pains began I went to Mama Elizabeth mng’hunga and she did the examination and told me that I have no problem and can begin to deliver. The problem came when the strong contractions started, I was urged to push hard but that was impossible, when I was trying to push,
I experienced searing pain - I was so tired and exhausted. Then Mama Elizabeth put her hand into vaginal to checkout if there is any problem and then she discovered that the umbilical cord was around the neck of the baby; she put her other hand in and tried to cut the umbilical cord internally. She tried to do that times three till I heard sound “TA”. I was praying God to help me deliver safely, but after delivery I fainted for several hours and the bleeding was so severe. Then, when I was fully conscious, they took me to health centre, where we found the nurse-midwife she did examination to see whether there is remaining placenta or membrane inside the uterus, but she found nothing inside. But because I was feeling dizziness I got rest for a while before discharged me home. Also, they gave some iron deficiency drug and they advised me to eat green vegetables. My baby was saved by my mng'hunga. I really appreciate although the delivery was been conducted by mng'hunga wa jadi and she helped me a lot, I am simply never going to a hospital.

Circumcised women prefer the mng'hunga. In another site, the RA met Lunaya who had given birth to three children. She said she had her first delivery at the health centre and, then the second with the mng'hunga and she felt much more happy and rested with the mng'hunga as the language was polite and calm. As most women who are circumcised say the nurses in the hospital are rude to them - ‘muuguzi anasema kwani wakati mnakula raha mimi nilikuwepo niachie kelele zako.’

In contrast, if I failed to push, ‘Muuguzi alinichana bila ganzi, na pia alinishona bila ganzi. Kwakweli sikutamani, na huu ujauzito nitaenda kwa mkunga wa jadi.’

The Mng'hunga, the local midwife

Not surprisingly, pregnant women attend ANC merely to confirm they are pregnant and return home happy in that knowledge. They rather prefer to deliver with the assistance of the wang’hunga. They confide their fears to them as they are kind to them and speak gently to them and allay their fears. At district hospitals, health centres and dispensaries we found very negative remarks being made about wang’hunga. Mostly, the nurse midwives we met alleged that some of wang’hunga or local midwives actively discourage women from going to the hospital by feeding into their fears. But as the above account of pregnant mothers shows, the midwives are always available and women find being with them comforting as the nurses look down on them and give curt commands. In fact, the mng’hunga is much kinder, more conversational and much cheaper. She will accept low payment and, also payment in kind such as chicken, or a bag of millet, maize and dried vegetables.

They also identify with the fears and beliefs of the woman. For example, Zaituni said that it was believed that a woman who is pregnant and waiting to give birth is not allowed to eat ‘msunjilo’, that is a certain part of cow’s or goat’s large intestine. The reason is that if she eats, during childbirth ‘migongo inatoka’. The RA asked her what did she mean, and she said that there is a certain muscle that comes out which were not supposed to come out, after birth. Another woman, Asia, indicated that the muscles come out from the anus and the RA found out that they meant haemorrhoids mgongo umetoka/kiuno. All these beliefs are common and pregnant women appeared to follow the mng’hunga’s instructions carefully.

In all the sites the RA’s found on an average two – three wang’hunga. They were not often forthcoming in the beginning and maintained a silence but began to respond favourably when the RA’s showed interest in them continuing their work and asked what help they would like from the government. Often, what happened was that a pregnant mother accompanied by an RA went to meet the wang’hunga. The RA noted the procedure at each of these visits. Firstly, the mother-to-be although she walked in unannounced, was made to feel comfortable as if the mng’hunga had been waiting for her, and was always asked how she felt. and, how was her general well-being. Following that there was a discussion on her emotional well being. Inevitably, she was given some ground herbs from the trees - often, the mng’hunga refused to divulge the names of the trees or roots. But it had a visible effect and assisted the mother to feel relaxed; the
administration of herbs and chants formed an important part of pregnancy and the birthing process.

Each mng’hunga has her own individual style and her reputation is built around her practices:

For example, one traditional healer/midwife named Aisha noted how she treated her expectant mothers. She said she makes the mother lie on her back - kulala chali, and begins to chant ritual words, kuvimba.

“While doing so I move my hands on her stomach and say the following without stammering as that can be dangerous and a woman may fail to deliver safely:

‘Damba wii lyakhe’ – my hands to be light
‘Lyakhe kubusuree’ – if there is one which has missed
‘Umma upaa’ – a thing has to come out
’maafi khopoo’ – then it has to fall down

if whilst chanting I find I am unable to pronounce the words - then I refer the mother to the health facility immediately!”

Aisha the mng’hunga, in this case then advised the mother to go to the health facility.

In the interior, away from the principal sites, there were in eighteen cases, and no mng’hunga. Thus, the pregnant women in these neighbourhoods had to walk to the nearest village to be attended to by them. In these cases, more often than not, the RA’s noted that these women had not been to the ANC even once.

Martha, a mng’hunga, said that many of the women’s babies she has delivered come from extremely far off places and there is no possibility of transport. She can go there but at times some deliver and bring the baby and ask her to check if the baby born on their way to her is well. “Most of the time they deliver on the way I tell them to go to the health centre and nurse can help them. Women deeply fear cutting and surgery - episiotomy - as they feel it never heals and that is why they do not like hospitals or health facilities. They call for me and I go by bicycle to far away places and help them. I only charge chigulu chibili (2000 TSH).” The fear of their vaginas being cut is very deep as also forced delivery. Women know that childbirth is normal and the wang’hunga tend to be patient and wait for the mother to take her time.

There are many fears and misgivings that women and men experience. During childbirth the vulnerability of the foetus to spirits and bad omens is one such belief. When a mother loses her baby she is blamed because miscarriage is widely believed to be caused by infidelity, and bad spirits, jealous co-wives or lovers of the husband and, in most instances, husbands tend to be unsympathetic and are not caring of their wife who is about to deliver or is pregnant.

Image 21: Interviewing Zainab

When a danger is diagnosed, that is a baby or pregnant mothers feel unwell, Zainab a mng’hunga and healer begins the diagnosis like this--

“Hay uturrire – where are you coming from”?
“Nafumire Fyomi – I come from very far (Fyomi is the local name for Babati in Manyara region).
“Chee wujire saka – what follows here?
“Fyuuka kuri meenyu kuunu sikujuu tuku naviire nimekuwa ihungu hungu isuumbire mayasi” - go back to where you’ve come from. Here people they don’t ever come.”

“I have been hunghungu-hungu is a big bird, “Muuntu mulume, musesese, muuntu muuki nkuku lume katuuja. Kachuru kifaranga jike cha kuku kachuru kifaranga dume. Amuleta kifaranga, chukua ninguvi ya mwana - If they brought the chicken, then take a piece of calico-mbeleko and wave it to a baby twice
then throw it behind your back. If it is degedege, only God shall help the baby.”

Degedege is considered the most perilous threat to the well-being of pregnant women and their young. Many pregnant women we met were terrified even to mention the word, shaking their heads and covering their faces. ‘Degedege’, an indigenously defined medical condition translates as ‘bird bird’, is believed to be a malevolent spirit (that was called upon by a jealous or a wicked woman, usually a co-wife or lover of the father of the pregnant woman’s baby) to plague the body of their victim and, it is believed that it can suck the life out of unborn babies, their expectant mothers and, young children. The symptoms which are ‘seizures, twitching’, ‘stiff body’, ‘delirium’, ‘eyes turned white’, ‘kicking of legs and arms’, ‘froth in mouth’, ‘mouth twisted sideways’, ‘falling down’ and ‘easily startled’ cause fever and the those afflicted may die. While the correlation between homa ya malaria and seizures is acknowledged, degedege is managed by waganga wa kienji or the wang’hunga who alone are seen to be able to exorcise the wicked spirit that is tormenting or likely to take control of the pregnant mother or her baby or a child. Although local illnesses do not correspond always to biomedical nosology, they need to be taken into account.

They are also seen to be purveyors of magic and able to communicate with, to command and to control, the evil spirits. To ward off malevolence by performing rituals, it is to the mang’hunga that most women in these sites turn to before and after pregnancy. The fear of losing a baby, understandably, is so great here that all precautions need to taken – in this case, even to commune with the spirits and pacify them. Only she, they believe can understand their plight. During conception and the early months all mothers visit them as they believe they will protect their unborn baby from evil spirits. Also, their involvement with sexuality, and particularly female sexuality, is regarded by local women as reassuring. While the vaginal orifice is intimately linked with fertility and children, it also leaves women vulnerable to the invasion of milungu, or evil spirits attracted to genital blood, which may possess her and prevent her to deliver, kill her and her newborn, or even render her sterile. Their work also exposes midwives to different types of blood, the substance of life that is regarded with power to create and to destroy. In most areas, wang’hunga are the only people women trust to help them with deliveries. The wang’hunga are familiar with the vulnerabilities that many women during pregnancy experience and they give them confidence to cope with all sorts of ailments.

Agnes
She is her late thirties, maybe older. She was trained by the medical health workers. During the time of delivery she put on ‘mipira ya kuvaa mkononi- gafu’ (surgical gloves) and she disposes of them at the dispensary. If a woman wants to deliver a baby at her place her instructions are that the pregnant mother must arrive with a bucket of water for cleaning herself and, a razor blade. But as the RA noted, the water is not boiled and nothing else is sterilized. She also has uzi wa kufunga kitovu (thin thread). The RA asked her, “What was her advice when a woman is in prolonged labour due to witchcraft?” She replied that she prepared a traditional medicine called ‘Lihowe’. The medicine is prepared using leaves from the crow’s nest. The leaves are burned and the ashes are mixed with mafuta ya nyonyo (castor seed oil) and she applies it at the perineal area. The other ashes are mixed with water and the woman drinks it. After that they wait until the woman delivers a baby. The RA asked her why she preferred a crow’s nest and not the nest of other birds. She said that she was taught by her grandmother to use crow’s nest without any explanation and hence she doesn't have a reason.

If a woman is sterile as Zia whom the RA accompanied (thought she was sterile because of the curse by the co-wife), Agnes prepared a traditional medicine from roots of different trees. The trees were Mpelemee, Mnyamafu, Msada, and Mkamachuma. She mixed the roots and she added some water then boiled them. She gave it to Zia and instructed her to drink it. Then she talked to her and gave her some more powdered herbs for her to drink at regular intervals until she gets pregnant.
The RA asked her what happened if a woman gives birth to a premature baby? She replied that since there are no incubators to keep the baby, she applied castor seed oil on the baby and she covers the baby with a lot of warm clothes. She puts the baby on the bed and a charcoal stove is kept under the bed so as to provide heat to warm the baby.

Witnessing Childbirth with a Mng’hunga

Pulkeria conducts deliveries, like some midwives on the bed called ‘ulili’. The sticks are grounded on the floor and other are arranged in horizontal position. The ‘nyingo’ (animal skin) is put on it. The RA witnessed her performing childbirth when she accompanied Eudia to give birth. Pulkeria put on gloves and instructed Eudia to sleep on the bed and hold her legs. She told her to breathe deeply and, push ‘kundujitze, kundujitze, kundujitze’ meaning “push, push”. She had given Eudia some herbs and the baby was received without any problem. She covered the baby in the old kanga and pressed its nose to remove the mucous. She tied the cord after dividing it into two parts using uzi and she made a cut between the knots. She palpated Eudia on the fundal area to facilitate removal of the placenta. Then after five minutes the placenta came out. She cleaned her with kanga and warm water and gave her porridge to drink. Eudia started breast-feeding the baby after half an hour and she was given time to rest. “Maybe she will stay here for ten or twelve hours as she is so tired”, Pulkeria observed with sympathy, in marked contrast to what a mother would have experienced at the health facility where early discharge is frequent.

Nearly all of the midwives appeared to be well-off in comparison to the local standards. They were usually older women in their fifties. They, themselves often have had eight or nine pregnancies and that, in addition, gives them this authoritative status. And they were all circumcised. It has been noted that there is a noticeably widespread belief that circumcised women alone are capable of delivering babies.

Mlojani siyofunda mono yalawile kwikumbi (Kigogo) Mtu ambaye hajaenda jando hawezi kumfundisha chochote aliyetahiriwa.

“An uncircumcised woman who did not attend circumcision training she cannot be of use to a circumcised woman.”

Eva, a popular mng’hunga, told us that she uses the same mackintosh for all deliveries and washes it; it is made of plastic. She asks the mother to use her own kanga. Normally, the mother who is ready to deliver comes to her and she is made to lie on her own kanga, which she carries with her. She lies down on the mud floor- many mothers find that very comforting as opposed to the hospital bed where they had their ANC. Also, mothers are allowed to choose the position in which they wish to give birth. When a mother nods they rub oil and watch the abdomen to see if it is true labour. She then examines the cervix for dilation, njia imefunguka. She wears the gloves which the mother has brought and asks her to lie down on the ground, then inserts two fingers into the rectum to check if there is any progress of the movement of the baby's head. If the labour is long and appears to be difficult, she takes some local leaves called mazingiritonga and inserts it into the woman's rectum to induce enema and that enema or diahorroea will help the baby to come through and dilate the cervix so that the mother can deliver without any problem. She tries to avoid mfungula, a commonly administered bark from the tree to increase contractions as this it may cause a ruptured uterus because its very strong medicine and pregnant women usually die due to dakunyuma lisisilawii, retained placenta. She uses her finger to insert in the vagina and applies pressure to remove it and blood clots. She advises the mother to go to the clinic after four days for immunisation and weighing the baby. There is no special care for the newborn baby - only breast-feeding. She advises the mother to apply magadi (caustic soda) and minyyaa to heal the baby ‘cord’.

Sometimes she sings these songs to soothe the mother:

Nilkwenda barabarani nitakakuta fisi analia x 2
“I went on the road and founds a hyena crying x 2
Hallo hyena x 2
Why are you crying?
I am crying because there is water everywhere, this side no chance for me to cross the road.”

The meaning is that the hyena is a pregnant woman crying in pain during childbirth and the only way for her to be relieved of her pain is to give birth.

Note a typical conversation with the mng’hunga anonymously named ‘BQ’:

RA: What inspired you to be a midwife?
BQ: To assist mothers.
RA: How do you assist mothers?
BQ: I sometimes sing to them. And, give them herbs.
RA: What kind of songs?
BQ: Hia tl'abisoo sipbo tgkwa habooaa ci’ urigko, amanaa gkwii nxoo lhaai dtugkee. Hia uriipboooi nxo u tlaasii tlabisoodtana (Kisandawe)

“When the time for delivery has come, be courageous to push out the infant so that you can be safe and the baby as well, otherwise you may cause the death of the infant while still in the stomach.”

RA: It is not knowledge that you inherited from your mother?
BQ: No, it was when they were helping me to deliver my babies then I got some interest in joining them to help mothers. So my first test was for my daughter when she delivered and got helped by me everything went on nicely.
RA: You mean this is how you got your training course?
BQ: Yes
RA: When you helped your daughter to deliver was it her first pregnancy?
BQ: Yes it was her first pregnancy
RA: Most people believe that the first pregnancy has many complications, how do you rate it?
BQ: We had no such problems before this problem started few years ago, maybe because of modern food. We take packaged grains they have been affecting us so much, and, it is the main cause of first pregnancies.
RA: So you have not attended any other course apart from this one?
BQ: No I attended a course for two weeks it was conducted by the government and on completion of the course we were issued with gloves only, they told us that they will send to us hurricane lamps, clothes, umbilical cords threads but they did not bring those things so far.

Image 22: A mng’hunga

RA: Ok, before you attended the course what were the equipment you were using?
BQ: I was using bare hands, razor blade and a piece of soap and a basin and small piece of cloth to tie the navel.
RA: Did you ever come across some complicated cases such as an infant coming out abnormally?
BQ: Only once when twins were coming out the first one came out as usual but the second one a hand came first but I controlled the situation and they were safe and their mother too.
RA: How did you contain the situation?
BQ: I just controlled it.
RA: Any other episode?
BQ: It was a pregnant mother who gave birth to a
creature which I don't know what it was; it was like a steak of meat of about 2kgs it was not a human being, it was like that and nothing else. I have not had such other complications since.

RA: What happened to that woman?

BQ: When she got labour pain she fainted for sometime but when she delivered that piece of meat which had no life she recovered.

RA: Was this her first pregnancy?

BQ: She had some children before and she has never conceived since that episode, I think it is because of her age.

BQ: Our main problem in our clinic is lack of equipment and transport (ambulance) and also the nursing staff at the clinic who are supposed to be on duty, they are always not at their working places and at nights if you follow them in their houses they take long time to come and when they come they give abusive language to the patients and THEIR number is very minimal. The government should bring more medical staff members.

RA: Thanks very much and bye-bye.

As the conversations above show, the wang'unga have had very little formal education; in fact, in most instances, they have not received the necessary training in midwifery. They could not distinguish different medical conditions when quizzed by the RA's – for instance between a prolapsed umbilical cord, bleeding placenta previa, eclampsia seizures or placental abruption. They just labelled such conditions as complications that happen but had names for each of the conditions.

A few attended the course set up by the health administration that made them aware of cleanliness, but not much else. And, after all that was a very short course and they were given equipment which they continue to re-use. All they know is imbied from the received wisdom of their relatives which they modified according to their own experiences – that is, from their own deliveries and practice.

Advance preparations made by the Wang'unga:

The information below describes the advance preparations made by wang'unga for conducting deliveries; clinical procedures normally undertaken during deliveries by them and actions taken in case of difficult deliveries and maternity emergencies.

Virtually all wang'unga make some preparations before conducting a delivery. Very few of those use boiled or hot water. And what is worrying is that very few of the wang'unga keep some clean water and soap. Most wang'unga prepare in advance some materials for cutting and tying the cord. And, we found that most cases, in the interior, the majority of the wang'unga use medically unacceptable materials such as the reed, or pieces of broken bottles to cut the umbilical cord. There are some who use a new razor blade, and usually, it is because the pregnant women purchased them, or their mothers did.

Wang'unga keep and use sisal threads, and pieces of cloth to tie the umbilical cord. Squatting during delivery was a position preferred by a significant number of the wang'unga. Most of the time, they appeared to allow the pregnant mother to deliver in the position of their choice. Some of the wang'unga were not tying the cord before cutting it, leaving the cord stump too long or too short. None of the wang'unga was using any kind of prescribed medical dressing for the cord stump but were using herbs, cow dung, red ochre, soil or ash to cover the cord stump. All these products are known to be potentially harmful to the newborn.

It was also discovered that wang'unga carried out unsafe maternity procedures which are often associated with loss of lives of mothers and newborns. Whilst discussing their experiences, nearly all said that they attended to breech and multiple pregnancies, conducted deliveries as they thought was fit; re-used their cord cutting tools and, in the case of haemorrhage, preformed manual procedures within the reproductive tract of delivering women. They also described how they assisted in abnormal and complicated deliveries:
“Push, push the flesh; if it gets cut it cannot be mended again.”

The RA’s asked the mothers who had delivered to describe their births and also asked the wang’hunga what they did when it was a case of difficult situations such as retained placenta? The wang’hunga initially take no action and observe the mother’s bodily movements and they make her drink an herb preparation to expel the placenta. We documented a number of potentially harmful practices including applying fundal pressure while waiting for the delivery of the placenta, gentle traction of the cord without external support for the uterus, external massage of the cord while waiting for placenta delivery. They also carried out two or three of the following procedures:

"Put a hand into the vagina/uterus and pull the placenta out"
Winjitze umuwoko mugati ye ng’huma (nhutu) wibate limama ulikweje lilawile kutnze.

