To Claim, or Not to Claim Human Rights in Childbirth

Mothers' Experiences of Claiming Human Rights and Demanding Accountability during their Childbirth Journey in Tanzania and the United Kingdom.

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Signed declaration

I, Anna Katrine Nohr confirm that the work presented in my thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Abstract

The human rights-based approach to maternal mortality has been embraced as an attempt to address disrespect and abuse in childbirth, as well as overcome maternal mortality. Whilst the focus on human rights violations in childbirth is vital, the important role of women as agents during their childbirth journey seems to be neglected. The lack of focus on women's rights claims during childbirth within a biomedical healthcare context is surprising, since the notion of women's empowerment is integral to the human rights-based approach to maternal mortality. Ethnographic in-depth interviews with mothers in Tanzania and the United Kingdom are therefore central to this thesis, as their perceptions of 'violations' and 'wellbeing' during the childbirth journey are explored, as are their experiences of claiming their human rights and demanding accountability in childbirth. Drawing upon this ethnographic data, this thesis investigates whether the instrumental, linear rational policy assumptions inherent in the human rights-based approach to maternal mortality are relevant to the mothers own lived experiences, as well as explores whether there are any local consequences from introducing human rights policy into the arena of childbirth. This thesis shows that the majority of the respondents adopted a 'pragmatic,' rather than a human rights-based approach to claiming their rights and asserting their needs during childbirth due to the strong dyad mother/infant relationship. Finally, the thesis highlights that whilst the respondents did try to use rights-based approaches after childbirth to demand accountability and justice, many were re-traumatised rather than experiencing a sense of empowerment or justice, due to the replication of the biomedical knowledge/power hierarchy within associated accountability mechanisms.

Impact Statement

This thesis forms part of a growing number of ethnographies concerned with biomedical childbirths in countries where maternal mortality rates are high, healthcare systems inadequate and human rights violations prevalent. This thesis outlines a number of human rights violations that were detrimental to the wellbeing of mothers in childbirth, and reveals the socio-economic, political, and cultural barriers that proved too persistent when attempts were made to claim human rights and demand accountability in childbirth. Such insights could assist actors within the fields of international development, human rights, and global health to better support mothers seeking to claim rights and demand accountability during their childbirth journey.

This thesis provides evidence of the value of taking an ethnographic approach to childbirth and human rights. The human rights-based approach to maternal mortality uses the concept of human rights law, rather than the lived experiences of mothers, as the analytical starting-point. Even though human rights law is vital, an anthropological approach reveals that a rights-based approach to maternal mortality remains too a narrow a conceptual lens to ground an understanding of the local realities that mothers face during their childbirth journey.

I am committed to disseminating my findings widely. I have presented preliminary findings at seminars and conferences in the United Kingdom and in meetings in Tanzania over the past three years. Furthermore, I am scheduled to present my findings to the senior management of the clinics and hospitals described in this research study, as well as government officials. Finally, I plan to present the findings to all the mothers who participated in this research, as well as follow up on the additional research questions which I identify in the conclusion.

Acknowledgements

First and foremost, I would like to thank all the mothers that I interviewed and talked to during my research period. One of the main reasons I chose the field of anthropology was because it gives voice to those who are too often ignored. If nothing else, I hope at least to have given voice to some of the mothers in this research who would otherwise never have been heard.

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Much love to my supportive family and friends, who helped me find both the strength to write this PhD after I lost my brother and nearly lost my sons, while both Brexit and the Covid epidemic chipped away at my time.

Dedicated to all of those we have lost.

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Introduction

On an early research scoping visit to Tanzania, I bumped into a medical doctor at the airport, who joined me in the café for a cup of tea with plenty of sugar. When he heard about my initial research plans, he began telling me about a little maternity clinic that he was planning to build. We both realised that we had family friends in common, so we all gathered for dinner the following evening to discuss efforts to overcome maternal mortality in Tanzania. Later that week, he invited me to look at the building site, and soon we went on to discuss fundraising ideas, since the little maternity clinic would need new hospital beds, medical equipment and a generator.

A year later, I visited the little maternity clinic, feeling very happy as I had managed to fundraise enough money for new medical equipment and a generator. I sat down on a plastic chair next to the clinic entrance to drink a cup of tea with plenty of sugar. At first, I was excited to see some women with infants exiting the clinic, as I somewhat naively thought they would be discussing how the little maternity clinic had helped save their lives during childbirth. I was therefore disappointed when I overheard them discussing the healthcare workers' 'unwelcoming' behaviour among themselves. Then, it occurred to me that I had been solely focused on the fundraising output, such as the new equipment for the maternity clinic, and the overall outcome, saving birthing women, but had ignored something equally important, which is how the mothers were treated during childbirth. This made me wonder whether there was any way that mothers might claim their rights to prevent mistreatment in childbirth. As a result, I spent the next four years interviewing more than a hundred mothers in Tanzania and the United Kingdom about their childbirth experiences, their attempts to claim rights during childbirth and efforts to demand accountability after childbirth. Over the years, many mothers told me their 'empowering' stories of demanding accountability and justice, however, sadly, many other mothers also shared their pain from losing their infants, as well as close encounters with death.

