Medical Anthropology Quarterly

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"To Open Oneself Is a Poor Woman's Trouble":

Embodied Inequality and Childbirth in South–Central Tanzania

Various theories exist for the ways in which social and material disparities are incorporated within human bodies and then expressed as health outcomes with uneven distributions. From a political economy perspective, one pathway involves processes of social exclusion that take place on articulating local and global fields of power. This study explores such situated processes as they produce and perpetuate embodied inequality at childbirth in the Kilombero Valley of South–Central Tanzania. Ethnographic narratives illustrate how these processes differentially affect the kind of care women seek and receive. Also described are women's complex yet pragmatic responses to potential exclusion in the attempt to secure a safe and otherwise positive outcome. In a culturally constructed world of childbirth, face-to-face claims on entitlement to biomedical services collide with enactments of discrimination at multiple levels, creating a space of contestation for social and material positioning as well as for physical well-being. [embodied inequality; childbirth; Tanzania; social exclusion; maternal health]

The village dispensary had one room for laboring women and another for those already delivered, each equipped with two rusty beds and little else. In the labor room two women sat and rocked while another paced between them, back arched and hand pressed to the curve of her spine. Female relatives crouched outside in the shade of a mango tree, preparing chapatti and coconut beans for their daughter, sister, or mother. Now and then a nurse–midwife would bustle into the room and press a fetoscope to one woman's belly or fling up another's *kanga* to inspect for progress.[1] "Mama, open your legs!" she commanded a woman wearing tattered yellow and green. "Hmh! Not ready yet," she appraised. After scolding this woman for being weak, the midwife returned to a long line of mothers and infants waiting for vaccinations. The health aide had left hours ago to collect water from a nearby well.

This scene was not uncommon. From physical space to staff issues, it was one I had observed and participated in many times since arriving a few weeks earlier. What happened next, however, I did not anticipate. The woman in yellow and green beckoned me to approach. "Dada, tafadhali utanisaidia kuweka godoro kwenye sakafu?" [Sister, please will you help me put this mattress on the floor?]. Together we lowered the mattress to the crumbling cement. "Excuse me, Mama," I asked,

MEDICAL ANTHROPOLOGY QUARTERLY, Vol. 25, Issue 4, pp. 479–498, ISSN 0745-5194, online ISSN 1548-1387. DOI: 10.1111/j.1548-1387.2011.01181.x

"Why do you want to do this?" She spoke softly, "So the baby won't fall from the bed if I deliver by myself." The room became quiet and the two other women looked down at her. The older one with a red *leso* (headscarf) and gold earrings shook her head and clicked her tongue, a gesture I recognized as one of pity. The woman on the floor, who I'll call Asha, did not deliver alone. To relieve the midwife, I attended the birth—an act that prevents me from knowing what would have happened had I not been present.

This experience stayed with me for nine additional months of fieldwork in the Kilombero Valley of South–Central Tanzania. My attempt to understand how some women might deliver in a health facility unattended by a professional provider proved a central catalyst for my research efforts, shaping my ethnographic study and the perspectives presented here. The purpose of this article is to examine the problem of accessing care at childbirth—a pivotal and recurring life event that, I will argue, makes women vulnerable to a range of transformations that include physical risk but extend beyond it. This objective is addressed by exploring processes of social exclusion that simultaneously take place in small-scale, local arenas and in broader global contexts to produce embodied inequality—processes that differentially affect desires, decisions, and actions relative to childbirth and result in assertions, violations, and negotiations of claims to biomedical obstetric care and to safe delivery.

Embodied Inequality—Processes and Production

Embodied inequality is an interdisciplinary concept gaining ground in a number of fields. Social epidemiologist Nancy Krieger defines this term as "how we literally incorporate, biologically, the material and social world in which we live" and then express this assimilation in uneven population patterns of health and disease (2001:672). An established body of evidence shows that social and material status are strong and robust correlates of health outcomes, both across and within countries (Berkman and Kawachi 2000; Leon and Walt 2001). However, beyond the knowledge that socioeconomic positioning influences health and well-being, the multiple and specific pathways through which it becomes physically integrated within peoples' bodies are not sufficiently understood.

Theoretical perspectives on embodied inequality have emerged within epidemiology and anthropology, each with a growing base of empirical support. One strand hypothesizes that chronic stress is the primary mediator between social environment and disease; disadvantaged persons experience higher exposure to the endocrine sequelae of psychosocial stressors, thereby manifesting poorer health (Brunner 1997; McEwen 1998). A second strand holds that proximity of social capital correlates directly with well-being; a deficit of cohesion can lead to poor physiological outcomes, while adequate social networks provide a buffer for disease (Kawachi and Berkman 2000; Szreter and Woolcock 2004). Still a third strand takes a political economy approach, arguing that health disparities stem from inequitable distribution of social and material resources and that privilege and deprivation are authored by societal institutions (Braverman and Gruskin 2003; Navarro 2002). This perspective is critical of value systems that exaggerate individual agency and blame victims for their adverse circumstances.

Medical anthropology tends to adopt the latter stance, emphasizing connections between wide-ranging policies and physiological inequities. Soheir Morsy (1996) provides a review of how this subdiscipline draws on the work of Ibn Khaldun, Virchow, Galtung, and Foucault to situate social practices in historically delineated contexts, where the abstraction of culture emphasizes issues of power and control around health and illness. Movements within the field attest to this lens, including critical medical anthropology, political economic anthropology, and theories of violence that range from "symbolic" to "structural" to "everyday" (Baer et al. 2003; Lock and Scheper-Hughes 1996; Scheper-Hughes and Bourgois 2004). Vinh-Kim Nguyen and Karine Peschard (2003) define a "political anthropology of health" that calls for ethnographic methods in studying associations between social hierarchies and health outcomes—or how inequality translates into embodied effects.

