From Traditional Birth Attendants to Community Health Workers: The Politics of Maternal Health in Tanzania

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Efforts to address maternal health have been part of global health projects for decades, and have always mirrored the shifting political and economic interests of international development. The ongoing construction of maternal health at the global level reflects the way in which shifting solutions to problems related to low income countries are designed according to what is considered the 'best' solution at a particular point in time. The fictive example of Mrs. X's maternal death, as presented by the World Health Organization (WHO) in 1988 and which was adapted and retold in 2012 with a few changes, illustrates well how maternal mortality is constructed and solutions are designed according to fluctuating Western-global norms and ideas (see Video 1 below). The policy implications of this homogenized view of maternal mortality is the adoption of biomedical rationality as an intervention into traditional society, culture and economy, which are perceived as barriers to the improvement of maternal health. This kind of thinking initiated the creation of the profession of traditional birth attendants (TBAs) in the early 1980s, which then fully took off as a result of the WHO's Safe Motherhood Initiative in 1987 (Langwick 2011: 121-125).

The original story of Mrs. X's death is based on a lecture given by the founder of the Safe Motherhood Movement, Professor Mahmoud Fathalla, in 1988. Both the original story and the one retold in 2012 present the image of a 'universally' pregnant woman, though the adapted version explains in detail the socio-cultural and economic barriers that women face when seeking care during pregnancy and delivery. These circumstances are, however, presented as universal, and global action is called for to increase community awareness and encourage pregnant women to seek the skilled care of a professional midwife and/or doctor.

Langwick (2011, 2012) gives a detailed explanation of the historical context of the creation of TBAs (Kiswahili: *wakunga wa jadi*) among the Makonde of Tanzania. Before the 1970s, the concept did not exist. While there had always been women who had assisted pregnant women during childbirth, the term *mkunga wa jadi* only started to be used after the first women received official training.[1] For the past two decades, the work of TBAs has been supported by social science research, though it has received both positive (Kadets 2016, Kayombo 2013, Nyazi et al. 2007) and negative (Mbaruku et al. 2009, Bailey et al. 2001, WHO 2005) evaluations from public health research. Meanwhile, the overall situation of maternal health in low income countries indicates little improvement, and TBAs' work has been critiqued for causing a delay in medical treatment seeking among pregnant women. Against this backdrop, in 2005 the WHO decided to redefine the role of TBAs – from assisting delivery to becoming companions to women on their way to health facilities – in order to encourage hospital-based deliveries (WHO 2005). Responding to this new approach, in 2007 the Tanzanian government barred TBAs from assisting women during delivery and indicated that they insist that women go to a health facility

as soon as possible, when necessary accompanying them (Pfeiffer and Mwaipopo 2013). The training of TBAs in many areas of Tanzania ceased in 2010, although some do still assist pregnant women during childbirth. Furthermore, the training and operations of community health workers (CHWs; also known as village health workers) in maternal, newborn and child health (MNCH) since 2012 has rendered TBAs' role in addressing maternal health even more ambiguous, especially in rural areas.

In this paper, I draw on ten months of ethnographic research in Usandawe, Tanzania, and argue that the emerging role of CHWs, and the simultaneous muting of TBAs in local health systems, is the historical continuation of global maternal health initiatives that perpetuate the political and economic interests of international health policies and agendas. The idea of operating with globally standardized approaches to maternal health leaves the Tanzanian government, local health workers, and people in communities with limited alternative than to do what has been engineered and supported elsewhere. Local health challenges are, however, not necessarily solved by standardized global solutions; likewise, people are not merely passive recipients of health interventions, as they are linked to the wider political context of the target communities. Trained TBAs themselves struggle to secure their position given their newly assigned status, while CHWs for MNCH strive for recognition as a new category within the local health system. Finally, women, community members and even health care personnel and administrators must all try to make sense of these two coexisting – and often competing – professional categories.

Doing Research on TBAs and CHWs: An Historical Perspective

This paper is the result of ethnographic research carried out among the Sandawe of Chemba district, Dodoma region, in central Tanzania. With 80% of the population residing in rural areas, Dodoma region is among the top five regions in the country with the lowest income level and highest maternal mortality (UNDP and URT 2014). Fieldwork was carried out in Lalta ward in four villages, namely Magambua, Wairo, Manantu and Ilasee, for a period of ten months. Methods used in data collection included focus group discussions, in-depth interviews, participant observation, extended case studies, and document reviews. Seven focus group discussions were administered and a total of 116 interviews were conducted with various informants, including TBAs and CHWs, health personnel, pregnant women and their relatives, and community gatekeepers.