Maternal Mortality as a Global Health Concern

Maternal mortality was not recognised as a global health concern, let alone a human rights issue, until the 21st century. Historically, the majority of health professionals, policy makers, and politicians paid insufficient attention to the high number of maternal deaths in low-income countries, as maternal and child health programmes were mostly driven by concerns about infant mortality and morbidity (Rosenfield and Maine, 1985). In 1985, the World Health Organisation (WHO) finally hosted an Interregional Meeting on the Prevention of Maternal Mortality, which highlighted the problem of maternal mortality in low- and middle-income countries. Subsequently, the WHO, the United Nations Population Fund (UNFPA) and the World Bank sponsored the first International Safe Motherhood Conference in 1987. The conference officially launched the Safe Motherhood's Initiatives (SMI) to increase women's access to family planning, promote the value of prenatal care, and increase the access to emergency treatment. The SMI was successful in bringing international attention to maternal mortality in low-income countries, and even more importantly, cemented the fact that maternal mortality was not 'natural,' but instead represented avoidable loss of life. As Stroeng states, "it was a preventable tragedy that governments and the international community had an ethical obligation to address" (2010, p. 80).

In 2000, the UN General Assembly announced the Millennium Development Goals (MDGs), a set of eight goals to combat poverty, hunger, disease, illiteracy, environmental degradation, and improve healthcare. Each MDG had targets set for 2015 and indicators to monitor progress. MDG 5 aimed at improving maternal health by reducing the maternal mortality ratio by 75 percent by 2015 (United Nations, 2015). A key 'success' indicator was the proportion of births attended by a skilled birth attendant, with the aim to increase the number of births assisted by skilled attendants to 80 percent by 2005 and 90 percent by 2015 (Rasch, 2007).[1] Even though the MDGs succeeded in propelling the issue of maternal mortality to the top of the international agenda, the MDGs soon came under criticism for the slow progress in terms of maternal mortality in sub-Saharan Africa, as well as the predominant focus on (economic) poverty reduction whilst ignoring other dimensions of development, such as empowerment and human

[1] The MDGs were subsequently replaced by the Sustainable Development Goals (SDGs), which are 17 goals focused on peace and prosperity. Target 3.1 is focused on the reduction of the global MMR to less than 70 per 100,000 by 2030.

rights (Marten, 2022). The singular focus on aggregates was perceived as reductionistic, with its exclusive targets and 'tangible and measurable' indicators (Jong and Vijge, 2021). Freedman (2005) highlights that this single, technocratic focus on clinical expertise and capacity building in targeted interventions to reduce maternal mortality also tended to ignore human rights violations which many mothers suffered during childbirth in healthcare facilities.

Human Rights Violations in Childbirth

In 2010, the ground-breaking report by Bowser and Hill revealed the various human rights violations, as well as disrespect and abuse (D&A), that numerous mothers experienced during childbirth in healthcare facilities. The primary purpose of the report was to review the evidence in published literature with regard to the definition, scope, contributors, and impact of disrespect and abuse in childbirth, to review promising intervention approaches, and to identify gaps in the evidence. In their systematic review of the topic, Bowser and Hill drew upon examples from various human rights organisations, shining the spotlight on the violations and disrespect that mothers had experienced in childbirth. From this, seven D&A categories were established, which include i) physical abuse, ii) non-consented clinical care, iii) non-confidential care, iv) non-dignified care, v) discrimination, vi) abandonment, and vii) detention in health facilities. They stated that "the recognition, ratification, as well as enforcement of human rights treaties is one important strategy for reducing disrespect and abuse in childbirth" (2010, p.17).

In 2010, the Human Rights Council held a panel discussion on maternal mortality as a human rights issue, and the Office of the United Nations High Commissioner for Human Rights (OHCHR) subsequently publishing a report on the topic. The report highlights that States are obligated under international human rights law to respect, protect and fulfil human rights in relation to pregnancy and childbirth. It states that preventable maternal death is a violation of the right to the highest attainable standard of physical and mental health, including sexual and reproductive health, the rights to equality and to non-discrimination and the rights to information, to education and the benefits of scientific progress. Additionally, the report identifies seven human rights principles fundamental for understanding maternal mortality and morbidity as a human rights issue, including accountability, participation, transparency, empowerment, sustainability, international assistance, and non-discrimination (Human Rights Council, 2010).

In 2011, the White Ribbon Alliance launched the Respectful Maternity Care Charter (Maternity Charter), which anchors the rights of individual mothers in childbirth to international human rights law. The Maternity Charter states that childbirth care needs to encompass basic human rights, including the rights to respect, dignity, confidentiality, information and informed consent, the right to the highest attainable standard of health, as well as freedom from discrimination and from all forms of ill-treatment. The Maternity Charter highlights that the sole focus on preventing maternal and newborn morbidity and mortality is not enough, as the wellbeing of the mother and her infant during childbirth should not be compromised. The table below contains the Respectful Maternity Care Charter.