"Apply pressure on the abdomen/uterus"
Kandamitzaje inda ye mkombi.
(Mkombi is a pregnant mother)

"Ask mothers to blow and breathe."
Mlonjelaje mkombi yakundujitze mwana kwa muhe.

"Give ground herbs from the trees and grasses (to expel the baby from the birth canal or to stop bleeding)." Administered in this case — ground paste of mtakalang’onyo (Euphorbia).

Mpelaje miti ya usungu yalele mbela.

"Apply oil around the vaginal orifice and pour some inside it."
Mbakaje mafuta kupilima ng’huma na ganji mbakaje mugati ye ng’huma.

If all these above procedures fail or the midwife gets a bad feeling then:

"Refer patients to a health facility".
Mlonnjelaje yabite ku sibitali.

Such practices are extremely worrying as they increase the possibility of a PPH or other problems such as uterine inversion.

In the case of all kinds of distress of the newborn, for example, when the baby fails to cry at birth, the wang’hunga were reported to:

“Wash the baby in cold water"
Wakuwatajila wana mu malenga ge mbeho.

“Splash cold water onto the baby"
mnyunyitzilaje mgalika na vilenge vya mbeho.

"Slap the baby"
Mtowaje mgalika hadodo.

"Breathe into the baby"
Thus, in spite of the overall positive responses from the majority of local women about their mng’hunga, there were cases of deaths that were recounted by families of women who had died after going to the mng’hunga. And, more often that not, the mng’hunga never admitted that such maternal and neonatal deaths occurred on account of her incompetence. Thus, there is a critical lapse that such deaths cannot be recorded. We heard about nineteen stories and those below are typical of the accounts we heard in general.

Elinda began experiencing contractions and her husband took her to the local mng’hunga. She delivered a female baby but retained placenta—lakunyuma lisilawile—needed urgent attention. They lived seven kilometers away from the nearest health facility. And she died before any help arrived. It was very tragic as her young children were also left behind without a mother. In another instance in the same area, that occurred a week or ten days later—a pregnant woman died due to lakunyuma lisilawile, retained placenta. Another mng’hunga gave her some herbs to prevent the bleeding but the mother was unable to survive—neither was her new-born baby who also died after five days. Neither this maternal death, nor the baby’s death was recorded.

In a third instance, in another site, the mng’hunga washed the baby in cold water and shortly after that the baby stopped breathing. And, in one the mng’hunga beat the woman and her thighs were covered in bruises as she was unable to push as the mng’hunga ordered her to. In another instance, Furaha narrated how her sister had come from Chamwino and was working in Dodoma town. There she met a ‘rich’ man who bought her gifts, impregnated her and left her. She had little money with her and, unable to afford the payment that she was asked to make, died during childbirth at the mng’hunga’s home. The baby died with her.

Despite all these very tragic stories our research uncovered, it supports the findings of the Ministry of Health that most women still prefer giving birth at home. They reply when asked “what would make you feel comfortable in the health facility:”

Mng’hunga yanhapata mwingila mbagoyalute nayo kusibitali yakamlelese hamuredi na nesi. They say “they would like the mng’hunga to accompany them to the health facility and, to assist the nurse.”

But what is clear is that many wang’hunga feel that they are doing a good job and helping the pregnant women in a way that medical staff at the health centres and dispensaries cannot. Also, they do not see that they are doing any differently from the health centres. They also wish to work in the health centres and dispensaries and assist the nurse-midwives.

Narrative from a mng’hunga

RA: I have been told that you are a mng’hunga, is it true?
AK: Yes it is true.
RA: How did you become a mng’hunga?
AK: I inherited all the learning from my mother, but presently I am not practicing any more due to the orders from the government that wang’hunga should stop practicing.
RA: You have said you inherited the job from your mother?
AK: Yes she taught me practical training when I gave birth to my third child, after she had done to me when I started to learn the ethics of mng’hunga so I continued to work under her supervision and finally she commissioned me to go ahead. Finally, she resigned due to old age, so I took charge fully.
RA: During those days which equipment were you using, the modern equipment used in hospitals today or different equipment?
AK: I was using gloves, razor blades and soap for washing hands after the
completion of the exercise, but after attending a midwives seminar at Kwamatoro I started using modern equipment.

RA: Did you find any difference between the course which you were given by your mother and the seminar conducted by the government.

AK: Very slight difference but they resemble in so many ways.

RA: How do they resemble?

AK: My mother taught me to understand different stages of pregnancies, to the time when a pregnant mother is ripe for giving birth and at the seminar the subject contents were the same.

RA: Can you tell me in short the symptoms of a pregnant mother who is ready to deliver?

AK: The first thing she gives out dirty things and then the vagina widens after that the bottle breaks up and the infant comes out.

RA: Do you remember during your working days how many pregnant mothers you were attending monthly and if they used to come to deliver at your house or you were going to their homes?

AK: I cannot remember because I was not keeping records but if I am not mistaken at least five a month and both of them in their homes.

RA: What about the hygiene of a birthing place?

AK: I was making sure that they prepare a good area, warm area, clean clothes, new razor blade, gloves and soap. This was after I had attended a seminar, but before attending the seminar I was using knife to cut centre point.

RA: So you mean cleanliness of a birthing area had been insisted since even before you attended the seminar?

AK: Of course yes.

RA: What about pregnant mothers who stay far away from clinic centers, were they coming to you for clinical advice?

AK: They were coming in very large numbers and we were giving advice but we were insisting to them to go to clinic centres.

RA: What were you doing to the women who came to you with premature pregnancies?

AK: I never attended even one during my career but my mother taught me how to attend such cases, the first thing you keep baby in a warm room and then rub the baby with palm oil over whole body but if a mng’hunga gets such a case it would be good to transfer the case to a hospital, because premature is very complicated case.

RA: What is your contribution to the main causes of mothers and infants deaths during and after delivery?

AK: Actually the first pregnancies are very complicated if the size of the vagina is small and she needs scissors to add the size. I as a mng’hunga I cannot attend such a case, so that may lead to death of an infant or both of them though wang’hunga often do that. The good solution for her is to go early to the hospital, sometimes we were giving some local herbs to relieve the pain and give her time to reach the hospital. Long distances to the hospitals lack of transport to the hospitals and sometimes they may reach at the clinic centres on time but because the clinical staff members are not around also may cause deaths.

RA: Do you think it is right for the government to stop wang’hunga practising?

AK: It is not right if you attend a woman who is supposed to go to clinic to register the baby and, also for inoculation so if they come to know that she delivered outside the clinic centre they fine them Tshs. 10,000/= but I assure you that some people have decided to come to us because we attend them nicely and we only charge them Tshs. 5,000/= for the whole childbirth service. In clinic centres they say it is free medical services for mothers and children below the age of 5 years, this is simply not true! I assure you that all mothers are charged Tshs. 8,000/= if they go to deliver at the hospital; this is pure corruption. I wonder why the government is lying to us and saying that medical services are free; if you don’t believe my words you make a secret investigation you will come to get the truth. It is only exaggerations that wang’hunga are not experienced. We can work together with clinic centres if they need our services for mothers, but they have the power to enact by-laws which omit us because they are greedy for money, it is they who conducted the
courses to us and when we started to work together with them they came to realize that the income they were getting from pregnant mothers had reduced to nothing. So they came with an idea of stopping us and they won. The main problem is money and nothing else.

RA: Before we finish our conversation do you have any thing you want to add?
AK: Listen my son! You know when the time for a person to die arrives no one can stop it. There women who go to deliver in modern hospitals but, nevertheless, they die during delivery. Going to deliver to wang’hunga doesn't mean that they go to die; the government has stopped us doing the job, but I assure you a lot of pregnant mothers have been coming to us because of the low charges and good services and there is no corruption; but if they go to the clinic centres they must give bribes in order to get better service. If you don’t have money they don’t pay much attention. We advice our government to have a meeting with us and give us chance to explain to them about the problems facing the pregnant women in remote areas and the projects arranged by the medical staffs in rural areas who cheated the government leaders to monopolize the delivery of mothers alone. We urge our government to look again on it. We attended a course and we were not issued with our certificates of attendance.”

Indeed, it is worrying as such harmful practices contribute to maternal morbidity, mortality and neonatal deaths. These and many more reasons emphasize the acute need for health-care providers to initiate and to develop a better understanding and cordial working relationship with wang’hunga. Better service provided by wang’hunga also means fewer complications with home deliveries; less work for medical personnel and ultimately safer deliveries for all women in the country and a corresponding reduction in maternal and perinatal morbidity and mortality.

Certainly, the childbirth practices need to be discussed with the wang’hunga. But even when training has taken place and precautions are in place, trained midwives did not appear on the medical service staff lists and, crucially, they are not invited to assist at the health facilities. This is a serious omission. Their presence would encourage many women to attend the facilities. These issues will be discussed in the Section on Interventions.

Mainly because they are seen to have supernatural powers healers, both men and women, command great status. The traditional healer communicates with the mizimu (ghosts), mahokas (ancestors) and malaika (angels) so these mediums can communicate what problem the patient has through the traditional healer. But before this a patient should give some money so that the angels can be willing to tell what the problem is and what is proper for treatment. Sometimes the traditional healer gets money from the patient and speaks some words (kunuizia) during the night while the patient is asleep. The main aim is to identify the patient’s problem and the treatment through dreams from malaika (angels). After that, the treatment starts.

Administration of traditional medicines
- The medicines are dried and ground into a powder form.
- The medicine is boiled and it is used through topical application, bathing or oral administration.
1 The duration of using the drug depends on the prognosis of the disease.
2 If the patient does not feel better then the traditional healer changes the medicine.

Types of medicine

The medicines are from different type of trees and they are prepared from leaves, roots or bark. It was found that the bark of the tree or the leaves were pounded and mixed with water.

Examples, but by no means exhaustive, of some of the more commonly-named trees in Kigogo with the Latin equivalents are:
2 Mkungugu – Acacia Tortilis
Male healers

Like the mng’hunga, the mganga wa kienyeji’s importance cannot be underestimated. Many men go to them with sexual problems such as failure to have an erection, kiumeume. But for them to discuss it with anyone was not done, it was a matter of honour and male pride. The RA’s found that male healers also were very secretive and guarded about other men. But they did say that most men came to them as they wanted to remain sexually vigorous and fertile for a long time or they feared that someone wicked could bewitch or harm their sons.

The waganga with the watemi or village elders command strategic powers. It is thus interesting to note that village executive officers and henchmen from government seek their help. Msonga is in his mid forties, maybe older, is a highly regarded mganga wakienyeji at one site. But he said, “I am just a local medicine man and deal with minor issues. He plays down his power and importance as most of the village go to him. He has seven wives and rotates every night between each of them. He told the RA, “We give herbs according to what they tell us they are going to do to the person. My father is a big traditional healer and can do all kinds of healing! He lives in Maumi forest with his 50 wives and 374 children.”

They spoke openly about women without mentioning names. And, while they were happy to discuss treatments with the RA’s, they were not going to give their secret cures away. Their strength they were aware – like everyone here – lay in their secrecy. But common remedies they prescribed came easy as people were also in the know. An informative traditional healer in his mid seventies is Mr. Mnyole. When the patient reaches Mr. Mnyole’s treatment room he expresses how he is feeling, and Mr Mnyole administers accordingly, “Anaagwa na kuchimba dawa ili kumtibu”. He said that he started the work since he was about 30 years old when his father died - Akamwachia mikoba. He talks to mizimu (ghosts) and they show him which tree and where he can find it so that he can begin to treat the patient. The trees he commonly uses are Mnyamafu, Mngw’elangw’ela, Ngangamala and Mkamachuma. He usually takes the roots and gives the patient the powder to boil and drink until he feels well.

Image 23: Administering herbs

Another well-reputed healer said, “Mostly, I use this method for treatment ramiri au bao – to diagnose using traditional methods that get rid of evil sprits milungu. When a woman is expecting a child she comes to me and when she has difficulties in delivery I assist her by giving her a potion so that the milungu that are causing obstructions in her delivery will cease to have a hold on her. The roots he uses are mkakatika roots and mtafuta roots and after boiling them the patient drinks the water. He also dries roots and mixes them for the application on the body with Vaseline or oil.

“Love is what all want. I make mwendeso a love potion which is very powerful as it is medicine that causes a man to fall deeply in love with a woman so that he is always thinking of her day and night!” That is why many women whom the RA spoke to said they go to him to take it and hope that their man “will provide us with all our needs food, shelter and clothing, rather than going to the kangare and drinking ujimbi he comes
home and stays with me. It helps him to take care of the family. But also when you see a woman asking for mwendeso that means she fears that the man or husband does not love her anymore."

He has thirty goats and one hundred and fifty heads of cattle - he is regarded as wealthy. He cannot read but he is knowledgeable about trees and the human condition and will talk at length about it. “We have plenty of water here thus, Mikakaatitha, Mibuuyu and Midani trees are many. We need these trees for the health of women and children.” Clearly, they acknowledge that the needs of traditional medicine are directly linked to biodiversity and ecological enrichment.

Wang’hunga and the Waganga wajadi serve as good psychologists and social healers. Talking to them is very pleasant as they have a deep understanding of what women and men really experience at the ground level. They also learn about their unhappiness and sometimes act as confidants and render advice to them. They need to be taken on board in facilitating health field-schools and educating the women as they command great respect and trust in these villages.

Some traditional healers have a wide knowledge of symptoms and can distinguish between different diseases and illnesses. For example, many healers were aware of different manifestations of malaria and attributed to them different local names, which match the scientific terms which describe the different types of Plasmodium falciparum malaria, such as cerebral malaria, clinical malaria or febrile type, and gastrointestinal type, respectively. Differences compared to western medical knowledge were found in the conceptualisation - such as in its causation, and in the fact that severe malaria in children may not be perceived as being associated with malaria.

A note on Traditional Medicine

The importance of traditional medicine (TM) cannot be denied. The healers and wang’hunga are seen as the very source of sacred knowledge and are the first port of call by most people both in rural and urban Dodoma.

It is noteworthy that during the last decade the Government of Tanzania has addressed the need for legislation in the interests of promoting national health needs. Traditional healers need to be inducted and integrated into mainstream health care through the formal establishment of practitioners. There is now a record of traditional healers who belong to the ‘Chama Cha Waganga’, the society that is recognized by the government to promote traditional medicine but it needs to be made mandatory.

These critical measures, if followed, have weighty implications for biodiversity and could ensure environmental protection of the rich ecology. Two of the botanically most important ecological zones in Tanzania are the coastal forests and mountain forests; both of these suffer from severe degradation, 70–90% of forests outside Protected Areas being destroyed. Much of the medicinal plants the healers told us about are found in these zones. They go to these areas by foot or by bus and collect the plants themselves. By introducing new regulations and laws which aim is to use the genetic resources for the benefit of present and future generations, the healers feel confident that they can continue to administer medicines. The main legal framework seems to be in place, but the slow procedures of making the laws operational endanger its accomplishment. In addition, legislation related to the international trade in plants should be clarified and co-operation between agencies to implement existing laws should be promoted. This is also important as diagnosis and treatment of psychological and medical illnesses based on local knowledge and socio-cultural and religious beliefs, developed over centuries by local people within their belief systems and specific environmental (particular biodiversity) conditions of a particular area will contribute to participatory community development and establish links with the health services.

The traditional healers are regarded with skepticism by the health workers and many healers are regarded as confidence tricksters. But this needs to be investigated as some of them appear to have a sophisticated understanding of herbs and trees.
Furthermore, due to the lack of access to proper conventional health care systems, traditional medicine is often the first choice for providing primary health care since the accessibility to conventional medical doctors is very low compared to that of traditional medicine practitioners. This is a legacy of colonial rule when traditional healers were perceived as evil witch doctors who by virtue of their symbolic power undermined the colonizers authority. The vast corpus of pharmacopeias and sophisticated understanding and prescriptions of ethno-medicine needs to be seriously considered as it will allow for much more easy access for administering medicines across the health sectors.

**At the Health Facilities:**

**Narratives from the Health Workers**

At the health facilities the RA's found the health personnel forthcoming and helpful. They permitted them to watch the ANC examination and, in few instances, the RA's were allowed to assist if present in the vicinity of the facility.

Whilst in conversations with the health personnel, it was found that all health facilities were severely short-staffed. And, also in seventeen instances the relevant personnel, a trained midwife nurse attending to pregnant mothers and babies were not present. Nurse trainee or medical attendants were delivering babies. At the various levels within the health facilities studied, be it a hospital, referral, health centre or dispensary, there was an acute shortage of equipment, and medicines remain an overriding concern. Thus, all the health personnel rightly complained of the shortage of basic equipment including for example a lack of a microscope and Laboratory facilities. Some of the neonatal deaths could have been averted if they had oxygen masks - neonatal deaths in many cases were on account of birth asphyxia.

Also, as there are not enough laboratory facilities to identify STDs “The obvious ones such as GDS-Genital Discharge Syndrome, GUS-Genital Ulcer Syndrome, and PID-Pelvic Infection can be identified but what about the less obvious ones? Thus it is difficult to treat diseases such as Schistomiasis, Chlamydia, and malaria. We need to do tests and we cannot here. Macerated births could happen due to STDs and we cannot sometimes inform the mother beforehand” said a medical officer. “We also work under rather difficult circumstances; the kerosene supply we depend on is not always reliable and during the rainy season it is difficult to get wood. Thus without electricity how were they supposed to maintain the vaccines.”

What about sterilisation? “We were taught this technique”, said one nurse. The sterilisation of equipment is done in (Sodium chloride) jik solution for ten minutes and then it is soaked in soapy water for another ten minutes and boiled for thirty minutes. “That is Okay” she said, rinsing her hands. The Directives pasted On the walls of the health centre, indicated such procedures to be appropriate. Clearly this needs to be looked into urgently.

There was in general a shortage or lack of availability of water and this is extremely worrying. Mothers had to purchase water. Sanitation in most of the facilities thus was extremely poor. And, the lavatories in these facilities were also a cause for worry. Mosquito nets in most places were worn out and the wards were not mosquito-proof. No wonder many women said they caught infections in these facilities and regarded them as morgues.

**Image 24: Walking to outreach**

Although transport is a major issue, it is important to establish sanitation and civic facilities. After that, feeder roads need to be built. The distances between the facilities and outlying villages are considerable. And, referral hospitals at Hospital or the district hospitals are impossible with the
bad roads. “There is no transport, thus we cannot even visit the outlying villages and women cannot come here as they have to walk all the way or come by bicycle with their husbands and that is not possible because hardly anyone has a bicycle.” The health care workers are supposed to walk a distance of forty kilometres every month so as to provide Maternal and Child Health Services in many of the outreach villages. A car comes from the hospital as it did from Kongwa hospital. It came every month to take Mr. Masahai, a health worker, like many here in this region, to another village so as to provide the MCH service; otherwise, if there is no car then there is no service in that month at the village.

Thus, the health centres cannot provide service for the population and cannot provide assistance in referral matters or difficult labour pains. Relatives of the patient or mother have to find means of transport which are motor bike – piki piki – bicycle and cow carts, and mkokotweni. A journey from Fufu to Hospital, for example, takes fourteen to fifteen hours. We found at various chigonelas pregnant women undertake these perilous journeys, usually by foot, sometimes with fatal consequences.

Clearly, the delay in reaching the health facility is influenced by the cost and time of travel condition of the roads and the reliability of vehicles. The roads are impossible to traverse and require a sturdy 4 X 4 vehicle. But it was also found in many cases where women lived close to the health facilities, they continued to deliver at the mng’hunga.