A concept that might further theorize embodied inequality is social exclusion. Like social capital and other views that extend beyond economic criteria in defining disadvantage (i.e., those of Amartya Sen, Peter Townsend, and Partha Dasgupta), social exclusion accounts for relational as well as distributional aspects of poverty. But more than a static counterpart to social capital, this idea refers to the processes through which individuals or groups are excluded from material resources and societal belonging (Bhalla and Lapeyre 1997; De Haan and Maxwell 1998). Such processes occur on multiple levels of political economy. To distinguish between them, I will use Faye Ginsburg and Rayna Rapp's ideas, where "global" refers to wide spheres of knowledge and power that come to influence a range of contexts, and "local" refers to small-scale arenas where "social meanings are informed and adjusted through negotiated face-to-face interaction" (1995:9). Throughout my analysis I stress the entanglement of these levels, recalling Lila Abu-Lughod's claim that "the effects of extralocal, long-term processes are manifested locally and specifically, produced in the actions of individuals living their particular lives" (1991:150). Thus, through small-scale arenas situated in broader contexts we can attempt to explore processes of social exclusion that create and perpetuate health disparities.

Childbirth is an important site for the production and expression of embodied inequality. On a global scale, 99 percent of all maternal morality and morbidity occurs in poor and transitional countries, with 87 percent taking place in sub-Saharan Africa and South Asia. Among 11 countries that account for 65 percent of the world's maternal deaths is the United Republic of Tanzania, where women face a 1 in 23 chance of dying in their lifetimes from obstetric causes—versus one in 4,300 for women in industrialized regions (World Health Organization 2010). Because life-threatening complications tend to occur close to or at delivery and are treatable with allopathic intervention, the current strategy for improving maternal health is to make adequate biomedical care (or "skilled attendance") more available to women in labor. But this care must be sought if it is to be received, and women neither seek nor receive it uniformly. Within countries, births with biomedical services are far more common among wealthy, urban, and well-educated groups than among poor, rural, and less-educated groups (Houweling et al. 2007; Say and Raine 2007). Other sociodemographic factors associated with this care include age, parity, ethnicity, and indicators of women's autonomy.

Medical anthropologists have long considered matters of reproduction to be uniquely complex, in that bringing new members into society is as social as it is biological, as dangerous as it is mundane. A number of works examine how some people are empowered to reproduce while others are disempowered, including the ways in which women respond to reproductive technology on uneven terrains reinforced by medicalizing discourse and practice (Ginsburg and Rapp 1995; Lock and Kaufert 1998). Specific to childbirth, Brigitte Jordan (1997) applies the term *authoritative knowledge*, or the knowledge considered legitimate to justify behavior that shapes and reflects power relationships in a particular locality. A body of ethnographic work explores this idea in settings of medical pluralism, considering how indigenous–precolonial and biomedical–postcolonial ways of knowing intermingle with or bump up against each other at birth (Davis-Floyd and Sargent 1996; see also Fleuriet 2009). In Africa, such work includes studies by Carolyn Sargent (1982), Janice Boddy (1998), Nancy Rose Hunt (1999), and Denise Roth Allen (2004), among others. But although this research examines power relations in terms of contested knowledge, most does not explicitly look at how these relations produce embodied inequality.

In summary, a number of pathways exist through which social and material inequalities are incorporated within bodies and expressed as health outcomes with inequitable distributions. From a political economy perspective, one such pathway involves processes of social exclusion taking place on articulating local and global fields of power. Childbirth appears a critical site of embodied inequality, although its production remains vague. Notably lacking are studies of the ways in which social exclusion contributes to this effect, and how women like Asha confront and respond to potential exclusion in moments when the outcome is still uncertain. In a culturally produced world of childbirth, face-to-face claims on biomedical care collide with enactments of discrimination at multiple levels, creating a space of contestation for socioeconomic positioning as well as for physical well-being. As occurring in rural villages of Tanzania but located within broader spheres of influence, this is the dynamic my own work examines.

Research Methods

Research in the study setting was conducted from September 2007 through June 2008. Specific research methods included participant-observation and semistructured interviews. Several key consultants facilitated these activities, organizing my entrée into fieldwork and offering valuable perspectives on observations and interactions. Participant-observation was concentrated on three central villages in each district. These interactions, which usually took place in homes and health facilities, included women with childbirth experience, adult family members, and a range of birth attendants. I also volunteered clinical midwifery skills at local health facilities on a regular basis. Forty-eight semistructured interviews were conducted with purposefully sampled women throughout the villages who had delivered within six months. Broad topics included childbirth stories, views of local obstetric care, conceptualizations of childbirth and risk, and perceptions of how inequalities affect choices and experiences at this event. A research assistant, Christina Makungu, was instrumental in all field activities with the exception of clinical work.

Study Setting: The Kilombero Valley, Tanzania, and the World

The Kilombero Valley is located in the Morogoro Region of South–Central Tanzania, bordered by the Selous Game Reserve to the southeast and the Udzungwa Mountains to the west. Fringed by *mikumi* palms, the Kilombero River churns along the valley floor, irrigating lush rice paddies and marking the boundary between Kilombero and Ulanga districts. Dominant ethnic groups include Ndamba, Pogoro, Gindo, and Bena, but seminomadic groups such as Sukuma and Maasai also inhabit the valley. Christian, Muslim, and indigenous practices are prevalent throughout. Most residents earn their livelihood from subsistence agriculture and fishing, often traveling to *shamba* (farms with second homes) during the long rains. A small number take temporary positions on South African–owned sugar or teak plantations. The Tanzania Integrated Labour Force Survey 2000–01 (National Bureau of Statistics 2003) estimates average household income for rural areas at 36,304 Tanzanian shillings (Tsh) per month, or about $45.40.[2] This income fluctuates substantially between agricultural seasons.