RESPECTFUL MATERNITY CARE CHARTER
I. Everyone has the right to freedom from harm and ill-treatment.
II. Everyone has the right to information, informed consent, and respect for their choices and preferences, including companion of choice during maternity care and refusal of medical procedures.
III. Everyone has the right to privacy and confidentiality.
IV. Everyone is their own person from the moment of birth and has the right to be treated with dignity and respect.
V. Everyone has the right to equality, freedom from discrimination and equitable care.
VI. Everyone has the right to healthcare and to the highest attainable level of health.
VII. Everyone has the right to liberty, autonomy, self-determination, and freedom from arbitrary detention.
VIII. Every child has the right to be with their parents of guardians.
IX. Every child has the right to an identity and nationality from birth.
X. Everyone had the right to adequate nutrition and clean water.

Table 1: Respectful Maternity Care Charter. (Source: White Ribbon Alliance)

Although the Maternity Charter established human rights for mothers in childbirth in theory, human rights scholars were aware that they needed to find ways to ensure that these rights were implemented in practice. Freedman highlights that "human rights norms could be readily used to characterize and categorize the chilling scenes of humiliation, neglect and abuse" (2003, p.111), but to actively change the situation - so that the public health systems respected, protected, and fulfilled human rights in practice - the impetus provided by human rights law would have to move beyond the legal realm into healthcare practice.

The Human Rights-Based Approach to Maternal Morality

In 2011, the UN Human Rights Council received the OHCHR report on effective practices when adopting a human rights-based approach to preventing maternal mortality and morbidity, which included (a) an identification of how such initiatives embodied a human rights-based approach; (b) the elements of these initiatives that succeeded in achieving a reduction in maternal mortality and morbidity through a human rights-based approach; and (c) ways in which similar initiatives could give effect more fully to a human rights-based approach. The report makes clear that States should make efforts to build functioning healthcare systems with adequate supplies, equipment, and infrastructure, as well as an efficient and effective system of communication, referral, and transport. Furthermore, it highlighted that the strengthening of healthcare systems, however costly, is beneficial to all citizens, not just women, thereby illustrating the interlinkages among international development, human rights and public health. Finally, the report concludes that "accountability is at the core of the enjoyment of all human rights and has two main components: (a) addressing past grievances; and (b) correcting systematic failure to prevent future violations" (para. 31).

In 2012, the United Nations General Assembly (UNGA) was presented with the 'Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Mortality and Morbidity' (OHCHR, 2012). The human rights-based approach "identifies rights-holders and their entitlements and corresponding duty-bearers and their obligations and promotes strengthening the capacities of both rights-holders to make their claims and duty-bearers to meet their obligations" (para. 10). The UN Technical Guidance highlights that a human rights-based approach to maternal mortality "is premised upon empowering women to claim their rights, and not merely avoiding maternal death or morbidity" (para. 12). Finally, the UN Technical Guidance states that

mechanisms should be established to promote accountability, transparency, participation, empowerment, non-discrimination, universality, and equity, so that healthcare policies meet their citizen's needs meanwhile respecting their human dignity. Overall, the UN Technical Guidance provides a blueprint for states on how to integrate human rights-based approach to maternal mortality into government policy and practice.

My Research Focus on the Human Rights-Based Approach to Maternal Mortality

I grew up in Tanzania, where I attended both primary and secondary school. After I completed my final year of the International Baccalaureate in Denmark, I returned to Tanzania during my gap year to volunteer with a breastfeeding project for women living with HIV/AIDS. This volunteer work opened my eyes to the controversial marketing of breastmilk substitutes, as well as the high rates of maternal mortality and morbidity during pregnancy and childbirth in Tanzania. After university I went on to work for several different human rights and social accountability organisations, focused on 'empowering' citizens to claim their human rights and demand accountability in various countries, including Tanzania, Uganda, East Timor, Nepal, Sri Lanka, Liberia, Sierra Leone, and Yemen. Finally, I also worked for the Royal Danish Embassy in London, where I followed the progress of the human rights-based approach within the field of global maternal and reproductive health. At first, I was very enthusiastic about the human-rights based approach to maternal mortality. It seemed to address one of our most concerning problems: too many mothers disrespected and dying in childbirth. However, even though the policy premise inherent in the human right-based approach to maternal mortality is inspiring, since at its heart, it is about empowering women, it seemed to me to exaggerate the 'empowerment potential' of an individual women within a healthcare context. In fact, since I have witnessed the consequences for my NGO partners on the ground (such as harassment, fines, and prison) from doing so, I became concerned about the potential risk to vulnerable mothers, were they to claim their human rights and demand accountability in childbirth.

The human rights-based approach is not a new approach in itself. The 'empowering' and 'transforming potential' of the human rights approach was already celebrated within the field of international development during the early 2000s – with a special focus on the agency of rights claimants and assumed potential to transform social structures and power relations. Decades of implementing the human rights-based approach to development led to the recognition that rights are not only difficult to realise when resources are limited but that

claiming rights is ultimately a political process, not a technical or legal one, since rights are often negated and denied by structural inequalities and power relations in the first place (Andreassen and Crawford, 2013). Similarly, when the human rights-based approach to health emerged, even though important questions were raised as to how we might 'empower' women in the field of sexual reproductive health, e. g. in regard to fertility control (Unnithan, 2015), the problem remains: how is such an approach implemented in practice? Human rights scholars have done important work, which has resulted in the ratification of treaties that establish health as a human rights (Yamin, 2008; Hunt, 2016), however, even though a system of law might be in place, the effects can be limited in practice (Merry, 2006). Despite these important findings, the human rights-based approach appears to have moved afresh from the field of international development to the field of global maternal health, whilst the human rights discourse has trickled down to childbirth preparation courses and prenatal literature at the local levels.