Case-study of a Health Centre

At one health centre there are only four health workers, a clinical officer, a nurse-midwife, nurse auxiliary and a medical attendant. There should be one AMO, three nurse-midwives, and one nursing officer. “According to the rule there should be at least ten workers here. We cannot go on our annual leave as there is no one to replace us here.” We found short-staffed health facilities and overworked health workers in nearly all the health facilities.

The health workers of all ranks complained that they are run off their feet. They have to attend to OPD and all the patients and the pregnant mothers. One nurse, Juliana said, “We have to attend all departments such as OPD in the ward, labour ward, delivery room, dressing room and injection room. It is hard to imagine how anyone may attend to all departments at the same time? If in the delivery room there is a woman who is having a contraction how can a nurse go to assist her? And other emergency patients, they should be waiting?” Another nurse midwife, Aisha remarked, “We are working under very difficult conditions... especially when we get emergency cases, for instance when three mothers are in labour at the same time, sometimes they call the patients to assist them and this problem is known by the authorities at the national level, but it seems they do not pay much attention.”

Also, the Clinical Officer and other health workers blamed the central government and the local government of reneging on the agreement. No promotions are given. “I blame the central government... they ignore the agreement... that after three years of good service, we must be promoted but sometimes it can go up to seven years without promotion and upgrading courses. It is very discouraging but because it is our professional job what can we do?” Esther, a midwife nurse added, “The district council has all our employment records and sometimes they remind the central government by writing but there has been no action taken so far and, the only way is to be tolerant.”

She continued, “Although the health facility was constructed with a water tank in 1970s as Mwalimu Nyerere planned it was working well... however, the water supply has been disconnected a long time ago... the equipment needs be replaced...a pregnant mother consumes about five buckets of water a day and we need some for our own use. Water costs about TSH 100 for fifteen litres, which they charge the patients. The delivery facility is also open so passersby can see a mother giving birth and this is very bad. However, she did not see this as a cause for them not wishing to give birth
here. She said without sympathy “Thus far, the response of the pregnant women is not good as they fail to deliver in the clinic. At present we have formed a team of volunteers in the area to monitor those who deliver at their homes and they are fined 10,000 TSH and the money is used to strengthen the volunteer groups.” She noted that there is a need to construct a private birthing room, a laboratory and for the installation of good equipment. This is important to note as many women during childbirth value privacy as much as they do politeness.

“The main hospital is 65 kilometres away and it takes five hours for an ambulance to arrive. We had a case of a mother a few weeks ago and informed the District hospital for an ambulance. She arrived here as she was bleeding. Her baby had died shortly after she gave birth with the assistance of a mng’hunga and was brought in but, she also died on account of severe bleeding... If a baby dies when a mng’hunga assists no one says anything... but if the baby dies in the clinic the families are furious and want an investigation of the baby and dead mother by the central authority.” The Clinical Officer added that the police should co-operate with the heath administration in recording the number of deaths and births.

Overall, the health facilities have important information on the number of pregnant women in the villages. But in general, the records are poorly maintained and in some dispensaries no records are kept or, in other cases are missing. Also, the routine data collection did not include the types of complications pregnant women had experienced as we matched the records with the accounts by the women as much as we could. Much secrecy shrouds record keeping, but after a lapse of time and repeated assurances of anonymity by the RA’s, the health workers discussed some cases where maternal deaths had taken place and, said they could not write things down for fear of dismissal. Two of the RA’s checking these records at a health centre and another at a hospital were told by the health workers that they were aware of the discrepancy between the data they had collected and the data submitted.

“Iligundulika kwamba takwimu tulizopata hazikulingana na zile zilizopelekwa wizara ya afya kutoka wilayani.”

Only those women who visit the health centres have been recorded, the number of women who may be pregnant and have not visited the health facility is not known. In these sites they found that a number of women had come for antenatal check up and thus, were recorded as pregnant. Since then, they had not appeared again. To find out the number of pregnant women the mng’hunga appears to be a much better source. They may also know how many abortions (known as alela lifwiye) were performed, or how many miscarriages occurred, as they are the first to know given the importance they and their ritual knowledge are accorded.

What did some of the medical personnel in these health facilities think of the mng’hunga? They were contemptuous of them: “They are to be banished as they do no good.” Many of the health personnel do not belong to this region but are posted there and they speak Kiswahili but rarely seek to communicate in Kigogo. In one health centre as in many where the local language is simply not understood, the Assistant Medical Officer diagnoses symptoms through sign language for example, and then arrives at a conclusion as to what he believes the affliction might be. Thus communication in local languages is a paramount consideration if community participation is to be initiated. And, those who can speak and translate must be paid as community workers.

The health workers maintain a superior attitude vis a vis the local populace. Some comments: “It would help if these people got some education;” or, “They are so dreadfully backward, such beggars and stupid they come here at the last minute and then naturally either they are likely to die and their baby also with them”. Another said, “Well, some of these women are so dirty and full of sores - they need to wash and come here - so shameless.” “Do you advise them?” the RA asked. “What advice can I give? Will that help? I do not think so,” remarked the nurse. When the cleaner was asked why did she not wash after childbirth, the nurse remarked on her behalf that was not her job and it was the responsibility of the pregnant woman as it was feared that
cleaning someone else's blood would be infectious. However, it was found that in nearly all the cases, the relatives of the pregnant mother's family were made to wash the blood with bare hands and also clean the floors while the nurses, who wore gloves, just looked on. These issues need to be addressed.

Case-study of a Dispensary

As a rule, as in the case of the health centre above, water scarcity is widespread in this region and, during the summer months, without respite. At all the sites visited by the RA in one district, there was no water at the health facilities. This is a very big problem as patients have to come with water so as they can take medicine. The worst thing is that women who are in labour are required to come with a bucket of water for cleaning after delivery, to clean the delivery area and wash the clothes. The pregnant woman's mother or aunt carries the water in a plastic bucket on her head! Water is not boiled and not sterilized. There is no mackintosh and so after one delivery the relatives or the wahudumu took the mattress (which had a black plastic cover) to wash and dry it.

The dispensary has two rooms for attending patients and one store room for storing drugs and equipments (refrigerator, weighing scale, gauzes etc). One room is used purposely for antenatal, natal, family-planning and immunization services. The other room is used for attending patients who are suffering from malaria, gastritis, eye infection, acute respiratory infections and sexually transmitted diseases. There is also no electricity or power in the dispensary. It runs on kerosene and gas. There is a refrigerator that is used to store immunization drugs and ice packs which uses gas and sometimes kerosene as a source of power. There is also a kerosene lamp used during night in giving the delivery service to pregnant women. Kerosene is also used in the kerosene stove - jiko la mchina - to boil the instruments and sterilize them. These include scissors, forceps, kidney dish and galiopot.

There are no intravenous fluids at the dispensary although the worker in charge ordered them. There are three health care workers who are serving as 'doctors' although they are not qualified to do so, simply because there has been no 'doctor' that is a clinical officer appointed at the health facility for over five years. The health care workers at dispensary are: a Senior Maternal and Child Health Aider (in charge of the dispensary), a Senior Medical Attendant and a Nurse Attendant. Nurse Ana claims that she was told to refer patients to the health centre in case the patient requires intravenous fluid. This is too dangerous, especially for women who are in labour and needs Ringer's lactate solution for providing energy or 5% Dextrose solution. Many of the pregnant mothers who arrive there exhausted and in a state of collapse.

Disinfectants, antiseptics

16 cresol saponated (Lyso) liquid o.5- 5 litres- 21,500/=  
17 povidone iodine liquid 0.1- 250mls- 1,300/=  
18 Jik (unknown strength since they are given in a plastic bag since last year and not in 5ltr containers. This can lead to contamination of the liquid.)  
19 Acetamide

Medicines affecting the blood

20 Ferrous sulphate+ folic acid tabs 200+0.25- tin of 1000- 3,500 TSH

Vaccines

21 Measles vaccine  
22 Polio vaccine  
23 Diphtheria, Pertussis, Tetanus and Hepatitis B vaccine (DPT-HB)  
24 Tetanus toxoid (TT)  
25 Bacilli Chalmette Guerin vaccine (BCG)

Equipment at the facility

The building itself is not at a satisfactory level as a dispensary since it was
intended as a mch clinic wheh built in previous years. The OPD is on the west side and the clinic on the east side. There are not enough chairs and benches for patients and pregnant women while waiting for health service at the dispensary. There is not enough stationery for report writing and documentation. For example, There are no ball-point pens, and no blue ink for the official stamp. (The stamp is used for finger prints for pregnant women who do not know how to write.) The equipment that are not available yet are necessary include:

26 Delivery kit
27 Sheeting rubber mackintosh to cover the bed
28 Apron to cover a nurses cloth
29 Hospital blanket to warm the patient
30 Glucostic and albustick to test for sugar and albumin respectively
31 Intravenous fluids, dextrose, normal saline and ringer's lactate
32 Oxygen cylinder for oxygen therapy

The above equipment is necessary before, during and after labour.

The dispensary is supplied with drugs and equipment after every three months from the medical store department (MSD). The following is a list of drugs available at the dispensary:

**Anti malarial drugs**

33 Artemether Lumefantrin tablets- 120mg/20mg
34 Amodiaquine tablets- tin of 1000- 15,000/=*
35 Amodiaquine syrup suspension 50mg base/5mls- 400/=*
36 Sulphadoxine Pyrimethamine tablets 500mg/25mg -tin of 500- 12,400/=*

**Analgesics, Antipyretics, NSAID**

37 Acetylsalicylic acid (Aspirin) tabs 300mg- tin of 1000- 1,800/=*
38 Paracetamol tabs 500mg- tin of 1000- 3,300/=*

**Antiallergic and medicines used for anaphylaxis and shock**

39 Chlorpheniramine tabs 4mg- tin of 1000- 800/=*
40 Adrenaline injection 1mg/ml- 2,400/=*
41 Chlorpheniramine injection 10mg/ml- 1,300/=*

**Anti-epileptic and anti-convulsant**

42 phenobarbital tabs 100mg- tin of 1000- 5,600/=*
43 diazepam injection 5mg/ml- 10×2ml- 1,300/=*

**Amoebicides**

44 Metronidazole tabs 200mg- 4,000/=*

**Anthelmintics**

45 Mebendazole tabs 500mg- tin of 100- 3,600/=*
46 Mebendazole suspension 100mg/5ml-30ml- 300/=*

**Antibacterials**

47 Amoxicillin capsules 250mg- tin of 1000- 26,000/=*
48 Nitrofurantoin tablets 100mg- tin of 1000- 3,400/=*
49 Phenoxymethyl penicillin tabs- 250mg- tin of 1000- 14,000/=*
50 Oxytetracycline eye ointment 0.10% 5g- 250/=*
51 Oxytetracycline + hydrocortisone eye/ear tube 3.5gm- 900/=*
52 Cloxacinil injection 500mg- 50 vials - 8,200/=*
53 Procaine Penicillin Fortified inj. 4MU-50 vials - 16,000/=*
54 Ciprofloxacain tablets 250mg- tin of 100/-- 2,000/=*
55 Amoxicillin suspension syrup 125mg/5ml- 10,200/=*
56 Chloramphenical eye ointment 1%- 16,300/=*
57 Co-trimoxazole tabs 400mg/80mg- tin of 1000- 9,000/=*
58 Erythromycin tabs 250mg- tin of 1000- 28,000/=*
59 Benzathine penicillin fortified inj. 2.4 MU- 50 vials- 16,100/=*
60 Benzyl penicillin inj. 5MU- 50 vials- 17,800/=  

Anti-spasmodics  
61 Hyoscine-N-butylbromide tabs 10mg- tin of 500- 14,600/=  

Fungicides medicine  
62 Candigen cream (clotrimazole) ointment 20mg tube- 400/=  

Anti-acids  
63 Magnesium trisilicate BPC tabs- tin of 1000- 3,000/=  

Anti-diarrhoeals  
64 Oral rehydration salts (ORS) for 1 litre powder- 100 satchets- 10,000/=  

Oxytocics  
65 Ergometrine injection 0.2mg/ml- 1,300/=  
66 Oxytocin injection 5 IU/ml- 1,800/=  

At another health dispensary the only one in attendance was the health attendant who was not qualified to do the work of a nurse-midwife. The clinical officer was away and did not report that he was on leave. The other health worker is another health attendant. And, thus she, Veronica is not happy. She earns in total 130,000 TSH and her take-home pay is 52,000 TSH. “How can I manage? I do not have enough money for my household, no kerosene and little food. No travel allowance and I come from Tanga.” Veronica continued and said she sees seven pregnant women per day and does the ‘usual’ procedures or tries to. “I don’t understand why the government does not care at all. Although 73 came to ANC after six months – only 23 delivered and 53 went to mng’hunga or traditional birth attendant. We do not know their fate as no one has returned to register the babies for vaccines.” Maybe they have gone to Dodoma or Hospital but she is not sure. Thus facilities in the health centre are not good and women are not comfortable coming here.  

In a large number of dispensaries we found a lack of trained staff – especially nurse-midwives who were registered as being present but were absent. This is worrying, as outreach work cannot be carried out by others less qualified.  

Case-study of a District Hospital  

The health facility is at the level of a hospital. The hospital serves 188 villages in the district. The hospital has a total of 72 nurses, two medical officers, of which one is a district medical officer and the other one is a dental surgeon, 9 assistant medical officers and 10 clinical officers. Both AMOs and clinical officers perform surgical procedures for all patients who need operations because the hospital does not have any specialist. Among the 72 nurses, 29 are trained personnel and 43 are medical attendants. Furthermore, the hospital does not have a pharmacist and therefore one nurse acts as a pharmacist and manages the hospital medical store. The hospital also provides maternal and child health services to all the 188 villages they serve once per month. They use the three cars they have for taking the nurses to these villages.  

Image 25: Newly delivered in hospital  

The hospital has an outpatients department, a pharmacy, a theatre, medical store, laboratory, RCH building and patients' wards as well as one building which is used for paediatric clinic services. The medical store is a small room with one fridge and consists of many boxes with medicines in them. The room does not have enough air as it uses two fans because the air conditioning is not working. This situation of...
having insufficient air can possibly endanger the safety of the medicines as they can be damaged by high temperature and become toxic or inefficient for human use.

The RCH building is a new building; it is clean with enough benches for pregnant women who attend the clinic to be seated. It has four rooms: one room is for counselling services, the second one is for examination purpose, the third one is for PMTCT services whereby the pregnant mothers are tested for HIV test after counselling, and the fourth one is where the pregnant mothers sit and wait for the clinic services. There are only two nurses who provide the clinic services daily. They are overworked and exhausted.

Among the 9 patients’ wards, 2 of them are used as antenatal wards where pregnant women who are about to deliver but are not in labour wait for delivery. These women come from villages which are very far from the hospital. The wards are over-occupied because one ward (Ward #3) has only 17 beds but there are 58 women whereby two to three women sleep on one bed at a time and others sleep on the floor. The second ward (Ward #9) has 11 beds but there are over 35 pregnant women at any one time.

Both wards (#3 & #9) have beds with mattresses, bed sheets and blankets but the bed sheets are not clean, and the bulk of the space in these wards is occupied by luggage owned by the women who have been admitted in respective wards. Ward #3 has mosquito nets on each bed but they have lost their colours (white) and become brown due to dirtiness and have holes. Ward #9 does not have mosquito nets and the RA was told by one of the pregnant women admitted that the nets had been taken to the laundry four days ago.

The two wards are cleaned each day by the pregnant women themselves, they also collect food from the kitchen (two of them) in the bucket to the wards and serve the others. They drink porridge in the morning, ugali with beans in afternoon and at night except on Tuesday and Thursday when they are given rice and beans as a lunch meal. The women drink water from the tap and others fetch drinking water down the stream which is nearby the hospital. This is not safe because they do not boil it before drinking which can lead them to suffer diseases such as typhoid and cholera. The type of meal given to them lacks vegetables and fruit, which are very important for health.

The hospital also has a maternity ward which has six fixed members of staff. The ward has a capacity of occupying 20 beds whereby three beds are in the labour room. However, each bed carries two women with their babies at any given time except the three beds which are in the labour room. This is very dangerous because the babies might catch infection from their mothers or infect one another.

The ward has only eight delivery kits which are not enough compared to the number of pregnant women who are received at the hospital for delivery purpose and, therefore, the nurses have to economise by re-using the equipment so that they can provide the delivery services to every pregnant woman who needs their service at the same time.

The RA noted the following records in the hospital which she got with some difficulty.

**HOSPITAL RECORDS**

**Table 1: Delivery cases of 2008**

<table>
<thead>
<tr>
<th>S/N</th>
<th>CASE</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Number of abortions</td>
<td>120</td>
<td>36</td>
<td>33</td>
</tr>
<tr>
<td>2.</td>
<td>Normal delivery</td>
<td>608</td>
<td>539</td>
<td>593</td>
</tr>
<tr>
<td>3.</td>
<td>Birth before admission</td>
<td>3</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>4.</td>
<td>Vacuum</td>
<td>2</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5.</td>
<td>Caesarean</td>
<td>133</td>
<td>97</td>
<td>127</td>
</tr>
<tr>
<td>6.</td>
<td>Postpartum haemorrhages</td>
<td>2</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>7.</td>
<td>Retained placenta</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8.</td>
<td>Third degree tear</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
But as she was told there were more than eight deaths but not all had been recorded—only those that received publicity. There were also in the unrecorded deaths, six cases of abortion that went horribly wrong. But the nurse attendants on duty told her they were not aware of what went on in the days they were not present and she needed to talk to more of the health workers, but to do so with care as they could get into trouble.

Table 2:
<table>
<thead>
<tr>
<th>S/N</th>
<th>CASE</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Alive</td>
<td>606</td>
<td>649</td>
<td>697</td>
</tr>
<tr>
<td>2.</td>
<td>Infants &lt;2.5 Kg</td>
<td>5</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>3.</td>
<td>Macerated still birth</td>
<td>6</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>4.</td>
<td>Fresh still birth</td>
<td>6</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>5.</td>
<td>Deaths &lt;24 hours</td>
<td>6</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>6.</td>
<td>Death &gt;24 hours</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

The RA’s met a few conscientious nurses such as Lola who works at a district hospital. She noted, “We are working very hard but there are some things which demoralize our efforts for example we were promised overtime allowances and breakfast meals but nothing really happened.”

Lola also narrated a maternal and two neonatal deaths which had happened in the labour ward, both of which had different causes, that had occurred a few days apart. In her opinion, “Many maternal deaths occur due to pregnancy induced hypertension PIH and PPH. There was a mother who died last night due to postpartum haemorrhage. I was present then and the mother said it was her fourth pregnancy and, all the three children were born at home by a traditional birth attendant without any problems.

The mother had a fresh still birth (FSB) when she gave birth to a dead baby; she started bleeding continuously, and it became a very severe case. She told us that whenever she gave birth she used to bleed severely and the TBA gave her some herbs and the bleeding stopped. We decided to inject her oxytocin to help stop the bleeding because we don’t know those herbs which TBA used to give her. The bleeding did not stop and she died. The worst thing is that the mother didn't come with her ANC card and we had not kept her records properly so the midwives didn’t know the history of the particular mother but they had to help her deliver. Maybe, we performed the wrong procedure but how could we know? We do not record maternal deaths here as investigations occur and we usually are blamed.”