The idea to write about TBAs and CHWs resulted from the obvious overlap of the two roles that was highlighted during interviews. Available statistics indicate that 48% of pregnant women deliver at home, with 29% being assisted by a relative and 15% by a TBA (URT 2010). Given their relative importance to pregnant women during delivery, TBAs thus expressed their dissatisfaction with the shift in their role to becoming simply pregnant women's 'companions' on their way to a health facility, and also to the discontinuation of the training they had previously received. On the other hand, CHWs who have received training in MNCH have gained more power, not only as educators and companions for pregnant women but also as overseers of TBAs. Thus while TBAs and CHWs are supposed to work as a team, it emerged from interviews that TBAs feel that their domain has been invaded. This clash of power has led some TBAs to stop working, while others declared that it was difficult for them to stop because

pregnant women still needed them.

Both TBAs and CHWs started to receive increasing global attention after the Alma Ata declaration in September 1978, which focused on primary health care and recommended training TBAs and CHWs in resource-limited countries. This was perceived as a solution to allow more people, especially in rural areas, to access primary health care from workers well suited to the local lifestyle and economic conditions. The Alma Ata declaration and the WHO guidelines for achieving health for all by the year 2000 (WHO 1978) were also in line with Tanzania's Arusha declaration of 1967, among whose main objectives was the provision of free and equal access to health services for the entire population. In the Arusha declaration, 'working with the locals' was emphasized because the improvement of primary health care was perceived as relying strongly on the connection between local communities and referral hospitals. Today, however, governments, multilateral agencies, donors and non-governmental organization (NGOs) all emphasize the role of CHWs for primary health care, particularly maternal health, and have withdrawn their support for TBAs, whose importance is fading at both the international and national level. As part of these global and transnational political shifts, the Tanzanian government ceased to train TBAs. Their services continue to be regarded in vague terms as a type of informal support, with no clear guidance on how they should collaborate with, and how they differ from, CHWs (Turinawe et al 2016).

TBAs as Global Subjects and Local Actors

Langwick (2006, 2011, 2012) gives a detailed account of how TBAs were conceived and created as global subjects by the WHO in the late 1970s. The model of the TBA was created to fit the image of a 'specialized Third World woman', who was generally defined as old and residing in a rural area; as having had children herself and being past menopause; and as being an accomplished herbalist yet illiterate and with no formal education (WHO 1978).2 The definition further included someone who assisted women during childbirth, and who had initially acquired her skills through her own deliveries or through apprenticeship with other TBAs (WHO 1992). This definition set the basis for the recruitment and training of TBAs by the WHO in developing countries in Africa, Asia and Latin America.

While governments in developing countries were asked by the WHO to start recruiting TBAs, Tanzania was initially skeptical because such a strategy would further strain the already limited resources available to improve health care, especially in rural hospitals and dispensaries (Langwick 2012). During British (and previously German) colonial rule, government health services were mostly urban-based, while some rural areas were catered for mainly by mission hospitals. Following independence in 1963, the government established health services in rural areas and the situation of maternal health saw promising improvements, with maternal mortality decreasing from 453/100,000 in 1961 to 167/100,000 in 1985 (Shija et al. 2011).

During the late 1970s and early 1980s, however, Tanzania faced severe economic problems, and was thus forced to accept a package of structural adjustment programs, which among others led to reduced spending for the health sector. The government was therefore left with no choice but to comply with international health policies and plans (Lugalla 1995), and the first group of TBAs was trained in 1985. The official and nationwide training of TBAs began in 1986

and was expanded further following the 1987 Safe Motherhood Initiative (Langwick 2011). Various NGOs also became involved in the training of TBAs, and in Lalta ward, for instance, TBAs received training from both the government and World Vision Tanzania. However, while World Vision Tanzania trained TBAs in the region from 2000 onward, the trainings for assisting delivery were discontinued in 2010.