My Primary Research Focus

The human rights-based approach to maternal mortality has been embraced as an attempt to address disrespect and abuse in childbirth, as well as overcome maternal mortality. Whilst the focus on human rights violations in childbirth is vital, the important role of women as agents during their childbirth journey seems to be neglected. The lack of focus on women's rights claims during childbirth within a biomedical healthcare context is surprising, since the notion of women's empowerment is integral to the human rights-based approach to maternal mortality. The human rights-based approach to maternal health itself lacks a definition of 'empowerment,' but Batlilawa defines women's empowerment as,

> a process that shifts social power in three critical ways: by challenging the ideologies that justify social inequality (such as gender or caste), by changing prevailing patterns of access to and control over economic, natural, and intellectual resources, and by transforming the institutions and structures that reinforce and sustain existing power structures (2007, p.560).

Merry (2006) states that there is relatively little research about how human rights law works in practice, so she thus argues that we need more research on how such rights are claimed in everyday life. This thesis addresses this very gap in published academic research by focusing on the mothers' lived experiences of claiming human rights and demanding accountability in childbirth. A group of 'empowered' mothers in United Kingdom are compared with a group of 'disadvantaged' mothers in Tanzania. Comparing and contrasting two very different groups of mothers encountering two very different healthcare and legal systems provides a clear

indication of the different capabilities, opportunities and motivations that they have when claiming human rights during their childbirth journey, and highlight the vast barriers that they encounter, especially where healthcare and legal systems remain weak. Finally, it tests the linear-rational assumption inherent to the human rights-based approach to maternal mortality that 'empowered' mothers will automatically claim their human rights and demand accountability during their childbirth journey.

This thesis forms part of a growing number of ethnographies concerned with biomedical childbirths in countries where maternal mortality rates are high, healthcare systems inadequate and human rights violations persistent (von Hollen, 2003; Unnithan and Khanna, 2015; Wallace et al., 2022). Using ethnographic data collected over four years among mothers in Tanzania and the United Kingdom, the thesis tests the universalist, linear-rational policy assumptions inherent in the human rights-based approach to maternal mortality against the lived experiences and local realities of mothers from different socio-economic and cultural backgrounds. Freeman et al., (2018) argue that in order to transform the relationship between mothers and healthcare providers, the human rights-based approach needs to go beyond articulation, dissemination, and even legal enforcement of human rights, and seek to develop a deeper, more nuanced understanding of how power operates within healthcare contexts. This thesis specifically explores how these power dynamics either enable or restrict the agency of individual mothers to claim rights and demand accountability during her childbirth journey, both within a biomedical healthcare context and its associated accountability mechanisms.

With this thesis I contribute to the anthropological work on global maternal health policy (Castro and Singer, 2004; Stroeng, 2010; Wallace et al., 2022). I have been strongly influenced by Allen's (2002) work which highlights that global maternal health policies are doomed to fail when the priorities of the beneficiaries are ignored. She illustrates in her ethnography how safeguarding fertility is more important to the Sukuma than fertility-control. Secondly, I contribute to research on human rights-based policies from a social and cultural perspective (Wilson and Mitchell, 2003; Merry, 2003; Turbine, 2007). Set in a broader scholarship on the anthropology of human rights, international development and global health, this PhD thesis also contributes to the research focused on the connections and disjunction between universal and local conceptions of reproductive health and rights. These studies examine how the body and healthcare is experienced in/through the new rights-based regimes of health (Petchesky and Judd, 1998; Unnithan, 2019). I have also been strongly influenced by anthropologists who

focus on policymaking processes and the impact of policies on people lives (Shore and Wright, 1997; Carrington-Windo, 2018; Irvine, 2021;), as well as anthropological critiques of global maternal health policy and practice (Whiteford and Manderson, 2000; Pfeiffer and Nichter, 2008; Wallace et al., 2022). Finally, this PhD thesis contributes to research studies focused on the socio-economic, political, and cultural meanings of childbirth and its impact on women's lives (Jordan, 1978; Gottlieb, 1995; Nichols, 1996; Callister et al., 2003; Lock and Kaufert, 1998; Hunt, 1999; Humenick, 2006; Dahlen et al., 2010), but challenges the feminist anthropologists' perspectives surrounding 'natural' vs. biomedical childbirths (Davis-Floyd, 1992; Daviss and Davis-Floyd, 2020).