Image 26: Delivery at a Health Centre
Lola continued with another foetal death case by saying, “Sometimes the health workers are careless. For example, there was a foetal death which occurred a week ago due to the callousness of the doctors. Here, they have a lot of business in town which they prefer to concentrate on, apart from their work here. A certain doctor was called by a midwife to attend the mother who had a foetal distress. But the doctor was not at the hospital although he was supposed to be on duty and when he was called, he flatly refused to assist. Then, upon contacting the medical officer in charge (who was also out of the hospital) He decided to call another doctor whom he thought could agree to go and attend the patient although he was not on duty. When the doctor reached the labour ward the baby had already died. This was very painful to the mother.
and she keeps crying."

From the dispensary to the health centre and then to the district hospital, records are supposed to be collated and compiled and sent to the Regional hospital. But these records are not reliable and thus the reports of maternal and neonatal deaths are not meticulous. We found this to be true in most of the sites and in general, given the nature of childbirth and experiences of pregnant mothers, from the above findings there was no accuracy in the maintenance of records of births and deaths at any of the sites. A total rehaul of statistical evaluation is required.

In the ANC, women take their card with their recorded history home with them as they are expected to do so. The records used for prescribing medical treatment to patients are the small exercise book which the health centres use. For example, the MTUHA Book Number One, page 28, Section 3 states:

Kwa sasa kadi za wagonjwa wa nje hazitolewi kutokana kwa mfumo wa MTUHA, Hali hii itakuwa kwa muda tu wakati Wizara ya Afya inafikiria kufanya mabadiliko makubwa katika kadi hizo, kipindi hiki wasisitize wagonjwa wa OPD waje na madaftari yatakayotumia kuandikia kila mara wanapokuja kituoni na wayatunze madaftari hayo.

Since 1995-96 no changes have been effected from that system of the record keeping by law, the clinical officer uses the exercise book for the prescription and returns it to the patients. This matter needs to be looked into as the exercise books get used by the children who scrawl on them and rats residing in the roof eat the pages. Mothers do their best to maintain them under such conditions.

Although much essential medication such as Ringer’s Lactate was not available -- the following drugs were listed for sale in the hospital (with selling prices, where known):

1. Anti malaria drugs.
2. Quinine injection – A/mps @ 200/= 
3. Quinine Tabs – T/1000 @ 30/= 
4. Artemesini Tabs – PUT @ 500/= 
5. Artemether Lumifontrine (ALU)

2. Medicines affecting blood
3. Ferrous sulphate & Folic acid T/1000 @ 63/= 
4. Folic acid T/1000 – 18 - @ 5/= 
5. Heparin injection – 8 - @ 2000/= 

3. Aspasmodic
4. Hyoscyn butrybromide T/500 – 16 - @ 30/= 
5. Propatheline Tabs T/100 – 1 - @ 25/= 

4. Fungicidal drugs
5. Ice tosmazole Tabs T/100 – 40 - @ 100/= 
6. Nystutin Tabs T/100 – 8 - @ 100/= 
7. Fluconazole Tabs T/10 – Free 
8. Fluconazole injection BOT – Free 
9. Miconazole cream – Free

5. Antiacids
6. Cimetidine tablets T/500 – @ 50/= 
7. Magnesium trisilicate T/1000 – @ 10

6. Anti diarrhoea
7. Oral rehydration salt (ORS) PKT/1000 – 23 - @ 100 
8. PRICES NOT TOLD TO THE RA 
9. Oxycitocis 
10. Oxycitocin injection – Amps 
11. Ergurumetrin injection -Amps
Disinfectants & Antiseptics
- Chlorhexidine and Centrimide - SLTS
- Chloxylenol - SLTS
- Cresol seponated - SLTS
- Formaldehyde - SLTS
- Peridone Iodine
- Spirit
- JIK

8 Analgesics
9 Aspirin Tabs
10 Paracetamol Tabs
11 Diclofenac Tabs
12 Allopurinol Tabs
13 Diclofenac injection - Amps

9 Anti epilepsy & Anticonvulsants
10 Carbamazepine
11 Diazepam
12 Magnesium Sulphate injection
13 Phenobarbitone
14 Phenobarbitone
15 Phenytoin Tabs

10 Anti allergic medicine used in anaphylaxitic shock
11 Chlorpheniramine
12 Adrenaline injection Amps
13 Hydrocortisone injection vials

11 Anti bacteria
12 Amoxycillin Caps
13 Chloramphenical Caps
14 Cloxacillin Caps
15 Cotrimoxazole
16 Doxyccline
17 Gentamycin injection Amps
18 Penicillin benzothine benzyl vials
19 Penicillin procain benzyl
20 Penicillin benzyl

44 Spectinomycine powder
45 Ciproflaxine 500mg Tablets
46 Phenoxy methyl penicillin Tabs

Amoebicides
47 Metronidazole
  - Metronidazole injection

12 Anti helmintics
13 Mebendazole
14 Albendazol

The issue, however, is not only one of an inadequate supply of drugs but, as observed in hospitals and health centres in this region there was "unfair and inefficient" distribution of these drugs once they arrive at the dispensaries. Even when essential medicines that are supposed to be free are ‘officially unavailable,' staff at one health centre often offered to arrange for these medicines if patients had the money. Generally, those people who are able to buy medicines from the drug stores do so, even if they are only able to buy partial doses.
Another major problem was that the need to maintain a cold chain for the drugs could not be assured. For example, the cases of Methergin and Oxytocin drugs which lose their potency when stored in room temperatures for three months and six months respectively. Injecting a mother with these drugs would be injecting distilled water - thus atonic PPH could occur.

All these drugs had to be purchased and often the RA's found the pregnant mothers and their families simply could not afford these prices. Also, though these drugs were listed they were not on the shelf and one of the RA's had to pay a high price when she tried to buy some paracetamol tablets.

Case Study at the Referral

At another hospital, the visiting missionary Doctor was more sympathetic. She noted that in her experience in this region active labour was not medically encouraged as it should be. Active labour – the physiological process that propels a full term foetus spontaneously from the uterus through the vagina into the outside world – should normally be completed within 10–12 hours once labour begins but these women were suffering from all kinds of health deficiencies and, in addition, were exhausted and not in a position to afford to be pregnant. Naturally, family planning was impossible and they never would use condoms - “No one did use condoms” she said, pointing to the supply in the corner of the health facility which were well past the usable date. “If we supply them then they would never come here again – their husbands would not let them!”

A main difficulty in her view was vesicular – vaginal fistula and, less commonly, the recto-vaginal fistula. VVF was extremely common and this needs to be investigated as women suffering from such a condition are abandoned. She explained that as most of these circumcised girls delivering are barely our of their teens, there was an abnormal opening between two body cavities that develops as a result of protracted labour - labour obstruction combined with the force of uterine contractions wedges the foetal head of the baby deep into the maternal pelvis and injures her and often leads to foetal death and, as the foetus decomposes, macerated birth. The mother, of course, has now suffered and fistulas have formed between her bladder and vagina. This causes a continuous and uncontrollable stream of faeces and urine out of her vagina and many women are ostracised or abandoned. “We cannot operate here sadly and they cannot afford to go to Dodoma Regional and get surgically treated and require to be hospitalised as it costs money.” Most of the health facilities have no surgical facilities, and fistula can be repaired by simple surgery. This is an area that requires immediate attention not just from the point of view of treating women but surgeons need to take care whilst performing delicate surgical procedures. The following case of a pregnant mother who lost her baby and developed complications – an obstetric fistula - which has recently occurred in Dodoma was narrated to me by a visiting missionary Doctor who did not wish to be named.

Happiness is not sure of her age but the visiting foreign surgeon reckons she is not out of her teens. “Why do you care for me when it is of no use?” she had said. “My baby is not with me” she said sadly. “I am cursed and bring bad luck to all.” Two months previously she had delivered with a ruptured uterus and a dead baby at a government facility in Dodoma. The staff performed an emergency hysterectomy to save her life, but postoperatively she was diagnosed with a fistula, with urine and faeces running out of her vagina as well as out through the surgical inclusion in her abdomen. She was transferred when the surgeon was present and advised that three months of medical care and nutrition support was required before she was strong enough to undergo surgery. When the surgical procedures were underway, and the surgeon began the operation, it was revealed, “that accidentally the surgeon who had operated upon her earlier had removed her entire bladder at the time of her hysterectomy, had transacted her left urethra, had injured her sigmoid colon, leaving her with pelvic cloacs where urine and stools collected before running out through the vaginal cuff where her cervix once had been, and out through the infected surgical incision in her
abdomen.” The surgeon had to perform a colostomy to divert her faecal stream. Ureters were implanted in her colon as it was impossible to reconstruct her bladder. The surgeon believes she would not recover and her prognosis remained grim.

Obstructed labour produces injuries to many other areas outside the urinary tract as well. Nearly two-thirds of women who develop fistula experience cessation of menstruation from hypothalamic dysfunction, pan-hypopituitarism (Sheehan’s Syndrome) or inter-uterine scarring. The vascular ischemic injury that results in fistula formation also results in vaginal scarring that could result in stentonic, rigid, narrow vagina that no longer permits sexual intercourse and makes fistula repair difficult. Many patients also suffer severe damage to the cervix. The cessation of menstruation, vaginal scarring, cervical injury and pelvic infections contribute to women’s deep suffering both physically and emotionally. Vaginal injuries make sexual intercourse impossible. In addition, they become destitute.

As roads are in many parts non-existent in the interior and impossible to traverse without a sturdy 4 X 4 vehicle, it is likely that many women are unable to attend and certainly cannot get to the referral hospital to get the care. Thus, in many areas it is difficult to record cases where obstructed labour can or has occurred untreated. And, these conditions are alarming. If left more than a week, the uterus will continue to contract to the best if its ability but it is unable to affect any progress in expelling the foetus. In such cases the mother often dies out of sheer exhaustion and causes the uterus to rupture as has been the experience of Happiness. Intrauterine infection is followed by progressive sepsis. Delivery must be accomplished promptly as soon as labour becomes obstructed or the foetus dies from trauma, haemorrhage, asphyxiation and sepsis.”

This was a narration of an important medical condition that needs to be understood in terms of its widespread prevalence. We cannot have the exact figures, as obtaining accurate statistics requires a major rehaul of the statistical system currently in operation.

Related to such conditions are tuberculosis, anaemia and other wasting illnesses. Emmanuel, a Clinical officer remarked,” another major problem is some diseases such as TB are contagious and where do we put pregnant mothers who suffer from it? We put them all together regardless of their medical condition.” Thus, a mother who may not have TB could contract it whilst in the health facility. Important checks need to be made of patients and those who have infectious diseases must be kept in isolated wards and sanitised care is of the greatest import.

Charging Insurance
In two sites, the RA’s found certain practices exist such as ‘health insurance’. This was decided by the VEO and the health centre and is part of the privatization efforts that were introduced in 2003. Every household is supposed to pay 10,000/= per year for health insurance and can get health service at any health facility in one district without paying extra money except for Ultrasound service which costs 20,000 TSH; The service is found at the same district hospital. If the family does not pay the cost they are charged 1000 TSH for consultation and 1000-3500 for medicine. For example, antibiotics costs 1500/= and analgesics and anti-malarial costs a total of 1000/. Very few can afford the price. Mariam came with her three children at the hospital. Two of them were sick. She claimed that they were 6 and 4 years of age. Both were suffering from fever and cough. She was told to pay 7000/= but unfortunately she did not have money! She gave Masahai 5000 TSH to add on the other 5000 TSH she paid to Nurse Jane so as to get a receipt for health insurance. She was told that the money would be reduced to 7000/= and she was requested to bring her husband so that he could pay the insurance. Masahai didn’t listen to her as she claimed that she was no longer staying with her husband since they quarrel as he is alcoholic. She paid the money for herself, her children and her mother-in-law after selling maize. At last she took medicine and her money was deducted.

In another instance, the RA in the health facility noted that Eliza, who was eight
months pregnant, had walked 8.5km to the facility. She came to the clinic on Wednesday instead of Tuesday for a routine antenatal clinic visit as she did not know the days. The nurse at the dispensary found her outside when the RA told her that a woman was waiting outside. She did not greet her but just looked at her and returned to provide service to other patients who were not pregnant and had arrived later, after Eliza. The RA asked the nurse what the matter was the nurse replied said, “I don't know, I didn't ask her”. She then called Eliza and scolded her, “If you come for clinic visit why today and not yesterday?” Then she told her again “you should go back to your village until 24th September” (the village is at a distance of 8.5 kms). Then the nurse asked her, “did you pay BIMA?”; “if you have not paid there is no service until you pay!” The RA then walked discreetly away and spoke to Eliza who cried and said “Sister I have no money, nothing at all. What am I to do?”

Evidence from previous regional studies and technical research based in Tanzania notes the abyss between government policies and its translation into practice. The issue of waivers and exemptions has been left to be decided at the discretion of the local community leaders and health workers on grounds that they know better the lifestyles, backgrounds and health conditions of the people. Thus by decentralising such decisions local governments were granted authority to assist the people. But nothing has been done about it from our research. And, the vulnerable groups such as the pregnant women are left unassisted. No one was aware of the exemption or waivers that they are entitled to in these and many other discussions.

Penalising Mothers

Another practice the RA's noted was that fines were levied for those women who delivered at home. The mother is told to pay a fine of 50,000 Tshs and the money is taken by health care workers and wahudumu. The amount was decided on 21 May 2008 by the village health committee where the MCHA is the chairman of the committee. Jennifer was a woman who delivered at home. She claimed that the reason why she gave birth at home was that there was no one at home during labour, as her mother and her husband were at shamba which was very far from her place, and hence she delivered by herself since there was no one to take her to hospital! One week after giving birth she went to the clinic to immunize her baby boy and it is there where they ask her to pay the money as a fine for delivering at home. She said that she did not have 50,000/= and they told her to pay 15,000/=. The Mhudumu Kasili was told by nurse Jane to follow Jennifer to her home and take the money. She harassed Jennifer for payment. Jennifer had to borrow from several neighbours and family. The Mhudumu then divided the money as follows: 5000/= for himself, 5000/= for Sara (another mhudumu) and 5000/= to buy a chicken for lunch on that outreach day! Firstly, given the circumstances the RA noted they should not have collected the money as Jennifer was so poor and had no money to feed her baby or her family. Secondly, the midwife and the Wahudumu had cheated and not put the money into the health centre fund. Such cases were common as “extra” charges were levied in nearly all the maternal cases in the health facilities as the pregnant mothers told us and, the RAs’ also noted, in the health facility as the above case illustrates.

A group of men who had gathered at this site discussed what was happening. Mzee Lubeleje, a village elder, remarked authoritatively as others agreed solemnly,

Ni kosa kwa serikalimkoa wilaya na kata na vijiji kuwaomba wananchi fedha za mchango. WaTanzania ni watu wanaoheshimu serikali yao, hivyo si halali kuwaomba fedha ambazo hawazo."

“It is wrong of the government at the centre, district, ward and village to ask for contributions from the people. We respect and trust our government. It is a travesty to ask for money when they know we have no money!”

In five of the sites in the interior, the health services are provided at the VEO’s and WEO’s office respectively since there is no dispensary in the village. There is no hospital bed and women have to borrow a bed from the nearest house. The bed is made up
of ropes. It is not comfortable for the pregnant woman herself and for the health worker since during physical examination, the health care worker has to bend or kneel down and in poor light make a diagnosis. Under such circumstances women would prefer to deliver at home and be examined in the privacy of mng’hunga’s residence.

Shortcomings of the in-service system

Nearly all the health workers we spoke to were extremely dissatisfied with the quality of the education they had received. Many of them had chosen this profession as they were interested in receiving a medical education. There were frequent allusions to education and how bereft some of the health workers felt working for excessively long hours and, often, being expected to undertake surgery and complicated medical procedures, knowing fully well that they did not have the proper training but having to do it anyway.

“Elimu yetu tuliyonayo siyo nzuri na ya kutosha tungepedekeza iimashwe na kuweza kuhusisha nyanja zote za kazi zetu”

“Our education was not that good and we would have liked it to be more comprehensive”– this is a common complaint from many of the health workers who are frustrated by their desire to assist patients and yet constrained. “It is a very long time ago that we qualified and now we only know we are lagging behind the times,” said a nurse who had been working in her job for twelve years. One Clinical Officer remarked,

Njia pekee tunayotumia kupataujuzi ni baada ya kufanya kazi karibu miaka sita au saba wakati tunajifunza kutoka kwa wakunga/wauguzi vituoni. Pia tunaikutwa madaktari wakati hatujapata mafunzo ya udaktari, ingawaje tungependa toypadpe. Hatufundishwi hata vitu rahisi kwa mfano kutoa limama na C section, ilipaswa tunfundishwe chuoni.

“The only way we can get experience is after a period of six or seven years when we learn everything to start with from the midwife/nurse. And, we are known as Doctors but we are not trained as Doctors although we would like to be. Simple procedures such as placenta removal and C sections should be taught to us”.

Such evaluations by the health personnel were, we found, shared by many of their colleagues.

Also, it was noted that there was in general a low compliance with official directives, partly because of the discouraging environment at work with much of what seemed to be confusion in understanding what was to be done as much as fear of authoritarianism.

We heard from many health workers time and again,

“There are a lot of mind-games and bullying threats in government by officials at all levels of the health ministry: we have to respect and fear authority rather than speak the truth. We are not expected to criticize the shortcomings of our education systems or even our salary: we are supposed to accept everything and remain silent.”

Kuna kutishwa kwingi serikalini na maafisa wa serikali katika ngazi zote za wizara ya afya –tunaheshimu ha kuogopa mamlaka kuliko kuongea ukweli. Hatutazamiwi kukosoa mapungufu ya miundo ya elimu na mishahara na badala yake tunapaswa kukubali na kunyama kima.

Three Clinical officers known as ‘Doctors’ who were sitting together noted,

“All hospitals and dispensaries in the country have a Clinical Officer in charge. The training of the Clinical Officer takes three years. In order to enrol as Clinical Officers, they have to complete Form Four or in some instances complete high school. Our hospital is one of the better places but even here we have no books. The Library is outdated and most of the books are twenty years old. Thus, most of the teaching and
learning by the 53 available seats in our hospital is mainly through lectures. Those who teach them are other Clinical Officers. After the three years, we have some medical training; it is given in a medical school done by Assistant Medical Officers.” These remarks and general findings are supported by a Rapid Assessment Baseline study of the health facilities in the Dodoma region by UNICEF which also illustrates that in many cases there had been no refresher or training courses for health workers trained over eighteen to twenty years ago.

These were some of the many comments we heard during the course of our field work:

“None of the teachers have formal medical degrees and we are given no operation theatre experience. The tools are not explained to us. And, until recently I could not identify the different kinds of forceps and their uses. Not that we have these in our hospital. Also, none of those who taught us was trained with medical degrees - Doctors,” noted Mr Luanda who had been working for three and a half years as a Clinical Officer.

“Examinations are also a farce,” noted Dr E, a mission Doctor. She continued, “The questions for the examinations are set by the Ministry of Health. There are three sections, a multiple choice, true or false and two essays. The standard of written English of the questions is quite poor and the exam sheets do not come with an answer sheet to guide the examiners. As I corrected the examination, I was pleased to find the questions were important. For example, recently one question was: What are the causes and management of postpartum haemorrhage? The biggest killer of mothers during childbirth is postpartum haemorrhage. The answers should have been three causes failure of the uterus to contract after childbirth; partial retention of placenta; tears and damage of the uterus and vagina. The three causes have three different kinds of management – I was shocked to read that in nearly most of the answers the examinees could not state the three main causes nor did they answer what is common sense the three different kinds of management - that is if it tears stitch it, if uterus does not contract administer oxytocin and so forth. Also, the examiners did not have any uniformity in marking the papers and did so rather carelessly. Many should have failed but were given a pass.”