Today, the training of TBAs – which previously equipped them with skills to conduct a safe delivery and identify risks in pregnancy and birth – has shifted towards facilitating their new role as 'promoters of facility-based delivery'. This came about as the result of limited evidence that TBAs contribute to the improvement of maternal health in developing countries, while the intended goal of health for all by the year 2000 was far from reality (Pyone et al. 2014, WHO 2005). The WHO revisited and redesigned the role of TBAs to facilitate the achievement of the Millennium Development Goals (MDGs) numbers 4 (to reduce under-five mortality) and 5 (to reduce maternal mortality by 75% between 1990 and 2015). Delivery with the help of trained health personnel is one of the main strategies that aims to improve maternal health, as identified in the MDGs (WHO 2015). Introduced to their new role, TBAs in Lalta ward received training from health personnel from the Kondoa district hospital in 2012, with the promise of receiving five thousand Tanzanian shillings for every pregnant woman they brought to deliver at the health facility – a promise that never materialized in practice. The financial compensation for their new role was obviously too much for the government to sustain, although some TBAs do still accompany women to health facilities when they are called to do so.

CHWs for Maternal Health

CHWs are not a new category, but resulted from the WHO's adoption of 'barefoot doctors' as a guiding concept in early CHW programs in resource-limited countries such as Tanzania. In the late 1970s and early 1980s, there was a rapid increase in CHWs at the national scale in the country. However, unlike TBAs, while the idea of CHWs was adopted quickly, it began to fail already in the late 1980s and 1990s due to insufficient remuneration for training and work incentives as a result of the economic recession of the 1980s. Since the CHW program had foreign donor support (for instance, by the UNPD and WHO), the Tanzanian government quickly withdrew its own financial assistance. CHWs were viewed as a temporary solution only and the political will to support them was weak (Perry 2013). Other countries were, however, more successful in implementing CHW programs, and through their help Bangladesh, Nepal and Brazil have been able to reduce under-five mortality since the 1980s (Robert et al. 2015).

Drawing on the successful experiences of the abovementioned countries, the WHO began to reemphasize the CHW model in the late 1990s and early 2000s, but this time with an additional focus on MNCH. Similarly to TBAs, guidelines for the recruitment and training of CHWs were also set by the WHO. In Tanzania, Morogoro region became a pilot area for the implementation of CHWs for maternal health in 2012; other regions soon followed, including Mtwara, Mara Iringa, Lindi, Shinyanga, Dodoma and Tanga (MoHSW 2016). Depending on the availability of resources, the program is expected to be scaled up to all twenty-five regions of the Tanzania mainland.

The main roles of CHWs are to identify and follow up pregnant women in their villages, identify

danger signs, advise pregnant women to go for antenatal care, assist delivery together with skilled personnel (when necessary accompanying the woman to a health facility), as well as to provide family planning information (WHO 2006). The current training of CHWs is mainly supported by the Ministry of Health and Social Welfare (MoHSW) in partnership with Jhpiego, an affiliate of Johns Hopkins University that has worked in the Tanzanian health sector since 1999 and is mainly funded by USAID and the United States President's Emergency Plan for Aids Relief (PEPFAR), which trains CHWs on the follow-up of HIV positive pregnant women and children. NGOs have been at the forefront in championing globally designed interventions in local settings, with support from international organizations and donors. Thus while TBAs were trained (in collaboration with the government) by different NGOs and faith-based organizations (FBOs), both NGOs and FBOs are now also involved in the training of CHWs, in most cases without being rooted in the local health system (Tulenko et al. 2013).

The Global-Local Politics of Maternal Health

TBAs and CHWs are both global subjects intended to curb health crises in developing countries. The history of their rise reflects global health initiatives and management, which operate at different levels – from global to local – and govern the health of populations across the world with largely homogenized actions (Richey 2003). The homogenous view of both TBAs and CHWs – along with the homogenized notion of the 'Third World woman' – demonstrate how health issues and maternal health needs are perceived in the plans and strategies of global, and often also national and local, actors (Campbell 2010). Several anthropological studies (see e.g. Kadets 2016, Nyazi et al. 2007) have questioned the viability of doing away with TBAs, not only because of the limited medical facilities in developing countries but also because of the bond of trust that has been created between TBAs and local women over years of practice. Ana (2011) argues that TBAs relate to and understand the women they serve as they share the same cultural experience in giving birth. They are more than mere companions to health facilities and an aid during delivery; they are knowledge custodians (in the villages) and women trust them.

