Childbearing in Contemporary Africa:
Situating Local Realities in Structural Inequality
Or:
What *Uchafu* Has to Do with Foreign Debt

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Chapter One:
Introduction to Childbearing in Contemporary Africa

Maternal mortality is disproportionately high on the African continent, with almost half of all maternal deaths occurring in Africa, though only 12% of the world's population resides there (WHO/AFRO 2003). Furthermore, the burden of maternal mortality and morbidity varies greatly by country, region, and community, by social and economic position, between rural and urban settings, by age, and even by ethnicity or culture. What social processes have created this inequality of safe childbearing, and what does it mean for the way women in Africa seek childbearing care? How can a shift in perspectives on childbearing in contemporary Africa reflect these social processes? I will explore this topic by looking at both macrosocial and microsocial factors which affect childbearing care, including history, policies, and economy of maternal health in Africa, the stratification of access to care between populations of varying socio/economic class, the cultural directives which influence how childbearing care is perceived and used, and the individual circumstances which relate to the outcome of a birth. I will anchor the importance of this integrative and critical perspective by providing an in-depth case study of Mombasa, Kenya. By drawing the boundaries of this stud

around the African continent, I am not trying to reinforce the concept that Africa is a homogeneous and isolated entity. Rather, I have chosen this scope to be able to highlight some of the common historical, economic, and political processes which have been foundational in the circumstances of childbearing in many diverse setting in Africa, as well as showing the diversity, inequality, and intersectionality that makes them irreducible to essentialized categories. This work will contribute to the study of childbearing in Africa by showing the importance of using an applied and critical anthropological perspective to uncover inequalities in safe childbearing.

In this chapter, I will introduce the topic of childbearing in Africa and the theoretical framework which I will use in my analysis. I will start by discussing the current dominant theoretical perspectives which are used when studying childbearing in Africa, and argue for the importance of critical medical anthropology in this field. Next I will give a historical sketch of African maternal health since early colonial contact, followed by an overview of the contemporary childbearing situation in Africa. Lastly I will discuss the contribution my work makes to the field of anthropology and the study of childbearing, and give a brief summary of the chapters which will follow.

Childbearing in Africa: Theoretical Perspectives

In this section, I will introduce some of the basic theoretical models which are dominant in the study of childbearing in Africa. Though each of

these models contribute key elements to my integrative, critical approach, I argue that none of them are sufficient on their own to examine childbearing in Africa fully. By combining these perspectives to apply a Critical Medical Anthropology approach, I hope to create a more complete and holistic analysis of childbearing in Africa than any one of these perspectives could produce alone.

Public Health Perspectives/Theoretical Models

Much work has been done from a Public Health or Development perspective to try to reduce maternal and child mortality. Public health interventions which apply to childbearing come from local, regional and national governments, international institutions, and non-profit organizations. Public Health efforts often synthesize perspectives from diverse fields, such as medicine, economics, anthropology, politics, epidemiology, and others to reach the common goal of improving health on a society level.

Biomedicine has been central to Public Health efforts, but the efforts to improve health through the increase in use of biomedicine has not been limited to clinics and hospitals. In my own contact with Public Health in Kenya and Tanzania, I have seen efforts that included educating the public about biomedically-defined health issues, improving roads to facilitate rural access to clinics, incorporating or training non-biomedical healers and childbirth assistants into the biomedical system, and a legal advocacy group for women's health, in addition to the work that happens in formal health

facilities. A central, biomedical goal has remained dominant in Public Health largely because of the efficacy of biomedicine in acute and infectious health problems, and its support from the international community (International Development Research Center 1989, Kenya Ministry of Health 2002, 2005, Ripple Africa 2008, WHO/AFRO 2003).

Biomedical interventions can have tremendous benefits for many people, such as with the near-eradication of polio due to widespread dispensation of the polio vaccine. It is important to recognize, however, that biomedicine is a socially produced and understood medical system, and it cannot be treated as a universal truth (Joralemon 2006). There are known values and disadvantages of biomedicine, as there are of any medical system. In addition, biomedical interventions cannot stand alone and be successful, but must be introduced and constantly re-assessed in each socially-specific setting.

The discipline of Public Health seeks to improve the health of all people, regardless of their nation or culture, and subscribes to the biomedical model. The global nature of this discipline lends itself to establishing global guidelines, parameters, and goals. This can be good because it allows for the comparison of information about health across nations, and gives a clearer idea about the health of the human population as a whole. However, global guidelines can also be problematic because they generalize the diversity and complexity of human health and health care, making their guidelines less

meaningful, useful, or effective in a socially specific situation. This study will draw on the work and perspectives of the Public Health discipline, while seeking to add a more culturally informed perspective to understand the positions of women who seek childbearing care.

Interpretive Perspective in Maternal Health in Africa

Anthropologists have always had an interest in the health and medical systems of the people they study, because health and illness is a central and culturally-specific aspect of life in almost any society. Traditional methods of medical anthropology focus on observing and documenting medical systems and the experience of health. More specifically, the interpretive perspective in medical anthropology aims to understand the networks of meaning and cultural frameworks in which people interpret health and illness (Joralemon 2006). An anthropologist who applies this perspective might study a specific illness in a particular society: learning how the illness is interpreted, the meaning attached to being afflicted, what people believe to be the cause, how one attempts to treat it, the kind of specialist or healers a sufferer may consult, and how medicines might be used to cure it, etc. An anthropologist who uses this model would not typically focus on the biomedical interpretation of the disease, nor would they discuss the relationship of the illness to international politics or economics in great depth. The methods used in interpretive medical anthropology require in-depth participant-observation to gain an intimate knowledge of the cultural framework of health.

This perspective can be useful when studying childbearing in Africa because of the depth of knowledge gained from long-term participant-observation. Where continent- or country-wide women's health initiatives tend to over-generalize the needs, conditions, and experiences of women in Africa, an interpretive approach to childbearing describes culturally-specific context and complexity. However, by isolating ethno-obstetric systems from their place in the contemporary globalized world, it is possible to miss how the meaning and experience of illness is connected to outside forces, like national health policy or neoliberal economic development. Furthermore, studying childbearing as a cultural artifact makes it difficult to recognize and criticize its relationship to the global network which has produced staggeringly high maternal mortality rates in the developing world.

A Critical Perspective in Medical Anthropology

Critical Medical Anthropology (CMA) seeks to study health, illness, medicine, and health care in its political, economic, and historical contexts in conjunction with the more traditional anthropological methods which emphasize specificity and cultural context (Singer 1986, Singer and Baer 1995, Lock and Nichter 2002, Castro and Singer 2004). Critical medical anthropologists argue that, especially in issues of health, it is necessary to examine situations from the individual level, the community level, the national level, and the international level (Singer and Baer 1995). Health has always been relevant to the work of anthropologists, but in the post-modern

era it became impossible to ignore the impact of *global* processes on the health and health care of all people (Singer 1986, Singer and Baer 1995, Lock and Nichter 2002, Castro and Singer 2004). This perspective allows anthropologists to analyze the connections between history, colonialism, capitalism, and biomedicine, and be critical of what these forces mean for the health of individuals and communities. This is in contrast to the public health perspective, which puts biomedicine as central and engages other structural or cultural factors less, and in their relationship to biomedically defined health. Most importantly, a critical perspective has the potential to put medical anthropology into action, by making it relevant to changing and complex health issues and policy-making (Castro and Singer 2004). This perspective will be central to my analysis of childbearing care in Africa, as I will try to integrate a critical macrosocial and microsocial perspective.

Methods

This work will incorporate research on childbearing in Africa from diverse fields. Anthropological literature takes a contextual perspective, which shows how the way people bear children is a product of their specific context. Accounts of the history of health, economics, and politics in Africa contribute to understanding the background which has produced contemporary situations of childbearing. Public health literature of various kinds provide a more society-level, and population-based perspective on childbearing, such as the prevalence of certain obstetric complications and utilization of different kinds

of care, as well as global and continental statistics about childbirth.

My perspective is also augmented by my own experiences studying, working, and living in Tanzania and Kenya for about seven months cumulatively between September 2006 and September 2007. While in Kenya, I conducted a self-designed, one-month research project about childbearing options and the way women and their families choose them in the city of Mombasa. I conducted in-depth interviews with women who have given birth in Mombasa, and had interviews and good rapport with five traditional midwives. In addition, I spent time observing women at a primarily maternal-child health clinic, and spent extensive time with the nurse-midwife who founded the clinic. Lastly, I spent some time observing and touring two private hospitals and the one regional public hospital. I will use my research and my conclusions to support this study, particularly in a case-study of Mombasa which will combine my work with that of Fatma Soud, an anthropologist and nurse from Mombasa who conducted her dissertation research on a related topic.

In addition to my research in Mombasa, my experience living and working with rural and urban people in Africa contributes to my ability to understand the issues of health care and childbearing on a personal level. I am conversant in Swahili, the *lingua franca* of East Africa, which has been enormously helpful in making personal connections with people and gaining a more general understanding of life in East Africa. Through friendships and

mentorships, I have heard firsthand accounts of the difficulties of accessing emergency care, paying for treatment, and the complicated process of choosing how to use various kinds of care.

Political and Economic History of Health in Africa

In this section, I will provide a brief historical summary of health in Africa since early colonial contact. More specific historical context will provided in the individual chapters as they relate to the topics discussed therein. This background focuses mainly on the way health in Africa has changed through the major political and economic changes the continent has experienced over the last several centuries. This will provide a basic foundation for understanding the political and economic history of health and childbearing in Africa.

The first western inquiries into the health of Africans focused mainly on the differences between Africans and Europeans. There was an emphasis on 'comparative anatomy' which aimed to prove that Africans were inherently different than Europeans and Asians, and were evolutionarily less advanced (Comaroff 1993). Early writing on health in Africa made observations (without criticism) about the different diseases and disease environments of Europe and Africa, claiming that Africans and Europeans were not evolutionarily equipped to manage one another's diseases. New diseases which were introduced by colonizers, such as measles and whooping cough

were indeed a problem for African populations, and other infectious diseases which had previously been present endemically, such as smallpox, flourished and spread due to the movement of people under colonialism through labor migration, porters, and military troops (Ranger 1992).

The colonial period of African history was characterized by the extraction of land and labor from African populations, putting increased strain on health and nutrition (Patterson and Hartwig 1978: 13). Steven Feierman has shown that previous to colonization, reproductive crises and health management were dealt with collectively by kin groups, but that migrant labor meant that these support networks were destabilized in many cases. There was an initial population decrease on the continent during colonization in the 19th century, followed by population growth in the 20th century, though this growth in population is not necessarily an indicator of improved health (Feierman 1985). Colonial governments had a serious concern for the stability of the labor supply, and many enacted strong pro-natalist policies, such as the Belgian government in the Congo (Hunt 1999), and the French government in former French colonies (Feierman 1985).

Missionaries and colonial hospitals provided some of the first biomedicine in Africa. Colonial hospitals built in the 19th century were created primarily to serve government employees and growing populations of white settlers. Colonial governments rarely intervened in the health of Africans unless widespread illness threatened the pool of inexpensive labor. The aim of

missionary clinics and hospitals was to aid in converting Africans (Hunt 1999, Ranger 1992), the “greasy, pagan savages” into “clean, civilized Christians” in a way that Jean Comaroff called “humane imperialism” (1993). In many cases, missionary medicine did not have any defined concept of what we now call ‘Maternal-Child Health’ (MCH) but cared for children primarily and women by extension as an act of Christian charity (Ladjali 1991: 125, Turshen 1991: 206). In the Congo, missionaries enacted pro-natalist agendas as a form of indirect rule from the Belgian government (Hunt 1999). In some cases, missionaries and the medical services they offered gave rise to independent churches, but in others, such as in the Masasi region of Tanzania, local inhabitants used medical services to their advantage among many other methods of therapy, and took little of the Christian message with them (Ranger 1992).

In the 20th century, new African states were formed through winning independence from colonial governments. In many cases, liberation struggles created a need for military hospitals, but the kind of care offered in that setting was mainly male-oriented and curative, instead of community-oriented and preventative (Ladjali 1991, Turshen 1991). Though most new African states struggled with creating and managing a new health system, many saw new improvements over the paucity of care provided by colonial regimes. Tanzania and Mali both became socialist states after independence, and showed public interest in providing equal access to health care and education (Richey 2003,

Turshen 1991). Mozambique gained independence in 1977, and created a promising health program with minimal fees, but these gains were destabilized by persistent attacks by anti-government resistance forces (Cliff 1991).

Economic hardships in Africa in the 1970s, along with growing concerns about overpopulation, led most African countries to adopt Structural Adjustment Programs (SAPs) in the 1980s from the International Monetary Fund (IMF), and to accept the stipulations and guidelines attached to aid and loans from other multilateral and bilateral agreements (Richey 2003, Cliff 1991, Turshen 1991). In Tanzania, SAPs forced the government to demand user fees from patients where health care had previously been free (Richey 2003), and in Mozambique the removal of food subsidies enacted devastating food price spikes (Cliff 1991). In Tanzania, the use of health staff for deliveries has steadily decreased since Structural Adjustment took place, showing that maternal health services have been put out of reach financially for most Tanzanian women (Richey 2003).

In this period of economic crisis and alarmism about overpopulation in the developing world, the primary focus on women's health was through an international interest in controlling the fertility of third world women. The Cairo Conference on Population in 1994 brought issues of women's reproductive health and autonomy into the discourse on health policy for women, but it was still enacted through the agenda of population control and

neoliberal economic development (Richey 2003). The discovery and proliferation of HIV/AIDS in Africa in the 1980s changed the dynamics of health and health policy for the continent drastically, not least by increasing the surveillance and control of sex and reproduction which was started by population politics (Richey 2003). In my experience working with village savings groups and health/community advocacy groups in rural and semi-urban Tanzania, older members expressed that there has been a drastic increase in the education and interventions surrounding issues of safe sex and fidelity in marriage, in response to the HIV/AIDS pandemic.

Today, health and economic policy from international institutions persists in making health programs conform to neoliberal-friendly development, even citing the economic impact of health in terms of dollars per lives lost or saved (WHO 2003). Increasing multilateral and bilateral agreements tighten the pressure on developing countries to conform to the agenda of the international development establishment, which Lock and Nichter have called “the new colonial forces” (2002). SAPs regularly increase the privatization of health care, which simultaneously decreases the access to affordable primary health care, especially to marginalized people. Many Non-Governmental Organizations (NGOs) have stepped in to try to fill the gap in primary health care in Africa. Though this process has helped to increase access, it also aids in the removal of national governments from their role in public health, by absolving them of their responsibility to serving their

citizens.

Contemporary Maternal Health in Africa

At the turn of the 21st century, there are at least 600,000 – 1 million maternal deaths each year worldwide, but only about 1% of those deaths happen in industrialized countries (Wall 1998, WHO/AFRO 2003). In Africa, the overall Maternal Mortality Rate (MMR) is greater than 1,000 deaths per 100,000 births. Though only 12% of all births worldwide take place in Africa, African births account for almost half of all cases of maternal mortality (WHO/AFRO 2003).

Maternal morbidity is even more widespread than maternal mortality, and can result in serious disability and suffering. It is estimated that for each woman who dies of pregnancy-related causes, there are at least 20-40 women who suffer from seriously debilitating injuries resulting from childbearing (Wall, 1998: 341).

According to WHO/AFRO, the biggest direct causes of maternal mortality in Africa include hemorrhage (25%), sepsis (15%), hypertension disorders (12%), complications from abortion (13%), and obstructed labor (8%). Indirect causes account for approximately 20% of maternal deaths in Africa. The major indirect causes include malaria, anemia, and HIV/AIDS. Long-term physical disabilities common to complicated births in Africa are chronic anemia, infertility, stress-incontinence, fistulae, chronic pelvic pain,

emotional depression and physical exhaustion or weakness (WHO/AFRO 2003).