Research Aims

The main research aim is to investigate whether the policy assumptions inherent in the human rights-based approach to maternal mortality correspond to the lived experiences of mothers' human rights claims and accountability demands in childbirth. Firstly, the thesis investigates whether the 'universalist' policy assumptions integral to human rights-based approach to maternal mortality is relevant to the mothers' local perceptions of wellbeing and violations in childbirth. This is done by comparing two groups of mothers from two very different socio-economic, political and cultural contexts. Furthermore, the thesis questions the instrumental, linear-rational policy assumptions inherent in the approach which assumes that 'empowered' mothers will claim their human rights and demand accountability during their childbirth journey, in order to improve healthcare systems, with the overall aim of reducing maternal mortality rates. Even if a group of mothers are 'empowered' can we automatically assume that they will claim their human rights in childbirth? Furthermore, are there barriers to rights-claims and accountability-demands that all mothers encounter during their childbirth journey, whether categorised as 'empowered' or 'disadvantaged'? Wallace et al. (2022) state that an anthropological approach to policy contrasts with the instrumental, linear-rational model of policy processes that is often found in political science, as the anthropological approach reveals that the implementation process is often complex, ambiguous and 'messy.' Finally, this thesis investigates whether the mothers themselves felt a sense of 'empowerment' as a result of demanding accountability for the human rights violations they experienced in childbirth, or whether there were any unintended consequences from doing so? Previous research has found that claiming rights and demanding accountability is far from an apolitical process - human rights and accountability reforms ultimately challenge powerful interests that benefit from

institutional discrimination and the poor protection of rights (Englund, 2006). As Merry (2006) puts forward, there will be resistance to human rights claims from elites who fear the loss of power, national states unwilling to have their activities exposed, and men who want to retain their authority over women. Simply put, power pushes back.

Aim 1:

To conduct ethnographies of mothers' childbirth experiences within different socio-economic, political, and cultural contexts in order to explore whether their local perceptions of 'wellbeing' and 'violations' correspond to that of the 'universalist' human rights-based approach to maternal mortality.

Aim 2:

To conduct ethnographies of 'disadvantaged' and 'empowered' mothers' to investigate whether their lived experiences of claiming their human rights in childbirth correspond to the linear-rational policy assumptions integral to the human rights-based approach to maternal mortality.

Aim 3:

To conduct ethnographies of 'disadvantaged' and 'empowered' mothers' lived experiences of demanding accountability for human rights violations after childbirth in order explore whether the mothers experienced a sense of empowerment, or whether there were any unintended local consequences from doing so.

Outline of the Thesis

This thesis begins with Chapter One on methodology, in which I set out my ethnographic approach to studying childbirth stories, the methodology underpinning my approach to data collection, as well as ethical dilemmas and considerations during my ethnographic fieldwork. Chapter Two provides an in-depth description of my two field sites: Tanzania and the United Kingdom, as well as the research participants. Drawing on the ethnographic data gathered during my fieldwork, Chapter Three describes the childbirth experiences of the mothers in

Tanzania and the United Kingdom. The narratives of the individual mothers are situated within their particular socio-economic, historical, political and cultural context, whilst the mothers' own notions of 'violations' and 'wellbeing' in childbirth are explored by reference to the international human rights framework. Chapter Four investigates mothers as agents within a biomedical healthcare system and outlines their own experiences of claiming human rights in childbirth by reference to the international human rights framework. The experiences of mothers who chose *not* to claim their rights due to the power hierarchy within the biomedical healthcare context are also outlined, with a special focus on their 'resistant' agency and 'practical' considerations. Chapter Five describes the mothers' experiences of lodging complaints/reports about human rights violations in their childbirths, as well as demanding accountability by accessing complaints and justice mechanisms. Even though the international human rights framework is the focus of all chapters, it is ultimately the mothers' lived experiences of human rights claims and accountability demands, rather than the human rights principles, which is the analytical starting point of this thesis. Finally, the Conclusion summarises the main arguments and lessons drawn from this research and discusses their implications and direction for future work.

Chapter One

Methodology

In this chapter, I provide an overview of the methodology of the thesis. I briefly provide an overview of what is meant by an 'anthropological approach' in the context of my research, as the empirical evidence I present in this thesis is derived from ethnographic studies in the Tanzania and the United Kingdom. Such part is followed by an overview of the methods which I used to collect the ethnographic research data, including in-depth interviews, participant observation and document review. In conclusion, I describe my ethical considerations and reflexive approach to this research study.

An Anthropological Approach to Childbirth

Anthropology plays an important role in defining problems within the field of childbirth, because ethnographic methods can be used to collect data about women's specific health problems, in order to ensure better policy and practice, as well as evaluate future health interventions. During the first decades of the twentieth century, anthropologists paid very little attention to childbirth within different cultural contexts, perhaps due to the dearth of female anthropologists, and therefore a lack of interest, and access to an exclusively female domain. However, with the influx of female anthropologists, their ethnographies and comparative studies have shown the different ways in which pregnancy, childbirth and the postpartum period have been managed physically, but also socially constructed in unique ways within different cultural contexts (von Hollen, 2003). Inhorn (2007) states that, by listening to the women themselves through ethnographic research, anthropologists are able to determine women's own health and childbirth priorities, as the setting of priorities in women's health still tends to come "from the top down" (2007, p.4). With regard to the anthropology of childbirth, childbirth story interviews with mothers are often a research method in the anthropology of childbirth (Davis-Floyd, 1992; Callister and Vega, 1998; von Hollen, 2003), as it is understood to produce vital insights into the experiences of birthing women (Kay et al., 2017; Savage, 2001; Carolan, 2006). Carson (2016) explains that childbirth stories tend to feature descriptions of pregnancy and childbirth itself, while Leamon highlights that, within each mother's

childbirth story, lies a 'complex combination' of factors involving the storyteller, her sense of self, the childbirth, and her reflections about the experience (2009, p.171). Farley and Widmann describe how childbirth stories are "symbolic representations of birth through word" and argue that articulating the birth experience into a story gives it structure, as well as "an onset, a climax, and a resolution" (2001, p.22). Livo and Ruitz (1986) maintain that, in the 'narrative exchange' that takes place when a childbirth story is told, the 'learner' reconstructs knowledge amassed from the story. The shared story therefore becomes a 'vicariously learned experience' (Savage, 2001).