Some leaders in low income countries, such as the Minister of Health of South Sudan, have also complained about the rise in maternal mortality as the result of the misdiagnosis of risk signs by CHWs. Thus success in some parts of the world does not guarantee similar results in other countries where the model has simply been transferred. Early challenges that CHWs have faced in Tanzania in promoting primary health care have not been addressed, and a new role has simply been added to their previous function as promoters of primary health care in the community. The two CHWs in Lalta ward that I interviewed during my research complained primarily of not having received any incentives during their five years of service. Although the job of CHWs is presented as 'volunteer work' by the government and global health initiatives (see Greenspan et al. 2013), they nevertheless expect to receive some form of incentive from the government. As one CHW expressed, "My child, you see I have to work on my farm. We have not been paid anything since 2013. That's why I am now looking after my cattle."

CHWs' task of conducting follow-ups is obviously demanding in terms of time, and they therefore have to be committed to the job. CHWs receive a list of pregnant women from the midwives at the dispensaries, and if they identify some who have not yet started antenatal care,

they must also include them on their follow-up list. Incentives are promised during trainings but hardly ever materialize. For instance, CHWs in areas with transport challenges like Lalta were promised bicycles, but had still received none by the last time I talked to them in August 2015. TBAs also receive no incentives from the government, but are instead rewarded by the pregnant women they attend, in cash or in kind.

From my research, it became clear that some pregnant women do not seem to welcome CHWs as one would expect. One day a CHW accompanied me to an interview appointment I had with a local pregnant woman. Upon our arrival at her home, it was obvious that the woman was not happy to see the CHW with me, and her husband quickly started repairing a bicycle that was lying on the ground and told the CHW that they were preparing to go to the hospital. Later during the interview, I learnt that the woman's estimated due date had already passed and that the CHW knew about it. It was the woman's fifth pregnancy and it was obvious she had no plans of going to the hospital. During the interview she meekly told me, "I have no one to leave my children with… and the livestock too, there is no one to look after them." When we finished the interview, the CHW insisted that the woman go to the hospital, saying that he would follow up with her. Five days later, I was told by the CHW that the woman had given birth at home with the help of her mother. Women feel that their privacy is being invaded, especially when they have no plans to go to a health facility. Although the follow-up by the CHW is meant to be for their own good, they do not appreciate such close monitoring. TBAs on the other hand are called only when they are needed and they do not just show up uninvited.

With the marginalization of TBAs – as a result of which some feel less motivated to work – pregnant women will gradually have to depend more and more on the assistance of CHWs, who are now trying to get closer to them. A midwife at Magambua village dispensary expressed her concern about pregnant women who would only come to the dispensary at the last minute:

> When the labor pain begins, they wait for so long before coming to the dispensary and some of them as a result deliver on the way. When a pregnancy is complicated it leaves us with little choice to help but to tell them to go to Makiungu Hospital [the mission hospital, which is better equipped and about 80km away from the dispensary].

The midwife expressed this concern when we were discussing the challenges that health staff face when encouraging women to deliver at the dispensary. Narrating their side of the story, pregnant women explained that if they go to a health center before the onset of labor pains, they are usually sent back home to keep waiting. I witnessed the case of a young girl of sixteen who felt what she thought were labor pains and was accompanied by her mother to a health center, only to be told to go home until the next morning. Soon after arriving home she delivered with the help of her mother, who had never assisted a delivery before.

Health care providers at the village level work closely with CHWs, the latter of whom are not trained to help women during delivery. The midwife that I interviewed admitted that deliveries on the way to the dispensary are a big problem in Usandawe. On Friday July 17, 2015, three women delivered on their way to the dispensary; two were assisted by the TBAs who were accompanying them and one was assisted by her mother-in-law. None of the women I talked to during fieldwork had ever been accompanied by a CHW to the dispensary, although they admitted that the CHWs had visited them at home. Pregnant women went to the dispensary with either a TBA or a relative, mostly their mother or mother-in-law. CHWs may help in educating and following up on pregnant women, but when it comes to the choice of whom to go with to the dispensary, TBAs were always preferred. In Usandawe, childbirth and the accompanying rituals have always primarily been the domain of women. CHWs comprise both men and women, and in a village like Magambua, where both CHWs are men, the chances that they will be called to accompany a pregnant woman are very slim. When I asked a twenty-six-year-old woman in Magambua village, who was in her seventh month of pregnancy, if she would call a CHW to accompany her to the dispensary, she replied in a somewhat puzzled voice, “I cannot call him to accompany me... *kwani mkunga hayupo?* (Is the TBA not available?) He cannot help me with anything.”