The conditions of childbearing in Africa are similar in some ways to those of most of the developing world. High rates of malnutrition and infectious diseases such as diarrheal disease, malaria, and HIV/AIDS mean that many women are not in ideal health during pregnancy to begin with, and are less able to bear children safely (Soud 2005). Western biomedicine has developed some techniques and technologies which can intervene in complicated births, but these services are often sparse, expensive, inadequate, impossible to access, or otherwise undesirable to women and their families (Chapman 2006, Okafor 1994). Biomedical health care is particularly inaccessible for families who are rural and poor. Traditional childbearing practices have their own ways of perceiving, diagnosing, and managing childbearing and maternal risk, and in many cases, these methods are more accessible, affordable, or attractive to women and their families. In many societies, even in the industrialized world, social control of women's reproduction results in a lack of women's ability to advocate for their needs, rights and interests (Barnes-Josiah 1998, Feidler 1996, Wall 1998). All of these factors contribute to the high rate of maternal mortality and morbidity in Sub-Saharan Africa.

Many studies have been done to try to determine the social and economic factors associated with the use of prenatal and delivery care,

especially biomedical care. Though these studies often lack specificity and social context, they are helpful in providing a general look at the way care is used. Most studies have found that younger women, poor women, and women who are ethnically marginalized are less likely to use prenatal health care or deliver in a biomedical facility. Women who are in stable marriages, are educated or have an educated spouse, and are more economically stable are more likely to seek biomedical prenatal and delivery care (Celik 2000, Magadi 2000, McCaw-Binns et al., Soud 2005). I will situate these demographic studies in their global, economic, and cultural contexts to gain a more complete picture of the use of maternal health care.

Locations and Assistants of Childbearing Care

There is great diversity in childbearing care in Sub-Saharan Africa. Some women may have several different kinds of childbearing care to choose from, while others may have a very limited number of options. For example, a friend of mine in Mombasa, Kenya who is an upper-class woman with a college degree, accessed care from her family, a prenatal clinic, a private hospital and a midwife for her first pregnancy. By comparison, rumors in maternal-child health in Mombasa tell of Somali refugee women who can only afford to deliver at the regional public hospital or at home, assisted by family or the least expensive midwives. The rumors say that fear of the public hospital causes many refugees to stay at home, even in the event of an

emergency. These rumors, true or not, show the significance of the way women perceive various kinds of childbearing care in a medically plural environment, and how this affects the way they seek and use care. It is important to look at the location and assistants of childbearing care with many lenses: one which looks at the economic and political situation which put them there, another which looks at the power or authority which is found in those situations, and another which understands the way people perceive them.

Contribution to the Field

There has been much research in Africa about childbearing and issues of utilization of care, resulting in everything from location-specific accounts of ethno-obstetrics to World Health Organization publications on continent-wide maternal mortality rates. There are several reasons that there is so much interest in this topic at this particular point in time. The huge gap in maternal mortality rates between wealthier and poorer countries is particularly telling of the global stratification in access to health care and safe reproduction. Also, much of Africa is experiencing the introduction of western biomedicine inconsistently among traditional childbearing ways, which has produced unique and unexpected hybrid models of care. Both biomedical and traditional methods are framed by the economic pressure that many people are facing in Africa. Current research from many perspectives has tried to address these issues.

In this study, I will discuss the global, national, local, and individual

processes which impact childbearing in Africa. I will argue that this integrated, critical perspective is vital for understanding the complexity of maternal health in Africa. In Chapter Two, I will discuss how women and their families make decisions about childbearing. I will reference anthropological work which has explored risk-perception, medical pluralism and health-seeking behavior, and analyze it along with global and national processes which affect childbearing. Chapter Three will focus on the people who assist with childbearing. I will discuss the variety of assistants which participate in childbearing in Africa to emphasize the problems with generalizing this diverse group, while situating birth-attending in its political and economic setting locally, nationally, and globally. In Chapter Four, I will explore the significance of the place where childbirth happens through the concepts of birth territories and authoritative knowledge. This chapter will help to expose the kind of macrosocial and microsocial processes which shape authority in childbearing, and what that means for the places where women give birth. Chapter Five will synthesize the concepts discussed in the previous chapters by presenting a case study of childbearing in urban Mombasa, Kenya. This case-study will combine my own research on childbearing choices with the work of Fatma Soud. It will discuss how economic status, religion and tradition, and community pressure impacts the way the women seek and receive care, and how local politics, and national and international policies affect the medically plural environment in Mombasa. In Chapter Six I will

conclude my work by arguing for the importance of a holistic, critical anthropological perspective when studying childbearing in Africa, and discuss ways that this perspective can be included in policies, programs and initiatives which aim to improve maternal health. By studying these topics with an integrated and critical perspective, I hope to produce a holistic and useful analysis of childbearing in Africa.

Chapter Two:
Decision-Making: Risk-Perception, Medical Pluralism, and Health-Seeking Behavior

In this chapter, I will discuss childbearing in the modern African context by exploring the way that individuals and families navigate, seek and make decisions about childbearing care. Much international effort has been focused on trying to reduce maternal mortality by increasing the availability and use of biomedical services, but in many cases, these services have been deemed "underused" despite their relative accessibility (Chapman 2006, Okafor and Rizzuto 1994). What these interventions often fail to recognize, however, is that choosing not to use biomedical care is often a conscious, legitimate, and logical response to the complicated social, economic, and political circumstances of childbearing that women face. I am interested in understanding why women and their families seek childbearing care as they do in the first place, as a way to understand the other things they are seeking besides a physiologically safe pregnancy, and as a way to inform the role that the social, economic and political environment has on seeking care.

An example from a non-African setting with relevant political, economic, and social circumstances comes from *Reproducing Inequities* by

Catherine Maternowska (2006). She writes that high fertility and low birth-control use was identified in the urban slum of Cité Soleil in Port-Au-Prince, Haiti, through demographic data. Intense resources were focused on creating family planning centers and providing contraception to slum residents, yet these services were said to be 'underused' and high fertility rates persisted. However, through years of field work, Maternowska learned that non-use of birth control can often be a choice consciously made, when pleasing a man or securing his obligations through having a child can be a woman's strategy for survival. This example is telling in several ways: it shows how well-intentioned but broad plans for health interventions need to include more in-depth and context-specific knowledge to meet peoples' needs, that exploring the way people make decisions about health can show what they value and need, and that the way people are navigating particularly difficult situations of marginalization or economic hardship informs us of the superstructure of the global economy and its failure to rectify inequality in the developing world. These economic and social constraints on women in Port-Au-Prince are comparable to many situations of poverty and deteriorating social cohesion in contemporary Africa, and Maternowska's analysis shows that one must looked deeper than demographics to understand such circumstances.

Decision-making involves the particular cultural assumptions, family position, personal character and circumstances of each individual, making it ultimately unique and context-specific. However, that does not mean that it is

unrelated to the greater social contexts in which it takes place. I will explore how childbearing decision-making in Africa has been studied through analyzing studies of health-seeking behavior, risk-perception, and medical pluralism. By discussing decision-making, I intend to argue two main points: first, that one cannot make assumptions about the way people will and should seek childbearing care, because it is based in very complex circumstances which may not place a premium on biomedical efficacy; and second that the way that people seek, navigate, and interpret childbearing care is a reflection of the social, economic, and political circumstances in which it takes place.

Health-Seeking

The term 'health-seeking behavior' is used to describe the actions people take to improve their health, especially through treatment and care (Feierman 1985). The high rates of maternal mortality and morbidity in Africa are often framed in terms of the use of biomedical prenatal and delivery care, so there is a great deal of interest in understanding how people seek care. Much work has been done to look at the social and economic factors in a woman's life as they relate to her use of childbearing care and to find out why certain people are not utilizing biomedical care, so to find ways to increase their participation in the formal health sector. These efforts are generally done with the genuine intentions of improving safe childbearing, but I argue that they need to widen the scope and depth of their research to ask why people

seek care as they do, and what they are seeking besides physiological health.

Magadi et al. and Soud have both done studies of maternal health-seeking behavior in Kenya, and have found similar results. Magadi et al. used data from the 1993 Kenya Demographic and Health Survey to compare the frequency and timing of prenatal care between communities, between women, and between births. Their analysis involved 3,930 women and 5,104 births. Their results showed that higher socio-economic status, being married, being older, having longer spaces between births, and closer proximity to a biomedical health facility were all associated with more frequent use of biomedical prenatal care. They pointed out that within rural communities, use of prenatal care is generally low, but that in urban areas, there is wide variability in the frequency of use. They posited that this might be related to differences in cultural perceptions of health care, though I would imagine that income and the cost of care are a more significant factor.

Soud's study, which I will describe in more depth in Chapter Five, was based on her own research in Mombasa, Kenya, involving 265 Muslim women who had given birth within the previous six weeks. She looked at demographic characteristics and compared them to the utilization of prenatal care and the choice of delivery facility, and she asked women to explain the factors which impacted their decision-making. Her results concerning demographics and the use of care were fairly consistent with those of Magadi et al. She found that higher education, higher age, higher economic status, and

marriage were associated with more frequent use of prenatal care. Ethnicity and parity were significant indicators of the facility/location used for delivery. The costs of services, the services available, and the attitude of the care provider were significant for most women when choosing a facility for delivery, but distance from a facility or the religious affiliation of the facility was less significant.

These studies are helpful in understanding how the use of childbearing care is stratified by socio/economic class on a society level, but when it is time to put that information into action through policy changes or health interventions, they may have limited usefulness. Though they might show that a particular demographic group is not utilizing biomedical care, but they do not explain why. For example, according to Soud Mijikenda people, who are traditionally marginalized in Mombasa, have a low rate of use of hospital prenatal care. Is this simply because they cannot afford it? Is it because they discourage the use of hospitals? Is it because they prefer to ask family members or midwives for advice during pregnancy? If those women were to advocate for improving maternal child health in their communities, would they demand lowered user fees in the hospitals or more support for midwives? When studies indicate a low use of formal maternal health care services, one should not assume that an increase in the provision of biomedicine will necessarily improve maternal health. A deeper look into the motives and interests of women and their families can help to create a more socially-

informed approach to improving safe childbearing. In the next section I will discuss studies of risk perception, an approach which puts “why?” back into the conversation, though in some cases it does not sufficiently uncover the logic people use in seeking childbearing care.

Risk Perception

When a woman's pregnancy is considered to be 'risky', the way she seeks care can change drastically. But what are the risks of childbirth, and how can they be avoided? Risk perception is a culturally specific concept, and in this section, I would like to examine this idea as it applies to childbearing in contemporary Africa. While an obstetrician would consider persistently high blood pressure to be a sign of risk, and advise a woman to reduce salt in her diet or prescribe treatment, a Swahili midwives with whom I spoke in Mombasa consider persistently high temperature to be a sign of risk, and would advise the woman to avoid 'hot' foods, such as dates, chicken, or honey. The ideology in which a person assesses risk in childbearing can have a significant impact on the kind of care a person seeks, how frequently she seeks care, and at which points in her pregnancy.

Furthermore, there may be multiple, often competing viewpoints on maternal risk which can interact in a single birth. An example from my experience in Mombasa comes from a young, wealthy woman who wanted to deliver at home with a traditional midwife, but whose father and husband

would only allow her to deliver at a hospital, “just in case”. She received prenatal care both at a maternal-child clinic run by a nurse who is a family friend, and at a private hospital. When she was about one week overdue, her obstetrician at the hospital wanted to induce labor, but the nurse at the clinic judged that she was not at any risk yet, and should wait longer. After a few more days, the family decided to follow the obstetrician's advice, and induced labor. In this situation, multiple people perceived the riskiness of the pregnancy differently, and had different ideas about how to cope with that risk, which shaped the way that she sought and received care. There are also interesting dynamics of authoritative knowledge going on in this example, but I will be discussing that concept in more depth in Chapter Four.

Chinyelu Okafor and Rahna Rizzuto did a study of the perceptions women, traditional midwives, and formal health care workers have of one another in rural areas in four states in eastern Nigeria: Akwa-Ibom; Enugu; Rivers; and, Benue (1994). In the regions involved in the study, 60% of women give birth at home, and only 10% are seen by a doctor. The researchers had observed considerable animosity between traditional midwives and formal health professionals, and they wanted to find out whether this animosity had a role in keeping women from using biomedical services. They found differing risk-perceptions between the two kinds of care-givers, and identified “superstitions and misconceptions” among traditional midwives and women as a barrier to receiving “effective health care”. This

study explored the social and cultural reasons why women might not seek to use biomedicine even when it is accessible, but it did not describe the reasons for avoiding formal services as legitimate or logical, instead labeling them as barriers. A more effective approach, such as the one discussed below, would seek to understand the reasons that people seek maternal health care as they do, and recognize those reasons as a legitimate reflection of the values, needs, and circumstances of the people, not as irrational superstitions.

In her study about risk perception and health seeking among Shona women in central Mozambique, Rachel Chapman argues that reproductive vulnerability, risk-perceptions, and social inequalities are connected by showing how women seek maternal health care to minimize *social* threats as well as biological threats. Similar to the study by Okafor and Rizzuto, Chapman worked in an area which had low use of biomedical prenatal and delivery care despite its accessibility. She learned that Shona families believe that exposing one's pregnancy makes women vulnerable to witchcraft by jealous community members, so women are encouraged to carry their pregnancy in secrecy. This need for secrecy means that most women will avoid getting prenatal check-ups unless they feel a compelling reason to do so. Chapman argues that Shona women, like women in impoverished communities worldwide, must make reproductive choices which will protect them amidst a loss of social cohesion and economic hardship. The need to protect one's self socially can often outweigh the need to protect oneself

biologically and the way women are seeking childbearing care reflects that. Based on these conclusions, I am critical of public health interventions that assume that biological interventions in childbearing are adequate, that the proponents of biomedicine always know what is best for women, and that women who do not choose biomedical care do so only out of ignorance. In the next section, I will discuss the theory of medical pluralism, which takes Chapman's approach a step further by arguing that when people navigate multiple ways of seeking health, they do so primarily to access or solidify social resources, and secondarily to optimize their corporeal health.

Medical Pluralism

In the modern context of health and medicine in Africa, many settings have more than one type of childbearing care available. Hospitals and clinics are present in many urban and rural settings, and the people who assist with birth outside of the formal biomedical system can range from family members to religious healers to specialists in birth. I will focus more on the assistants and locations of childbearing in Chapters Three and Four, but in this section I will discuss the significance of the way people navigate a circumstance of multiple kinds of childbearing care.

Several studies have highlighted situations of medical pluralism in contemporary Africa, including some which have looked at the plurality of childbearing systems (Beckerleg 1994, Feierman 1985, Hunt 1999, Janzen

1978, Marsland 2008, Ranger 1992). In this section, I will discuss how an analysis of medical pluralism can be applies to a Critical approach to Medical Anthropology, and revisit the study by Okafor and Rizzuto about views of maternal health in Nigeria to show how their analysis could go further.

Libbet Crandon-Malamud was one of the strongest and most original voices go beyond documenting medical pluralism to apply it to a critical analysis when she wrote *From the Fat of Our Souls* about health-seeking in an economically, ethnically, and religiously mixed town in the Bolivian altiplano. Her main argument was that medicine is a primary resource, which people use to gain access to secondary resources of social relations. Furthermore, she wrote that negotiating a medically plural environment creates and regulates power within and between class relations, particularly between the oppressed and the oppressor. Lastly, she viewed medical pluralism and decision-making about health as a discourse, which does not end with the patient and healer. Like Rachel Chapman's discussion of risk perception, this model shows the logic and reasoning that people use when seeking care, which often includes motives beyond biological efficacy, especially in circumstances of marginalization. However, Crandon-Malamud's use of medical pluralism goes a step further by saying that medicine is in fact a resource that people seek in order to gain access to other things, meaning that health may not even be the first objective. This is particularly useful, because it exposes economic inequality and the way that people cope with it through health-seeking.

