Since the Millennium Development Goals were launched in 2000, decreasing maternal mortality has been a major focus of governments across Sub-Saharan Africa. In Tanzania, where about 7,500 women die from pregnancy and childbirth-related complications each year, the rights to health-based international and national response has been through policies, programs, and projects focused on increasing the utilization of facilities for childbirth. From the MDG-driven international policies to the local, embodied experiences of women providing and receiving maternal health care in rural Tanzania, my research critically examines the intended and unintended consequences of the global push for more facility births.

From January to August of 2016, I conducted multi-sited, ethnographic research in three rural villages in Mpwapwa District, Tanzania (central, Dodoma region). Mpwapwa was a brand new field site for me, as my previous experiences in Tanzania have been in Arusha Region, where I worked as a development practitioner from 2009-2011, and where I also conducted Swahili language training on a summer FLAS from June to August 2015. Research support through a large, U.S.-based maternal health project called Transparency for Development (http://t4d.ash.harvard.edu) brought me to Mpwapwa for my seven months of field research. Throughout my time there I was able to complete my Master’s research while I also conducted ethnographic research for the Transparency for Development Project on community-based transparency and accountability activities, indicators, and maternal and neonatal health outcomes.

Main methods for my MA research were informal and formal interviews with mothers, traditional birth attendants, and health-care workers, and weekly participant-observation conducted at three different health dispensaries. Thanks to extensive language training provided by two academic FLAS fellowships in Swahili, I was able to conduct the majority of my research without the use of translators or research assistants. This helped me gain access and build relationships and trust with the many women I encountered in these communities to talk about pregnancy and childbirth. One of my main findings is that technologies of governance aimed at increasing facility births ultimately create more inequalities for women on the ground. For example, in response to national pressures, Mpwapwa District founded policies illegalizing home births and promoting fines for women who give birth at home in order to increase numbers of facility births. These policies get implemented into community-based bylaws that work against the poorest women in the community, who are often denied access to care for themselves or their infants until they are able to pay the home birth fines.

It is not just mothers or the recipients of care who feel the weight of these larger policies on the ground. Dispensary-based nurses and traditional birth attendants also experience increased inequalities and vulnerability in their roles as pregnancy and birth care providers. For example, health care workers are increasingly stressed and overworked in attempts to balance their roles as both regulators and care providers. Moreover, these policies have led to the illegalization of the work of traditional birth attendants, who increasingly operate in secret and in opposition to the goals of health care workers and village government. Unfortunately, this illegalization of home births and attempt to transform local birth attendants to facility escorts has forced women to act on the margins of society at the same time home-based childbirth care remains a vital, and often only, option for the poorest mothers. For my PhD work, I hope to return to Tanzania to conduct more research on these complex, local effects of international and national childbirth policies and the embodied experiences of mothers, traditional birth attendants, and health care workers in rural communities.

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