Regarding the risks that TBAs may take to help pregnant women, the story that a 63-year-old TBA in Magambua narrated to me illustrates this well:

> The woman came here like two years ago, it was in the year 2013, and the baby was lying in a bad position. The doctor looked at her and told her to go to Makiungu… On the way I checked and the legs were already getting out. I took her to my house and I helped her… She gave birth safely and after that she had no energy. I told my grandson to slaughter a chicken and we made soup and gave it to her and until today the baby and the mother are all fine and are now my friends… But the doctor was not happy with what I did. I was even expelled from my job as a cleaner at the dispensary. My child, what should I have done? Not help her as he did?

TBAs are highly motivated and sometimes ready to take risks for the sake of other women. Most of those I talked to had clear records of the births they had assisted and had few complaints in regard to their lack of remuneration. None of the TBAs I talked to admitted to having experienced a maternal death, though several infant deaths were reported. Assisting women to deliver is becoming more challenging for them as they no longer receive medical supplies from the government. Medical personnel at the village dispensary, on the other hand, who are supposed to monitor CHWs on a monthly basis, are for various reasons unable to fulfill their task. A study conducted by Roberton et al. (2015) in Morogoro region revealed that some CHWs continued to work for more than two months without being monitored, despite the fact that supervision is identified as key to improving their performance.

Are CHWs a Solution?

The above dynamics indicate that it is not a simple case that training CHWs will lead to the improvement of maternal health in countries like Tanzania. CHWs need to be accommodated and accepted by women, but they cannot help in the important moment of delivery when the need arises. It is obvious that women still trust TBAs. Moreover, financial constraints are particularly detrimental to the national implementation of these global initiatives, as the costs of training these 'second class health personnel' must be drawn from governmental budgets, despite existing donor support as they work in collaboration. As CHWs in Tanzania are only trained according to the availability of resources, since 2012 only a few regions have been running the program (MoHSW 2013). Some health personnel have also been highly skeptical of the training of CHWs for maternal health, as expressed, for instance, by one administrative officer at Chemba district with whom I spoke:

> In 2010 we requested the Ministry of Health to help us with the training of new nurses, because we had an acute shortage: two nurses in Dodoma region attend about 60 women during a night shift. The ministry trained about 600 nurses, but only 100 were employed because the treasury had no money to employ all of them. Now we are training community health workers instead!

According to the above officer's statement, the training of CHWs is a waste of resources – and the work done by CHWs will bear limited fruit – as long as local health services and the referral system are not strengthened. Given that two nurses must attend about 60 pregnant women during one nightshift, this raises numerous critical issues, including what should happen if more than two women need to deliver at the same time. This dilemma is also reflected in the situation at the national referral hospital of Muhimbili in Dar es Salaam, where the maternal mortality rate is 1,541/100,000. This high figure is mostly the result of avoidable maternal complications, insofar as 82% of such cases occur due to the provision of substandard care (Pembe et al. 2011). Thus even when CHWs encourage women to deliver in health centers, and encourage women with danger signs to seek care in referral hospitals, there is still no guarantee that they will be assisted by skilled medical personnel.

Such matters are overlooked when global maternal health initiatives are implemented. There is also a lack of communication between ministries in terms of addressing maternal health. The Ministry of Health, for example, should have known about the (lack of) willingness and capacity of the Treasury and the Ministry of Labor, Employment and Youth Development to employ the newly trained nurses that they had commissioned. Responding uncritically to international health policies will most likely lead to more harm than good if critical issues such as these are not adequately addressed first. Various ministries do not collaborate to achieve national goals. The officer I quoted above was worried not so much about the training of CHWs as such, but about the national priorities regarding whom should be trained and employed according to local,

regional and national needs, especially in referral hospitals where most maternal deaths occur.