But even here the training is not specialised as is the training of Doctors at the University of Dar-es-Salaam. Nevertheless, the Clinical Officer after his (usually a he) training conducts operations and surgeries. As Dr E, an obstetrician noted, “Any wonder why health facilities are viewed with such fear and pregnant mothers feel so afraid to come here.”

But she admitted that these problems were part of a chain – no equipment. “One had to use one's wits”, she noted. For example, the stages in labour are very clear - WHO regulations have specified them as follows:

**First stage:**
Monitoring the Foetus during Labour

Monitoring foetal well-being is part of essential care during labour. The occurrence of foetal distress, usually through hypoxia, can never be fully excluded, even though a labour may meet the criteria for "normal" that is: it starts at term, after an uneventful pregnancy without factors indicating an increased risk of complications. The risk of foetal distress is somewhat higher during the second stage of labour and in the case of prolonged labour—which usually happens in this region – what with circumcision and anaemia.

The passage of meconium may reflect foetal distress and is associated with intrapartum stillbirth and neonatal morbidity or death.

**Monitoring the foetal heart rate**

**Foetal scalp blood examination**

A micro technique of sampling blood from the foetus

**Signs of the start of labour are:**

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- Painful contractions with certain regularity
- Effacement and/or dilatation of the cervix
- Leakage of amniotic fluid
- Bloody discharge

The Onset of the Second Stage
The beginning of the second stage is marked by the following symptoms:
The woman feels the urge to bear down, because the amniotic sac or the presenting part protrudes through the dilated cervix and presses against the rectum; often the membranes rupture spontaneously; usually there is full dilatation of the cervix, but sometimes the woman feels the urge to push at an earlier stage of dilatation. If a rim of cervix is left it will be pushed aside by the presenting part.

From the above-mentioned it becomes either when full dilatation has been diagnosed, or sometimes even earlier. The physiological approach is to wait until the woman feels the urge to bear down herself. At full dilatation sometimes the urge is not yet present, and by waiting ten or twenty minutes the expulsion phase may start spontaneously.

DR. E. concluded, “At this time the prophylactic use of Oxytocics, controlled Cord Traction and the Timing of Cord Clamping needs to be carefully managed. But instead of waiting and doing as above, women are forced to push and left on their own and thus, we have neonaturum asphyxiation and PPH.”

There is no accountability as health workers are so few and, no matter how under qualified or unfit for the job they maybe, “we keep them,” said one Assistant Medical Officer. He said, “So much bungling takes place in the examination of patients. They do not know what to do and the patients are supposed to trust them.” Rehema, a duka owner remarked, “Do you know sister, and it happened to my man, the clinical officer was drunk and gave him an injection and left the needle inside. My husband got gangrene and lost his arm.” There is not much the patient, his or her family can do. There is the burden of getting proof and a lawyer – and as there exists no financial or legal assistance, accountability is not a given.

Nurse trainers in theory are taught well but when they come to the hospital they do not adhere to the principles that guided their training. They are not supervised and one nurse, Christa notes, “After Form IV which I completed in September 1996, I was 18 years old and went to the Kilimatinde College of General Nursing where I was enrolled for three years. We were taught by Mr Hawala who had after he completed Form VI enrolled in Muhimbili for four years to train as a teacher of Nursing. Thus he was not a Medical Doctor but a trained teacher. In the first year we learnt the Principles of Nursing and Pharmacology – for both of which we had no books. Then we studied Medical and Surgical nursing and continued with Pharmacology and we had no books in the library. We studied community nursing and we had books in the library for that course. We also studied growth and development of children under five, for which we had no books. In the second year we went into the operation theatre – but in the theatre we were not told about the instruments. Thus we did not know the different kinds of forceps as even the instructor did not bother to tell us. In the third year we continued with the same courses. The examinations consisted of essays, multiple choice and pick and match. It was Ok. All of us passed the exam. The cost of the education was 700,000 TSH eight years ago. And, it is almost double now, for a two-year diploma. I have completed one year and need to do another to proceed to the diploma.”

Said a young nurse midwife Anna, “We all take loans and interest is very high on these loans.” “No one cares for us really. Older nurses do not like to teach us and we found them quite disinterested and we were left mostly unsupervised. However, they assist the Clinical Officers.” “In many ways we are better educated than the Clinical Officers and they learn in the wards from the older nurses and us midwives,” noted Jane a midwife. This was admitted by the Clinical Officers in most instances. Said Mr Elihud, “Our teachers, the AMO’s themselves know little about surgical practices.”
Clearly from the ethnographic work we found that there is an abyss in pre-service and in-service training that needs to be addressed.

“The doctors who are educated at one of the four places, after training become District Medical Officers. It is quite ironic that they are the only people qualified to undertake medical procedures and they are so few in the country. But we need to undertake such jobs. Most of the operations and surgical procedures in the clinics are conducted by the Clinical Officer - this is a very big problem and dangerous.” This was remarked by Mr. Kaale, a Clinical Officer who dreams of becoming a Doctor.

As for ambulance operations, they are not seen as affordable. Mama Jamali, who is seven months pregnant and lives at Bonesa village complains that they were told by the District Commissioner that the three ambulance cars available at hospital which are known as “OKOA” are supposed to provide the transport services free to any pregnant woman who is at the village and needs to be taken to the hospital for treatment. Mama Jamali added,

“Lakini tunashangaa ukiwa na mzazi amepatwa na uchungu nyumbani unaambiwa ulipe kwanza elfu thelathini ili mzazi akachu kulwiw apelekwe kwanza hospitali sasa tunashindwa kuwaelwa tunamwamini nani eti wanasema hela ni kwa ajili ya kununulia mafuta wakati tumeambia na mkru wa wilaya tusitoe chochote.”

“But it is so surprising that if you are a pregnant woman who is in labour at home in the village, you are told to pay first thirty thousand shillings so that the driver can go to the village to take the pregnant woman. We really fail to understand who to believe any more, they claim that the money is for buying the car fuel while we were told by the District Commissioner not to pay.”

In addition to these complaints, we noted that many pregnant women do not see any difference in the quality of treatment they receive at a health facility or at their mng’hunga. At least the mng’hunga was not as invasive or rude as the nurse-midwives and did not leave them abandoned in a corridor lying down while they were about to give birth or return later to tie the cord.

In none of these health facilities were the health providers able to carry out their tasks as outlined by WHO guidelines which states that the tasks of the caregiver are fourfold:
● Support of the woman, and her family during labour, at the moment of childbirth and in the period thereafter.
● Observation of the labouring woman and allowing her to rest for half a day at the facility.
● Monitoring of the foetal condition and of the condition of the infant after birth.
● Assessment of risk factors- early detection of problems and performing minor interventions, if necessary, such as amniotomy and episiotomy; • Care of the infant after birth.
● Referral to a higher level of care, if risk factors become apparent or complications develop that justifies such referral was done when it was too late.

In many sites the RA’s who were working in the hospitals and other health facilities such as dispensaries and health centres noted cases where the nurse-midwives did not attend to childbirth procedures as correct training required. One RA observed this while she was asked to assist in childbirth. She noted that the nurse put on her gloves and examined the cervix and found that this was the second stage of labour and the cervix had dilated seven to eight centimetres. The Nurse said, “I do not detect the presentation of the baby” which was a wrong statement to make - clearly the nurse was not qualified to undertake the delivery. The nurse continued checking and kept poking her fingers into the vagina and the RA was asked to intervene and, thus asked her to stop as she might cause harm. The nurse asked the mother to push and began to pressurise her to do so which took almost thirty minutes and she was about to apply episiotomy. At that stage the RA discouraged her from doing so. As the nurse was not sure what to do, the RA encouraged the mother and she co-operated and presentation was
She was torching the baby's face while doing PV. The RA narrated, "I stopped the nurse from doing episiotomy and I supported the mother's perineum. There was, sadly, no sign of life from the baby, no sound of respiration and, the colour of the baby turned from pink to green after two minutes. It was a neonatal death. This happened due to lack of supportive equipment such as oxygen to resuscitate the baby or, a vacuum mask..." The RA removed the placenta and evacuated the small membranes. Bleeding was normal and the mother was very tired. The nurse called the relatives and explained that the baby died on account of a difficult delivery. "What I could see" said the RA. "was that the baby's face was swollen and there were bruises on the baby's cheek as the nurse had carelessly applied pressure with the fingers." It is clear that, in addition to the lack of availability of essential equipment, re-training of all medical personnel every a year or two years should be made mandatory.

In another case at the Laboratory:
The RA who was attending the hospital narrates that the hospital had a reasonably sized laboratory which had four rooms: biochemistry, microbiology, haematology and an office room. The office also acted as a storeroom. The laboratory did not have enough air as the windows were fixed except one and therefore the doors had to be open all the time, which is not safe for either the patients or laboratory workers. She states, "The laboratory has four people: one laboratory technician who is on leave and two laboratory attendants remained as laboratory workers, Mr. Luanda and Bi. Kassanda. The RA noted that the conditions were not acceptable in the laboratory. Most patients were allowed to enter the laboratory which is against the laboratory rules without correct footwear, and the worst thing was that the patients' blood samples were taken carelessly --without being sterilized with spirit. This is very dangerous because it leads to contamination which again leads to wrong results. The pregnant women who come for clinic in the afternoon are told to come the next day in the morning by the Laboratory attendants by telling them, "Your re-agents for bal test have finished so come tomorrow morning", something which is not true but they say they do that just because they have to reduce the number of patients as they become very tired. But they also do not speak politely to the pregnant mothers." Nothing was explained to them and they were ordered as Rehema complained afterwards to the RA who had been watching. Rehema was hesitant to give blood as she had not been counselled or told why. The nurse shouted loudly at her again, "nisikilize vizuri mwanamke, usinipangie kazi kila mwanamke mjamzito lazima apimwe ukimwi kabla ya kujifungu.

'Rehema said, "kama ulivyooona dada, manesi wengine ni wakatili sana hata hawaelekezi vizuri ndio maana wanawake wengine wanaona ni bora waje wakati wa kujifungu." Rehema looked away dejected and embarrassed. The RA comforted her after the nurse left. She told the RA, "As you have observed sister, some of the nurses are very harsh, and they don't instruct us well thus why women should opt to come to the clinic when they feel labour pains? Why?"

Also, the laboratory attendant sits comfortably while he is pricking a pregnant mother's or another patient's finger to obtain a blood sample for malaria or HIV test and while he or she is sitting, the patient is standing with arms outstretched. He/she could miss the vein which is more than probable and hurt the patient. Furthermore, the laboratory does not have disinfectants for laboratory workers to wash their hands before and after work and instead they use powdered soap for washing their hands. A laboratory technician says,

"Tuna mazingira magumu sana ya kufanya kazi, hanna hewa kabisa na kama unavyooona tupo wachache na tunachoka sana kwani wagonjwa ni wengi sana.

"You can see our working environment is really tough and we are very few and the patients are too many for us to serve."
However, the laboratory technical did not take whatever precautions he could have done. It was noted that he had no formal training and was just working there and learning by observation. He had been recommended by the Assistant Medical Officer to do this work.

There was a tendency on the part of health workers to depend exclusively on their 'clinical' judgments rather than verify by laboratory tests. Diagnostic support can be seen as both physical and organisational and the diagnostic support was constrained both physically and in organisational terms such that malaria became the easiest diagnosis to make. For example, one obvious alternative cause of severe symptoms (high fever, convulsions, reduced level of consciousness) is meningitis, but clinicians were observed to be reluctant to carry out lumbar punctures, a more complicated and time-consuming test; perhaps, it was because they did not know how to do it as was clear when quizzed by the RAs'. In addition, HIV related disease might be considered but would require far greater effort on the part of the clinician, with the need for counselling contributing to diagnostic barriers. As donor-recipients, Tanzanian health officials are under pressure to channel efforts into malaria-specific activities. This has a knock-on effect throughout the healthcare system of emphasizing malaria to the detriment of other diseases.

Clinical officers are called 'doctors' but they have, as discussed, often complained of very poor education, not to mention that they have no theatre experience. However, villagers and also, people in semi-urban towns, are led to believe that they are educated as Doctors. This needs to be immediately rectified. In international medical protocol, an occupation constitutes a profession in so far as it possesses a catalogue of essential attributes: theoretical knowledge as the basis of skill, specialised training and education, testing of members by formal examinations, development of a professional organisation, emergence of a professional code, and the articulation of an ethic of altruistic service to the public. An occupation possessing all of these attributes, such as medical practice, would be a profession in the fullest sense. Possession of only some of these attributes would lead to a conclusion that the occupation was only incompletely professionalized or still on its way to full professional status.

Salaries
Social processes guiding human resources for health workers appeared to contribute substantially to the provision of health care and to affect adversely their performance. In addition to their own dissatisfaction with the system of education, there was the grinding problem of salaries not covering their cost of living. During our study, all the health workers complained about their salaries as not being enough. They had to have another business – shambas or a business to keep the home fires burning. This was common at all levels – from the AMOs, COs, Midwife-Nurses, MCHAs, Nurse Attendants, Nurse AssistantS, Auxiliaries, Laboratory Assistants and Medical Attendants.

The medical attendants were disheartened. Their take-home salary was 52,000 TSH and at the nurse-midwife and clinical officer levels it was 220,000 TSH. All stated that although they had free accommodation they had to pay for the electricity and water and that worked out to about 10,000 TSH per month, then food was about 180,000 - 200,000 TSH per month, school fees were exorbitant and amounted to 30,000 TSH per child, including books and uniforms, and transport costs were about 20,000 - 40,000 TSH per month. Of course, they did not buy clothes for themselves or have entertainment funds.

On an average thus, for a family which often included nephews or nieces staying with them, the costs were about 550,000 TSH and the take-home salary after deduction did not balance their expenses. A nurse-midwife told us that, like so many we met, she doubles up and works as a ward attendant and also as a receptionist, and her take home pay is 255,000 TSH. So, not only was she underpaid for her job but she was not compensated like many others for the other responsibilities they have to undertake because of shortage of staff. Even after eighteen years, some complained that they had
no promotion in many cases - but even so the salary was not good enough. “Then the newcomers join us with the same salaries and terms of work. And, as they are young they manage, but in time they will also suffer like us,” said Maria a nurse-midwife at a hospital. Thus, they recommended that under current conditions, take-home salary should be a minimum of 500,000 TSH and that means a salary of 600,000 TSH or above. If they received such a salary then they could also cope better with the long working hours.

Lena's narrative
“I was trained as a nurse while attending a training course at Kondoa. During 2001-03, I went to a nursing college where I received the public health nursing grade. The course cost 200,000 TSH but we paid only 130,000 TSH as the government gave us assistance. I was transferred to the dispensary from the hospital after that and have remained here EVER since. We have no doctor here and I have to look after all the patients coming from the villages under our dispensary. And, the other nurse is not well. There is no midwife so I do everything...The salary I get is not enough as I get below 200,000 TSH after deductions and contributions. But I have already tried to seek redress. Even if you want an increment there is no one who is willing to listen to us. For example it takes a long time to rectify the salary after it has been upgraded as my co-worker also has found. My sister advised me to leave the job and go to a private hospital. But I chose to remain here because with the government job one can take up training and not lose the job as will be the case in the private sector. At least I am earning money now even, if it is so little to cover my basic requirements and that of my family - my mother, my young brothers and sisters. I am not married as yet but if I get married it will be another story with this income.”

The Clinical Officers said that salaries should be increased and the take home salary should be 700,000 TSH after tax deduction. To quote, Mr Semakafu, an AMO, “We all have at least five children and extended families to look after! In addition, we pay for the water and electricity. Food is expensive and on an average we spend 240,000 TSH per month, that is a conservative estimate - and there are school fees, transport. We have a deficit of 200,000 so we seek as far as possible additional ways to make money to make our ends meet.” And, when they go on work allocated or training trips they are not paid for those days as the district council says there is no money.

It is also not uncommon not to be paid on time. THEN there are arrears pending, especially with the new health workers who complained that they have not been paid for three months in arrears and paid only in the fourth month or more. One nurse-midwife at one hospital we met noted that, like the 29 other colleagues, she also had not been paid her arrears. “I have not been paid for four months and, now was paid in May for the salary for May. I was asked to meet the accountant and, he said I have been paid already.”

Sijaliipwa mshahara wangu kwa miezi minne na nimelipwa mwezi wa tano kama mshahara wangu wote. Niliambiwa nimuone mhasibu na akaniambia nilishalipwa tayari!

It can be concluded from these discussions that current salary structures are not adequate to cover the livelihoods of the health workers. And this is further exacerbated by the delay as most complained that they are not paid on time and, sometimes, they do not appear to be paid at all. These matters need to be regulated. Also, the long hours they keep are against labour regulations and they cannot perform their duties well as it affects their own health and well-being.

Most of the health workers work extremely long hours and need to be on call 24 hours. This is largely due to the fact that all the health facilities dealing with MNCH care, including the hospitals are severely understaffed. Nurse-midwives are rushed off their feet.

“We have to leave the pregnant mother unattended often as there is so much to attend to and there is no one to assist us. We have to do OPD, pregnant mothers, children, other patients - all at once.”
“What happens when five mothers decide to deliver at once? We cannot cope and there are not enough of us. We ask patients to help us.”

“We work all day and night - does the government not know this? Are they without any feeling? We also cannot be patient and smiling all the time, can we? We have also our families waiting at home. When the time to go home comes we cannot as there is some patient here to be attended to. But we have to go home and eat. So we do that. Then we get called back without any rest. How do you think we are going to react?”

“Day and night I am working, sister – I am a medical attendant delivering babies for over twelve years and no training! Why? Because we have no-one else here. The Nurse Auxiliary left and I have to do it all. We need a clinical officer, a nurse-midwife and nurse attendant at least. But there is only me. And, I take home 52,000 TSH. Of course I cannot survive with my family so I have another business of shamba.”

Such comments reverberated at many of the health facilities regardless of their size. The problems of the health workers need to be seriously redressed.

The sufferings of the health workers with the inadequate salaries and the long working hours at all levels in the health facilities is being investigated in much greater depth by ILO in a separate study. Their preliminary findings are in concurrence with our own findings.

The forthcoming ILO study and the baseline study by UNICEF will help to widen the base of evidence and allow for intervention measures to address dissatisfaction by health-care providers as also enlighten the government who might feel that the policy is well implemented but not supported by research findings. This is because of many researchers observe from their experience in Tanzania that, sometimes national policy makers and health care managers of health facilities feel disenchanted when they hear about or personally see research presentations indicating that in the real situation, there is a perceptibly poor translation of government policies in practice.

**Interventions**

The findings from the Ethnographic study highlight key areas for interventions to be carried out to strengthen local and national ownership.

A Participatory Approach

It is argued that people should be at the centre of health systems and services. In this way, they can participate in many ways: as advisers of health inputs and utilisers of goods and services for health; as consumers of health and health care inputs; as recipients to the financing of health systems, and as citizens in defining and guiding the implementation of the norms, standards and policies that shape health systems. Yet it is ordinary people who are marginalised and, excluded from accessing health. Thus for interventions to succeed, it is imperative to not just draw people into health policies but to encourage their active engagement in policy making.