The specific study setting included 25 villages comprising the Ifakara Demographic Surveillance Site (DSS), an ongoing project of the Ifakara Health Institute (IHI). From DSS data in 2008, the population came to nearly 94,000 people spread over 2,440 square kilometers. Total fertility rate was estimated at 5.3 births per woman and maternal mortality at 500 deaths per 100,000 live births. About 49 percent of births occurred at home and 51 percent in health facilities. Formal maternal health services were implemented through a national system that employs reproductive and child health (RCH) personnel at country, regional, and district levels. Obstetric services were available at two hospitals, two health centers, and 11 dispensaries, including both mission and government facilities. Care providers consisted of physicians, nurse–midwives, clinical officers, nurses, and an assortment of health aides. *Wakunga wa jadi* (traditional birth attendants [TBAs]) informally attended births in women's homes and sometimes also in dispensaries. Overall, the picture approximated what Gerald Bloom and Henry Lucas (2001) describe as typical for sub-Saharan Africa—a pluralistic patchwork of weakened formal services, accelerating informal markets, and all manner of improvisation between these poles.

Charles Gore (1994) specifies four tiers of social exclusion in sub-Saharan Africa: transnational, state, community, and household. Volumes of writings explain how colonial rule and its inherited institutions have resulted in the region's subaltern position as a "global ghetto." But besides being itself marginalized in global arenas, the state is simultaneously a vehicle for this action; national political–legal structures play a major role in shutting certain people out by restricting access to land, employment, organization, and representation. Frederick Kaijage and Anna Tibaijuka (1996) document forms of state-level exclusion within Tanzania and evaluate the marginalizing impact of development strategies. As manifested in communities and households, these authors highlight intrarural inequalities resulting from unequal access to agricultural inputs and gender inequalities resulting from unequal access to land and paid labor. But perhaps equally fundamental to state-level exclusion is the bureaucratic and political corruption found in public sectors such as tax administration, public procurement, police force, judicial services, and resource management. Despite concerted anticorruption efforts over the past decade, Tanzania continues

to suffer from entrenched corruption and patronage (U4 Anti-Corruption Resource Centre 2009).

Evidence for situated microprocesses of social exclusion in the Kilombero Valley can be found in Maia Green and Simeon Mesaki's (2005) work on antiwitchcraft practices. These authors show how national aspirations for *maendeleo* (development) in aid-recipient Tanzania transfer moral and political values aligned with neoliberalism to the local arena through public reform policies. The modern Tanzanian subject is a citizen of a free-market, democratic society who uses purchasing power to get ahead, where poverty is antithetical to development in that it contravenes this representation. Within villages, maendeleo becomes interpreted as personal achievement marked by better housing, more consumer goods, and a sensibility that disparages rural customs. Although success in this struggle is still perceived as being somewhat beyond an individual's control (often determined by occult forces), societal worth is increasingly equated with personal wealth and engagement with particular notions of progress.

Kujifungua and Embodied Inequality

Swahili for childbirth is *kujifungua*, which literally translates as "to open oneself." In the Kilombero Valley, the recurring act of opening oneself was an integral event for a majority of women. Unlike food production or malaria prevention, childbirth was not an everyday concern. But given the frequency of this occurrence and its associated risks and significance, it occupied a prominent place in the life course of many. Childbirth posed an extraordinary predicament for women who were socially or economically disadvantaged. This understanding crystallized for me while walking with Mwanamisa toward her family's shamba. We were talking about the care at a local dispensary when suddenly she stopped, staked her hoe in the dirt, and exclaimed "*Ehh-heeh*! Childbirth is a poor woman's trouble! It can be a problem for anyone, but if you are poor like me . . . All we can do is pray to God!"

Apart from the literal act of giving birth, kujifungua also opens one to a space of social, economic, and physical vulnerability. My attempt to explain embodied inequality explores this space as a central dilemma that is indeed greater for women who are relatively deprived. I start by using representative narratives to examine specific global–local processes of social exclusion at childbirth, keeping in mind that the resulting states are not fixed but, rather, constantly reforming according to actors' responses and interpretations—yet, for a time, durable enough to affect real outcomes. I next consider the transition from social exclusion to embodied inequality, showing how exclusion (and inclusion) on articulating levels of political economy determine the kind of care women can access. I end by reiterating the key finding that, as both a product and architect of socioeconomic hierarchies, social exclusion powerfully affects women's ability to negotiate risk at childbirth, contributing to uneven chances of health and survival.

Social Exclusion at Childbirth

What about the vifaa? Sakina arrived at the health center on a rented bicycle that her husband, Ayoub, had managed to maneuver over 20 kilometers of rutted

road. Pregnant with her fourth child, she was instructed to deliver at the health center, rather than the dispensary ten minutes from their home. They were drenched with sweat when they got to the labor ward—he from the pedaling and she from the contractions becoming stronger by the minute. A portly nurse–midwife stepped out to greet them. Looking the pair over, she asked "Habari za vifaa?" [What about the things?]. From out of her blouse, Sakina produced one pair of gloves and a single folded kanga. "Is this all?" demanded the midwife, "Where are the rest?" Sakina turned her face down, a response that elicited a barrage of scolding: How could this mama be so irresponsible? Surely she was told to get the vifaa ready, but no, this mama could not be bothered. Disobedient and lazy, that's what she was. Ayoub thrust his wife's antenatal card into the midwife's hands, pointing to a green star that indicated she should deliver at the health center. The midwife's response: "She can deliver here when you find the vifaa. Until then, she can wait."