On the other hand, some of the medical personnel that I interviewed during my research questioned the government's willingness to actually ban TBAs due to what they claimed to be the 'ongoing training' of TBAs in other areas of Tanzania. In Bunda, for instance, one interviewee claimed that TBAs were still being trained and authorized to help women deliver, while in Dodoma the regional medical officer was strictly against such trainings. The government has left the ban on TBAs somewhat open to interpretation by medical administrators, and there is no uniformity in terms of how the ban is implemented nationwide.

Conclusion

CHWs, just like TBAs, have become an emotionally charged topic in global health and have been viewed (at different times) as a magic bullet to address maternal health in resource-limited countries. On the other hand, maternal health has become an increasingly homogenized biomedical problem, with delivery with the help of a skilled health care provider being the advocated solution for safe delivery. The use of TBAs is no longer considered safe and therefore women are encouraged to go to health facilities. This shift, which involves the training of both male and female CHWs for MNCH, has not taken into consideration women's understandings of birth, which in Usandawe has always been the domain of women. Understanding why, for example, TBAs delay women from seeking care entails an understanding of the values that women attach to TBAs, who embody cultural experience and knowledge. Furthermore, trust certainly plays an important role. I do not deny the relevance of other factors such as payment TBAs may receive from assisting women to deliver, but understanding why women still call on TBAs and not on CHWs – and are likely to continue to do so – questions the viability of using CHWs for MNCH. The mere fact that women still deliver at home even when they are followed up by CHWs raises even more questions about the acceptability of the accommodation of CHWs in women's lives.

CHWs for MNCH are rather new in the field of pregnancy and motherhood, and do not have the experience and trust that TBAs have built up over the years. Apart from women's attachment to TBAs, Kudetz (2015) has argued that the universal abolition of TBAs is being considered because of the lack of conclusive evidence of whether they actually contribute to the reduction of maternal mortality. Training CHWs allies with the need to increase hospital-based deliveries, but the performance of TBAs does not threaten this aim. Investing in CHWs and muting TBAs in a country where half of all deliveries take place outside of health facilities overlooks the potential of TBAs, who are equipped with experience and the trust of the women they serve. While CHWs derive their power from the support of health care providers, TBAs receive support from local women and their families.

Looking at the current state of maternal health in Tanzania, and in Lalta ward in particular, I cannot avoid but question whether we need CHWs for MNCH, rather than TBAs. Why give more responsibilities to CHWs, while TBAs could do much of the same thing yet with more experience, trust and acceptance? It is not only because a lot of resources have been used to train TBAs over the past two decades, but also because the subjective experiences of women regarding TBAs warrant second thoughts about the training of CHWs for MNCH. The larger

health system requires significant changes in order to meet the target of delivery with the help of a skilled health provider, and the mere training of CHWs to motivate women to go to a health facility is insufficient. The case of Tanzania shows that the challenges that TBAs have long faced in their work remain the same today as in the past decades, and will most likely be faced by CHWs too, as no substantial improvements have been made regarding the larger health system in which they must operate. Given the realities of women in rural areas and the place that TBAs have secured in their lives, it would seem to me to make more sense to invest in the training of TBAs rather than CHWs when dealing with pregnant women.

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References

Allen, R. Denise. 2002. *Managing Motherhood Managing Risks: Fertility and Danger in West Central Tanzania.* Ann Arbor: University of Michigan University Press.

Ana, Joseph and Harrison Kelsey. 2011. Are traditional birth attendants good for improving maternal and perinatal health? In: *BMJ* 342. doi:10.1136/bmj.d3310

Berry, S. Nicole. 2010. *Unsafe Motherhood*. *Mayan maternal mortality and subjectivity in post-war Guatemala*. New York; Oxford: Berghahn.

Campbell, Oona MR. 2001. What Are Maternal Health Policies in Developing Countries and Who Drives Them? A Review of the Last Half-century. In: *Studies in Health Services Organization and Policy* 17, 415-437.

Greenspan, Jesse, Shannon McMahon, Joy Chebet, Maurus Mpunga, David Urassa, and Peter Winch. 2013. Sources of community health worker motivation: a qualitative study in Morogoro Region, Tanzania. In: *Human Resources for Health,* http://www.human-resources-health.com/content/11/1/52. Accessed: November 21, 2016.