Oral traditions:

The entry point for such a participatory approach implies communicating through the oral traditions. Thus, devising a systematic inter-sectoral programme led by experts in the socio-cultural, economic, legal, political, and religious and epidemiological arenas in collaboration with the experiences of local community leaders and representatives from the community would provide a good basis for long term effective participatory engagemen

**Community Participation**

It has long been formulated that the basis for all successful intervention efforts in
public health programmes at local and national levels is a need to concentrate on community participation. Nevertheless, despite longstanding policy support and decades of experience, the term ‘participation’ as also the term ‘community’ has been acknowledged to be poorly operational in national health systems. As a result, the poor have been marginalized and forced out of the health system with critical consequences for reproductive health. However, the egalitarian culture allows for communication within all ranks of people and it augurs well for community participation.

How do we recognise a community?

A community is to be characterized in terms of a shared ecology, common locale and, participation within a social system which eventuates in common interests between people sharing many-stranded multifarious relationships with one another, combining feelings of interdependence, loyalty and identity whatever their familial and, generational differences. Such interactions generate continuing inter-functioning between interests groups, and the gradual development of perspectives can be encouraged to lead to development of joint action and activities with institutions through participation.

A number of additional elements also need to be taken into account beyond the simple implication of a more active public role through interactions between health services and members of the community at the individual and at the collective level. There needs to be agreements in place to elaborate the nature of policy actions that would promote a joint feeling of ownership on agreed values, goals, plans, and resources. Thus, shared involvement in, contribution to, ownership of, control over, responsibility for health needs of ordinary men and women to be nurtured.

Committees need to be formed from the lowest administrative units that are already in existence. The Elders of the village, the Village Executive Officer, the Bwana Shamba and, representatives from the local health facility should form a committee along with local Midwives, (trained and untrained) and representative members from the village. Thus, by listening to and drawing out local community experiences and views; identifying the problems that need to be addressed; collecting and organising information relevant to identified problems; systematising individual experiences and perceptions into collective forms and subjecting them to collective validation, the committees could lead to the creation and establishment of social networks between the health facilities and the communities. Such measures would enhance community control over and commitment to health interventions and enhance management at the level of the health facility. Community participation is a process that strengthens foundations of primary health care.

The Remit of the Community Participation teams should be:

● To organise local teams of community diagnosis investigators composed of male and female workers of the communities who are suitable for the work that is to be carried out. They would seek the opinions of the group of older, more experienced, members of the community in matters of health and development activities.

● To explore the extent to which these lay investigators could be taught basic communication skills, such as participant observation, interviewing through training exercises and active modelling by experienced social science instructors.

● To conduct a diagnosis of community health care priorities, patterns of health care utilization and expenditure, and health related issues denitrified by both local health care providers and the local population.

● To document Community responses to government health personnel, services and community workers scheme.
• To identify innovative approaches to health education which would be sensitive to lay health concerns and cultural communication styles.

• To document health workers' responses to the community and seek their proposals for a health workers' scheme.

• To collect statistics on the number of pregnancies and thus, pregnancy related deaths as also of maternal and neonatal deaths. Rehauling of data collection at the local levels would provide accurate figures and, assist in monitoring and evaluation procedures at the national level.

Communication

For successful communication, it is important to introduce culture sensitive health interventions and understand the local conception of illness and disease in the explanation of symptoms for accurate diagnosis. Respecting and communicating using oral traditions as also, speaking in the local language - hiring of locals to teach the health workers - or to act as translators. Every health facility needs to have personnel with reliable knowledge of the local languages such as Kigogo, Kirangi, Kimaasai or Kikaguru. The medical attendant could for example be a local hired to do this job. It is important to grasp popular health cultures, social behaviour and understanding of indigenous explanations of diseases to assist epidemiological investigations. Oral traditions need to be respected and employed in all forms of communication for education.

Dialogues on Poverty

Discussions of maternal and neonatal health may not be the way or even the entry point to encourage community participation and social networking. For effective participation, linking the health sector to addressing poverty - economic and social development - requires an understanding of the culture of poverty. Such efforts will strengthen MKUKUTA 'Cluster of Improving Quality of Life and Social Well-Being' for all citizens.

There is an urgent need for a stronger advocacy and articulation on poverty-health interactions and measures for incorporating health interventions into economic policies and poverty reduction strategies. Most of the women and men know and understand that health is related to other dimensions of development/poverty and bureaucratic systems need to further conceptual understandings by introducing measures to address health-development-poverty interactions. These can be made operational within existing primary health care programmes through economic measures:

• Civil registration of all births and deaths made mandatory

• Exemption cards

There is discouraging evidence regarding the practicality and limitations of administering exemptions and waivers in the Tanzanian health care system. Almost all the case studies indicate the existence of such protective mechanisms both at public and private health facilities but on a limited scale. It generally remains evident that targeting the poor through the waiver system is more difficult to implement in the Tanzanian setting than the government policy stipulates, and this makes the whole cost sharing policy questionable on its effects on the poor. Introducing exemption cards to the poor to carry to the health facility would prevent any demands on them to pay. Thus providing all the poor with exemption cards should facilitate free health care to them.

Provision of Civic Amenities

Implementing environmental health control and sanitation policies.

• Water Supply: Tanks need to be built at all health facilities and, villages need to be fitted with pipes to transport water within easy reach for every household; Water storage facilities and construction of wells; Rain-water storage.

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● Electricity supply: Wind, solar or biogas - health facilities need permanent supply and with environmentally-sound measures the communities would benefit. This will also prevent the rapid de-forestation.
● Ventilation of the Tembe houses: larger windows and mosquito proofing and eco-friendly fumigation of termites; Cooking in a separate room with a chimney, outside the sleeping and living areas.
● Latrines: Construction of permanent latrines with water supply and, disinfectants supplied.
● Waste disposal: Waste disposal units in the health facilities must be cleared every day.
● Plastics disposal: Burning of plastics must be actively discouraged; people must be educated on the toxic effects of the smoke, and recycling plants encouraged.
● Glass Recycling also introduced
● An Used Batteries and chemical disposal units need to be set up

Addressing Low Cash Incomes
Creating employment opportunities - Marketing assistance for agricultural and livestock produce; Setting up of local businesses - mat making, baskets or furniture for export purposes; Musical groups that could perform around the country etc.

● The government and the donor communities must bear the entire costs of providing civic facilities and also, in the construction of health facilities and schools thenceforth and not ask the community members, especially the rural and urban middle-classes, to raise these funds to construct health centres, roads or schools. They are incapable of providing any resources with their depleted cash incomes. Existing payments from the poor results in them having no income at all and severe indebtedness. Once prosperity is generated and the majority of livelihoods secure, voluntary contributions and demands be made from the communities.

Partnerships with Business: Housing, Water and Electricity
Mandatory conditions could be set up for those private companies undertaking business ventures such as mining. They could be contracted if they can build schools, provide housing estates, together with a ready supply of tap water in the homes and schools within the first two year of their contracts.

Investing in Solar Energy, Biogas and Wind power:

The technical wherewithal and investments could also be raised from business partnerships and the donor communities.

As part of the primary health care programme, vast sums have been set aside to finance the national drive to build dispensaries and health centres to cut the distance people have to walk. Thus, although the construction of new health facilities is important civic amenities must precede the setting up of all facilities and paid for by the government.

The Environmental Health and Sanitation Section of the MOHSW have in place set procedures that cover the interventions suggested above. Its activities are to:
Formulate environmental health control and sanitation policy guidelines; Liaise with regions and districts on control of pollution in the environment for appropriate measures to be taken in collaboration with other agencies; Review international sanitary regulations in force, for the purpose of preventing inter-country transmission of diseases or disease agents in collaboration with World Health Organisation and other international organisations; Review and up-date public health laws in the country for improving and sustaining sound public health interventions; Monitor and evaluate effectiveness of different environmental health and sanitation interventions instituted in the country; Disseminate to regions information on new developments pertaining to environmental health and sanitation obtained from national and international organisations.
Training of Traditional Midwives

● To conduct a census of wang’hunga and record their locations and ‘clinic' status. What equipment do they use?

● To learn about the knowledge, practice, attitudes, scope and concepts of work of wang’hunga. Are they aware of the Chama Cha Waganga organisation?

● To respect the attitude of the general public towards wang’hunga and their activities; their social and personnel status.

● To invite them to participatory workshops and training.

● To assess the current functional relationship between wang’hunga and the formal health-care system.

● The distance from the nearest health facility to their ‘clinics”

● The history of their last pregnancy, delivery and puerperium

● On the use of traditional methods of care for themselves

It is important to note:

● A well-established and functioning information transfer between the wang’hunga and community leaders could be a very promising entry for community participation in maternal well-being and neonatal health.

● Their assistance should be sought in setting up ‘Births and Deaths’ Registration Offices or, in co-operating with the health facilities. They form a very important source of obtaining information on home deliveries. They also have intimate knowledge of the reproductive histories of women and could assist the health facilities in the maintenance of records.

● Training of wang’hunga needs to be done on a long term basis, and involve periodic reviewing by visiting staff, locally at the health facility. This would draw women to the facility in great numbers to deliver. These trained midwives could also travel and train others. If possible they could be paid an honorarium if not a government salary. As they are expected to support themselves, they do so by the fees paid to them in cash or kind for deliveries (and, in some cases, circumcisions). They need to be compensated in order to assist the health administration.

● Trained wang’hunga accompanied by nurse midwives should carry their own caseload and take full responsibility for the women in their care.

● The wang’hunga could also assist in the education women and men to address ill-health across generations.

At the Level of the Community

Health Field Schools: Afya Darasa; Film medium

It seems to me that as community oriented field school experiments in forestry and livestock have done exceedingly well in developing countries, the principles guiding field schools could be applied to health also. The Field Schools are not a new idea, just an effective idea that has been ignored by those caught in the system of top-down research message delivery and who too often turn a deaf ear to time-tested wisdom that privileges local beliefs and values. Field Schools succeed because they provide basic scientific conceptual frameworks and knowledge through democratically run, participatory field groups- everyone is given a chance to make a presentation or raise
questions.

A field school could be held anywhere— in a clearing, a field or under a tree or outside the VEO’s office or health facility. Ideally it should be held when it is cool and people are comfortably seated. The idea of a school ‘without walls’, *darasa wazi au schule huru*, indicates an approachable, open-ended, non-judgemental method to learning through dialogues and discussions that highlights gender sensitive approaches to community priorities, linking them to health sector.

**EDUCATION OF THE HUMAN BODY – CULTURAL**

<table>
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<tr>
<th>Training of Trainers (technical-facilitator)</th>
<th>Health Field Schools</th>
<th>Community Action</th>
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<td>Basic science: Female and Male Body</td>
<td>Women/Men/ Music</td>
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All discussions must be done in the local languages. The purpose of such periodic gatherings, once a month or once in two months, is to describe and discuss the human body and bodily functions in simple locally understood medical terms, including male and female through all stages, birth to old age, specifically discussing reproduction. All the bodily changes girls, women, men and boys undergo will need to be explained.

- Nutrition and dietary habits need to be discussed.
- The rites of passage will be discussed separately. The medical effects of female circumcision will be shown on film – and discussed. The lifecycle and roles of men and women, boys and girls will also be discussed at the gathering.
- The work-load of women will be discussed as well as that of the girls. The work and daily activities of men and boys will be discussed. For example, in a discussion, men could be asked if they—Think about their pregnant or tired wife too?

*Hono akubita ku sibatali mtegulaje.*

Escort their wives/lovers to the antenatal clinics?
*Mchekulu yono yading’hvye siiku sachigwa yetume malimo.*
Ask her to rest and not perform hard tasks?
*Mlajilaje vyono umwendile.*
Take care of her, etc.

- All education needs to be done through gentle dialogues and discussions. The participants would provide input by raising questions and conclusions will be noted.

Separate groups of men and women, and girls and boys – age sensitive – will be maintained if required for some discussions, in order to listen to and draw out community experiences as also to create new knowledge.

- Technical Facilitators: While there are many other programmes which have successfully provided good educational results, in these regions and beyond, given the specific conditions and values of the people, it seems that the setting up of Health Field Schools would be extremely useful. These ‘schools’ could operate on the principles of informal education – and will be sensitive to local metaphors and beliefs whilst educating them about the human body and its functions. The technical facilitators will be the *watemi, mganga* or *mng’hunga* – or Village Executive Officer/Medical Officer with
the participation representation from local girls, boys, men and women.

- **Film in local languages - Kigogo:** In most contexts in the developing world many people cannot read or write and even if a few do, they are not able to communicate effectively – the medium of film is invaluable. For instance, with regard to female circumcision, the body of a circumcised girl and that of an uncircumcised girl will be compared and the life cycle of both will be charted through to childbirth and by such illustrations discussions will follow. Also, sexuality and sex will be discussed by men and women separately, with boys and girls in attendance in respective camps. Women must be encouraged to discuss their reproductive histories and emotional worries openly with each other. There needs to be dialogues initiated among women and men themselves about issues that concern their well being such as polygamy, civic education, nutrition habits as much as to be able to afford decent livelihoods.

- **Teaching of Basic science/ knowledge of the Body and health care:** could be explained in Kigogo and, in the best ethnographic traditions of literacy education, so could village-level basic health care. This would enable the local people to:
  1. Understand and explaining the epidemiology in simple terms.
  2. Understand the main causes of maternal and neonatal mortality.
  3. Define elements of essential health care.
  4. Understand and discuss best low cost practices and technologies for promoting good health.

- **Gender:** Exchange of ideas on men and women: In these ‘schools’ men and boys could initiate discussions on girls and women and their own responsibilities towards them. Fatherhood and having many progeny could be discussed as well as polygamous liaisons. Through such discussions in both institutional and community settings, locals are trained to identify and analyse both the formal and informal aspects of health care systems, and to reflect on the gendered nature of relationships between the socio-cultural and biomedical dimensions of health and illness beliefs and behaviour.

- **Participatory workshops set up to explain commonly occurring infections and wasting diseases such as Tuberculosis, Anaemia, Trachoma, Schistomiasis and Ticks – and what prevention measures can be undertaken by individuals and by the community at large.**

- **In relation to Tick borne diseases and other debilitating conditions, such as trachoma, the MOHSW - Epidemiology and Diseases Control Section controlling both non-vector borne diseases and vector borne diseases has excellent guidelines:** Formulate and develop policy guidelines and manuals for vector borne and non-vector borne diseases and epidemics; Collect and analyse data for vector borne diseases and non-vector borne diseases; Co-ordinate vector borne diseases and non-vector borne disease control, surveillance, and collaborate with other institutions in research on vector borne diseases and non-vector borne disease control; Co-ordinate, monitor and evaluate implementation of vector borne diseases and non-vector borne diseases policy guidelines and programmes. Finally, monitor drug sensitivity pattern of vector borne diseases and advise on interventions.

The dialogues for some of these issues are incorporated in the health education policy guidelines of the MOHSW which seeks to: co-ordinate the designing, development and distribution of health information, education and communication materials in the country; formulate, promote and coordinate research activities in liaison with health systems research in the field of health education within the community; promote intra-sectoral and, inter-sectoral collaboration by establishing a forum for information, education and communication; provide consultancy services on health education issues
to individuals, health related sectors, NGO's and the community; ensure that delivery of health education is in conformity with the national health policy and finally, to monitor and evaluate implementation of health education policy guidelines.

Health Workers

● Introduction of revised incentives and improved salaries:
As discussed, the salaries of the health workers are woefully inadequate to cover the costs of their livelihood. Many health workers perform additional tasks often taking on other duties that should be performed by appropriately trained personnel. They also work very long hours and often are alone in the Dispensary or health centre.

They need to be compensated. Most agreed that the take home salary is graded but the minimum must be 300,000 TSH at the lowest level— that is after taxes are deducted.

● Education and Re-training of Health workers:
National programmes to strengthen links for district and staff delivery services are in existence, but the administration of training and refresher courses need to be re-visited by the relevant Department of health education in the MOHSW.

Medical educators have a responsibility to train physicians and other health professionals in the core competencies needed to improve the sexual and reproductive health of their communities.
● It must be made mandatory to behave with professional propriety. And, to practice politeness, to avoid verbal behaviour that is rude, arrogant or patronising and to resist making denigrating remarks or otherwise humiliating patients, which many women seeking sexual and reproductive health services complain of in nearly all the facilities.
● Teaching skills need to be improved and smaller classes can be encouraged to assist students better. Experts and former retired lecturers could be invited from other universities, or overseas, as long as they can bear their own maintenance costs and housing is provided for them. Many students are completely dependent on their lecture notes to pass the final examination.
● Libraries need to be updated and several copies of the important books must be made available as well as research papers.
● Tutorials and weekly presentations by students must be included in the syllabus. Practicals should be made mandatory.
● It is necessary, therefore, for all trainees to spend periods of time attached to health centres in remote areas in order to get adequate training and experience in dealing with day-to-day problems and emergencies when there is effectively no access to properly equipped theatres for teaching.
● By allocating sufficient time for such attachments, some of the short staffing would also be addressed. It may also be necessary to supplement training for students intending to work in remote areas with additional advanced vocational training, provided in small groups.
● Laboratories must be modernised. Low cost laboratories have proven to function effectively with trained personnel. Surgical procedures must be introduced and all equipments explained. Also, students must be initiated into their work whilst studying.

● To reduce the degree of understaffed personnel, medical students training as Doctors could be sent for one year after internship to villages in the districts and they could re-train the health workers while they are in residence working at the facility. They could also visit out-reach areas and teach sanitation and preventive medical care to the locals.

● Direct entry to a midwifery programme, with comprehensive training in obstetrics and related subjects such as paediatrics, family planning, epidemiology etc. has been acknowledged as both cost-effective and specifically focused on the needs of childbearing women and their newborn.
Midwives and Clinical Officers should be taught how to perform Caesarean sections, placenta removal hysterectomy and surgical procedures to repair fistulas.

ANC, puerperal to postpartum care

A PERSONAL PLAN

All pregnant mothers who attend ANC must be encouraged to give birth in the health facility and be allowed to articulate a personal plan for childbirth. This should comprise an individually tailored personal plan determining where and by whom birth will be attended, made with the woman during pregnancy and made known to her and to the family. They should be given assurances and other forms of support and told not to worry if the pain is not strong but get ready to come to the health centre. If necessary, the midwife-nurse should be able to go to the woman's home.

PROCEDURES:
1. Risk assessment of pregnancy during prenatal care, re-evaluated at each contact with the health system and at the time of the first contact with the caregiver during labour, and throughout labour.
2. Monitoring the woman's physical and emotional well-being throughout labour and delivery, and at the conclusion of the birth process.
3. Offering oral fluids during labour and delivery.
4. Allowing her to express herself without censure.
5. Respecting women's informed choice of place of birth.
6. Providing care in labour and delivery at the most peripheral level where birth is feasible and safe and where the woman feels safe and confident; allowed freedom in position and movement throughout labour. Encouragement of non-supine position in labour.
7. Respecting the right of women to privacy in the birthing place.
8. Empathic support by caregivers during labour and birth - allowing them to keep their amulets and charms and also, if they wish, to be accompanied by the mng'hunga.
9. Respecting women's choice of companions during labour and birth.
10. Giving women as much information and explanation as they desire.
11. Non-invasive, non-pharmacological methods of pain relief during labour, such as massage and relaxation techniques.
12. Foetal monitoring with intermittent auscultation.
13. Single use of disposable materials and appropriate decontamination of reusable arterials throughout labour and delivery.
14. Use of gloves in vaginal examination, during delivery of the baby and in handling the placenta.
15. Careful monitoring of the progress of labour, for instance by the use of the WHO Partograph.
16. Prophylactic oxytocin in the third stage of labour in women with a risk of postpartum haemorrhage, or endangered by even a small amount of blood loss.
17. Sterility in the cutting of the cord.
18. Prevention of hypothermia of the baby.
19. Early skin-to-skin contact between mother and child and support of the initiation of breast-feeding within 1 hour postpartum in accordance with the WHO guidelines to breast-feeding.
20. Routine examination of the placenta and the membranes
21. Visiting the residence of the Mother for check ups every month or three or six months depending on her condition

Emergency Obstetric Care

- Emergency Obstetric Care should be made available in formally trained midwife-managed maternity units within and outside hospitals preferably - accompanied by the wang’hunga.