Previous research on childbirth stories has focused on the social construction of childbirth experiences and perceptions of childbirth choices, obstetric violence, or D&A in childbirth (Bylund and Makoul, 2005; Munro et al., 2009; Hirschenfang, 2011; Hodnett et al., 2011; Mosier, 2016; Kay et al., 2017; Hastings-Tolma et al., 2018) However, as Fitzpatrick (2019) argues, there has often been too strong links between the 'natural' childbirth discourse and the anthropology of childbirth, hence, extra efforts have been made in this research to situate the mothers' childbirth stories within their particular historical and cultural context, as well as deconstruct the notion of a 'natural' childbirth. My particular focus is, nonetheless, not only on the childbirth story but also on the human rights dimension to childbirth, investigating whether the universalist, linear rational policy assumptions inherent in the human rights-based approach to maternal mortality are relevant to the mothers' own lived experiences. Similar to Merry (2006), I somewhat side-step the universalism-relativism debate which has preoccupied many anthropologists in the 1990s, as I focus on the socio-economic, political, and cultural factors that influence the human rights implementation. Instead of discussing the theoretical opposition between culture and rights, this PhD research is focused on whether the human rights-based approach to maternal mortality can make a difference to mothers in childbirth. Thus, this thesis not only contributes to the body of knowledge relevant to the anthropology of childbirth, but also contributes to the scholarship on the anthropology of human rights, international development, and global health policy (Whiteford and Manderson, 2000; Pfeiffer and Nichter, 2008; Unnithan, 2019; Wallace et al., 2020) as the divergence between the 'rational' policy assumptions inherent inhuman rights policies and the lived experiences of mothers are explored.

An Anthropological Approach to Maternal Health Policies

Medical anthropology examines how perceptions of health and wellbeing are socially and culturally constituted, both the ways in which culture influences the experience of illness, the practice of medicine and the process of healing for the individual/community. Medical anthropologists are often engaged with 'local realities' and question universal ideas about society, rights, bodies, and wellbeing. They might explore the impact of global health interventions and practices, by investigating the complex socio-economic, political, and cultural factors involved and, in the process, reveal any local unintended consequences (Singer and Erickson (2011). Medical anthropologists have found that the local context has to be considered when formulating and implementing global health policies. A number of ethnographies reveal the stark contrast between the ideals promoted by policies in contrast to the local realities of mothers 'on the ground' (Justice, 1989; Allen, 2002; Berry, 2010; Wallace et al., 2022). Therefore, when medical anthropologists research and approach a global maternal health policy, such as the human rights-based approach to maternal mortality, they tend to think of it in terms of policy as a social and political construct. As Wallace et al. state, "It is a window into larger processes of governance – the mechanisms of power, knowledge, values and vested interests." (2022, p.3). An anthropological approach to policy therefore contrasts to the instrumental, linear-rational model found in the political sciences, as this ignores the complex and 'messy' nature of local realties. Thus, an anthropological approach is particularly valuable when investigating the local consequences of the human rights-based approach to maternal mortality, as the 'universalist,' linear-rational policy assumptions are tested up against the lived experiences and local realities of mothers on the ground.

During my fieldwork, my main focus was on conducting participant observation and interviewing mothers in Tanzania and the United Kingdom. However, I also analysed policy papers and followed policymakers within the fields of international development, human rights, and global health in order to investigate how they conceptualised and promoted the human rights-based approach to maternal mortality in practice. Nonetheless, while this thesis investigates the divergence between policy and practice, the research presented in this PhD thesis is not framed as an anthropology of policy per se. That would entail detailed empirical, ethnographic investigation of the bureaucracies, power structures and institutions involved in the formulation of the human rights-based approach to maternal mortality, and whilst that may be an opportunity for future research, it is beyond the scope of the present study. The findings

could nonetheless contribute to informing policy in addition to shaping future academic research by emphasising the mothers' own lived experiences of claiming human rights and demanding accountability in childbirth.

Ethnographic methods

Three primary research methods were used to collect the ethnographic data from the mothers in Tanzania and the United Kingdom: in-depth one-to-one interviews, focus groups interviews and participant observation. Both the one-to-one and focus group interviews provided an opportunity to explore childbirth stories, whilst participant observation allowed access to off the record conversations about their entire childbirth journey.

I conducted both semi-structured and unstructured interviews with both group of mothers in Tanzania and the United Kingdom. The interviews with both groups of research participants followed similar trajectories. I generally began by asking the mothers about their childbirth experience. As I discussed the childbirth stories with the mothers, I would ask questions around the themes of 'violations' or 'wellbeing' in childbirth which provided an opportunity to dive deeper into how such concepts are socially constructed, how 'violations' might have been dealt with, the specific ways in which the mothers might have asserted their needs, claimed their rights or demanded accountability during their childbirth journey, as well as the experiences/results/consequences of doing so, within their particular socio-economic, political and cultural contexts.