Okafor and Rizzuto's study about the views people have about maternal health and health seeking in rural areas of Akwa-Ibom, Enegu, Rivers, and Benue states in eastern Nigeria, which I have discussed above, is an example of a study which could have gone farther by exploring the dynamics of medical pluralism. Such an in-depth and intricate analysis would require a completely different study, involving long-term participant-observation instead of focus group discussions, but the data the researchers have collected about the relationship of economic hardship and reproductive vulnerability hints that a study of medical pluralism would likely be very informative.

The authors had contact with over 500 women, and learned that in their view, maternal death is not merely a health problem, but is a symptom of the difficult position of marginalized rural women, making otherwise manageable problems fatal. Informants named things such as inadequate education for girls, nutritional deficiency, harmful reproductive patterns, obstacles to family planning, heavy work, harmful traditional practices and inadequate concern or understanding of maternal health[1]. They observed that traditional birth attendants often advised women not to use formal health services, that many women had heard threatening stories about the clinics, and

1 One wonders how much some of these answers may have been influenced by health-outreach initiatives or the presence of outside researchers with the expressed intention of improving and increasing the use of formal health services. In my own experience, I have met people who barely speak English, but will recite to me information about 'harmful cultural practices', speaking in Swahili except for that one phrase. The extension of biomedicine has clearly had inconsistent and sometimes troubling moral and social influences, which are also painfully telling of the power dynamic between researcher and informant.

that health staff regularly spoke disapprovingly of traditional birth attendants. The results of the study concluded that womens' misconceptions about maternal health and health services were the main barrier to their seeking formal services.

The setting which Okafor and Rizzuto have described has a very lively discourse on maternal health seeking, with different specialist, professional, and lay perceptions of the kind of care which should be used. Discourse analysis is a key tool in studying medical pluralism. One could follow this discourse closely to see what kind of secondary resources people are seeking through accessing medicine. For example, the authors reported that people generally attribute convulsions during pregnancy to witchcraft or infidelity between the woman and her husband, which is an etiology that most agree cannot be addressed at a maternal health center. If a woman was experiencing convulsions, what are the different kinds of social resources they might be trying to access if her husband brought her to a traditional birth attendant, a maternal health center, or both? By going to the traditional birth attendant, he might be able to convince his skeptical community that he still identifies with the local beliefs in witchcraft. Alternatively, by going to a maternal health clinic, he might be avoiding having his recent infidelity exposed. This imagined scenario simply serves to show how the secondary resources a person seeks through medical care, and the way they seek care are inextricable. As Chapman and Crandon-Malamud have found, this kind of

research can be telling of the ways contemporary people are coping with economic hardship by trying to reaffirm or reinvent disintegrating social ties, often through the way they make decisions about health care.

The purpose of this chapter has been to emphasize the importance of understanding childbearing in modern Africa from a ground-up perspective, through examining how people seek care. Significant amounts of money, time, research and labor has gone into trying to improve maternal health through the increased provision and accessibility of biomedical health services, and these services have brought real benefits to many women and their families. However, I propose that there must be an increase in the efforts to truly understand what people need and value in seeking childbearing care, which can inform us of the other problems people are trying to negotiate simultaneously, such as economic hardship or the breakdown of social safety-nets. Most people do not see their needs for childbearing care as being an isolated and solely physiological 'problem' in their lives, but a complex social process which will have a huge impact on every aspect of their life. Despite this, the majority of health interventions have tried to 'treat' childbearing vulnerability with solely physiological solutions. By trying to understand the circumstances of childbearing through risk-perception and medical pluralism it is easier to reconcile the more broadly-defined social needs of safe childbearing with the desire of outside interventions to reduce maternal

mortality and morbidity.

Chapter Three:
Childbearing Assistants

The role and significance of caregivers extends far beyond their ability to assist with the physical and emotional challenges of birth. From the duties which caregivers perform to the social roles they occupy in society, there is vast variation between caregivers from different cultural settings, medical ideologies, economic situations and political landscapes. This shows that the characteristics of childbearing assistance are largely a product of the social, economic, cultural, and political framework of childbearing, and is not simply a functional response to physiological challenges. Looking at childbearing assistants is an important part of my analysis because they embody the local contexts, national policies, and international economics which characterize the complex, varied, and uneven terrain of childbearing in contemporary Africa. The dominant research-generated discourse on childbearing assistants in Africa tends to center around two seemingly opposed themes: ethno-obstetrics, and the extension of biomedical care, though a growing body of research is inquiring about the interface between the two. By combining multiple perspectives, I aim to tell a story about caregivers that shows it is more nuanced, mixed, and flexible in response to the ever-changing cultural, socio-economic, and political circumstances characteristic of contemporary

Africa.

In this chapter, I will discuss the changing circumstances of childbearing assistants through some of the common social, political, and economic themes of African history. I will begin by discussing how diverse concepts of childbearing gave rise to diverse traditions of assisting with childbirth. Next I will look at how colonial and missionary contact began to introduce biomedically-trained assistants, and the impact that contact has had on the mix of childbearing assistants in contemporary Africa. The following section will discuss urbanization, and the way it has created economic and social changes to childbearing, and brought multiple concepts about childbearing into contact. Lastly, I will discuss how national health policies, economic strain, and the role of the non-governmental development institutions have solidified the discourse about childbearing assistants into an opposition between 'Traditional Birth Attendants' and 'skilled assistants'. The things which have shaped and currently influence childbearing in contemporary Africa is complex and multi-sided. It is not just a physiological problem with a physiological solution, but also a social, economic, political, often spiritual and emotional part of the lives of the majority of people in Africa, and the narrative of childbearing assistants should be just as multi-sided and integrative.

Concepts of Birth and Assistance: Not your typical 'TBA'

When thinking about childbirth and assistants anthropologically, it is important to remember that the way people conceive of birth is culturally interpreted, and there is no essential, correct concept of birth. Previous to the introduction of biomedicine in Africa, different cultural concepts of birth determined whether a woman ought to have assistance with birth, who should assist with birth, what parts of the process of birth and reproduction require assistance, whether spiritual, emotional, social, and/or physical assistance is necessary, etc. These traditions of assisting with childbirth have been changing and evolving constantly, especially in response to political and economic changes of the past few centuries, but for many people in contemporary Africa, these cultural conceptions are still a very relevant framework for thinking about childbirth and assistance. For this reason, there are many different kinds of people who assist with childbirth in contemporary Africa who get some or all of their framework for thinking about birth from a traditional or non-biomedical world view.

A few key examples will illustrate how different traditional African concepts of childbearing interact with contemporary ideas about assistance with birth. The traditional belief of the Ju'/hoansi of Botswana is that women express their spiritual and social strength by facing the risks of childbirth completely unassisted and without fear (Bisele 1997). It is not uncommon for a woman to receive help during her first delivery or for a particularly difficult birth, but this assistance comes from a family member, not a specialist, and it

is intended to help with the physical challenges of labor, since the fear of childbirth is of important social and spiritual significance (1997).

By comparison, Lewis Wall studied Hausa conceptions about pregnancy and birth in Northern Nigeria, which revolve around the traditions of wife-seclusion (*purdah*) and shame (*kunya*). Women are supposed to remain unseen indoors, and are supposed to conceal their pregnancy, so it is uncommon for them to seek assistance or advice during their pregnancy. Older women who have given birth several times can acquire the role of an *ungozoma*, who act more as ritual officiants over birth than technical specialists. A third example comes from the interviews I had with Swahili *wakunga* in Mombasa, who can offer advice on herbal remedies for prenatal discomfort, receive experiential training to gain specialized skills to assist with labor, and have a very active role in the post-partum period in giving massage and teaching women techniques for expediting the thorough expulsion of the afterbirth. The *wakunga* with whom I spoke said that the woman's family is responsible for seeing that her spiritual needs are met, though some of the practices and techniques which *wakunga* use are related to religious needs.

In each of these contemporary cases, the traditional concepts of childbearing have provided the cultural framework for the roles and responsibilities of childbearing assistants.

Stacy Pigg has explored the way that the many different kinds of non-

biomedical birth attendants have been categorized as 'Traditional Birth Attendants' (TBAs) by the language of the international development establishment. She argues that these labels change the existing setting of birth-assisting, and that by trying to work with healers and midwives, they are actually devaluing and dismantling them (1997). Beyond being an easy short-hand way of referring to non-biomedical birth assistants, the term TBA has truly gained profound meaning among UN agencies such as WHO (WHO/AFRO, 2008), national health policies, non-profits, and NGOs. A TBA is most commonly discussed as someone who assists with childbearing who can be trained or replaced with biomedical obstetric procedures, to the benefit of women's health. Pigg draws attention to the problems of essentializing traditional childbearing assistance for the purpose of grouping them and overriding them with biomedical practices.

Colonial Contact and Missionary Medicine

As discussed in Chapter One, the earliest significant presence of biomedically-trained birth assistants, such as nurses and doctors, in Africa came in the 19th century with colonial officers, white settlers, and missionaries (Camaroff 1993). Colonial medical staff were intended to serve the European population and sometimes the Africans who worked for them, while missionaries offered education and health services as charity with the hopes of converting Africans to Christianity (Hunt 1999, Ladjali 1991, Ranger 1992,

Turshen 1991). At this point the vast majority of Africans did not have access to biomedical care. Missionaries would often try to discourage traditional spiritual healing practices, denouncing them as paganism or devil-worship, and it is likely that birth assisting traditions were similarly discouraged in some cases.

The introduction of biomedicine, the changing economic pressures on Africans, and social changes such as labor migration and wars all combined in complex ways to change the circumstances of childbirth assistance in Africa significantly through the colonial and post-colonial period. Hunt described the missionary medical work in a town called Yakusu in the Belgian colonial Democratic Republic of the Congo through historical and social research. She found that British missionary medical institutions were drawn into providing obstetric services due to demand from Congolese for help with obstetric emergencies, and at the same time were carrying out the Belgian colonial government's pro-natalist agenda to secure the labor force (1999).

Feierman has shown that the best medical services in the colonial period were reserved for foreigners and elites, and this pattern is still reflected among today's most and least privileged women in contemporary Africa (1985). Amidst the plurality of childbearing assistance, economic stratification, and the social significance attached to ways of giving birth, choosing a childbearing assistant becomes a way of announcing one's class and cultural affiliations. Carolyn Sargent described a situation like this in

Parakou Hospital in Benin, in which giving birth in the hospital with a biomedical attendant was at one time exclusive to the elite (1989). In addition, some elite women said their husbands would be “furious” if they delivered at home with a traditional midwife. From the initial starting point of colonial and missionary contact, Western medicine has continued to expand and gain authority in Africa, though its actual accessibility and equal distribution lags far behind the scope of its ideological hegemony.

Urbanization and Urban Environments

Urban life presents a unique set of influences, limits and opportunities for contact for the various kinds of childbearing care which people use in contemporary Africa. Many African cities, from long-established towns to newer, former colonial administrative centers, are experiencing rapid urbanization, which was initiated by the need for wage labor and the weakening of rural economies (Sheldon 1996). To me, cities provide one of the most interesting landscapes for childbearing care because there are such diverse kinds of care co-existing, each with different dynamics of power, meaning, and legitimacy for the city dwellers who seek them.

Urban migration is a global trend which has been particularly rapid and intense in Africa and the greater developing world (Sheldon 1996, Feierman 1995). During colonial administration, the imposition of taxes on indigenous homes and the appropriation of land by settlers meant that

Africans had to find a way to enter the cash economy. For many rural people, this meant sending at least one family member, usually male, to find wage work. Pre-existing cities, colonial administrative cities, and port cities became common destinations for people looking for wage work (Sheldon 1996).

The migration of young, productive men and women out of rural areas left families to manage without them. Production of food and subsistence took a turn toward cash-crops, which brought slim incomes and an increasing dependency on a cash-economy for food and other necessities. More and more women and families moved to urban centers as rural subsistence became increasingly difficult, and today urbanization continues for the same reasons. Contemporary African cities are often intensely stratified socially and economically. Pre-existing social networks are divided, rearranged and transplanted as people move away from rural communities. Cultures come into contact and are selectively reinforced or diluted from being interpreted in a multi-cultural, cash-driven society, with urban rules that dictate class, status, and respect. The concepts of childbirth and childbirth assisting which people hold take on new meaning in urban environments.

Carolyn Sargent described how Bariba concepts of healing, modesty, and childbirth impact how traditional midwives fit into the urban setting of Parakou, Benin (1989). Bariba healers and midwives are supposed to maintain secrecy about their practices, but Sargent learned that there was usually at least one prominent midwife practicing in each neighborhood. The midwives

she interviewed said that almost all Bariba women would prefer to deliver at home, but that most deliver in the hospital. The government had enforced policies indicating that all women are supposed to deliver in the hospital, and at the time when Sargent was doing research, many people felt that delivering at home would label them as backward, rural, or uncivilized. However, Bariba women stated that it is ideal to deliver unassisted at home, and expressed great anxiety at the prospect of being "seen" by a man in the hospital. For these reasons, Bariba midwives in urban Parakou were still making themselves available to provide women with the kind of childbearing care that reflected Bariba values, but had to operate in a semi-clandestine manner because of government policy, the secrecy of healing practices, and the potential stigma of home birth. By comparison, urban midwives said that rural Bariba women would completely refuse to deliver in the hospital (1989). This is one example of how an urban childbearing assistant operates in a medical setting in which multiple kinds of care exist among one another.

Urban poverty is another outcome of urbanization which impacts childbearing assistants. I have not come across any detailed examples of the urban poor and their use of childbearing assistants in Africa, but accounts of urban poverty and health seeking can suggest some of the important common trends. In her book *Reproducing Inequities*, Catherine Maternowska explained how poor women in Cité Soleil, Port-Au-Prince, Haiti negotiate economic and social vulnerability when making decisions about birth control (2006). It is not

as surprising as it should be that single mothers would often choose to spend their money on food for their children rather than treatment for a sexually transmitted infection. What was more surprising, and often missed by demographers, was that women would sometimes consciously choose not to use birth control in order to gain a more stable relationship with a man, who could potentially provide a more stable situation for her family. She found that women were not just trying to find birth-control resources to fill birth-control needs, but that they were patching together as many different kinds of social, medical, and financial resources as possible to try to ensure the wellbeing of themselves and their families (2006). In similar situations of urban poverty in contemporary Africa, it is likely that women will similarly consider the broader picture of their economic vulnerability and use childbearing care in the ways that will best maintain their security. Urbanization and urban environments in contemporary Africa create situations of class stratification, urban techniques of survival, and the interaction of multiple medical systems and ideologies, and the use of urban childbearing assistants are a focal point of this complexity.

National Health Programs and Development Efforts

Newly independent African states were given the responsibility to create a national plan for health care. In most cases, this meant try to extend biomedical care in general, and in particular trying to increase the use of

biomedically-trained birth assistants for prenatal care and deliveries. [2] In addition, charities, development agencies, multi-lateral and bi-lateral efforts, and non-governmental organizations have also taken an interest in promoting the increase of access to western biomedicine, and like national development policies, one of the major focuses of this push has been to increase the attendance at birth by a biomedically-trained specialist. People have tried many different things to get more biomedically-trained attendants, from training and importing doctors nurses, and nurse-midwives, recruiting and training nurse's and physician's assistants, as well as clinical officers and other lower-level trained positions. Especially in rural areas, training community health workers and existing non-biomedical birth assistants has been another common strategy. In this section I will discuss how public health and development efforts have enacted a diffusion of biomedical techniques, by giving several examples of birth attendants who have been incorporated into this movement.