Ayoub got back on the bicycle and frantically rode to the homes of relatives to collect what he could. He needed soap, a basin, a razor, some cotton wool, a needle and syringe, a plastic sheet, and a few more kanga. Best to also get kerosene and disinfectant. Sakina had tried to prepare a number of these items earlier in pregnancy, but some she used, others she lent out, and the rest she couldn't afford—especially three or four new kanga, which could have cost the family up to 16,000 Tsh or nearly $12.30. When he managed to borrow a basin and soap and purchase cotton wool from a local pharmacy, Ayoub rushed back to the health center. But by this time Sakina had delivered alone in an empty room. On hearing cries, a health aide came in and cut the umbilical cord, then dried and wrapped the infant. As the couple readied to leave some hours later, the midwife appeared at the veranda and asked Ayoub to pay for the razor. Before benches full of onlookers, he handed her a crumpled 500 Tsh note. Sakina slowly started down the path leading away from the health center.

During my first months of fieldwork, I found myself asking "what about the vifaa?" as well. Vifaa, Swahili for "things," refers to the collection of items providers required women to bring for delivery at health facilities. Nearly all my investigations would at some point turn to the topic of vifaa. It was an RCH coordinator who tipped me off to the weight of this matter: "You know, many are ashamed if they can't get the vifaa or new kanga. They stay home because they don't want others to know of their hardships." After her comment, I listened more carefully to stories like Sakina's about how difficult it was to be deficient in these items at facilities—women publicly humiliated, delivered by their mothers, or even turned away. I also observed interactions involving vifaa at health facilities and asked Tanzanian friends to obtain them at village shops and *duka la dawa* (pharmacy). Including three new kanga, one such attempt cost about 21,000 Tsh ($16.20)—a substantial amount of money given the economic context.

It appears the practice of requiring women to furnish their own supplies was initiated in the last few years; previously women brought only a few old kangas for themselves and the baby. Around the time the district adopted WHO's Focused Antenatal Care (FANC) package, however, women started being told they must bring vifaa to receive services. Part of FANC instructed providers to establish a birth plan with pregnant women, including a list of supplies to have ready in case they deliver outside a facility. But in a setting where nurses were attending

deliveries with condoms on their hands for lack of gloves, this list took on a different purpose. Inefficiencies in the national Medical Stores Department (MSD) had been contributing to supply shortages for years. Coupled with the threat of HIV and increasing demand among health workers for occupational protection, FANC arrived at an opportune time. To be clear, there was no official policy that women bring their own supplies to government facilities—on the contrary, all public services for pregnant women were supposed to be free.

Certainly this improvised rule offered some benefits. It enabled providers to conduct clean deliveries and not worry about infectious diseases. It also ensured that laboring women had basic supplies and prevented the use of dirty instruments. But providers in some facilities were extending the already long list of items to include kerosene and disinfectant. Others required that women purchase drugs and antenatal cards, both distributed to facilities by the government (albeit unreliably). To complicate things, there was a growing trend for providers to own local pharmacies and thus profit from the rule. This conflict of interest was not lost on residents, who complained bitterly about seeing the MSD truck at the dispensary but on arriving were told to purchase the desired drugs or supplies at a provider's duka la dawa. Although requiring vifaa and related practices were primarily occurring in public facilities, providers at mission dispensaries were starting to catch on.

All these changes were occurring in a climate of federal deregulation that accompanied the nationalist goal to become a more capitalist democracy. Many providers applauded each other's entrepreneurial efforts and felt entitled to their actions. "Owning a business is the way of the modern world," one clinical officer explained of his pharmacy. As for their view of vifaa: individuals must strive for self-reliance and if they don't, the results are their own fault. Some villagers who could afford vifaa held similar opinions, but others fretted about what this rule was doing to the poor, or what it might do to themselves should they experience a hardship. Vifaa could push people into a state of (further) exclusion. Sakina and Ayoub's status as poor farmers was perpetuated by the treatment they received at the health center. In part, having insufficient vifaa marked them as socially inferior—publicly demonstrated and justified of commensurate service in the eyes of authority. As filtered down through national programs and adjusted at the local level, the policy to implement FANC in this context seems to have undermined some of the women it intended to help.

"*Asante kwa nini?*" "Yes, we know care is supposed to be free! We go into the dispensary and see the posters on the wall." We were sitting with a group of five in the frame of a half-built house. A frangipani shrub sprouted from the would-be floor and the leaves of a cashew tree provided a roof. Rosi, a young woman in a pale pink leso, continued, "But then, in front of these very posters, the nurse holds out her hand and says, 'Don't be selfish. We helped you deliver. You need to say *asante*.'" "Does the government truly want to help us?" asked Mariam, an older mama. "Let's be honest," chortled Teofrida with hazel eyes, "they want to help themselves! To buy fancy shoes because they're too precious to be barefoot!" The women laughed uproariously. "Look at the Richmond scandal.[3] It's no different here. The fat are only getting fatter," Mariam remarked, sipping a *dafu* (young coconut). "What if you refuse to pay?" I asked. The shrieks of disapproval must

have been audible clear to the ferry. "Listen to me," snapped Teofrida, "you don't have the power to refuse. What will happen when your child gets malaria? Or the next time you go to deliver? No, no. This you cannot refuse." "Asante?" they scoffed, "Asante kwa nini" [Thanks for what?].