I conducted the one-to-one interviews with several of the research participants in their own homes to ensure privacy, bringing with me a babysitter to look after their children. The research participants were free to withdraw at any point if the interview process was too emotionally distressing. In cases where I encountered such instances during the interview process, I had prepared details of appropriate sources of help and encouraged the research participants to seek advice from those sources. Due to concerns about the wellbeing and safety of the research participants, and in order to create an environment in which they felt able to talk freely about personal experiences, they were guaranteed anonymity, and their names were replaced with an anonymised pseudonym. Finally, due to the sensitivity of the subject matter, multiple interviews were often held with each research participant in order to ease the conversation and to facilitate reflection on previous statements during the follow-up interviews. Subsequently, I

asked the mothers, whether there were any issues during the childbirth (however, this was mostly raised by the mothers themselves without prompting). Some of the mothers did not express concerns and grievances in terms of 'human rights violations,' and some human rights violations were just perceived as 'normal.' My questions focused on issues that have been identified as human rights violations within the meaning of the Maternity Charter. If a mother had filed a complaint or reported a human rights violation, I enquired whether an administrative, legal, or human rights body was involved, and whether NGO support was needed, or whether alternative routes were used, along kinship or ethnic lines, to redress the grievance. However, I wanted to refrain from interviewing mothers directly about their access to human rights and accountability mechanism at national, regional, and international levels, as I did not want the interviews to turn into a 'test' of the individual mothers' knowledge about human rights and accountability mechanisms. Instead, I used the informal conversations to establish whether the research participants felt that there were any human rights or accountability mechanisms available to them.

If the interview went silent, I employed picture prompts to re-instigate the interview. Such prompts included pictures of pregnant women, doctors, nurses, hospitals, and infants. Collier and Collier argue that pictures can help foster a relaxed atmosphere by acting as a 'third party' in interviews so that an interviewee no longer feels they are the sole centre of attention (1986, p.105). Furthermore, as Schwartz (1989) highlights, research participants often respond directly to the photographs and pay less attention to the 'formalness' of the interview context and the interviewer. Similarly, I found that pictures at times helped put some of the more hesitant research participants at ease, as the potential tension generated by constant face-to-face contact was lessened by the shared focus on the picture (Prosser and Burke, 2006). According to Harper, pictures can help 'building bridges' between the interviewer and interviewee, as they look over the pictures together and discuss what they see and its meaning-communication is thereby encouraged and rapport and trust are built (2002, p.23).

Finally, I found that some of the conversations that took place 'after the interview' provided a rich source of data (Warren, 2005). In fact, Goffman argues that the time period immediately after the end of the formal interview can often reveal the most interesting data, as research participants might feel self-conscious during the 'formal interview' or even doubt their suitability as an informant, which results in them giving the 'answers' they think the researcher wants to hear on the research topic, rather than what they may really think about the research

topic (1974, p.102). Hence, I scheduled in some extra time to talk at the end of the interview, where the research participants were free to informally ask questions or express opinions. Allowing additional time for this kind of valuable engagement was an important element of my research methodology because I anticipated, as Warren states, it might redress power imbalances with respect to the research participant, hopefully creating a more reciprocal research interaction (p.103).

Focus Groups Interviews

Focus group interviews can be summarised as directed or undirected group discussions that address a topic considered relevant or of interest to a group. The researcher leads the interview with a group of participants, each responding to the questions that the researcher asks, and discussing their answers with the other participants throughout the interview. The aim of interviewing methods is to achieve an in-depth understanding by employing an exploration of a range of the research participants' personal experiences and perceptions, using the group interaction to effectively produce a breadth of responses (Berg and Lune, 2011). This form of collecting data is regularly used in qualitative research and its benefits are widely documented (Rabiee, 2004; Freeman, 2006). In my focus groups in the United Kingdom, I set up a circle of chairs as the focal point, as well as a carpet with toys for the children in the middle of the circle. There was also a babysitter present to take care of the children, so the mothers were free to fill out consent forms and answer questions. The informal set-up of the focus groups interviews allowed me to talk to the mothers relatively effortlessly, and I also sometimes contributed my own childbirth experiences, where appropriate – the mothers were generally very happy to talk about their experiences, and often showed an active interest in my research. Some even commentated that they appreciated the new 'mummy friends' they gained because of the focus groups, and frequently pointed to the need for research on childbirth experiences as well as the future improvement of maternity services. In total, I conducted 6 focus group interviews with 20 mothers in the United Kingdom.

Inversely, I decided, after conducting a couple of focus groups in Tanzania, not to continue doing them, as I discovered that some of the mothers appeared to change their answers according to what the other mothers had already said. Furthermore, I was worried that the research participants might be disclosing information that might be used against them in their local community or even by local authorities – as this was the time when Magufuli was still

President of Tanzania. Since Magufuli – the bulldozer - took power in 2015, the overall human rights situation in Tanzania deteriorated with a wide-ranging crackdown on the media, NGOs, and opposing political parties. Authorities censored and suspended news outlets, arrested and detained journalists, arbitrarily deregistered NGOs, banned political rallies by the opposition, and arrested several opposition party members for criticising the President (Human Rights Watch, 2020). I became painfully aware from speaking to old friends in Tanzania that the former President Magufuli had been successful in instilling a fear in people of speaking out in public about political issues due to fines and prosecution. Therefore, I decided that further focus groups should be discontinued in order to safeguard the research participants. Instead, I conducted one-to-one interviews in the privacy of their own homes, and anonymised both names and locations.