As stated above, the first doctors and nurses in Africa served colonial officers and settlers, worked in medical institutions, and in many cases provided general health care to Africans to secure the labor supply, following an initial increase in disease and mortality in the early colonial period. Many colonial governments, such as the Belgian administration in the Democratic

2 It is interesting to note how much the officially acceptable set of obstetrical procedures has changed over time within the western biomedical obstetric tradition. The rate at which tools, positions, caregivers, techniques, advice, and medicine which have come in and out of fashion in western obstetrics makes one wonder if any one of them is actually much of an improvement over any other.

Republic of Congo put particular effort into getting African women to use biomedical maternal health services, in keeping with pro-natalist policies (Hunt 1999). In the 20th century, military hospitals started to appear during wars between colonizers, and wars against colonizers, but these tended to be focused on curative, male-oriented medicine, and not primary or maternal care (Ladjali 1991, Turshen 1991).

When Kenya gained independence in 1963, the majority of health workers were expatriates, and there were virtually no African RNs, as well as no nurse's training programs open to Africans (Maxon 1995). One of the first goals of the new government's public health plans was to increase the number of trained health workers, and to replace expatriate professionals with Kenyans. To help accomplish this, the government initiated Kenya's first medical school, located at the newly re-named Kenyatta National Hospital (after Kenya's first president). Between 1963 and 1974, the number of registered nurses and midwives[3] more than doubled, going from 2,308 to 4,876 and 900 to 2,171, respectively (1995).

As countries like Kenya have continued to train health workers, their progress has coincided with the characteristic 'brain-drain' experienced in many developing countries today. The most resource-poor, under-staffed, and financially strained places tend to have the hardest time recruiting and

3 Although it is unclear in the text, it appears that 'registered midwife', in this context refers to midwives who gained all of their training from biomedical procedures, not traditional midwives who have participated in a government training to become certified.

retaining health workers, and this is true on many levels. Doctors and nurses coming from a coveted, elite education in cosmopolitan medicine are often disinterested in working in small rural clinics, so rural areas often have a high turn-over rate of health workers (doctor interviews, Tanzania 2007). Conditions at public hospitals are often overcrowded, with a chronic shortage of staff and supplies, and in the opinions of many, the relationships between patients and professionals can be disinterested at best, and rude, inhumane, and abusive at worst (Soud 2005, Sargent 1989, Wall 1998, my interviews/observations). Health workers would often much prefer to work in private hospitals and clinics, or open a private practice, where higher prices and/or social capital limits the clientèle (Sargent 1989, my interviews/observations). Finally, trained and certified health professionals are often tempted out of their countries by better paying jobs, less stressful conditions, and more opportunities in general in other countries.

While working in Tanzania in 2007, I had the opportunity to get to know the District Medical Officer of Kyela District, a refreshingly genuine man among many disillusioned and burnt out doctors I have met in Kenya and Tanzania. He explained that of the eight other doctors who graduated medical school with him, five have left the country to work elsewhere, two are working in Tanzania for private ventures, and only one other is employed by the national health system. Brain-drain is a self-perpetuating problem, because countries are spending money training new personnel, and then they are being

funneled to wealthier patients as soon as possible, exacerbating the unattractive conditions in under-served areas. However, the majority of health personnel who seek a better life for themselves, or who become burnt out with the ceaseless stress providing health care amidst economic impossibility, cannot really be blamed personally. It is a cruel irony that money spent on trying to right inequalities in health care often goes to widening that gap.

There are many different kinds of biomedical care-givers who have received less-time consuming, less-resource intensive, and less specialized training, in an effort to promote primary care. This can include nurse's assistants, community health workers, volunteers, and government-trained birth attendants. Maternal and child health is a major priority of primary care, so many health workers with less specialized training regularly function as birth assistants. In the several clinics and health centers which I visited in rural Tanzania, most of them dedicated at least half of the facility to assisting with prenatal care, deliveries, and/or recovery from labor.

I had the opportunity to meet a couple of different kinds of health workers in Tanzania and Kenya, who had received a lower level of training than nurses and doctors. At Sahla clinic in Mombasa, Kenya, the nurse in charge takes on a few female high-school graduates each year, and trains them to help with lower-skilled tasks such as clerical and lab work, and they were regularly called in to assist with examinations, prenatal care, and deliveries. In her book *Monique and the Mango Rains,* Kris Halloway described the time

she spent working with a government-trained and -employed health worker and midwife in rural Mali. Monique (the midwife) worked in a dilapidated birthing center with chronic shortages of supplies. Monique had originally been from the nearest city, but married into the village community. Though the community was initially skeptical of Monique's government training, young age, and relative inexperience in giving birth herself, the women in the community came to have great respect for her (2007). In the current trend of training people in primary care and including maternal health as an important focus of primary care, less-specialized health workers have taken on the role of birth attendant in a variety of settings in contemporary Africa.

Another kind of biomedical training, which deserves recognition in its own right, is the trend of giving non-biomedical birth attendants minimal training in biomedical techniques, and trying to incorporate them into the formal health system. Governments and other groups interested in development have different attitudes about non-biomedical assistants, ranging from labeling them for their 'harmful cultural practices' to considering how they are often more accessible and affordable that western biomedical care and seeing them as access points into communities, which are useful for spreading their own messages about development and health (International Development Research Center 1989, Kenya Ministry of Health 2002, 2005, Ripple Africa 2008, WHO/AFRO 2003).

In Kenya, traditional midwives are only legally allowed to assist with

birth if they attend a government training about hygiene, referring patients to the hospital, and dealing with HIV/AIDS. A TBA (Traditional Birth Attendant) training program in Ghana which was evaluated by the WHO held eight, three-hour training sessions every two weeks for both male and female birth assistants (Maglacas and Simons 1986). Drs. Jambai and MacCormack described the training of traditional midwives and regular women in rural communities in the Pujehun District of Sierra Leone (1996). They said that the trainings begin by reinforcing the knowledge which healers, midwives, and women already know about how to be healthy and cure illness, and then add biomedical knowledge about infection diseases and complications in childbirth.

The primary interest in training non-biomedical birth attendants is to improve the safety of childbirth for women. To some of the promoters of training programs, the trained birth attendants are seen as just a compromise, where the ultimate goal (stated or not) is to have every birth attended by someone more specialized in biomedical obstetrics. To quote Bulterys et al. writing about trainings for TBAs in Sub-Saharan Africa, “Although providing highly skilled medical attendants for all deliveries in poor communities remains a long term goal, an intermediate solution is to identify, support, and train birth attendants who are already practicing in local communities” (2002). In her study about training and labeling TBAs in Nepal, Stacy Pigg argued that the development establishment makes the appearance of taking local

circumstances, beliefs, and traditions surrounding birth into account by working with local midwives, but that they are actually dismantling these local sociocultural realities by trying to replace them with the biomedical model (1997). This conclusion applies equally to some of the attempts of training birth assistants in contemporary Africa. The benefits of increasing access to primary health resources should not come at the expense of subverting local social and cultural systems for managing birth.

The development and public health agenda, and biomedical childbirth assistance by extension, has an authoritative legitimacy in contemporary Africa, being supported and promoted by African governments, UN agencies, bilateral and multilateral aid agreements, and the non profit sector. The conventional wisdom of the development world is that African countries need to train more skilled birth attendants, get more of them into under-served areas, and get people to use them more. This dominant narrative often places specialized biomedical care on one end of the spectrum, being associated with better health outcomes but easier access for wealthy and urban populations, which is opposite from TBAs, who are more accessible to marginalized people, but are unable to handle complicated deliveries.

I would like to propose an alternative narrative about childbearing assistants in contemporary Africa. First, the roles and practices of non-biomedical birth attendants are extremely diverse across the continent. They

are not just a less-effective version of physiological techniques for managing birth, but an important part of the social realities and cultural concepts of birth. Second, birth assisting is not totally segregated between biomedical and traditional birth assisting. Especially in the urban setting, different kinds of care are present amidst one another, and women will often draw on multiple resources to have the best possible physiological, social, and economically stable outcome of their pregnancies. Furthermore, training of community members and existing birth attendants has mixed a few biomedical techniques into traditional methods, and the scope of the biomedical/development narrative reaches further than its actual services. The power of the development agenda as the potential to extend real benefits through increased access, but without having a better understanding of the complex social realities of childbearing assisting, the success of these efforts is likely to be less effective.

Chapter Four:
The Places of Childbearing: Birth Territories

"It is trivial to raise the point that birth takes place somewhere, be it in the bush, in a hut in the jungle, or in a modern hospital. What is not quite so trivial is to consider that birth, by the mere fact that it is located somewhere, inevitably takes place on somebody's territory." - Brigitte Jordan, 1978

The spaces in which birth takes place are largely characterized by the people, ideologies, and technologies which have authority there. With such a diversity of locations where birth takes place in contemporary Africa, it is important to analyze the dynamics of authority and power in different locations to understand when those dynamics have potential to hinder or support safe childbearing. These locations can be thought of as 'birth territories' when we consider who controls the environment, the access to knowledge, and the decision-making in maternal care (Fiedler 1996, Jordon 1978). In keeping with a critical, integrative perspective on childbearing in Africa, I will examine both the microsocial authoritative forces which characterize birth territories, as well as the macrosocial trends which have created common experiences in childbearing in many parts of Africa. This analysis will show that the perspective on the locations for childbearing must reach beyond a conversation about using biomedical services and access to facilities to include structural and social elements of power and authority.

In this chapter, I will use this concept of birth territories as a tool to explore the dynamics of power and authority in childbearing spaces in modern Africa. In seeking and using biomedical care, women and their families negotiate between several different facilities, ideologies, and methods, and taking advantage of them selectively to suit their, physiological, social, spiritual, and economic needs in the best way possible. By looking at the way different women have perceived and responded to different birth territories, I will show how some territories have been better at incorporating women's needs, voices and knowledge, while others are more likely to alienate women or discourage their participation. In particular I will highlight how the highly specialized knowledge and tools of biomedical facilities, combined with economic strain and the authoritative message of formal health systems can construe a woman's knowledge and needs negligible. I argue that removing women's knowledge and authority from birth stands in the way of women getting the maximum potential benefits that a location for childbearing can offer, and that therefore their needs could be more effectively addressed by involving them more in the process.

I will start this chapter by defining the concept of birth territories as it has been used by other scholars, particularly by Debora Cordero Fiedler and Brigitte Jordan, and discussing its relevance to an integrative perspective on childbearing in Africa. Next I will discuss the range and diversity of locations and facilities for childbearing in modern Africa by looking at some common

modern trends in childbearing care. In the next section, I will examine three key examples of birth territories in Africa in terms of the power and authority which are privileged in them, and the way women experience that privilege. Lastly, I will propose that these accounts of how people experience different birth territories are telling of the kinds of places which alienate or involve women's voices and needs, and can be useful for understanding how to improve maternal health and wellbeing.

Birth Territories Defined

To call a place a 'birth territory' means that it is more than just a location for giving birth. When a woman arrives at a place to give birth she will be in the domain of whoever controls that place, and to a certain extent, expected to conform to the authority, methods, and interpretations of those people. Brigitte Jordon first introduced the idea of birth territories in her book *Birth in Four Cultures* (1993 [1978]). Jordon argued that when several forms of knowledge exist, by consensus one will often be given more weight than others. In childbirth, authoritative knowledge which is given more weight than a woman's knowledge can have the effect of devaluing a woman's voice (1993 [1978]).

Deborah Cordero Fiedler expanded on this notion of a birth territory, when she conducted her study of hospitals and midwife-run clinics in Japan. Fiedler defined a birth territory as "both the physical location of birth and the

professional paradigms of care associated with different locations" (1996), including the people who control that place, the methods and tools they use, and the authority they have to control care. Fiedler showed how in the obstetrical model, women were usually isolated from the birth and from knowledge about the birth process. In contrast, the midwifery model, which she observed in a midwife-run clinic, emphasized involving the mother and her partner and minimizing technological intervention. Fiedler argues that both birth territories come with a birth specialist with an authoritative voice, though the hospital model creates more distance between the woman and knowledge about birth (1996). The dynamics of power and authority, as they are mediated through birth territories, is a significant factor in childbearing, and I will use Fiedler's analysis as a model for exploring birth territories in contemporary Africa. I will use several examples of childbearing spaces in Africa, and explore them as birth territories to gain a better understanding of the impact authoritative knowledge has on the outcomes of childbearing.

Spaces of Childbearing in Contemporary Africa

To understand how a birth location can be constructed to be a birth territory, it is important to first understand the diversity of spaces in which birth takes place, and the circumstances which have given rise to that diversity. It is neither possible nor useful to try to represent every kind of birth location to be found in Africa, but there have been some common trends in

African history, politics, and economics which have produced commonalities between many settings. To provide a brief background on the kinds of birth locations which are common in modern African settings, I will discuss hospitals, less-specialized biomedical facilities, such as clinics and health centers, specialized non-biomedical locations, and homes, with the cultural, economic, historical, and/or political framework which has made them given them some common circumstances in many settings in contemporary Africa. I will also include some specific examples of each of these kinds of locations to show how larger social processes interact with local circumstances.

Hospitals in Africa can range from highly sophisticated urban facilities, to small-scale compounds in semi-rural areas. Hospitals are usually set in relatively population-dense areas to be able to reach the maximum number of people, though Feierman has argued that the ratio of health resources and facilities in urban centers versus rural areas in Africa far exceeds the ratio of urban people to rural people (1985). Hospitals may be managed and funded publicly by the state or privately by non-profit organizations (Maxon 1995), faith-based organizations, international agencies or for-profit enterprises (my observation). The amount of funding available to a hospital and the support it receives from the public health system can greatly affect the quality and availability of staff, equipment, medicines, and facilities.

When doing research in Mombasa, Kenya in 2006 and rural Tanzania in 2007 I was able to observe several hospitals first-hand. The public hospital

I visited in Mombasa had highly-trained staff and specialized technology available, but the waiting, birthing, and recovery rooms were crowded well over capacity, and both patients and staff reported that the hospital is chronically understaffed. By comparison, the district hospital which I visited in Kyela Town, a town of about 30,000 in a rural district (Tanzania Census 2002) had fewer patients, but was still understaffed, and did not have the facilities or equipment to do complicated interventions, such as a cesarean section. Furthermore, the rural hospital is intended to serve people in the surrounding villages of the district, but many villagers complained that distance, poor roads, and the cost of transportation often prevented them from reaching the hospital.

Smaller facilities, such as clinics and health centers, usually have less specialized equipment for birth than a hospital, and may have fewer specialized staff. As with hospitals, the quality and consistency of services found at a clinic often relies on the reliability of funding. Especially when they are supported by the government or international organizations, biomedicine is usually the preferred system used in these facilities. Clinics and health centers often exist to extend primary health care to people who might not be able to easily reach the hospital, and to ease the strain on the hospitals themselves. Problems of access to care are common among many countries in Africa today, so smaller facilities such as these are common.

Kris Holloway described a rural, government-funded maternal-child

clinic in Mali which, previous to her arrival, just had one biomedically-trained midwife. The facility was in serious disrepair, and there was very minimal equipment or supplies available for intervention during delivery. The trip to the nearest hospital was often too long or difficult for women in labor (Holloway 2007). By comparison, Fatma Soud described some urban health centers in her research on maternal health seeking in the city of Mombasa, Kenya. She explained that there are seven department health centers in Mombasa, which are managed and financed by the Ministry of Local Government (2005). Though the staff at these health centers often need to refer women to the Provincial Hospital, there is very little communication and collaboration between the clinicians from one facility to another. She said that this was particularly problematic for women who were diagnosed with an obstetric complication at the health center, but then referred to the hospital because medical history, patient documentation, and/or diagnostic information often had to be collected a second time at the hospital, meanwhile losing time in an emergent situation (2005). These situations are just two examples of the many smaller, less specialized locations where women sometimes go for childbirth. They demonstrate the impact that funding and support for smaller facilities can have on the services they can provide.