Asante, or Swahili for "thank you," was a term that also referred to a tip for services rendered. Unlike most gestures of thanks, however, asante as related to childbirth wasn't always voluntary. Most providers in small public facilities expected money for "helping" with a birth. Although I never witnessed a provider ask for payment, I heard remarks like Rosie's on a regular basis and observed women handing Tsh notes to providers on many occasions. Common perception held that the more a woman could pay, the better her care. In all likelihood, those who could afford a good bribe did receive higher-quality services. The wife of a government official did not deliver alone, was not openly shamed, and received whatever supplies were available. Such amenities could not be guaranteed for those unable to pay an acceptable amount (at least 3,000 Tsh or about $2.30).

This kind of forced bribery reflects the problem of corruption rampant throughout the civil service. Pinning the practice down was difficult, however, partly because of differences in official payment structures at facilities and partly because different providers asked for different amounts. Maternal services were officially free at public facilities, and mission facilities charged a flat fee of 3,000 Tsh. St. Francis, the district hospital of Kilombero, was a mission-run, parastatal entity that charged 10,000 Tsh for vaginal deliveries and up to 38,000 for cesarean sections. Like vifaa, asante was more prevalent at public than private facilities but at the same time, not all providers in the public sector engaged in this practice to the same extent or in the same ways. For example, one health center did not take asante at all. Two dispensaries charged 3,000 Tsh up front, explaining this was fair (indeed a bargain) relative to St. Francis. And four other dispensaries expected money even from women who delivered at home, charging 5,000 Tsh to "register the baby" but "waiving" this fee for women delivering there.

Similar to the dynamics around vifaa, in an emerging capitalistic system with limited opportunity and few means of accountability, rural health facilities became privatized enterprises for the gain of those who work there. Although overworked, providers (often from more urban areas) had far higher incomes than villagers—according to RCH officials, monthly salaries for clinical officers and nurse–midwives were approximately 325,000 Tsh, while nurses made between 180,000 and 240,000 Tsh. However, if supporting family members living in a city, this income could be quickly eaten away. When asked, one RCH coordinator expressed dismay at the problem of corruption: "If we fire providers, with whom do we replace them? The best we can do is transfer them to another facility." Indeed, transfer was the only consequence I detected for inappropriate behavior, and providers hoping to reside in a more urban setting did not always see this result as unwanted.

Birth in the season of growing. Zamda found herself pregnant again in the rainy season, nearing delivery for what would be her tenth child. Although one of her previous babies was born dead and she'd lost two others to fever or *degedege,*[4] so far she was not as pleased about this pregnancy as she'd been in the past. At age 42, Zamda was tired of fretting over how to survive childbirth, tired of

working on other people's shamba to get money for the health facility, and tired of struggling to care for children. Since her first pregnancy at age 16 she'd given birth in dispensaries, health centers, hospitals, and homes. For reasons of safety she preferred facilities, but at this point wasn't sure it mattered. Just so long as her condition didn't put her family into more debt. They had still not recovered sufficiently from her last birth to be able afford clothing or schoolbooks, let alone have their land plowed properly.

Zamda's last birth was also during the time of growing, when the rice paddies around her village were at their brightest green. She remembered the two-hour journey to the dispensary with her mother-in-law and husband, Juma. Together they crossed a river in a dugout canoe and waded through mud up to their knees, vifaa balanced in a basin on her mother-in-law's head. Even though her pains were mild and irregular, Zamda was worried she might deliver quickly and was told she could have a problem with bleeding. At the dispensary she was found to be six centimeters dilated, but two hours later, nothing had changed. The clinical officer on duty said she would have to go to the hospital in Ifakara. She was told this is what happens when women have too many babies and if she was going to continue conceiving, she should be prepared to deliver in town. All passing lorries were stopped where the road had washed out, so the family had to use the ambulance from the health center a few villages away. After getting stuck twice, they finally made it to St. Francis, where Zamda delivered safely and without intervention. But by that time, her family had incurred 55,000 Tsh of debt: 35,000 for the ambulance "petrol fee," 10,000 for hospital charges, and another 10,000 for food and lodging.

This was why, in the seventh month of her tenth pregnancy, Zamda moved to shamba—to help her family work so they might produce a surplus they could sell. Although the other adult household members supported this decision, Zamda claims to have made the choice herself.[5] She knew she would likely deliver in the temporary thatch-and-bamboo structure at their fields, but she couldn't risk a meager harvest this year, or another birth at St. Francis. If necessary she could send for Tekla or Lucrecia, wakunga wa jadi who delivered women at home. Although some received training at a UNICEF workshop 14 years ago, most TBAs relied on experience alone. They did not require vifaa but appreciated a pair of gloves and bit of soap. Reimbursement was negotiable, around 3,000 Tsh or payment in kind when a family could manage a chicken or bag of beans. By going to shamba, Zamda could work until she delivered and deliver without much expense. This way, Juma could repay what they still owed the shopkeeper who lent them money for the previous birth.

Zamda's story shows how economic and opportunity costs of obtaining childbirth care in facilities can create exclusion by forcing people into deeper poverty. Zamda's family was of average standing until the birth of her ninth child. But this baby came at the wrong time of year. *Kipindi cha kilimo*, or the growing season, is life at its harshest. Not only is it a time when heavy rains impede mobility but also when food is less available and cash is hard to come by. People have consumed last year's crop, sold the surplus they produced, and spent the money they made. Most make ends meet with petty trading or other informal work on top of tending their crop. But to some extent, villagers without regular employment are likely to suffer during this season. To pay for Zamda's care, Juma acquired a loan that

would disrupt whatever stability the family had achieved. Now due to deliver again in kipindi cha kilimo, Zamda felt her best option was to stay close to her fields. Of course it was dangerous, but risking further poverty was an even higher-stakes gamble. Trading one chance for another, she made the most pragmatic decision she could.