It should always involve skilled attendants and a 24-hour Emergency service.

Drugs – need to be in emergency health kits
- Ampicillin, Amoxicillin, Metronidazole, Nystatin, Cloxacillin, Erythromycin
- Gentamicin, Penicillin G, Benzathine benzyl penicillin, Ceftriaxone
- Sulfadoxine – Pyrimethamine (SP)
- Isoniazid
- Nevirapine, Zidovudine (AZT), Co-trimoxazole
- Silver nitrate solution (1%), Tetracycline 1% ointment, Polyvidone Iodine solution 2.5%
- Vitamin A, Vitamin K, Folic Acid
- Ringer’s Lactate

Equipment and supplies
- Newborn face masks, resuscitation bag
- Suctions apparatus (bulb, mucus extractors, mechanical suction)
- Thermometer (axillary) – as low as 35 ºC
- Thermometer (rectal) – as low as 25 ºC
- Foetal Stethoscope, baby weighing scale
- Delivery kit, gloves, syringe, needles
- Disinfectant solution, gauze, gentian violet

Other materials
Clean delivery kits – at least 50 sets, baby cups, wraps, soap, and baby diapers

All health facilities should have new born face masks, resuscitation bags and suction apparatus.

Summing up –

From these interventions, indicators can be developed for policy making that would incorporate listening posts capable of monitoring community response to community health work within the national primary health work programmes. This would in turn assist in a comprehensive review for the joint programme to be integrated as part of the overall health sector review, policy making and implementation strategies.
ANNEXE I: Health Training Manual

Q1: Why a Health Training Manual? Why was it developed to be used for UNJP2 Ethnographic research?

This health training manual has been designed for training health workers in Tanzania – at all levels from the medical attendant to the RMO – on how to incorporate gender-sensitive social and cultural realities experienced by pregnant mothers, their husbands or men who made them pregnant, young girls and boys and their families into biomedical practices.

This manual was written primarily in order to train health workers who were engaged in Ethnographic Research and can be used for participatory training of health workers in professional health programmes.

Developing a training manual came to be seen as a necessity to provide an essential component of the training programme in Ethnographic methods, in the hiring of research assistants. Training manuals are required, not just to support the training objectives but also to broaden the scope of these objectives during the course of the field work. The main reasons for developing the manual are as follows:

The health workers, mainly nurse-midwives, hired as research assistants were not trained in participatory field work research and were not knowledgeable about what was meant by ‘gender’, or ‘gender-sensitive research’ or the critical significance of social and cultural beliefs. At the time of training, teaching them the guidelines as listed below was necessary so that they felt confident and were equipped to carry out the fieldwork.

Using a formal training manual helped to ensure that there was consistency in the presentation of the content of the training programme. All the training information on skills, processes, and other information necessary to perform the tasks were together in one place.

Although training forms one aspect of the fieldwork and research, in practice the realities that they are likely to encounter can often be unexpected and the hardships of living without electricity and water require great stamina and commitment to the Project. There was no means of predicting how the research assistants would perform or how much they were willing to learn and improve their cognitive and communication skills. Thus, the hiring of the RA’s was in itself a big challenge: some experienced difficulties and just left the field after a brief stint, others endured those difficulties and stayed the course and completed the fieldwork in keeping with the methodology.

Thus, it was important that well-spoken, honest and trained health workers were selected, not only because as health workers they enjoy a privileged status, but also because issues surrounding reproductive health require considerable sensitivity and demand great patience.

Q2. What is Ethnographic Research?

Ethnography involves the researcher’s study of human behaviour in the natural settings in which people live. Specifically, ethnography refers to the description of social economic, political and cultural systems based on fieldwork in which the investigator is immersed in the ongoing everyday activities of the designated community for the purpose of describing the social context, relationships and processes relevant to the
issues being examined – in this case all matters related to maternal mortality and neonatal deaths – that may require investigating. This included all aspects – and sometimes going beyond reproductive health. Ethnographic enquiry focuses attention on beliefs, values, rituals, customs, taboos and behaviours of individuals interacting within socioeconomic, religious, political and geographic environments. Ethnographic analysis is inductive and builds upon the perspectives of the people studied. Ethnography emphasises the study of persons and communities, in both international and domestic arenas, and involves short or long-term relationships between the researcher and research participants. Multiple methods are used in ethnographic research. These include but are not limited to the following: unobtrusive direct observation, participant observation, and unstructured interviewing, discussions with individuals and community members, analysis of texts, and audio-visual records. Ethnographic methods can be employed in non-traditional ways in interdisciplinary projects that bridge the sciences and humanities.

Q3. What is meant by a participatory approach in ethnographic research?

Participatory Approach

Go to people,
Live with them,
Learn from them,
Love them/accept them

Start with what they know, and ask
How they would like to build with what they have,
Put them at ease and record activities,
When the work is done,
The task accomplished,

The people will say,
“We have done this ourselves”.

Mbini Shirikishi
Nenda kwa watu kwa unyenyekevu,
Ishi nao,
Jifunze kutoka kwao, Wapende.

Anza na kile wanachojua, na unawulize
Wanajengaje na kile walichonacho,
Watulize na urekodi kazi zao,
Kazi inapofanyika,
Jukumu limekamilika.

Watu wastasema,
“Tumefanya hili sisi wenyewe”.

The complexity and length of ethnographic research engenders an approach to ethics that is both dynamic and flexible. The process of obtaining informed consent may be continuous and incremental throughout the course of the research, and review of consent obtained may be periodic. Ethnographic research involves "a systematic investigation... designed to develop or contribute to generalised knowledge." Although ethnographic research takes place in natural settings and differs significantly from clinical research, ethnographic research projects are subject to review, in this case by National Institute of Medical Research, to ensure that the participants in the proposed research are not harmed. Because of its complexity, variable contexts, and duration of different ethnographic projects, ethnographic research should be reviewed on a case-by-case basis. Ethnographers should inform NIMR and participants how they plan to use and protect data from disclosure and if personal identifiers and other data will be preserved or
destroyed. They should inform participants of the possible benefits and risks of providing identifiable information and should also respect participants' wishes if the participants would like to be identified and/or credited.

Q4. What is Gender? And, what is meant by gender-sensitive research? Why is it important?

There continues to be a taken-for-granted belief in popular imagination that Gender is about women, to "add women and stir", implies having taken gender into account, that it is both of practical or, theoretical research value to study women and girls by segregating them from the men and boys, that is to ghettoise women. Another common practice is the concept of sameness, or the notion of universal 'woman' and 'man'.

However, images, attributes, activities and behaviour of women and men, girls and boys are always culturally and historically specific. Gender is what it means to be a man in relation to what it means to be a woman, what it means to be male and masculine in relation to female and feminine, or what it means to be a boy in relation to what it means to be a girl – that is, gender is about inter-relationships, between men and women, boys and girls and, includes intergenerational relations, as also how people within the same sex interact within age groups. This defines the role of gender in structuring human societies, their histories, ideologies, economic systems and political structures - all of which is conditioned by cultural values.

Also, the understandings of gender and masculinity that are being brought to bear tend to focus on biology - the Sex of the individual rather than Gender. However, it is precisely because the interaction between biology and culture is multifaceted and fluid that that we need to draw a distinction between the Sex of any individual and his or her Gender. By sex, biologists mean the specific genetic and hormonal makeup of the individuals and their secondary physical characteristics, which make the individual either female (XX) or male (XY).

Biological differences cannot provide a universal basis for social definitions – there is no universal fixed category of what constitutes a 'man' or a 'woman'. In the life of every person--biology and culture interact to produce differences in terms of their life experiences. Women and men are a product of social and cultural understandings; any changes in either, transforms understandings of categories ‘woman’ and ‘man’. After all, every person remains in a permanent relationship with other persons and with aspects of the natural world, in a way in which human and non-human elements are constitutive of the person.

In addition to birth and social status, gender identities are transformed through the physical and conceptual positions of persons through different scales of time symbolised during the ritual processes of birth, circumcision, menarche and the onset of puberty, marriage, loss of virginity, procreation, old age, death and immortality.

Thus gender needs to be understood as a process rather than a category, of "Doing gender" rather than the "Being" of it. The benefits of gender-sensitive ethnographic research maybe long-term and far-reaching. General examples range from helping men and women of all ages to record their ways of life as part of their heritage, to gaining recognition of their needs and rights. An understanding of institutions and processes of change through time can be gained, as well as assessing particular challenges institutions and societies face. Such research can benefit health care, by providing an understanding of health workers needs and those of the health institutions and processes of change through time, as well as assessing particular challenges institutions and societies face in general.

Q4. What are the Steps to be used for Ethnographic research? The first step is to ask the three health workers to write a detailed personal account in English about their lives from birth up until their current engagement with the Project. This should concentrate mainly on describing their family, the social
life at home, and economics and everyday problems. That is, they are to write about all events which they believe to have made them the way they are and, especially, to write in detail about their desire to become health workers and undertake training as midwives or nurses. They should then write about their medical training and education in detail and identify the strengths and weaknesses which they found when they took up their jobs as midwives and nurses. If they wish, they could write about their health centres or the facilities at the health centre; their colleagues and senior staff in the health facilities in which they worked and, also in their training institutes. Finally, they could mention the general attitudes they have experienced from their patients. If they wish these details to be confidential their wishes will be respected. The purpose of this exercise is to create an awareness of what is required of them and to initiate them into communicating through the written word as also to familiarise the CTA/CLT with their own backgrounds.

In the current Project, this task was given to them as the CTA/CLT did not know them or their levels of competencies. The CTA/CLT or Trainer needs to know these details in order to understand their values and experiences so as to be able to communicate with them whilst understanding and empathising with their outlook. Also, through their own observations about their lives as individuals, the levels of maturity and sympathies expressed educates the Trainer on how they will be able to cope and empathise with the various issues that this research seeks to unearth and examine. The responsibilities they feel, disappointments with the parent, teacher, heartbreaks in love and, in general, the hardships they have otherwise endured, all provide experiences which sensitise or harden them to life in different ways and which will, inevitably, be reflected in their communications and interactions at all levels.

Finally, the Trainer could evaluate their command of the English language as they were going to write their field notes in English. And, after that, s/he would know at what level s/he needs to pitch the training in the Ethnographic research methods.

STEP TWO
Give them a copy of the Methodology for the Project and ask them to read it in depth. Then ask them to narrate what they have read and explain the project and objectives of the research. Discuss if they have any medical problems or family issues that would interfere with their engagement in the field. They have to live in the villages and it was absolutely necessary that they “immerse themselves” – without which the ethnographic field work is deemed incorrect and incomplete. They have to do it at their own pace and discretion – if necessary slowly and stay in the area and gain the trust and co-operation of the people – women, men, boys and girls – in the communities and, also with the health workers in the local dispensaries, health centres and district hospitals.

They were told that it was essential to keep discipline and write each evening just before going to bed all those they meet and the conversations they have had – even what seems unimportant to them is required to be noted if it is said. A daily record is to be maintained – and, pens, note books, registers and maps were given to them. Tape recorders, cassettes, camera and torches were also provided.

STEP THREE
These are the instructions on personal behaviour once they are in the field:
Etiquette – be extremely polite, show respect and be honest. Learn the local language and communicate in it. Many locals do not speak Kiswahili and in some parts – Kisandawe and Kimaasai – only communicate in Kigogo, Kirangi or Kikaguru in the main. Wear attire that is not just comfortable to them but also fits in with what locals wear and that includes hairstyles. Shoes must be closed and they should take mosquito nets. Yellow fever vaccination is also important.
Boil water and take the necessary precautions and, take extra care not to fall ill. The women RA’s are told that should they feel at any time threatened by men in the field or sexually harassed they should contact the Village Executive Officer (VEO) and let the Trainer know.
The Trainer will communicate with them when she receives text messages, also just to know that they are coping well. She will call them weekly in the field.

STEP FOUR

RESEARCH ASSISTANT

MAKING A PERSONAL INTRODUCTION

Travel by public transport to the area and observe the conditions of travel. Make notes on the passengers and especially pregnant mothers or mothers with babies. How are they seated and how are they treated? Note the cost of travel, condition of the roads, quality of the food available at the roadside and other such conditions.

Upon Arrival to their destination:

Meet the Village Executive Officer and present the letter of Introduction letter by the Trainer to him or her and meet the Elders of the Village.

Building Rapport- a relationship of trust

Explain slowly and graciously the project and, if asked, state that they are researchers trained in health work. They are to say that they are not journalists and state that they are not from the government (for example, general fear of authority and the police - Field Force Unit (FFU) - Salaama wa Taifa, fear of government spies, or fear of being fined for alcohol brewing which is widespread. Many women are engaged in the latter and fear the government).

Thus from the start they are to define clearly why they are there in the field to all they encounter who ask them their business. That they are in the site because they are research assistants for the UNESCO Ethnographic project, that came about from the 'Delivering as One', ONE UN Joint Programme 2 which seeks to reduce maternal mortality and neonatal deaths and by doing so addresses a wide range of interconnected issues that plague their lives. Thus to state that the project was designed specifically to learn from the local women (and men) what their troubles and experiences of life and health are and what were their explanations for their customs and beliefs and how best they believe they could be assisted so that they could enjoy better their lives as mothers and fathers, as young girls and boys so fulfilling what they are expected to do according to their families' expectations.

Seek the advice and help of the VEO with their accommodation. They are to stay among the people in the community and immerse themselves - and assist if required. They will gather information during their stay and record only if allowed to do so and respect confidentiality at all stages. Staying in one area is critical to the research as they can build relationships and interact with the local people.

An important point here is that in this respect they are to be given complete freedom without any interference from the CLT/CTA or the Trainer. They should know/be able to feel they belong to the place and that their observations matter and they need to establish relationships with locals and forge networks of understanding to foster discussions and dialogues.

STEP FIVE

The same explanations given to the individuals in the various communities are to be offered to Health workers at all levels of the health administration - from the RMO, DMO's, Assistant Medical Officer, Clinical Officer, Midwives, Nurses of all levels, Laboratory Technicians, Laboratory Assistants, Nurse Auxiliary, Medical Attendants and Walensi.(watchmen)
In this case they should stress that this project’s objective is to study both the needs of the community and the requirements of health workers at all levels of the health facility – from the Regional Medical Hospital (Referral) to the District Hospital, Health centre and the local dispensary.

STEP SIX

FIELD WORK and RELAXED CONVERSATIONS

All questions must be couched in conversational form and asked carefully, not in an interrogatory style. No questionnaires are allowed at any stage; people lead the conversation and the formulation of the questions emerges from such conversations which are open-ended and relaxed. As the field work progresses, many more questions will be generated than the ones listed below but those given here can be taken as a guide:

What constitutes the setting?

Records from the VEO’s office - population, men and women, boys and girls; the number of households, water availability, electricity, pit latrines and latrines, etc – as many details as he or she has recorded.

Bwana Shamba – who maintains records of the climate, livestock, cropping patterns, soils and in general is in the know about horticulture and forestry.

What constitutes the local environment?

Geography - the terrain; soils, main crops and harvest; climate, the seasons and rainfall; field sizes; cropping patterns; storage of food animals – cows, goats and poultry. Who are the big and powerful families, and how many owned animals and poultry? Any further suggestions?

History - constructing history of the area from popular understandings. How beliefs are echoed through fears and hopes; traditional received wisdom and knowledge.

The lives of the participants

(i) Livelihoods - How does an individual family make a livelihood; what is the nature of work that men do and women do – including boys and girls of all ages?

(ii) Daily work patterns - women and men; boys and girls;
Size of the family; Accounts of pregnant mothers at work, from the time they wake up to the time they go to bed at night.

(iii) House - description and utensils; hygiene and nutrition. Eating patterns and diet.

(iv) Social, sexual and emotional relationships: Interactions between men and women - How do women feel in these accounts from individual women and girls, especially pregnant mothers and mothers? What are their main thoughts on what it means to be a girl, a woman and through different ages, that is life stages? How do they feel about men and boys? What are their daughters and girls supposed to be like? What were their mothers supposed to be like? What is the role of the father? What was the role of the grandmother and the grandfather?

(v) Social, sexual and emotional relationships: Interactions between men and women - How do men feel in these accounts from individual men and boys, especially about their pregnant wives and mothers? What are their main thoughts on what it means to be a boy and a man, through different ages and stages. How do men feel about women and girls? What are their daughters and sons and boys supposed to be like? What were their
mothers supposed to be like? What was their role as fathers? What was the role of the grandmother and the grandfather?

(vi) Inter-generational interactions: Interactions between women and boys and girls, and between men and boys and girls. Children and the upbringing of boys; Upbringing of girls.

(vii) Body-Knowledge of the human body: Girls and women; boys and men—what are their understandings? What are their proverbs and beliefs. What is the body of an ideal girl and a woman? What is their notion of the ideal body of a boy or man? And his desired character and form of behaviour?

(viii) Individual reproductive histories of girls and women: How do they find the health facility and how many times do they go to the Ante-Natal Clinic?

(ix) Personal experience of giving birth with the help of the local Mng’hunga (traditional Midwife): What was the experience like; can she describe it and the suggestions given by the Mng'hunga? If possible ask the woman being interviewed to accompany the RA to the Mng'hunga and discuss the childbirth and customs.

(x) Ask the Mng'hunga to educate the RA on what she believes to be important during childbirth and what rituals need to be followed from conception to birth. For example—

How they came to become traditional midwives?
Discuss their knowledge about the body and explanations they offer to pregnant mothers. What roots and herbal medication are being prescribed and why?
What are the practices they follow at childbirth and beliefs involving spirits, séances and magic?
What are the conditions of work and civic procedures that they follow? And, what preparations are in place when a pregnant comes in ready to give birth?
What does the mng’hunga think of present day society and what are her views on women who visited her? What is her opinion of men?
Could she give samples of her medicine?
Would she like to say anything about what could be done to help her assist women better?
And so forth

(xi) Female circumcision: how widespread is it, and why?
Record description of a ceremony and talk to all the women concerned including, if possible, the grandmother of the girl.

(xii) Songs and Festivities: rites of birth, circumcision and marriage.

(xiii) Taboos and Restrictions: what are seen as taboo and why? And, dietary restrictions and beliefs surrounding girls and women—menstruation, pregnancy, childbirth and breastfeeding.

(xiv) Prostitution: How is it regarded— and how is it practiced by women? Who are seen as prostitutes? What do men and boys feel? What do women and girls feel?

(xv) Polygamy: How widespread is it and how do the women see it? The men who practice it and children; households and expenditure; and consequences.

(xvi) Local business and Alcohol processing; food crops.