The hospitals and smaller facilities described above rely primarily on western biomedicine, but the line between primarily biomedical locations and primarily non-biomedical locations can be very permeable. For instance,

traditional midwives have in some cases been allowed to practice in otherwise biomedical institutions. Similarly, many primarily traditional birth spaces employ some biomedically-encouraged techniques, such as hand washing or sterilizing of instruments (Pigg 1997). By describing these different kinds of locations for birth, my intention is not to separate them into distinct, opposite categories of 'biomedical' and 'traditional', but to show how they are often intertwined, and that this creates opportunities for contact, synergy, and conflict between them.

Among spaces for birth which do not rely primarily on the western obstetrical tradition, there are those which are identified as specialized places for birth, and those which are not. Specialized locations could include a religiously-affiliated place, a hut or building, a particular place outdoors, or a special room in a home, to name a few. Though these are specialized places for birth, they may also occupy other functions as well, such as healing or religious practice. A midwife who I visited several times in Mombasa lived with her daughters on one floor of a three-story building. They reserved one room solely for working with pregnant women, doing deliveries, and giving women post-partum massage. A demographic study of maternal health seeking in rural Nigeria by Osubor et al in 2006 found that 7.8% of respondents named churches as their preferred place for delivery. Okafor and Rizzuto, who studied views of maternal risk in rural Nigeria also found that some women sought prenatal advice and delivery care in churches and prayer-houses

(1994).

A common non-specialized place to give birth is in a home, be it the home of the woman, a family member, friend or birth attendant . These births may be attended by a specialized birth attendant, a midwife, or a family member, or they may not be attended at all (Sargent 1989, Soud 2005, Wall 1998, my observations/interviews 2006). It is interesting to note that there is not necessarily much variation between one home-as-birth-location and another, but that there is still huge variation between how homebirths happen. It seems that with homebirth in particular, it is the birth attendant, the methods he or she uses, the cultural perceptions of birth and the economic situations which shape how different homebirths take place. In this way, different traditions of home birth might present very similar birth *locations*, but very different birth *territories*.

L. Lewis Wall described how Hausa women in Northern Nigeria are usually sent to their parents' homes for their first delivery, but are encouraged to deliver alone at home for subsequent births (1998). He explained that there is a significant element of shame surrounding birth among the Hausa, and women are expected to maintain modesty and not show pain during labor. The traditional midwives who attend to home birth possess few specialized technical skills or tool to assist with delivery, and operate more as ritual officiants than birth technicians (Wall 1998). By comparison, homebirths in the United States are often attended by licensed and formally trained nurse-

midwives, who may use any combination of tools, equipment, and remedies ranging from aromatherapy to a birthing stool. Ordinary homes are used as a location for birth all over the world, but there is great variation in the way that this non-specialized environment gets transformed into a birth territory. There are also notable examples of women who deliver outdoors, and some who prefer to deliver unassisted, such as the Ju/'hoansi of Botswana (Bisele 1997).

Locations for Birth as Territories in Contemporary Africa

In this section, I will discuss different spaces for childbearing in modern African settings, by looking at them as birth territories. Using this model, which Fiedler and Jordan have applied elsewhere, is one way of looking at childbearing spaces in Africa which exposes the infrastructure of power and authority which function in a location. This approach is an important part of a holistic and critical perspective on childbearing in Africa, because it highlights both local-level and larger, ideological systems of authority. In this section, I will highlight three examples of birth locations in contemporary Africa, and discuss the roles of authoritative knowledge which make them birth territories. The examples I will draw on include the government provincial hospital in Parakou, Benin, a nurse-midwife run clinic in Mombasa, Kenya, and unassisted birth among the Ju'/hoansi.

Carolyn Sargent's book *Maternity, Medicine, and Power: Reproductive*

Decisions in Urban Benin explores the way Bariba women in Northern Benin make decisions about reproductive care, by comparing urban patterns to rural patterns of seeking care (1989). Her understanding of the way urban Beninois are continuing to adopt the western biomedical model is important because she relates it to national policy and economic strategy changes, which are comparable to the post-independence political histories of many African states. Though Sargent's research occurred considerably earlier than that of the majority of the studies I have used, the elements of power and authority which she has described in Parakou Hospital are still relevant in many contemporary African biomedical settings.

Sargent's discussion of the Parakou Hospital centers largely around a common pronouncement made by urban Beninois: “The hospital will save you if you suffer”, showing people's optimism about the benefits of western biomedicine, though they were often reluctant to seek services there. The Bariba people, who are the dominant ethnic group in Parakou and Northern Benin, do not traditionally see pregnancy as a pathology, and prefer that women give birth without specialized assistance, or alone. However, a series of developments have increased the number of people seeking biomedical obstetric services. In the 1950s there was very low attendance at the hospital, and in the 1960's and 1970's the government imposed a fine on any people who delivered at home. When Sargent was writing in the 1980's, it was still possible to be punished for not conforming to the official government policy

to use the hospital (1989).

At first, the majority of maternity patients at the hospital were elites, such as the wives of civil servants, and they would make a big display of bringing expensive items to the hospital with them. This situation supports Crandon-Malamud's argument that people seek and use medical care as a primary resource to gain access to secondary resources, such as social status. Until nurses started to limit the amount of unnecessary items women could bring, less-wealthy women were reluctant to come to the hospital for maternity services, feeling that they did not belong there. However, the hospital continued to foster class distinctions, and Sargent described how elite women receive preferential treatment. Elite women were examined on a vinyl-covered examining table, and with gloves which had only been used a few times, while less wealthy women were examined on a tile table, and with a single surgical glove used for the majority of examinations. Women often expressed that the hospital was dirty and uncomfortable, and that they did not like how they were treated by staff. However, their optimism about the benefits of using the hospital outweighed these feelings.

Sargent recognized several ways that power and authority were mediated through maternity services at the hospital, and I will expand on these to discuss it as a birth territory. The first, most obvious locus of power is the government authoritative narrative about biomedical obstetric care. The government used its power to endorse only the biomedical model of care, and

threaten to punish women if they did not deliver in the official facilities. Their reasons for supporting this paradigm certainly include a recognition of the benefits biomedical care can have for childbirth, but likely also included the international legitimacy given to biomedical care, which views it as the universally applicable and effective paradigm instead of a socially produced and meaningful medical system. In addition funding and aid for biomedical facilities provides an incentive for governments to stand behind biomedical care financially, legally, and ideologically. These financial, legal, and ideological processes extended themselves into the social meaning and experiences of families in Parakou. Though Bariba women did not usually view normal birth as a pathology, the government authoritative knowledge treated it as a pathology by trying to force women to seek hospital care. In this way, the hospital became the territory of the government, because they had the power to make women come there, and control of the techniques, decision-making, and knowledge used in services. Clearly the biomedical obstetrical paradigm is given authority in this hospital, which is the official public health strategy of not just the government of Benin, but the majority of international public health initiatives as well.

The biomedical system had much power and legitimacy in Parakou, but there are also other kinds of authoritative knowledge which are at play in the discourse about maternity services at the hospital. As mentioned before, there was a general sense that a normal pregnancy was not an illness, yet

many people decided to go to the hospital anyway. Many women complained that the hospital was dirty and uncomfortable, and that they did not like the way they were treated by staff. However, despite this, some wives of civil servant's said their husbands would be “furious” if they did not deliver in the hospital. Residents of Parakou had legitimate reasons to not want to receive maternity services at the hospital, such as discomfort with the facilities and staff, and a cultural preference to minimize intervention, but used the hospital despite these, in order to access the benefits they saw in biomedical care and to maintain the state-imposed and socially-reinforced imperative to use hospital services. The authority which dictated that proper maternal care can only be received at the hospital penetrated the system from the international community to the husbands of pregnant women.

A clinic I visited frequently in Mombasa provides an interesting example of a birth territory. The clinic is run by a well-respected nurse-midwife, Asya, who is also a Muslim scholar. Asya does almost all of the prenatal examinations and deliveries, and though I did not observe her working during a delivery, I was present during several prenatal visits. The environment in the clinic was welcoming and friendly, and Asya continually spoke with the women she was examining by asking questions and explaining her procedures and diagnoses. She showed me the tools she uses for deliveries, and described the treatments she prescribes to patients. Though women in this setting are not as isolated as they are in some of the hospital

settings described above, Asya clearly has the agreed-upon authority to make decisions about the pregnancy and instruct the women accordingly.

As a well-respected Muslim scholar, operating in a predominantly Muslim city, Asya also has the ability to incorporate her authoritative knowledge about Islam into the clinic. Islam, as interpreted by Asya, has many important teachings about such relevant things as health, cleanliness, nutrition, childbirth, parenting, marriage, etc, and she brings many of these teachings into her work with patients. She negotiates between her belief in biomedicine and her belief in Islam, and sometimes the two come in conflict.

For example, she explained to me that when she diagnoses a pregnant woman with anemia, she will instruct her to drink milk and eat dates together, to give her more iron. She says she learned this from Muslim teachings. However, another Muslim student with whom I worked disagreed with Asya, stating that calcium is known to block the absorption of iron, and it would be better to tell her patients to eat dates with orange juice because Vitamin C increases the absorption of iron. Asya said she has seen very positive results from telling women to use this treatment, and would continue to do it. Another time, Asya was explaining to me that in Islam, a woman is not supposed to breastfeed another woman's child. However, she argues that this teaching must be flexible in the modern reality of HIV/AIDS as communities struggle to prevent spreading the virus from mother to child through breast milk. Asya is seen as an authority in both biomedicine and in Islam, and she uses both forms

of authoritative knowledge in her clinic regularly, even when they appear to be in conflict.

In the case of Asya's clinic, women are given the opportunity to voice their concerns and have some role in the way their birth will be handled, but Asya's knowledge is not questioned and she maintains control over the physical space of the clinic. Asya expressed that she tries to be attentive to the needs and interests that her patients describe and that she tries to keep them involved in the process. However she values her own specialized knowledge over that of her patients, and maintains control of the clinic through diagnoses, advice and decision-making. Women who used this clinic often said they chose it because Asya was much more, gentle, understanding, and attentive than the staff at the hospital, but that she also had professional background of biomedical knowledge (unlike traditional midwives). They saw it as an ideal situation, in which they ceded some of their autonomy to someone who they saw as having more authoritative knowledge, but they still felt like they had some control over their birth. This clinic was constructed as Asya's territory, but it did not entirely exclude women from participating in their prenatal and delivery care.

Megan Bisele's work with the Ju/'hoansi of Botswana gives an important account of a birth territory which is extremely self-managed and un-technological. The Ju/'hoansi have lived in the Kalahari semidesert of

Botswana and Namibia, and until recently, subsisted as foragers (1997). The cultural ideal of the Ju/'hoansi is to give birth "in the bush" totally unassisted, although many women do receive some help from a family member, especially the first time they deliver. Bisele shows that this process of childbirth is logical within the spiritual and cultural context of the Ju/'hoansi. They believe that fate, including that of the mother and child, is in the hands of God. Furthermore, they value the equal strengths of men and women, which is demonstrated by their encouragement to face danger alone and without fear through hunting for men and through childbearing for women.

The cultural ideal of unassisted labor reflects the belief that a woman is typically competent enough to handle her own delivery, and if God wishes her to be successful, she will be. Bisele argues that the outdoor, isolated place where a woman gives birth unassisted values the woman's authoritative knowledge, and so it might follow that she is delivering in her own birth territory because nobody else is controlling that space. However, a Ju/'hoan might disagree, saying that a woman delivering in the bush is located on God's birth territory, because he will ultimately decide the outcome of the birth. Furthermore, although the woman is typically alone or almost alone while giving birth, the place where she is giving birth is not only her territory, because the way that she gives birth, including the location, is a product of the Ju/'hoansi social paradigm of childbearing. This is equally true of any birth territory, though, because the paradigms which govern any birth location are

culturally produced.

The Ju/’hoansi, including women who give birth, are proud of women who deliver unassisted, and are skeptical of going to a clinic or hospital to give birth. According to Bisele, informants said they would feel like they were losing control of their birth if they went to a clinic, and they would lose their dignity if they exposed themselves to a stranger. To the Ju/’hoansi it is very shameful to show one’s fear, so women are encouraged to embrace the process of unassisted childbirth and minimize any fear or pain they may have.

In this section, I have given key examples of very different birth territories to show that power and authority in a childbearing location is enacted from the structural level to the individual level. This is important for understanding the dynamics of childbearing and negotiating one's needs and desires within a terrain of multiple kinds of authority, but I will push this approach further by examining what these dynamics can mean for the circumstances and experiences of childbearing in contemporary Africa.

Birth Territories and Safe Childbearing

The point in looking at locations for birth as birth territories is to try to understand the role which power and authority can have in supporting or obstructing safe childbearing. Accounts of women's experiences of birth territories provide a useful link between understanding the dynamics of power which are dominant and how they incorporate women and serve their needs.

In this section, I will explore this by looking at whether women felt comfortable, competent, involved, and in control of their birth. I will conclude the chapter by proposing that the benefits of any location for birth can be more accessible and useful to women when the control of knowledge, methods, and spaces is attentive to the needs of women and involves them in the process of childbirth.

By looking at birth territories through the lens of women's experiences and responses, I hope to take this analysis in the opposite direction of essentializing “womens' voices” or “African women”. Each woman and family approaches birth locations with a different set of social and economic circumstances, physiological needs, cultural concepts, and ideological prerogatives, so the authority which characterizes a territory is met differently by different women. However, learning from different women's various experiences and responses to childbearing care can be a powerful tool to understanding the lived experiences and implications of authority in childbearing.

A key message which I wish extract from the experiences of women in different birth territories is that the use of specialized, biomedical knowledge does not necessarily have to exclude women from the control of birth, though these two things seem to regularly occur in concert. Despite its many benefits, perhaps one of the downfalls of western biomedicine is that its extremely specialized nature can isolate patients from understanding their diagnoses and

treatments. This seems to be especially true in large, underfunded, understaffed facilities which serve a largely under-educated population. In the Parakou Hospital described by Sargent, it appears that staff are too overworked and disillusioned to be able explain procedures to patients at length and involve them in the decision-making process. Furthermore, the professional esteem given to hospital staff often places them in a much higher social category than patients, so patients are regularly treated with disrespect, and their individual needs are seen as unimportant. In Parakou, it seemed that this was especially true, as maternity patients were given more attention and respect the closer they were to the high social status of hospital staff.

By comparison, the women who were seen in Asya's clinic in Mombasa felt much more comfortable, competent, and involved in their maternity care, though they were still being treated with the highly-specialized methods of western obstetrics. This was due to a couple of key factors: the staff at the clinic are able to devote more time to each patient; the staff treat patients more like equals, because they are a part of the local community; and the women feel they have a better understanding of the diagnoses, procedures, and treatments because they have been explained well. Asya and the other staff at the clinic maintain authoritative knowledge, but try to allow women to share in that authority when possible.

By comparison, Ju'/hoansi birth ideally happens in a place that is completely without specialized tools, knowledge, techniques or assistants.

This example is different from the others because, according to Bisele, it privileges women's authoritative knowledge about childbirth over the use of technology (1997). Though the woman's knowledge is considered sufficient enough to manage the delivery, she is not thought of as totally in control of the birth. It is recognized that some women fear giving birth, but this is strongly discouraged, and women attempt to minimize this fear and allow God to be in control of the outcome of the pregnancy. Bisele argues that women are able to address their own spiritual and social needs by giving birth unassisted, in a way that might not be possible if the space was controlled by another form of authoritative knowledge, such as biomedicine. Though the cultural ideal of the Ju/'hoansi is to give birth unassisted, it would be important to see how they might have selectively used biomedical services to their advantage if these services had been more accessible to them, and how their ideals have changed within their society over the last decade since this article as written.