Wanawake wa kisasa, mwenzangu na mimi, and women in-between. The morning was still fresh when we arrived at the dispensary. Semeni, the young nurse–midwife on duty, was washing up after manually removing the placenta of a woman who had delivered at home during the night. Another woman in the labor room was singing in a low voice. Semeni rushed to attend to this woman. "Mama Esta, habari yako?" [How are you?]. "Mmm . . . I think it is close now," came the reply. Mama Esta was tall and stately, swathed in a rich turquoise *kitenge*.[6] Her ethnicity was Chagga, and she had migrated from an urban part of northern Tanzania three years ago after her husband was posted as a primary school teacher in the village. Mama Esta had planned to live in a maternity waiting home at St. Francis called "Tumaini" (hope) until she delivered. But labor started early, the very day she'd arranged to take the train to Ifakara.

Soft cries rang out from the recovery room. Mama Esta and I looked at Semeni. "Oh, that girl," she said, "she is just feeling the after pains." As Semeni had no intention of leaving Mama Esta, I went to check on things. In the adjacent room, a young woman was sprawled on the floor. Apparently she'd fallen or passed out after getting up to use the latrine. Her hair was short and she wore a thin black cloth tied at the chest and a few red-and-white beaded necklaces. After ruling out hemorrhage, I helped her back to bed. Tausi explained that, after giving birth at home around midnight, the placenta failed to deliver so she left her baby with family and walked to the dispensary at first light. At 18 years old, Tausi was unmarried and this was her second birth. "Why did you wait until morning to come?" I asked. She replied, "Can you imagine? A *daktari* [doctor] or *nesi* [nurse] disturbed in the night by someone like me? Hospitali si kwa mwenzangu na mimi" [The health facility is not for people like me].

Shortly thereafter a commotion erupted in front of the dispensary. In a clash and clamor of color and sound, four women heaved a wheelbarrow up the path to the veranda. In it, a fifth writhed with pain, clutching a plastic basin in one hand and a shiny handbag in the other. She wore a tailored blouse with puffy sleeves and shoes with a three-inch heel. On reaching the door, she exclaimed, "Mama, nitakufa leo, kwa kweli, nitakufa!" [Mama, I will die today, surely, I will die]. "Ah, Amida," Semeni called, "I wondered when you would come." The woman struggled to stand from her makeshift carriage amid a small crowd gathering to see the clinical officer. As she tottered toward the labor room, the aides derided, "Amida, you enjoyed yourself with a man and now you want our help? "No, it is not for us to help you!" Her face unreadable, Amida smoothed back her braids and held out her basin containing vifaa. Semeni looked her up and down, "*Dada* [sister], what is all of this? You think you're a mwanamke wa kisasa [modern lady] like Mama Esta there?" Wincing, Amida merely laid on the examination table.

Maureen Mackintosh (2001) aptly describes health inequalities as framed by legitimizing conventions of thought upheld by social institutions (i.e., health care

systems) that themselves become bearers of disparity. But people do not always comply with taken-for-granted cultural logic or social hierarchies; they resist, revise, or otherwise act, improvising within what Pierre Bourdieu describes as "concrete indices of accessible and inaccessible, of what is possible and not possible 'for us,' a division as fundamental ... as that between sacred and profane" (1990:64). A theory of identity by Dorothy Holland and colleagues (1998) helps to explain. These authors describe identity as comprised of multiple self-understandings people hold in relation to "figured worlds:" collective interpretations of local arenas in which specific characters are recognized, meaning is assigned to particular actions, and certain outcomes are valued over others. Cutting across these worlds are aspects of identity that concern socioeconomic positioning. The bounds of agency are constructed accordingly; constraints and possibilities for behavior are determined by identity as playing out in distinctive figured worlds.

In these brief interactions at the dispensary, we see processes of social exclusion taking place through the workings of identity in a figured world of childbirth. Relative positioning is evident in physical appearance alone—Mama Esta's folds of kitenge, Tausi's threadbare cloth, Amida's heels and handbag, Semeni's white uniform. Women generally made an effort to look their best when at a health facility, giving the impression they are well off and *safi* (clean), thus deserving of quality care and respectful treatment. However, beyond outer presentation and even ability to provide vifaa or pay bribery fees, other characteristics converged to construct a social appearance that also influenced exclusion: age, family, ethnicity, parity, occupation, rural–urban affiliation, education, sexuality. Local health facilities are public spaces where what occurs is a matter of public knowledge. When a woman seeks obstetric care there, she brings a constellation of significant indicators with her—some of which she can affect but most she can't. For women whose indicators add up to an identity of lesser value, the act of opening oneself also opens one up to social discrediting, emotional abasement, and physiological risk.

Exclusion and inclusion happened within women as well as without. Like Tausi, women who were marginalized or deprived often made statements to the effect of "*Madawa hospitali* [modern medicine] is not for people like me." In contrast, prosperous and educated women like Mama Esta were considered *wanawake wa kisasa*—modern women who acted in accordance with ideals of maendeleo. More general terms for these categories were *wanaweza* (the ables) and *hawawezi* (the unables); the latter tended to self-censor from biomedical care while the former felt entitled to it. But what about women not as privileged as Mama Esta but better off than Tausi—women like Asha, Sakina, Zamda, and Amida? For these women, elements of identity coupled with perceived risk influenced desires, decisions, and actions. Asha negotiated her place, attempting to belong but hedging her bets. Sakina was trying to get the care she was told she needed. Zamda was unwilling to risk additional degradation. And Amida resisted inferior positioning, using her own resources (income from sex work but also other activities) to claim an identity of greater worth and thus obtain better care.