(xvii) Pregnant mothers and the health facility: What do they truly feel about medical care at the government health dispensary/health centre, District hospital and regional hospital. How did they get pregnant and are they happy with the man or husband who made them
pregnant?
Which pregnancy is this – and discuss their reproductive history.
How regularly do they menstruate and what do they feel about their own health and their own prognosis?
How did they know they were pregnant the first time?
How is the Antenatal Clinic examination done? What did they feel about their visit and advice was given to them?
Did they benefit by the visit?
How did they go to the Antenatal Clinic?
How often do they go there?

(xvii) Detailed accounts of individual cases and treatment the individual women recall being meted out to them:
Comparison with traditional midwives and medically trained midwives/nurses at the health facility.
What was the ANC visit like? What did the nurse do and what is their opinion of the facility and how can the government improve it? What needs to be done for it to be accessed and used by pregnant women for delivery?

The Health Facility
What is the facility - centre or dispensary, hospital or referral? Number of rooms for RCH care?
How many staff in the facility looking after reproductive health? Describe their status and hours of work.

Is there water? Is there electricity?

Condition of the facility – beds for pregnant mothers, mosquito nets and malaria prevention; hygiene; latrines and availability of food for mothers.

Record keeping of pregnant mothers - To what extent to they keep records about the pregnant mothers, how do they take notes, and what are the procedures in place?

Delivery records – To what extent to they keep records about the deliveries? Are they recording deaths of mothers and babies? Are they recording births?

How do they treat pregnant mothers when they arrive at the facility?

What about the Staff? What are their opinions on the pregnant mothers who arrive for ANC? Do they test blood pressure, anaemia and inform the mother of the result of these tests etc?

What requirements and demands do they make of pregnant mothers?

Are the mothers charged fees? If so, in cash or kind?

Narratives from each member of staff looking after reproductive health:

What are their main grievances?

How do they regard their education – when did they get their diploma and how many years have they been working since their diploma? Why did they take up such an education?

(xiv) What needs to be done to improve RCH care in their opinions?

(xv) According to them, what are the main causes of MMR and Neonatal deaths?

(xvi) What is their opinion, if any, of the fathers of the pregnant mothers?
(xvii) What suggestions do they have to create a network and dialogues between them and the community at large?

(xviii) How does the Medical staff interact amongst themselves and what tensions do they experience in such interactions?

(xix) What kind of suggestions would they like us to record to assist them so that they can feel greater satisfaction in their working conditions?

(xx) What is their opinion of the health administration? How do they regard the Ministry of Health's directives? How could the MOH be more effective in its programmes and how could they assist the MOH? Do they have any suggestions?

(xx) Would they consider working alongside or training traditional midwives? Would they consider learning from traditional midwives how to talk to and treat pregnant mothers given the beliefs and fears they experience?

(xxii) What do they think of local women's beliefs in witchcraft and magic? How do they deal with it and what remedies do they prescribe?

(xxiii) What are their own suggestions about the many maladies and dangers inherent in life that one needs to guard against, in the case of women, men and girls and boys?

The same questions are to be asked of the male healers and, also, anxieties and problems that men and boys faced in general should be explored as well as medicinal prescriptions.

Writing

Each evening all conversations must be recorded and dates and times of each conversation noted. If necessary, notes must protect the anonymity of the individual if she or he should so request.

Once a fortnight the notes must be reviewed and put into order and details recorded. Each month a monthly report must be written and submitted to the CTA/CLT.

The RA should, whilst creating a network of relationships within the area, identify further lines of enquiry that need to be pursued. This is because research is iterative and one step leads to another.

The language of communication must be local dialect and it must be respected. If words are not clear or not understood, the RA must not translate them, but the spellings must be done correctly for example, in the case of proverbs and old songs.

Tape recordings must be done correctly and, as always, the Ethical Codes must be respected.

Photographs must be taken with permission of the individual or individuals.
APPENDICES
APPENDIX I: To Whom it May Concern

KWA YEYOTE ANAYEHUSIKA


Nitafurahi zaidi ikiwa utashirikiana naye, na kumsaidia. Ikiwa unahitaji maelezo zaidi kwa ufanuzi, unaweza kuwasilisiana na mimi.

Ahsante sana,

Wako Mwanimifu,

Dr. KUSUM GOPAL,
Chief Technical Adviser/Consultant UNESCO.
UN Joint Programme 2 Reduction of Maternal Mortality and Neonatal deaths
UNESCO Sub-Office
P .O. Box 1950
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Telefax: + 255 26 2323388
APPENDIX II: Memories of Hunger in Ugogo

<table>
<thead>
<tr>
<th>NAME OF HUNGER</th>
<th>YEAR IT HAPPENED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Chonyamagulu</td>
<td>1860</td>
</tr>
<tr>
<td>2. Mudermu</td>
<td>1870</td>
</tr>
<tr>
<td>3. Magubika</td>
<td>1888-89</td>
</tr>
<tr>
<td>4. Nzinje</td>
<td>1894-5</td>
</tr>
<tr>
<td>5. Sabatele</td>
<td>1913</td>
</tr>
<tr>
<td>6. Matunya</td>
<td>1918-19</td>
</tr>
<tr>
<td>7. Wanyanbwa</td>
<td>1919-20</td>
</tr>
<tr>
<td>8. Nzalandele</td>
<td>1924-25</td>
</tr>
<tr>
<td>9. Mabilazi</td>
<td>1928-29</td>
</tr>
<tr>
<td>10. Joni/Masaje</td>
<td>1939-44</td>
</tr>
<tr>
<td>11. Hambaya</td>
<td>1946-47</td>
</tr>
<tr>
<td>12. Mvunje</td>
<td>1949-50</td>
</tr>
<tr>
<td>13. Maumau/Machingo</td>
<td>1953-54</td>
</tr>
<tr>
<td>15. Matama</td>
<td>1961-62</td>
</tr>
<tr>
<td>16. Makombele</td>
<td>1962-63</td>
</tr>
</tbody>
</table>

Source: Mzee Mabwe, who recited from memory —

Recorded also by Mathias Mn'ynamapala in Historia Mila na Desturi za Wagogo, 1964.
APPENDIX III: Months and Festivals of the Year

Dodoma Region

Mosi - first rains - December
Mhiri - rains everywhere - January
Mhalungulu - cessation of rains - February
Munye - possessing and enjoying fresh fruits - March
Mwezi we litika - the month of plenty - April
Mwezi we lisololela - month we are going to reap - May
Mwezi we nhwanga - month of threshing - June
Mwezi we taga matoto - completed harvesting - July
Mwezi we tutula -- forest clearing - August
Mwezi we ndawa mbereje - digging up stubbles - September
Musisimuka - budding - October
Muchilanhungo - partial rains - not general - November

“The yearly calendar describes our agricultural activities. Along with these months there are celebrations - we know about them even if we cannot have cause to celebrate as life now is extremely hard.

Saigwa is performed during the months of November to February - primarily to entertain people in the evening, men jump up and down like the Maasai.
Mshunyunho is performed during March and April - rains divining for rains
Nindo - May to June - circumcision
Chasi or Chipanche is performed during circumcision
Ngoma also during circumcision or marriage
Isumbi is performed by men alone
Ndondondo is performed by a single man
Chisaigweda is performed at the death of a mtemi
Masemhegu or sinanule is performed in the grassy plains during the dry seasons
Chisinjila or chilimbara himbwa is performed like Ndondondo
Kabati or seli is performed by the eastern Wagogo especially in Mpwapwa.”

Narrated by Mr Patrick Kingola.

There are new styles of performance, over and above the ones mentioned
APPENDIX IV: Brewing of Beer

The common local beers are komoni and kangala. Every woman has her own way of making brews, but these instructions below are commonly followed to make komoni. It takes a total of more than ten days to brew beer.

Ingredients

Maize 4 cans - 'debe'
Water

Procedure

67. Soak the whole maize into water for two days.
68. Then remove from the water and put on the floor inside the house for two days to dry - 'unawamba'.
69. After that you take 2 kg of maize and grind it to obtain flour and after that soak the flour for 5 days. This is called 'kugongomoa'.
70. Then boil in the pot and leave it to cool for 2 days. Take the remaining part of maize and grind it - the flour is called 'kimela'. The boiled flour is called 'makomba'.
71. Mix 'makomba' and 'kimela' 4-5 litres; then stir the mixture on the next day.
72. Then take 2 debe (kimela) of maize flour and mix with 100 litres of water. The mixture is called 'kirusu'.
73. Boil the mixture at a high temperature and then cool the mixture.
74. Mix the 'kirusu' with 'makomba' and leave it until the next day.
75. 'Komoni' is ready for sale after filtering it.

A litre is sold for a price of 150/= and it should be finished on the same day. If it remains you throw it away. But if you have honey, you can add it and obtain another local beer 'kangala'. This is also sold for a price of 150=/=

Narrated by Mariam
APPENDIX V: Terms of Local Diseases

Cough -- nghololo
Headache -- mutwe ukutama
Stomach-ache -- mzireda
Eye infection -- meso yakutama
Pneumonia -- ichomi
Diarrhoea -- kuharisa
Epilepsy -- chinalisa
Vomiting -- kudeka
Ring worms -- mangoga
Anaemia -- sakamee msina
Labour pain -- usungu
Tuberculosis -- ng’ololo mbaha
Hypertension -- wetumbula
Oedema -- kufunjila
Margots -- mavunza
Gonorrhoea -- kisonono/mphungo ya chilumelume
Syphilis -- kaswende/sondo
Infertility in men -- mapinde gagwa
Haemorrhoids -- mgongo umetoka/kiuno
Anaemia -- Yasina sakami
Oedema -- Kuvimba migulu
Diarrhoea -- Kufwaka
Hypertension -- Chimbwa
Dysmenorrhoea -- sinda sikutama.
    Headache -- ditwi likutama
    Worms -- lusango.
Infertility -- msilatungula.
Circumcision -- kugotola
Measles -- iseleng’enyе
Hypertension -- Ndumbula
Epilepsy -- chisilisi
Halitosis -- iponja
Epitasis -- mfunung’hula
Goitre -- idefere
Impotence -- kamphende
Abortion -- kalafainda
Eclampsia -- chisilisi cha indа
Pneumonia -- vihomi
Malnutrition -- baridi
Tuberculosis -- lhumu
Sterility -- g’hakweleka
Polio -- ibelebele.
APPENDIX VI: Songs in Kigogo

LS: Tumekuja tumekuja na ngoma zetu za utamaduni x 2
Chorus: Tumekuja tumekuja na ngoma zetu za utamaduni x 2

Vijana wote tuchangamke hizi ni ngoma zetu tumerithi kwa mababu michezo ni burudani tena ni ku mbukumbu ya jadi zetu toka zaman i wata nzania wote tuimarish e jadi zetu na michezo ni burudani na kutunza mili yetu iwe na afya.

LS: Here we have come with our traditional dances x 2
Chorus: Here we have come with our traditional tunes x 2

All youth be cheerful with our traditional dances, it is our heritage from our ancestors, and sports is a recreation; also it is a souvenir of our culture since long time ago.

All Tanzanians we should solidify our cultural heritage and also sports as a recreation and to keep our bodies healthier.

LS: Nye liwanza lyangu nene x 2
Chorus: Nye liwanza lyangu nene hee nitya mzee mlanje x 2

Mzee Mlanje x 2

Nyhinda za kumwaga, hoile ku kilugalo x 2

LS: You all at my playing ground ooh! I say I invite you all to see our dancing styles x 2

The melody bells to put on our legs are plenty, ooh to the festival x 2

LS: Wakulima wa Tanzania shiken jembe tuinue uchumi x 2
Chorus: Wakulima wa Tanzania shiken jembe tuinue uchumi x 2

Jembe ae jembe ni mali
Jembe ni mlezi ndio baba na mama
Tena ni mkombozi kwetu sisi wata nzania
Jembe lina faida.

LS: All the farmers of Tanzania carry your hoe with your hands to go to boost the economy x 2
Chorus: All the farmers of Tanzania take your hoes to go to boost the economy x 2
Hand hoe ooh hand hoe is wealth
Hand hoe is the guardian is father and mother and also our savior we Tanzanians
Hand hoe is very profitable

LS: Nyee maciwa yakulonga cibite kulugalo oohie nye mawanza ge wayetu wakupingana na sese x 2
Chorus: Nyee maciwa yakulonga cibite kulugalo oohie nye mawanza ge wayetu wakupingana na sese x 2

Iwababa iwayaya nye mdinde izinyumba cibite ku lugalo

LS: Hallo Machiwa says, that we should go to the festivals ooh you, other
traditional dancing groups are competing against us x 2

Chorus: Hallo Machiwa says, that we should go to the festivals ooh you, other
traditional dancing groups are competing against us x 2
The fathers the mothers close the doors of your houses and come to the festivals.

LS: Nyee mmanyhe!

Chorus: Nyee mmanyhe mmanyhe anye wadodo mwanze kwogopa x 2

LS: Ninga Wachogwe!

Chorus: Shemeji, - Amekuja mtoto wa kaka nhondo zasimba,
Ane sing'husaka mnhaniye kaa nalema.

LS: Hullo you run!

Chorus: Hullo you run run, you the youths now start to get worried.

LS: But you Chogwe!

Chorus: Hullo you my in-law, today my brother kid has come, my mood is not at its best, I don't want to be teased, no I don't like that at all.
APPENDIX VII: Participants and Sites

List of the number of Health facilities and Staff who assisted this project. Below is the number of women, men, boys and girls with whom conversations were held in these principal sites – including those in the interior. In addition to the numbers listed below we could not list the women, men, boys and girls in the sites who did not wish to be included but only wanted their voices to be heard. The need for anonymity was very great in all cases. Also in some cases under eighteen's were hard to identify among the women some of whom were mothers, and thus women/girls.

MPWAPWA
In Mpwapwa, Rudi – Ihumwa, Ikuyu, Chogola and, Mpwapwa district hospital

Rudi Health centre

2 Clinical officers
2 Nurse Midwives
1 Nurse Auxiliary
3 Medical Attendant
1 Driver
The RA spoke to 64 people which includes the health workers. That is forty nine women, seven men and eight girls.

District Hospital

Mpwapwa has 103 health workers in its records-and the hospital has a total of eight wards
Doctors
AMO
Clinical Officers
Male surgical Ward – 4 nurses
Male medical Ward – 4 nurses
Female Medical Ward – 4 nurses
Infectious wards – Diarrhoea – 4 nurses
Maternity ward – 15 nurses
Infectious ward – Tuberculosis – 6 nurses
Paediatric Ward – 7 nurses
Female surgical ward – 4 nurses
Private Ward–Grade – 4 nurses
OPD – 6 nurses
Operation Theatre – 6 nurses

Of these the RA spoke to about 50 health workers and about 60 people, forty two women, three men and twelve and three boys.

KONGWA
In Kongwa, Zoissa–Leganga, Wangazi, Ngutoto, Mgodoka and Ndebesi; Mlali–Nghumbi, Pemba Moto, Chituli, Isagara and Kongwa District Hospital

In Kongwa town the RAs’ spoke to twenty two women and three men.

Zoisa
Dispensary
Senior Maternal and Child Health Aider (In charge of the dispensary)
Senior Medical Attendant
Nurse Attendant

Mkoka Health Centre
The RA spoke to one health worker.

The RA spoke to 32 people—twelve women, five men, thirteen boys and two girls.

Mlali
Health centre
Clinical officers – 2
Nurses – 4

The RA spoke to 39 people, which includes some of the health workers. That is twenty women, five girls and eleven men and three boys.

KONDOA
Mahungo- Atta, Potea, Kisese and Bambuta; Kwamatoro- Banguma, Masera, Kurio and the District hospital
Hospital
2 Medical Doctors – one DMO, one Dentist
9 AMO’s
10 Clinical officers
72 Nurses, 29 are trained, 43 are medical attendants
No pharmacist, but one nurse acts as a pharmacist

The RA spoke to 44 health workers and 55 people. Of the fifty-five, thirty women, eight men, twelve boys and six girls

Kwamatoro
Health Centre
1 AMO
3 Nurse–Midwives
1- Nursing Officer
The RA spoke to 27 people which includes some of the health workers
That is twenty women/girls and seven men.

Mahungo–
No health facility
The RA spoke to 14 people
Of these twelve men and two women.

Bambuta
Dispensary
1 Clinical officer
1 Auxiliary Nurse
1 Medical Attendant

The RA spoke to 17 people who include two health workers, that is six women, ten men and one boy.

Kisese
Dispensary
2 Nurses
The RA spoke to 3 people
That includes the health worker and two men

Atta
Dispensary
1 clinical officer
The RA spoke to 6 people including the health worker.
These were five men and one woman –

Maya Maya
No health facility
The RA spoke to 55 people
That is about twenty nine women, four girls, and twenty one men

CHAMWINO
Chamwino, Hospital- Fufu, Manzase, Ivondo, Mlowa Barabarani, Iringa Hospital,

Mtikira
Dispensary
1 Clinical Officer
1 Nurse-midwife
The RA spoke to 15 people including the health workers
Eight women, three men, three schoolgirls.

Mpwayungu
Health centre
1 Clinical officer
1 Nurse Auxiliary
1 Nurse-midwife
1 MCHA
1 Medical attendant – trained to be laboratory attendant
1 watchman
The RA spoke to 28 people including the health workers that is nine women, twelve men, four schoolgirls and three school boys.

Mlowa Barabarani
Dispensary
1 Clinical Officer
1 Maternal Child Health Aider
1 Nurse attendants
Nurse Midwife – away on training
The RAs’ spoke to 36 people which includes the health workers that is twenty six women and ten men.

Mvumi
Mission Hospital
and the neighbouring catchment area such as Fufu

The RA spoke to 44 health workers and 53 people.
Women in the Chigonela and those who came with them about forty and ten men and three boys

BAHI
In Bahi, Huzi- Mwapayungu, Mtikira; Maya Maya – Zanka, Chenene; Bahi- Bahi Sokoni and Haneti-Hiso.
Health centre

Bahi Sokoni
1 AMO
1 Clinical Officer
1 Nursing officer
1 MCHA
1 Laboratory Technician
1 Receptionist/cashier
1 Cleaner
The RA spoke to 38 people which includes the health workers. That is twenty women and six girls. And, ten men and two boys.

Haneti
2 AMO
1 health officer
3 Nursing officers
1 Storekeeper
1 Watchman
The RA spoke to 25 people including the health workers. That is twenty men and five women

Huzi
Dispensary
One medical attendant
Nurse on duty away
No clinical officer here.

The RA spoke to 30 people that is ten women, twelve men, three boys and and five girls.

DODOMA MUNICIPAL
In Dodoma, Dodoma town, Regional Hospital, Chibelela, Kikombo- Chololo

Regional Hospital
2 Doctors - RMO and one Dentist.

We spoke to 45 health workers and 359 people. That is two hundred women, seventy five men, thirty three girls and forty nine boys.

Kikombo
Dispensary
1 AMO who works once a week
2 nurse-midwives
1 MCHA (Maternal and child heath Aider)
1 Nurse attendant,
3 Watchmen
The RA spoke to 45 people, that includes the health workers, thirty two women and rest is unclassified.

Chibelela
Dispensary
1 Clinical Officer
Nurse-midwife - away
The RA spoke to 32 people including the health workers- Twenty eight women and four men.

These were the people who agreed to speak to us during the fieldwork, individually. Only a few of them agreed to be recorded. But the RA's and I continued to engage in conversations with many individuals or sometimes group discussions during journeys and at bus stops, shops and also during the months in-between reports in the Dodoma region. These numbers are not included in the figures cited above.
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