From the examples above, birth territories where a woman were more comfortable, competent and involved usually resulted in more participation in the management of her delivery. Women in Parakou had ideas about how childbearing care ought to be, but they ceded to the authoritative knowledge of the hospital. They were isolated from control of the hospital birth territory, due to a gap in social class and understanding of western obstetrics. In the clinic in Mombasa, Asya fostered a familiar atmosphere, tried to keep women informed about their progress, and listened to their questions and needs, so

women felt more comfortable and involved. With Ju'/hoansi birth, women feel that they are competent to manage their birth since no specialized technology is used, so it is their authoritative knowledge which controls their birth territory.

These perceptions are not just the subjective feelings of women, but a powerful tool in exposing the kinds of childbearing systems which work well for women, and those that do not. A dominating western cultural assumption is that women's health and reproduction, in all parts of the world, can be improved simply by increasing the use of western biomedicine and reproductive technology. However, the examples above suggest that increased technology and specialized knowledge are often accompanied by the dominance of professional voices as authoritative, and the erasure of women's voices, needs, and interests. In addition, women who felt unfamiliar or incompetent in a birth territory felt that they had little control. Childbearing systems must be mediated through birth territories which will encourage women's participation in birth if they are to truly work toward improving women's health. In this sense, the potential benefits of biomedicine and reproductive technology, or any childbearing practice for that matter, are hindered by the exclusion of women's voices.

In response to these observations, I propose that childbearing systems must continually look for ways to encourage women's participation in childbearing in order to maximize the benefits for women's health. The model

of Asya's clinic in Mombasa approaches this ideal, by offering the benefits which women seek (in this case, the health benefits of biomedical care) through a trusting, communicative, and informative environment. The spaces in which birth happens are where changes such as these can take place.

Chapter Five:
Case Study of Mombasa

Journal entry, 15 November 2006

"To get back to the midwife's house, go right after the mosque, go straight along the corridor, turn right at the white iron gate, then follow the alleys more-or-less straight until you find Soumo selling fried potatoes. She will bring you back to the midwife's house. Don't forget to bring a *kanga* as a gift."

Journal entry, 21 November 2006

"Tonight while Fatma and Salma were leaving to go to Sahla Clinic for Fatma's pre-natal check-up they invited me to come. I met Asya there and she showed me the clinic, told me about what she does, and let me observe part of her examination. She said I could come back Monday morning to talk more."

Journal entry, 29 November 2006

"After seeing the doctor and then the director of nursing, I was told to see the Chief Administrator [at the public hospital]. The Chief Administrator is also the Provincial Director and was not in her office today. The secretary told me to go down the hall to talk to the Deputy Chief Administrator. …He asked

what I wanted, and I explained my research and that I was a student, that I just wanted to get to see the maternity ward and maybe talk to a few people, for one day or even just a few hours. …He told me that what I wanted to do was impossible, that one can't just walk into a hospital and expect to be shown around, that one needs to be approved."

The above excerpts are from my research journal from the time I spent in Mombasa, Kenya studying the different kinds of childbearing care found in the city and the ways Swahili women seek that care. With only one week of preparation and four weeks of research for the entire project, a large part of the time I was in Mombasa was spent trying to making contact with and learn from the people who provide childbearing care in the city. In many ways those experiences were a reflection of the way Swahili women themselves are trying to find those same caregivers. To meet midwives I asked female friends to teach me to navigate the alleys and neighborhoods of Old Town and introduce me personally to the midwives they knew. To go to clinics I asked friends and advisors about the clinics with which they were familiar, and they gave me directions on how to get there on my own and a point person at the clinic with whom they had a relationship. When visiting hospitals, I usually had a contact person as a starting point, but getting to the hospital was confusing. I was never very clear on where I was supposed to go once I arrived at the hospital, and I spent excessive amounts of time waiting, feeling anxious surrounded by

the sheer volume of humanity. I was often slowed down or stopped by administrative barriers.

As I rode back to town on a *matatu* (public transportation van) after leaving the hospital one day, I thought about what it is like to try to decide where and how, and from whom to get health care for pregnancy, childbirth, and post-natal care, which was essentially the question I was pursuing with my project. Different people make these decisions differently, but for many their level of familiarity with the facility and/or caregivers that serve them played a significant role in their experience. That day was the first time that I got a glimpse of why someone might choose to deliver at the clinic in their neighborhood rather than the public hospital, though the costs are higher and the ability to intervene in a complicated birth is generally more limited in clinics. Since that day, it has continued to become clearer to me that one cannot try to understand patterns or motives for seeking care simply by looking at demographic factors and socio/economic characteristics. Beyond those circumstances there are more complicated factors that can mean everything for how a woman perceives different kinds of care, how her family wants her to conduct her pregnancy, and how she will eventually cope with childbirth. This is why I have become increasingly certain that Anthropology, when it remains conscious of political and economic frameworks, is indispensable for understanding the way people use childbearing care.

In this chapter, I will combine the anthropological theories, methods,

and approaches which I have discussed in the previous chapters with my own research from Mombasa and the dissertation research by Fatma Soud, entitled "Medical Pluralism and Utilization of Maternity Health Care Services by Muslim Women in Mombasa, Kenya." Soud's study provides much useful information about the demographic indicators of the health seeking behavior of Muslim women in Mombasa, but I argue that this kind of data does not do enough to understand how and why women use care the way they do. As I have argued in previous chapters, it is necessary to look critically at the factors of national and international politics and economics which impact childbearing, as well as the local and individual level factors, such as risk perception and social vulnerability which show why people make decisions the way they do. Though the few weeks I spent studying childbearing in Mombasa was insufficient to get a real sense of these intricate and sometimes unexpected social, economic, and cultural factors, it was enough to show me that demographic indicators, though often useful, are not getting at the whole picture.

Soud is originally from Mombasa, a Muslim Swahili woman, and a native Swahili speaker. In addition, she was trained as a nurse-midwife in Nairobi, Kenya, and received a PhD in Anthropology from the University of Florida. She now works for the Centers for Disease Control in the US. As an auto-ethnographer, she had extraordinary advantages in linguistic and cultural competency, and she showed a genuine interest in improving maternal and

child health in Mombasa. Her research focused on reproductive health-seeking behavior of pregnant Muslim women in Mombasa, and the extent to which they are aware of Mother-to-Child Transmission (MTCT) of HIV. She investigated the different facilities and services available to pregnant women in Mombasa for prenatal and delivery care, and tried to explain how and why Muslim women choose to receive care as they do.

Her sample included 265 Muslim women who had given birth within the last 6 weeks. She found her informants by visiting the facilities that women would visit for postnatal check-ups, as well as visiting homes and traditional midwives (*wakunga*, s. *mkunga).* She collected information about the women's age, ethnicity, and education (both secular and Muslim), marital status, the education and occupation of her spouse, the support of her family, and the composition of family members in the household. She examined indicators of socio-economic status such having electricity, a car, a phone, medical insurance, and the availability of water. Lastly she asked how much women knew about MTCT, and where they got their information. She compared this data to the information about where and how women got prenatal and delivery care, to try to create a framework for understanding the factors that influence the reproductive health-seeking behavior of Muslim women in Mombasa.

This chapter will serve to synthesize the topics which I have covered in the previous chapters, to give an example of how history and

political/economic forces interact with local context to shape the experience of childbearing in a contemporary African setting. My intention is to use this Mombasa case-study as an example of the holistic, integrated and critical perspective which is necessary to understand childbearing in contemporary Africa. I will start with the big picture, by discussing the history of Mombasa, and the post-colonial political economy of health in Kenya, in terms of their impact on childbearing in Mombasa today. Next I will narrow my scope to focus on contemporary Mombasa. I will draw on Soud's work as well as my own to describe the kinds of childbearing care which is common in Mombasa, and I will use Soud's study to analyze the demographic factors which she found to be associated with use of care. Next I will focus in on the elements of childbearing care in Mombasa which require closer, more contextual observation and interpretation, such as risk perception, medical plurality, authoritative knowledge and birth territories. I will conclude the chapter with a final analysis of the key themes.

Background

Mombasa is Kenya's second largest city, with about 900,000 inhabitants. It sits about 4 degrees south of the equator on the Indian Ocean, which has allowed it access to Indian Ocean trade route for centuries. Mombasa is a hub of travel with various safe natural harbors, the beginning of the Uganda railroad, and Moi International Airport. This has made the city

highly accessible to tourists, and tourism has become one of Mombasa's most important industries as visitors come to visit the beach, see the Islamic architecture and buy the Islamo-African artwork and souvenirs in what they see as a benevolent, sleepy beach town.

The cultures, religion, and social stratification which characterize Mombasa and the ways people give birth therein are all tied into the history of trade and conquest in this city. The earliest accounts of East Africa's involvement with the Indian Ocean trading system are from the first century A.D. (Middleton 1992). As early as 1100 AD, a cultural group comprised of African and Arab ancestry called the WaSwahili (meaning 'coast people') functioned as merchants on the East African coast, facilitating trade between interior Africa and other Indian Ocean traders. Arab rule of city-states on the East African coast persisted until the Portuguese arrived in 1498 (Mirza and Strobel 1989).

After two hundred years of bitter wars and attempts to convert the coastal people, the Portuguese retreated to Mozambique around 1700. Mombasa and other city-states on the coast came under the rule of the Omani empire, and it was during this time especially that Arab immigrants and traders had a major cultural impact on the coastal people, solidifying the presence of Islam, and involving the coast in the slave trade. The British entered Mombasa in 1895 to establish the protectorate of British East Africa, with Mombasa as the capital (Mazrui and Shariff 1994). In 1963, Kenya

became an independent state, with Jomo Kenyatta as the first President.

The people of Mombasa have experienced an extraordinary history of domination, war, trade, and cultural contact. One of the most obvious cultural impacts of this history is Islam, which influences social organization, education, respect, and in many ways the way people manage health and childbearing. The history of trade and conquest also created social stratification which is still visible today, though it is changing with new trends of urbanization. The ruling class and merchant class of Mombasa was occupied by different mixes of Arab, African, Indian and European inhabitants through different points in history and today ethnic identities are still used as symbols of the socio-economic status. The WaSwahili merchants had had a dominant socio-economic status over most other indigenous ethnic groups throughout the history of trade, by earning trade profits from interior goods or owning slaves from interior ethnic groups.

Today, the WaSwahili, though not an economically homogeneous group, still often maintain higher esteem and inherit more opportunities than other African ethnic groups. Like most urban centers in contemporary Africa, the need for jobs draws people to Mombasa from all over Kenya and the surrounding countries, from the educated and professional elite to the rural landless poor. This has made Mombasa increasingly ethnically diverse, and has made the economic stratification less racially defined.

Post-Colonial Political Economy of Health in Kenya

After independence in 1963, the Kenyatta administration placed strong emphasis on increasing health care and education, and on equalizing the disparities in services between different regions of the country (Maxon 1995). The government aspired to provide free health care to all people, and though this goal was never achieved, they did pass legislation in 1965 to make medical services free to all outpatients and children (1995). By 1970, the average life expectancy of Kenyans had an amazing increase from 44 at the time of independence to 55 just seven years later (1995).

The late 1970s, however, brought a downturn in the Kenyan economy which slowed improvements to health care. The first problem was the world recession following the crude oil price increases of 1979, which slowed development and agriculture efforts in Kenya (Maxon and Ndege 1995). This meant that Kenya and other nearby African states were ill-prepared for the crippling droughts and subsequent famines which came in 1979 and 1980. Exports of food slowed, and Kenya came to depend on imported grain to feed the country. The Kenyan government issued a series of Session Papers, with strategies for regaining their economic stability that would come to be known as structural adjustment policies (Maxon and Ndege 1995).

By 1980 Structural Adjustment Programmes (SAPs) had become a key tool of the World Bank and International Monetary Fund (IMF). SAPs by these international donors usually included devaluing local currencies to

encourage export, reducing of tariffs so as to facilitate imports, the elimination of artificial price controls for agricultural products, encouragement of domestic savings, reducing government expenditure on social services and employment, and privatizing or reducing parastatals in the receiving country (Maxon and Ndege 1995). In Kenya, there was a shift from focusing on social services to focusing on agricultural production as the government's highest development priority. Debt to foreign lenders rose for several years, and in 1983 external debt took approximately 22% of foreign exchange earnings in Kenya (Maxon and Ndege 1995).

The economic struggles of the late 70s and early 80s, and the subsequent SAPs in Kenya meant that the spending on health care decreased significantly. Neighboring Tanzania experienced a similar post-independence increase in the provision of health care, followed by the economic strain, debt and structural adjustment of the 1980s. Lisa Ann Richey explored the use of maternal health services in Tanzania before and after structural adjustment and found that after independence, there was an increase in women using formal maternal health services, but following structural adjustment there was a significant decrease, due to the implementation of user fees for formal care (Richey 2003).

Today, the public health budget remains strained, and the external debt of Kenya in 2005 was at $6,169,221,000, which was equal to over 40% of the 2005 GDP. The percentage of births attended by “skilled health staff” has

decreased, from 50% in 1989 to 45% in 1993, to 44% in 1998 and 42% in 2003 (World Bank Development Indicators On-line, 2008). Though these data are not significant enough to draw a concrete conclusion about external debt and the use of formal health staff, they suggest that the trend which Richey observed in Tanzania has likely been the same in Kenya. The national and international economic influences which have characterized Kenya's post-independence years have been instrumental in producing the contemporary circumstances for health care.

Use of Childbearing Care in Mombasa

Hospitals in Mombasa range from the large, public, provincial hospitals, to smaller private for profit and non-for-profit hospitals. The public provincial hospital, Coast General Hospital (CGH), is intended to serve the entire population of over two million of Coast Province (Soud, 2005). Soud described the prenatal services at CGH as inefficient but well-organized. Though time constraints limited my ability to be approved to do research in the provincial hospital, I heard stories about day-long waits to be seen for maternal and child health care, and witnessed the vast waiting room, teeming with women and children waiting to be seen. An uncomplicated pregnancy in the public hospital costs between KSH 3,000 – 4,000 ($30-$50) (Soud 2005).

Private, for-profit hospitals in Mombasa are much more efficient and comfortable than the public hospital, but they are also much more expensive,

costing between KSH 20,000 – 40,000 ($250-400) for an uncomplicated birth (Soud 2005). There are also numerous obstetricians and other practitioners who have private offices, or operate within hospitals and clinics. Most women who use these hospitals are insured, either by the National Hospital Insurance Fund or private insurance. Interestingly, the national insurance is required for all salaried employees (Owino, 1998), but it is typically the elite few who have salaried jobs.

There are a number of private, non-profit charitable hospitals run by Christian and Muslim organizations in Mombasa. Soud's study included three Muslim-run hospitals, and I had observed one of them, which is called MEWA. These hospitals charge a minimal fee for services. One obstetrician who I interviewed at MEWA estimated that a normal delivery there would cost approximately KSH 3,000 – 3,500 ($40-$50), prenatal care is about KSH 120 ($2) per visit, and an antenatal profile costs KSH 570 ($6). These hospitals have small emergency rooms and can perform small surgical procedures, though are unlikely to be able to perform cesarean sections (Soud 2005).

Birthing centers and clinics are common in urban Mombasa, and are commonly used for childbearing care. The Ministry of Local Government and the Municipal Council operates seven health centers in Mombasa, where women can receive prenatal care, delivery care, and postpartum care, but complicated deliveries are supposed to be referred to CGH (Soud 2005).

There are also numerous for-profit and non-profit outpatient clinics and birthing centers which are run by health professionals. These facilities usually offer prenatal and delivery services, and many can offer basic lab tests and minimal interventions for a complication during delivery. Especially at the non-government birthing centers, both Soud and I observed that non-western biomedical treatments and procedures, such as massage and herbal remedies, are sometimes welcomed, depending on the health staff in the clinic.