Within this figured world, then, women crafted a range of responses that reflected high stakes outcomes as well as identity. When a woman's self-understanding collided with how she was understood by others, a space of contestation opened where new identities could form or old ones could be reproduced. But because

at least one actor in the biomedical setting was a health professional with greater knowledge and authority, the usual outcome was, at best, a reinforcement of the status quo. Women stood different chances of exclusion based on how they were assessed by those with authority and by society at large. People of every position described facility providers as exhibiting *dharau* (scorn, devaluing) for women determined to be hawawezi. But as with childbearing women, providers' behaviors were not dichotomous; gradations of care existed to reflect and reproduce the spectrum of identities operating in this world.

From Social Exclusion to Embodied Inequality

The leap from social exclusion at childbirth to uneven patterns of maternal outcomes in populations is not far to make. As noted above, evidence within low-income countries shows enormous socioeconomic disparities with respect to use of biomedical obstetric care. Such statistical differentials in death and disability can be hard to demonstrate because of measurement-related challenges; however as Anton Kunst and Tanja Houweling state, "there is little doubt that the burden of maternal mortality and morbidity falls disproportionately on poor and less educated women" (2001:294; see also Janes 2004). Although this higher burden may occur through mechanisms of chronic stress, infectious disease, or micronutrient deficiencies, this is not what my analysis shows. Instead, I am arguing that socioeconomic inequalities make their way into women's bodies through multilevel processes of social exclusion that determine the care they can access—their care-seeking behavior and the treatment they receive.

In her monograph on childbirth in south India, Cecilia Van Hollen reminds readers that, as shaped by political–economic context and sociocultural values, "choice" is never simply a matter of free will for rational individuals. Even so, she argues that such awareness "does not negate the relevance of applying a decision-making perspective" (2003:7). Within external and internal constraints, possibilities exist that make varying degrees of choice practicable. Women in the Kilombero Valley made decisions inside personal bounds of agency and amid immediate circumstances (i.e., distance, timing) that conditioned the available options. Economic and social costs clearly structured choice in this context. Official fees led to avoidance of mission facilities and the district hospital. Informal fees such as vifaa, bribery payments, transportation expenses, and opportunity costs created considerable difficulties. And exclusion by dharau was alone enough to keep some away from biomedical care. Studies in a variety of settings document the effect of socioeconomic status on women's control over childbirth and power imbalances that allow for demeaning, neglectful, or abusive treatment of laboring women (George et al. 2005; Kruger and Schoombee 2010; Kyomuhendo 2003; Lazarus 1994). The potential for such treatment in this study setting is why some women living in close physical proximity to a health facility continued to deliver at home.

It is critical to recognize that forces larger than the behaviors of individual providers are implicated in this discrimination. In Tanzania, the ideal of the self-reliant citizen competing in a capitalist society is gaining ground amid a reality of dismal social services. Across a range of sectors, those with purchasing power are accruing limited resources while "misrecognizing" growing inequities as the natural

order (Bourdieu and Wacquant 2004). Problems with the health care system must also be acknowledged. For many resource-poor countries, use of biomedical services does not automatically translate into healthy outcomes. Inadequately trained providers, staff shortages, insufficient supplies, and lack of standardization were probably responsible for a number of near-miss events I observed during fieldwork. Alongside an inability to enforce regulations and promote accountability, a situation is created whereby providers feel they can and perhaps must set priorities for who receives available services. In focusing on the experiences of childbearing women, this analysis does not offer a deep examination of providers' perspectives. It does, however, attempt to show that broader factors contribute to why, as two village women stated, "it is *impossible* for wanaweza to receive the same care as hawawezi."

The fact that some disadvantaged women sought biomedical care despite the hurdles they had to overcome speaks to the importance of considering motivators as well as detractors. Nearly every woman I talked with described childbirth as *hatari sana* (very dangerous).[7] Most expressed confidence in the capacity of biomedicine to handle complications and felt it safer to deliver in a health facility—but while agreeing a facility could help them, some questioned whether it would. Besides risk perception, another motivator involved identity and agency in struggles for personal development. As Green and Mesaki explain, people in the Kilombero Valley "engage with current notions of modernity in all kinds of ways, from accessing debates on the radio to making use of modernized facilities to choosing to keep 'modern' breeds of chicken" (2005:384). Although advancing social position through the use of biomedicine alone was unlikely, this action still offered the opportunity to perform an identity perceived as desirable—to appear in alignment with specific understandings of economic development and social progress.

In the end, women balanced risks and benefits to secure the best care they could. The goal was survival first (incl. family) and dignity second in an approach Lock and Kaufert describe as "ambivalence coupled with pragmatism" (1998:2). Social exclusion mattered in choices around childbirth; it strongly affected how women perceived, accessed, and experienced the biomedical option. The decision to seek facility care was easy for wanaweza, who enjoyed a sense of control over giving birth and over many other areas of their lives. But kujifungua left those who were disadvantaged open to all manner of loss. Most of these women wanted to deliver in health facilities, but not at any cost—not at the expense of their economic, social, or emotional well-being, where further degradation could threaten lives as surely as infection or hemorrhage. Some opted for biomedical care in the hope of receiving lifesaving services should they be necessary. Others stayed at home, concluding that the substandard care they would likely receive wouldn't be worth the effort required to get it. Hence the outcry of Mwanamisa and other women representing hawawezi, "All we can do is pray to God!"