Janes, Craig R. and Chuluundorj Oyuntsetseg. 2004. Free Markets and Dead Mothers: The Social Ecology of Maternal Mortality on Post-Socialist Mongolia. In: *Medical Anthropology Quarterly* 18 (2), 230-257.

Jordan, Brigitte and Robbie Davis Floyd. 1978. *Birth in Four Cultures: A Cross-cultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States*. Montreal: Eden Press Women's publications.

Kudetz, Paul. 2016. Problematizing the Global in Global Health: An Assessment of the Global Discourse of Safety. In: *Fudan Journal of the Humanities and Social Sciences* 9: 25-40.

Langwick, Stacey. 2006. Geographies of Medicine: Interrogating the Boundary between 'Traditional' and 'Modern' Medicine in Colonial Tanganyika. In West, Harry and Tracey Luedke (eds.) *Borders and Healers: Brokering Therapeutic Resources in Southeast Africa*. Bloomington: Indiana University Press, 143-165.

Langwick, Stacey. 2011. *Bodies, Politics, and African Healing: The Matter of Maladies in Tanzania.* Bloomington: Indiana University Press.

Langwick, Stacey. 2012. The Choreography of Global Subjection: The Traditional Birth Attendant in Contemporary Configurations of World Health. In Dilger, Hansjörg, Abdoulaye Kane, and Stacey Langwick (eds.) *Medicine, Mobility, and Power in Global Africa: Transnational Health and Healing*. Bloomington: Indiana University Press, 31-59.

Lugalla, Joe P. 1995. The Impact of Structural Adjustment Policies on Women's and Children's Health in Tanzania. In: *Review of African Political Economy* 22 (63): 43-53.

Mabaruku, Godfrey, Beverly Msambichaka, Sandro Galea, Peter Rockers, and Margareth Krunk. 2009. Dissatisfaction with Traditional Birth Attendants in Rural Tanzania. In: *International Journal of Gynecology and Obstetrics* 107: 8–11.

Ministry of Health and Social Welfare. 2016. Community Health Workers-Learning Agenda Project (CHW-LAP): Supporting the Implementation of Community Health Workers Cadre in Tanzania. http://chw-lap.muhas.ac.tz/. Accessed: November 21, 2016.

Mselle, Lilian T., Thecla W. Kohi, Abu Mvungi, Bjørg Evjen-Olsen, and Karen Marie Moland. 2011. Waiting for Attention and Care: Birthing Accounts of Women in Rural Tanzania who developed Obstetric Fistula as an Outcome of Labour. In: *BMC Pregnancy and Childbirth* 11, 75. doi: 10.1186/1471-2393-11-75.

Nyanzi Stella, Manneh Hawah and Walraven Gijs. 2007. Traditional Birth Attendants in Rural Gambia: Beyond Health to Social Cohesion. In: *African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive* 11 (1): 43-56.

Pembe, Adrea, Paulo Chetto, Brenda D'mello and Jos van Roosemalen. 2014. Maternal Mortality at Muhimbili National Hospital in Tanzania in the Year 2011. In: *BMC Pregnancy and Child Birth*. doi: 10.1186/1471-2393-14-320.

Perry, Henry. 2012. How Effective are Community Health Workers: An Overview of Current Evidence with Recommendation for Strengthening Health Community Worker Program to Accelerate the Achievement of Health Related Millennium Development Goals. John Hopkins Bloomberg School of Public Health. http://www.coregroup.org/storage/Program_Learning/Community_Health_Workers/review%20of%20chw%20effectiveness%20for%20mdgs-sept2012.pdf. Accessed: November 21, 2016.

Perry, Henry. 2013. A Brief History of Community Health Workers. Johns Hopkins Bloomberg School of Public Health. http://www.mchip.net/sites/default/files/mchipfiles/02_CHW_History.pdf. Accessed: November 21, 2016.

Preiffer, Constanze and Mwaipopo Rosemarie. 2013. Delivering at Home or in a Health facility? Health-seeking Behaviour of Women and the Role of Traditional Birth Attendants in Tanzania. In: *BMC Pregnancy Childbirth.* doi: 10.1186/1471-2393-13-5.