Traditional midwives, or *wakunga,* in Mombasa are women who have a specialized knowledge of assisting with childbirth. They are sometimes involved with prenatal care and advice, though their main function is to assist with delivery and postpartum care. They typically go to women's homes for deliveries, but their prenatal and postpartum work can also occur in their own homes. Most *wakunga* can advise women on herbal remedies during pregnancy and the postpartum period, but many of these remedies are also popularly known in the lay sector. In order to be legally allowed to practice as a Traditional Birth Attendant' (TBA) *wakunga* have to attend a government training session to the provincial hospital to learn basic hygienic practices, the signs of complications, and how to safely handle body fluids to avoid HIV transmission. According to Soud, *wakunga* typically charge about KSH 2,000 ($30) for their services, though they often have more flexibility with payment

than formal health services. The services of a *mkunga* can get much more expensive if she provides more services or is regarded as being particularly skilled.

Other non-western medical practitioners who assist with childbearing can include herbalists, *waganga* (traditional healers), diviners, and Islamic healers. Women will typically go to herbalists or *waganga* for physical ailments and discomfort, but may consult *waganga*, diviners or Islamic healers for a problems which have a social, spiritual, or somatic origin. Diviners are especially skilled at determining whether a problem originated from imbalances in social relationships.

Some women deliver without the help of a specialized assistant, although this is not considered ideal according to the people in Mombasa with whom I have spoken. Both Soud and I heard second-hand about very poor women, especially slum residents and Somali refugees who deliver at home alone or assisted by female family members. Unfortunately, neither of us were able to get first-hand information about who delivers without specialized assistance, for what reasons, or how common it is.

Demographic Factors Associated with Use of Care: Soud's Study

In this section I will summarize some of Soud's results from her survey of Muslim women in Mombasa. In her report, this data was sometimes accompanied with some social or cultural context which explained or

reinforced her findings.

Women with a higher income were more likely to have health insurance, and having health insurance was a significant positive indicator of use of prenatal care and delivery in hospitals. Soud found that women were more likely to use prenatal care and biomedical services the more education they had. Ownership of a mobile phone was an indicator of higher status, was highly regarded by women, and could facilitate the use of prenatal care and delivery services because they could call the clinic or call a cab easily. Ownership of a phone had a significant positive association with using prenatal services.

She found that age was not a statistically significant factor in the use of prenatal care or use of biomedical facility, but that younger women do use these services less. She related this to the fact the younger women often have lower income and social support. She added that primiparous women may not have acquired the “skills” necessary for dealing with formal health professionals, which might be one reason why they tended to avoid biomedical facilities more.

Data about household characteristics were collected, in order to assess women's social networks of support and other indicators of social and economic well-being. She found that 25% of respondents had husbands who were drivers (either locally or long-distance), and 35% had husbands who worked outside of the country. In addition, researchers at CGH had observed

that the majority of women who test positive for HIV there have husbands who were drivers. About half of all of the women reported that they consulted their husbands in deciding whether or not to use prenatal care, and many others also consulted other family members, especially when the woman need to ask family members for money to pay for prenatal care.

Ethinicity was an important indicator for choosing a delivery facility, and Soud found that Arabs, Asians, and WaSwahili were much more likely to choose a biomedical facility. More ethnically marginalized groups, like the Mijikenda, Bajuni, Jomvu, and Changamwe are more likely to seek care from *wakunga*. Ethnicity was not a significant indicator of use of prenatal care. The ethnic groups which were more likely to use biomedical care are the same groups that traditionally have higher socio-economic status.

Women who had previously had bad obstetric experiences were much more likely to use biomedical care, to seek prenatal care early, and to have more prenatal visits. She found that women who had previously miscarried had up to 14-16 prenatal visits during their more recent pregnancy, compared to the overall cohort average of seven visits. The vast majority of women were aware of Mother-to-Child Transmission of HIV, and women who knew they were HIV+ were more likely to seek biomedical care. First-time mothers, and mothers who had had more than five pregnancies were more likely to use non-biomedical facilities.

In addition to collecting data on indicators of use of care, Soud also

collected data about the reasons women gave for using care. Her primary source of data was from a survey, though she did also conduct interviews. However, the vast majority of her respondents were found in biomedical facilities, and she spoke with very few women in their homes, so there may be a bias in her cohort toward using biomedical facilities.

The most common reasons that women gave for why they chose the biomedical facility which they did were the services provided (70.2%), the kind of health care provider (43.4%), the cost of care (38.1%), the distance to the facility (31.3%), the facility's affiliation with Islam (11.7%), and the presence of existing health problems (6.8%). She found that distance was a much more important factor in seeking prenatal care than in seeking delivery care. Those women who traveled further away than the closest facilities for care said they did so in search of better facilities or cheaper care. Interestingly, although the majority said that they considered the services available when choosing a facility, only about 55% of women chose to deliver in a place that could provide life-saving care in an obstetric emergency. These statistics about the use of care and the reasons for choosing care provide an important piece of understanding childbearing in Mombasa, but applying some of the theories and approaches I have explored in other chapters along with some more contextual information shows a more complicated and nuanced picture.

Looking Closer at Childbearing Care: Authority, Risk, and

Pluralism

Soud's study included many insights and suggestions which could connect *how* women in Mombasa use care to *why* they use care as they do, but these were only a complement to her survey of demographic indicators. She drew these insights from interviews with women, as well as her own experience as a Swahili woman from Mombasa and a nurse-midwife with 20 years experience in Kenya. This kind of contextual, social understanding is invaluable when trying to understand childbearing in contemporary Africa. I argue, however, that these more micro-social elements need to be treated as more than complimentary to demographic data, because they can help to expose wide- reaching problems such as economic marginalization, power inequality, and social vulnerability. By only looking at childbearing care as determined by certain demographic indicators or social characteristics, one makes the differences in how women seek and use care into a largely apolitical, inert reality instead of the evidence of inequality that can lead to change. In this section, I will attempt to apply Soud's insights as well as my own observations to some of the themes I have discussed in previous chapters, including risk perception, medical pluralism, power and authority, to show why these individual- and local-level dynamics are a crucial bridge between observing the inequalities in childbearing in contemporary Africa, situating them in the larger political and economic framework, and interpreting them through a critical, applied perspective. Further research would be necessary to

fully explore these themes in Mombasa, but between Soud and I there is enough information to show that they are a critical part of understanding childbearing.

Risk perception is a very interesting component of seeking childbearing care in Mombasa, especially if it is defined to include social risk as Rachel Chapman did in her work from Mozambique (2006). It would be simple to say that women in Mombasa, or Muslim women in Mombasa, or Swahili women, do not view pregnancy as a pathology, but in my experience that would be essentializing the culture and beliefs of any of those groups. Many women, especially *wakunga*, did not feel strongly that women should have to seek prenatal care unless they were experiencing a problem. However, what about Mombasan women who work at a prenatal clinic, and encourage women to get a minimum of 6-7 prenatal visits for an uncomplicated pregnancy? Even among these groups, the perception of the risks of childbirth, and the necessity to use prenatal care varies greatly from person to person, and may be based on past personal experiences as much as it is on cultural norms. Soud alluded to this when she reported that women who had previously had complicated pregnancies, including miscarriages, and those who knew they were HIV+ were more likely to seek prenatal services or biomedical care.

An example of differing risk perceptions in Mombasa from my own

research is related to the desire for care during the prenatal and postpartum periods. Clinic and hospital staff with whom I spoke suggested that during an uncomplicated pregnancy, a woman should receive 6-7 prenatal check-ups, and should come for at least one postpartum checkup unless there were any problems. This advice was based on the perception that obstetric risks can be detected by biomedical procedures during the prenatal period, but that there are few risks following the delivery of a normal pregnancy, so minimal surveillance and care are required. By contrast, almost every Swahili m*kunga* and woman whom I interviewed spoke at length about the many necessary steps that must be taken to ensure that all of the afterbirth, or *uchafu* (translated as 'dirt', even by English speaking informants) is completely expelled from the uterus within the first 40 days following the birth. This process involved herbal treatments, massage from a specialist or *mkunga*, wrapping the waist tightly with cloth, and more. Any 'dirt' which is retained within the woman is considered pollutive and injurious to one's health, and just as when they are menstruating, women are told not to sleep with their husbands until the 'dirt' is gone (in keeping with Islamic teachings). In addition, several *wakunga* whom I interviewed suggested that a woman should not need more than one prenatal visit in the absence of complications. Many women took both of these differing risk perceptions seriously, and were able to combine them by receiving both kinds of care.

Physiological risk, as discussed above, can often exist in concert with

social risk which can sometimes outweigh physiological risk. One example Soud mentioned was the role that husbands and in-laws can have in the way a woman uses childbearing care. It is common for a woman to move in with, live close to, or be co-dependent with her husband's family, and disrupting these family relationships could have serious social, and therefor material, consequences for a woman. For example, a woman might feel that she should have several prenatal check-ups to try to detect possible complications, even if she is not experiencing problems, but her mother-in-law might consider prenatal care to be a waste of money when there are no signs of problems. Especially if a woman is socially and financially dependent on her husband and his family, she might consider the risk of going against her mother-in-law's word to be greater than the risk not getting prenatal care.

Soud uses the term 'medical pluralism' in the title of her dissertation, and as the theme of one of her key chapters, to refer to the variation in kinds of care which exist in Mombasa. When I was studying childbearing care in Mombasa in 2006, I was also surprised at how many different kinds of care existed there. I approached it wondering how women choose between them all, and what significance could be found in the way they choose. Since then, through studying other anthropologists who have observed medical pluralism and reproductive 'choice', I have come to see the situation a bit differently.

First of all, it is very common for women to draw on different kinds of

care, medical ideologies, and social resources to try to secure successful pregnancy and motherhood. It is not usually a question of a pregnant woman saying “I have been feeling weak and dizzy for the last week. Should I a) go to a clinic, b) go to an herbalist, c) go to an Islamic healer, or d) ask my mother-in-law about it”. However, both Soud and I originally approached the situation this way, asking “Did she use biomedical care during her pregnancy, or not?” Most people I talked to felt that there is never any certainty in whether a kind of care will be beneficial, but that there is often no harm in trying it. This meant that although some women went to a prenatal clinic, they were also using herbal medicines to relieve discomfort, and had no problem with going to an Islamic healer if they suspected they were a victim of the evil eye, or witchcraft by jealous neighbors. The way women seek care in Mombasa more resembles trying to exploit all of the resources and safety nets which are feasible, rather than choosing one medical tradition over another.

In addition, I would like to take the analysis of this medically plural setting further, by applying the model Libbet Crandon-Malamud used in Bolivia, which I discussed in Chapter Two. According to Crandon-Malamud, people seeking treatment and healing use medicine as a primary resource to gain access to secondary resources, such as social networks and status. She showed that the discourse surrounding health and healing can be a tool for seeing what secondary resources people are seeking, and how. When people in Mombasa are seeking childbearing care, they are not always seeking

physiological health as their first objective. The example above, about preserving one's ties to in-laws is one such situation. Neither Soud nor I had significant contact with very low-income communities, but it would be important to understand the intersection of preserving social networks and the limits of financial ability in seeking childbearing care in those communities to get a better idea of childbearing in Mombasa.

The elements of power and authority which impact childbearing have a significant role in shaping the people who assist with birth, the tools and techniques they use, the spaces used for childbearing care. As I have discussed in Chapters Three and Four, the power and authority which characterize these aspects of childbearing care can sometimes assume the role of 'knowing what's best' for women, essentializing their needs and the needs of their communities, and removing their involvement in managing their own pregnancy and birth. Childbirth in Mombasa, like anywhere else, is characterized by different kinds of power and authority deemed legitimate, depending on the people assisting with care and the place where it takes place.

In the hospitals, private practices, and government-run clinics in Mombasa, the western obstetrical tradition has the agreed-upon legitimacy to make it authoritative. In this sense, these facilities are the birth territories of the people who have the knowledge necessary for the skills and technology used there. Though the government acknowledges *wakunga*, it does not

acknowledge the legitimacy of their techniques. The authority of western obstetrics is reinforced by making it illegal for *wakunga* to practice unless they agree to adopt certain biomedical techniques. One can only assume that reinforcing only the biomedical narrative about health, risk and birth is done with the sincere intention of improving women's health, but it only recognizes this one system as legitimate when there are other, beneficial kinds of care which may address women's needs beyond physiological health. Jordan argued that the devaluation of non-authoritative knowledge systems supports existing hierarchical structures (1978), and this seems to be the case with the relationship between biomedical facilities and *wakunga* in Mombasa.

Though the government asserts the legitimacy of biomedical obstetrics, and there seems to be consensus about the authority of western biomedicine in the formal medical domain, other kinds of knowledge are regularly given more weight in other birth territories, such as the homes in which *wakunga* work. Most of the *wakunga* whom I interviewed described their techniques and procedures for assisting with pregnancy, delivery, and the post-partum period as being separate from the biomedical paradigm. When they spoke about the training they received at CGH, they almost always referred only to using gloves, tying the umbilical cord with thread before cutting it, and sterilizing any blades they used. Though they were not as exclusive as the formal health services in which systems of knowledge were used, it appears that their non-biomedical system of knowledge was given

more weight. By comparison, Soud and I both found that some of the birthing centers which were not run by the government gave more weight to the western obstetric tradition, but also accepted certain non-biomedical practices, like the use of herbs and massage, or giving spiritual and social advice.

In a couple of instances, *wakunga* spoke disapprovingly about the sutures which women often receive at the hospital following episiotomy or perineal tearing. They explained that when a woman has wounds after giving birth, they instruct her to place medicinal herbs in a clean piece of cloth, and then place it on the wound with some warm water to help it heal comfortably. They also recommend this for women who had received sutures at the hospital. I did not get to observe *wakunga* working with women, but it seemed that their knowledge was usually the agreed upon authority in the places in which they worked. Whether it is the authority of a doctor in a hospital deciding that a woman needs a cesarean section, or a midwife in a home, deciding that perineal wounds will heal better with herbs than with sutures, the influence of authoritative knowledge has the ability to shape the way women give birth.

Conclusion

Childbearing in Mombasa, and the way that women use childbearing care, is shaped by the economic strain on public funding for health care in Kenya and Mombasa, the social and economic resources which stratify

people's access to and use of care, and the perceptions of risk, a multiplicity of care and the dynamics of authority. The shortage of funding for public health has assisted in creating a range of biomedical services in Mombasa, from privileged, efficient care at private, for-profit hospitals to over-crowded, understaffed and undesirable care at the public hospital. Smaller facilities are also common, to try to provide more basic, low-cost care to the public. Soud found that demographic factors, such as income, education, age, and ethnicity are important indicators for use of prenatal care and biomedical facilities for delivery. However, these factors are not a formula which determines why people seek, access and use care the way they do. Perceptions of physiological and social risk shape how people seek care, and this often means using multiple health resources. The plurality of health resources in Mombasa, and the way that many people draw on multiple kinds of care at once shows that physiological health and the efficacy of care is not always the only factor considered when using care. Lastly, agreed-upon legitimacy of different kinds of care or caregivers in Mombasa has an important role in shaping the methods and techniques used in different places for getting care. In order to have a more holistic and accurate understanding of childbearing, it is necessary to incorporate an understanding of the political and economic framework, the local social and economic factors which indicate who is using what kind of care, and the more contextual elements which show that seeking and using care often involves more than one's financial situation and

physiological needs.

Chapter Six:
Conclusion

The circumstances of childbearing in any place are varied and diverse, with intersecting factors on the international, national, local, and individual level which impact the way women and their families conceive of childbearing, the way they seek and use care, and the outcomes of their pregnancies. However, the global stratification in resources and support for everything from food security to urban livelihoods and rural health services means that some women have a better chance at having a positive childbearing experience than others. One notable measure of this is the alarming statistic that 1:26 women on the African continent will die in childbirth, while only 1:5,100 women in North America will suffer this fate (WHO 2005)[4]. Much research, money, work, and energy is put toward trying to reduce maternal mortality and morbidity in Africa. The perspectives which drive these efforts shape the way research is conducted, policies are written, and funds are allocated. For this reason, I have explored the factors which shape the circumstances of childbearing, examined the kinds of perspectives

4 However, I will note that the risk of dying in childbirth varies within a continent, country, or other location almost as much as it does between them. For example, in 1999 it was found that in the state of New York, Black women were about 3.8 times more likely to die in childbirth than white women (New York Times, June 1999)

which have authority in contemporary Africa, and argued for a more critical and integrated perspective.