Disembodying Inequality—Better Knowledge, More Accountability

The act of opening oneself in south-central Tanzania is thus revealed as an essential dilemma that creates and reinforces uneven chances of health and survival. Embodied inequality as mediated by social exclusion at childbirth explains, in part,

disparities in measures of maternal health. Borrowing a term from Julio Frenk and colleagues' (1989) theory of epidemiologic transition, the very fact maternal mortality still exists as a significant "left-over ill" in poor countries indicates the global scale of inequity. This ill becomes distributed along similar lines as it permeates within countries. Ultimately, local communities are where social positions are crafted and where processes of exclusion play out in peoples' lives. Within towns, villages, families, and selves, childbirth produces and reinforces unequal states among women—just as these states determine the kind of care women can seek and receive. Of key concern at every level is the reciprocal relationship between socioeconomic positioning and access to resources. It is this alliance that allows for, as historian John Iliffe (1987) describes, the African "poor" to be distinguished from the "very poor." It is also what enables 90 percent of Tanzanian women in the highest wealth quintile to deliver in a health facility, while only 33 percent in the lowest quintile access this care (National Bureau of Statistics and ICF Macro 2011).

The World Bank report *Reaching the Poor* concludes that to reduce health disparities what is most needed are better approaches to services delivery (Gwatkin et al. 2005). But to be effective, services must explicitly meet the needs of societies' most marginalized—they must ensure equitable access in unique contexts. For this objective, we need to understand who "the poor" are, how this category is produced, and the myriad of ways social and material positioning influences behaviors. In particular, we need more studies that permit insight into the perspectives of health workers. As Zulfiqar Bhutta states in an editorial on maternal health inequities, "we do not simply need more research; we need the right kind of research" (2005:585). Ethnographic methods provide a valuable tool for disentangling discrimination as a deterrent of health and, more specifically, for shedding light on how embodied inequality happens from a political economy viewpoint. As Nguyen and Peschard state:

> Recasting the relationship between disease and inequality as the embodiment of social relations adds value to epidemiological findings by allowing affliction to be related to prevailing ideologies that inform policy, configurations of social violence, the way misfortune is conceptualized and managed, and how meaning systems influence how individuals interpret their bodily states, seek care, and fashion themselves according to prevailing moral notions. [2003:459]

When converting research to policy and action we must keep in the foreground that, as a system of knowledge, biomedicine is an apparatus of power. In the health development encounter, Pigg asserts that "relations of power, as well as states of health," are always at stake, and asymmetries of both can be strengthened through earnest efforts to save lives and promote well-being (1995:47). As interventions are rolled out on the ground, accountability should be a fundamental concern. According to Van Lerberghe and De Brouwere (2001), it is not enough to increase the supply of well-equipped facilities and trained health workers; it is also a matter of how health workers perform and how members of civil society build up sufficient pressure to claim legitimate entitlements. Beyond the core elements of answerability and enforceability, accountability (and lack thereof) is

intrinsic to wider power relations that dictate access to vital resources such as health care (George et al. 2005). Mackintosh argues that, "social inequality directly shapes inequitable health care systems" (2001:187); I would argue the reverse is also true.

Making biomedical obstetric care more available is, and must be, an imperative. But this care should be accessible to all women. Differentially positioned according to multiple markers of power, women approach childbirth in different ways and for different reasons—many of which hinge on relative standing in family, community, nation, and world. If implementation of the above goal assumes its intended targets are a homogenous group with fixed behaviors, the resulting interventions will continue to benefit some while depriving others. Citing Abu-Lughod, Chandra Mohanty, and others, Denise Roth Allen (2004) contends that such "trafficking in generalizations" leads to blanket policies and programs that erroneously presume what works for one "third world woman" will also work for another. Strategies based on inadequate knowledge of people's lives tend to fail, and those that assume universal ideals tend to reinforce power relations that structure global–local inequity in the first place. Conversely, approaches that seek to understand differences, focus on the needs of the disadvantaged, and address systemic power imbalances might lead to health development efforts that serve to disembody inequality.

Notes

Acknowledgments. This work was supported by the U.S. Centers for Disease Control and Prevention, The Center for Global Initiatives at UNC–Chapel Hill, and the Graduate School at UNC–Chapel Hill.

1. *Kanga* is a colorful rectangular textile made of lightweight cotton that is commonly used in Swahili-speaking areas to fashion women's clothing, carry babies, and so forth.
2. The conversion rate in 2000 was approximately 800 Tsh to $1. By 2007–08, the Tsh had depreciated to 1,300 Tsh to $1.
3. In the Richmond affair (in 2008), Prime Minister Edward Lowassa was found to have devised a contract between the Tanzanian government and Richmond Development, where $179 million in public funds were fraudulently allocated to the shell company.
4. *Degedege* refers to a severe childhood illness manifested by fever and convulsions. Although often attributed to cerebral malaria, this condition had a number of perceived causes.
5. Women's autonomy in the study setting was highly variable, depending on family, marital, and living arrangements as well as access to land and nonagricultural work. Women typically had some say in matters involving their own health, but most major decisions were made among a family collective.
6. *Kitenge* is another type of textile used for woman's clothing. It is of heavier quality than kanga and is more expensive.
7. Perceived etiologies for complications were usually a conglomerate of witchcraft, naturalistic medicine, and biomedicine. As etiologies were not mutually exclusive, a blending of therapeutic modalities was common and beliefs in nonallopathic causes did not appear a major factor for delay of care seeking at health facilities.

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