Pyone, T., S. Adaji, B. Madaj, T. Woldetsadik, and N. van den Broek. 2014. Changing the Role of the Traditional Birth Attendant in Somaliland. *Int J Gynaecol Obstet.* 127 (1), 41-6. doi:10.1016/j.ijgo.2014.04.009.

Richey, Lisa A. 2003. Women's Reproductive Health and Population Policy: Tanzania. In: *Review of African Political Economy* 30 (96), 273-292. doi:10.1080/03056244.2003.9693500.

Robert, Timothy, Idda Mosha and Jeniffer Applegate. 2015. Initial Experience and Innovation in Supervising Community Health Workers for Maternal, Newborn and Child Health in Morogoro Region Tanzania. In: *Human Resource for Health.* doi: 10.1186/s12960-015-0010-x.

Shija, Angela E., Judith Msovela, and Leonard E.G. Mboera. 2011. Maternal Health in Fifty Years of Tanzania Independence: Challenges and Opportunities of Reducing Maternal Mortality. In: *Tanzania Journal of Health Research* 13 (Suppl.1). doi:10.4314/thrb.v13i5.5.

Tulenko, Kate, Sigrun Møgedal, Muhammad M. Afzal, Diana Frymus, Adetokunbo Oshin, Muhammad Pate, Estelle Quain, Arletti Pinel, Shona Wynd, and Sanjay Zodpey. 2013. Community Health Workers for Universal Health-care coverage: from Fragmentation to Synergy. In: *Bull. World Health Organ.* 91(11): 847-52. doi:10.2471/BLT.13.118745.

Turinawe, Benon Emmanuel, Jude T. Rwemisisi, Laban K. Musinguzi, Marije de Groot, Denis Muhangi, Daniel H. de Vries, David K. Mafigiri, Achilles Katamba, Nadine Parker, and Robert Pool. 2016. Traditional Birth Attendants (TBAs) as Potential Agents in Promoting Male Involvement in Maternity Preparedness: Insights from a Rural Community in Uganda. In: *BioMed Central*. doi:10.1186/s12978-016-0147-7.

UNDP and URT. 2015. Tanzania Human Development Report 2014. Economic Transformation for Human Development. Economic and Social Research Foundation. http://hdr.undp.org/sites/default/files/thdr2014-main.pdf. Accessed: November 21, 2016.

URT. 2010. Tanzania Demographic and Health Survey 2010. National Bureau of Statistics, Dar es Salaam, Tanzania. http://dhsprogram.com/pubs/pdf/FR243/FR243%5B24June2011%5D.pdf. Accessed: November 21, 2016.

WHO. 1978. Primary Health Care. Report of the International Conference on Primary Health Care. http://apps.who.int/iris/bitstream/10665/39228/1/9241800011.pdf. Accessed November 21, 2016.

– . 2006. Improving Health Worker Performance: In Search of Promising Practices, http://www.who.int/hrh/resources/improving_hw_performance.pdf. Accessed November 21, 2016.

– . 1992. Traditional Birth Attendants. A joint WHO/UNFPA/UNICEF Statement. Geneva. http://apps.who.int/iris/handle/10665/38994. Accessed November 21, 2016.

– . 2015. Trends in Maternal Mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva. http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/. Accessed November 21, 2016.

– . 2005. Make Every Mother and Child Count - The World Health Report 2015. Appia, Geneva, Switzerland. http://www.who.int/whr/2005/whr2005_en.pdf. Accessed November 21, 2016.

1 See also the 1978 WHO report for more details on how TBAs were conceived at the global political level in the early years. These women have different names in different parts of the world, but universally are referred to as TBAs.

2 Being an accomplished herbalist was, however, not mandatory for women to be trained as TBAs (see Langwick 2011: 122). In Tanzania, some TBAs received no formal training, but acquired skills mainly through experience. Such ‘untrained’ TBAs had to be licensed by the government to help women deliver and, like the trained TBAs, were provided with delivery kits (see WHO 1992). In the area of my study, there was only one TBA who had not received any formal training but was licensed to help women. Like the other TBAs in the region, according to her newly assigned role she was only allowed to accompany women to a health center, but she showed no readiness to comply with these new rules.