One dominant perspective which has informed many of the international, national, and local efforts to address issues of childbirth and wellbeing has focused on improving physiological outcomes of pregnancy through the increase of access to biomedical services and techniques, or identifying under-served populations due to local or regional inequalities of access. Biomedical care clearly has important benefits for childbearing, especially in prenatal care and obstetric emergencies, and I am fully supportive of increasing access to these services. However, I argue that it is necessary to widen the scope of analysis to include other factors beyond access to care and local inequalities in order to understand the full range of processes which shape childbearing in contemporary Africa. This includes examining structural factors, such as reduced spending on public health, local-level processes like ethnic marginalization, and cultural concepts like risk perception which influence health seeking.

The way people seek and use (or do not use) childbearing care in contemporary Africa has attracted much attention through research. Studies of maternal health-seeking often try to identify demographic indicators associated with the use of care (Magadi et al 2000, Soud 2005). However, these kinds of studies do not typically try to learn *why* people seek care the way they do. One way to explore the reasons that people seek care the way

they do is by looking at risk perception, which directs how a person interprets risk and the actions they take to minimize it. Risks in childbearing are not limited to physiological risk, but can include social, spiritual, financial or other kinds of risk, and are rooted in legitimate experiences (Chapman 2006). Biomedical efficacy is not always the first priority for the way women conduct their pregnancies, and basing decisions on factors other than physiological risk can be a legitimate and logical way of trying to minimize different kinds of threats. It is important to use more qualitative research to be able to understand the reasons that shape how women and their families approach childbearing and to recognize them as legitimate.

Childbearing assistants in contemporary Africa are a diverse and mixed group of people, ranging from the aunt of the woman giving birth to obstetric surgeons. There is not a clear dividing line between biomedically trained and non-biomedically trained birth assistants. This is largely due to social and cultural frameworks, as well as political and economic processes have given rise to the current heterogeneous and inter-related circumstances of childbearing assistance. Primarily non-biomedical birth attendants vary widely from one tradition to the next, and cannot be generalized into one concept of Traditional Birth Attendants in a meaningful and useful way. Primarily biomedically-trained assistants have been introduced selectively since early colonial and missionary contact, and urban environments have intensified the contact between biomedical ideology and traditional birth attending. National

health programs and development efforts have continued to support the extension of biomedical practices through childbearing assistants. Looking at childbearing assistants through the processes which have made them heterogeneous and mixed is a more useful way of understanding childbearing assistance in contemporary Africa than trying to separate and define them.

The places where childbirth takes place in contemporary Africa are as diverse and mixed as childbearing assistants, with often more than one set of ideologies, methods, and ways of knowing about childbirth present among one another. Though several forms of knowledge may be present at a place, the one which has the agreed-upon legitimacy to be authoritative is given more weight than others. In this way, places for childbearing become the birth territory of those who are given authority there. Particularly with biomedical birth territories, the authority of one system of knowledge can become problematic when it excludes women from the process of childbearing. Looking at the differences of power and authority which take place in a birth territory can highlight local-level and structural systems of authority and power.

In Mombasa, Kenya, the history of the region and the economic structure of post-colonial development has given rise to a highly stratified society, where a huge range of ethnic divisions and cultural frameworks come in contact, and are experienced through an equally expansive range in ways of giving birth. From Somali refugees who avoid the overcrowded public

hospital, to the most elite and expensive *mkunga* in town, cultural values come into contact, authority is negotiated, and structural inequalities continue to reinforce local realities. Exploring demographic factors which are associated with low use of prenatal and biomedical childbearing care can help to identify the populations who are under-served by public health care, but it does little to understand the other things which influence the experience of childbearing, such as risk perception and authoritative knowledge. A Critical perspective in Medical Anthropology can provide a better frame for the circumstances of childbearing in Mombasa by tying the experiences of childbearing beyond biomedical access, to local and national history and international political and economic processes.

The perspective which I have applied in this work provides a wider and better-informed way of thinking about childbearing in contemporary Africa, but more importantly, it has powerful potential if applied to changes in research and the policies which that research informs. There is a need for sound anthropological, qualitative research in order to see the legitimate needs and experiences of childbearing which are not limited to issues of access to care. This requires long-term, dedicated, analytical methods. I have seen how frequently quick methods of research, such as rapid assessments and focus group interviews are substituted as sufficient for gathering data in the development world. In the absence of long-term, dedicated research, it is

troubling how frequently informants will repeat back development rhetoric, thinking it will impress the researcher, protect themselves from exploitation, or simply get them off their backs. I know how inadequate these methods are because I've used them, and this experience informs my insistence for more rigorous standards in research in the development and public health fields.

Interventions which address immediate, local-level inequalities and barriers to health are certainly valuable. I argue, however that these problems will only be partially mitigated without major changes to the international political and economic processes which continue to reinforce the global hierarchy of developing and developed countries. Structural Adjustment Policies punish the poor for the colonial legacy, contemporary corruption, and extractive industries they have been handed, and while private business elites and donor countries grow wealthier, public health care is still out of reach for many, and foreign debt continues to grow. Until this system is redirected, charity and aid will do little more than insist that Africa belongs in poverty.

This study has brought together themes of cultural frameworks, local authority and marginalization, national health policies and history, global political and economic processes to give a wider and deeper perspective on childbearing in Africa today. Its purpose has been to demystify the circumstances which make childbearing in Africa diverse, mixed and complicated, while contextualizing some of the larger processes which have been common to much of the continent and its inhabitants. By applying this

perspective to the powerful and well-intentioned efforts to improve wellbeing and childbirth in contemporary Africa, there is greater opportunity for change on a wider and more effective level.

Bibliography

Barnes-Josiah, Debora, Cynthia Myntti, and Antoine Augustine
1998 The "Three Delays" as a Framework for Examining Maternal Mortality in Haiti. *Social Science Medicine* 46(8): 981-993

Beckerleg, Susan
1994 Medical Pluralism and Islam in Swahili Communities in Kenya, *Medical Anthropology Quarterly*, New Series, Vol. 8, No. 3, pp. 299-313

Bisele, Megan
1997 An Ideal of Unassisted Birth: Hunting, Healing, and Transformation among the Kalahari Ju/'hoansi IN: *Childbirth and Authoritative Knowledge: Cross Cultural Perspectives* eds. Davis-Floyd and Sargent. Berkeley: University of California Press

Butlerys et al.
2002 Role of traditional birth attendants in preventing perinatal transmission of HIV, *BMJ* 324(7331): 222–225

Castro, Arachu and Singer, Merrill
2004 Anthropology and Health Policy: A Critical Perspective IN: *Unhealthy Health Policy: A Critical Anthropological Examination* Arachu Castro and Merrill Singer, eds., Walnut Creek, Calif. : AltaMira Press

Celik, Yusuf and David Hotchkiss
2000 The Socio-economic Determinants of Maternal Health Care Utilization in Turkey. *Social Science and Medicine*, 50:1797-1806.

Chapman, Rachel
2006 *Chikotsa* – Secrets, Silence, and Hiding: Social Risk and Reproductive Vulnerability in Central Mozambique. *Medical Anthropology Quarterly* 20(4):487-515

Cliff, Julie

1991 The War on Women in Mozambique: Health Consequences of South African Destabilization, Economic Crisis, and Structural Adjustment. IN: *Women and Health in Africa* Meredith Turshen, ed., Trenton, N.J. : Africa World Press

Comaroff, Jean
1993 The Diseased Heart of Africa: Medicine Colonialism and the Black Body IN: *Knowledge, power, and practice :The Anthropology of Medicine and Everyday Life,* Shirley Lindenbaum and Margaret Lock, eds., Berkeley : University of California Press

Crandon-Malamud, Libbet
1991 *From the Fat of Our Souls: Social Change, Political Process, and Medical Pluralism in Bolivia* Berkeley : University of California Press

Feierman, Steven
1985 Struggles for Control: The Social Roots of Health and Healing in Modern Africa *African Studies Review,* Vol. 28, No. 2/3 (Jun. - Sep., 1985), pp. 73-147

Fiedler, Deborah Cordero
1996 Authoritative Knowledge and Birth Territories in Contemporary Japan. *Medical Anthropology Quarterly* 10(2):195-212

Freund, Bill
2007 *The African City: A History* New York: Cambridge University Press

Hunt. Nancy Rose
1999 A Colonial Lexicon Of Birth Ritual, Medicalization, and Mobility in the Congo Durham: Duke University Press

International Center for Development Research
1989 Tradition Birth Attendants (Zimbabwe). International Center for Development Research, Harare, Zimbabwe http://www.idrc.ca/en/ev-83073-201_860004-1-IDRC_ADM_INFO.html

Jambai, Amara and Carol MacCormack
1996 Maternal Health, War, and Religious Tradition: Authoritative Knowledge in Pujehun District, Sierra Leone. *Medical*

Anthropology Quarterly, New Series, Vol. 10, No. 2, The Social Production of Authoritative Knowledge in Pregnancy and Childbirth pp. 270-286

Janzen, John M.
1978 *The Quest for Therapy in Lower Zaire*. Berkeley : University of California Press

Joralemon, Donald
2006 *Exploring Medical Anthropology, 2nd Ed.* Berkeley : University of California Press

Jordon, Brigitte
1978 (1993)*Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States 4th Ed.* Long Grove, Illinois: Waveland Press

Kaufert, Patricia and O'Neil, John
1993 Analysis of a Dialogue on Risks in Childbirth: Clinicians, Epidemiologists, and Inuit Women IN: *Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life* Shirley Lindenbaum and Margaret Lock, eds., Berkeley : University of California Press

Kenya Ministry of Health
2005 AIDS in Kenya: Trends, Interventions and Impact. National AIDS/STI Control Program (NASCOP). Nairobi

2005 Kenya National HIV/AIDS Strategic Plan 2005/6 – 2009/10: A Call to Action. National AIDS Control Council. Nairobi

2002 National Guidelines: Prevention of Mother-to-Child HIV/AIDS Transmission (PMCT). National AIDS/STD Control Program (NASCOP). Nairobi

Ladjali, Malika
1991 Conception, Contraception: Do Algerian Women Really Have a Choice? IN: *Women and Health in Africa* Meredith Turshen, ed., Trenton, N.J. : Africa World Press

Lock and Nichter
2002 From Documenting Medical Pluralism to Critical Interpretations of Globalized Health Knowledge, Policies, and Practices IN: *New Horizons in Medical Anthropology: Essays*

in Honour of Charles Leslie, Mark Nichter and Margaret Lock, eds., London: Routledge

Magadi, Monica Akinyi, Janet Madise Nyovani, and Roberto Rodrigues
2000 Frequency and Timing of Antenatal Care in Kenya: Explaining the Variations between Women of Different Communities. *Social Science and Medicine* 51:551-561

Maglacas, Mangay and John Simons
1986 An Evaluation of a Programme to Train Traditional Birth Attendants in Ghana, World Health Organization, 1986. :51-60. (WHO Offset Publication No. 95) http://www.popline.org/docs/0766/269645.html

Marsland, Rebecca
2007 The Modern Traditional Healer: Locating 'Hybridity' in Modern Traditional Medicine, Southern Tanzania, *Journal of Southern African Studies*, 33:4, 751 - 765

Maternowska, Catherine
2006 *Reproducing Inequities: Poverty and the Politics of Population in Haiti*. New Brunswick, N.J. :Rutgers University Press

Maxon, Robert
1995 Social and Cultural Changes *IN: Decolonization and Independence in Kenya* B.A. Ogot and W.R. Ochieng', eds., James Curry Ltd: London

Maxon, Robert and Peter Ndege
1995 The Economics of Structural Adjustment *IN: Decolonization and Independence in Kenya.* B.A. Ogot and W.R. Ochieng', eds., James Curry Ltd: London

McCaw-Binns, Affette, Janet La Grenade and Deanna Ashley
1995 Under-users of Antenatal Care: A Comparison of Non-AttendersAttenders for Antenatal Care, with Early Attenders *Social Science and Medicine* 40(7): 1003-1012

Okafor, Chinyelu B., and Rahna R. Rizzuto
1994 Women's and Health Care Providers' Views of Maternal Practices and Servicesin Rural Nigeria. *Studies in Family Planning* 25 (6): 353-61.

Osubor, K. M.

2006 Maternal Health-Seeking Behavior and Associated Factors in a Rural Nigerian Community, *Maternal and Child Health Journal*, Vol. 10, No. 2, DOI: 10.1007/s10995-005-0037-z

Patterson, David and Hartwig, Gerald
1978 The Disease Factor: An Introductory Overview IN: *Disease in African History: An Introductory Survey and Case Studies,* Gerald W. Hartwig and K. David Patterson, eds., Durham, N.C. : Duke University Press

Pigg, Stacy Leigh
1997 Authority in Translation: Finding, Knowing, Naming, and Training "Traditional Birth Attendants" in Nepal. IN *Childbirth and Authoritative Knowledge*. Robbie E. Davis-Floyd and Carolyn F. Sargent, eds., pp. 233-62. Berkeley: University of California Press

Ranger, Terence
1992 Godly Medicine: The Ambiguities of Medical Mission in Southeastern Tanzania,1900 – 1945 IN: *The Social Basis of Health and Healing in Africa* Berkeley: University of California Press

Ripple Africa
2008 Training for Traditional Birth Attendants (TBAs) http://www.rippleafrica.org/ripple_funding_oneoff.htm

Richey, Lisa Ann
2003 Women's Reproductive Health and Population Policy: Tanzania. *Review of African Political Economy* No.96:273-292

Sargent, Carolyn Fishel
1989 *Maternity, Medicine, and Power: Reproductive Decisions in Urban Benin*. Berkeley : University of California Press

Sheldon, Kathleen
1996 Introduction IN: *Courtyards, Markets, City Streets: Urban Women in Africa* ed Kathleen Sheldon Boulder: Westview Press

Singer, Merrill
1986 Developing a Critical Perspective in Medical Anthropology. *Medical Anthropology Quarterly*, Vol. 17, No. 5. pp. 128-129.

Singer, Merrill and Baer, Hans
1995 *Critical Medical Anthropology.* Amityville, N.Y. : Baywood Pub. Co

Soud, Fatma
2005 Medical Pluralism and Utilization of Maternity Health Care Services by Muslim Women in Mombasa, Kenya. University of Florida. Ph.D. Dissertation, University of Florida

Stolberg, Sheryl Berg
1999 Racial Divide Found in Maternal Mortality. *New York Times* June 18, 1999

Tanzania National Bureau of Statistic
2002 2002 Population and Housing Census http://www.tanzania.go.tz/census/

Turshen, Meredeth
1991 Taking Women Seriously: Toward Democratic Health Care in Africa IN: *Women and Health in Africa* Meredith Turshen, ed., Trenton, N.J. : Africa World Press

Wall, L. Lewis
1998 Dead Mothers and Injured Wives: The Social Context of Maternal Morbidity and Mortality among the Hausa of Northern Nigeria. *Studies in Family Planning* 29 (4): 341-359

World Health Organization/African Region
2003 RPM 30 “Toward the Millennium Development Goals: Advocacy for Improved Maternal and Newborn Care” http://www.afro.who.int/drh/safe-motherhood/script-rpm30-mdgs-reduce2.pdf

2008 Reducing Maternal Mortality: The Challenge of the New Millennium in the African Region. Brazzaville, Democratic Republic of Congo http://www.afro.who.int/drh/

World Health Organization
2005 Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and The World Bank

The World Bank Group
2008 World Development Indicators Online: Kenya

http://go.worldbank.org/3SGLDH5V10