Participant Observation

The use of a participant observation is considered essential given the underlying epistemology of this anthropological research. Hume (2013) argues that some research methods (such as questionnaires) stress the importance of the researcher not becoming personally involved with the informant, in the sense of the researcher maintaining both a personal and a social distance between themselves and the research participants. Participant observation, however, involves the researcher 'getting to know' the research subjects she is studying by entering their world and participating in that world. This means one will put oneself 'in the shoes' of the people one is studying in an attempt to experience events in the way they experience them. DeWalt (2011) explains that participant observation generates a rich source of highly detailed, high-quality information about people's behaviour. In short, this type of research produces a depth of detailed information about all aspects of an individual and a group's behaviour.

During my fieldwork, I conducted participant observation in various mothers' groups, as well as various spaces used by mothers, which gave me insight and access to a large number of childbirth stories from a diverse group of mothers. In the United Kingdom, I did participant observation among three different groups of mothers who had given birth at different hospitals in London. Similarly, in Tanzania, I did participant observation among mothers who had given birth at hospitals in urban areas.

Anthropology is characterised by embodied fieldwork, whereby the researcher's body is recognised as being deeply entangled in the study (Harris, 2016). My embodied experience as a mother during my fieldwork meant that I did participant observation during childbirth and motherhood, which meant that I could easily connect with other mothers about these topics. Gottlieb (1995) who has described life as an anthropologist during childbirth and motherhood, states that such anthropologists have something important to contribute from their analysis of childbirth cross-culturally.

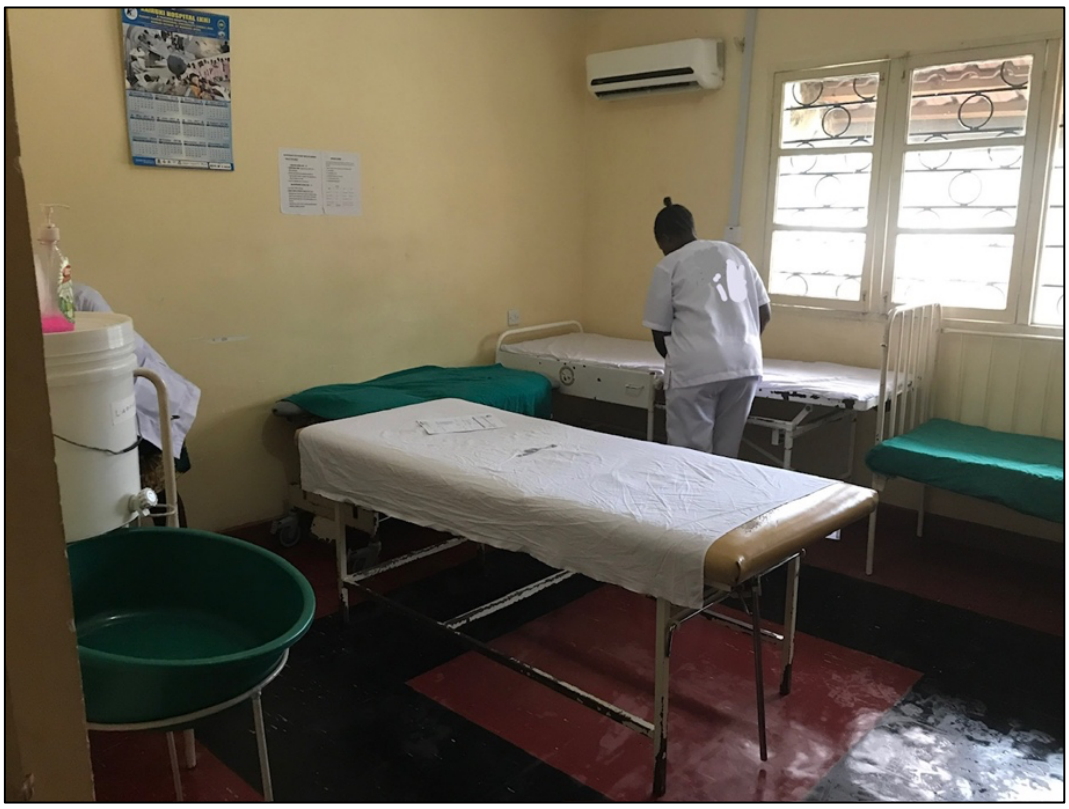

Image 1: Participant observation among healthcare workers. Source: Anna Katrine Nohr

During my fieldwork, I also carried out participant observation among healthcare workers whilst volunteering in maternal health clinics, as pictured above. Even though I did not recruit any research participants during my volunteer work in these clinics, it gave me the opportunity to learn from, and observe the interactions between patients and the healthcare workers. In this PhD thesis. I have categorised all the nurses, midwives, and medical doctors as 'healthcare workers,' in order to prevent stigmatising nurses and midwives. While there is a focus on the misuse of patriarchal power by male obstetricians in the 'obstetric violence' literature, the D&A literature is often focused on the disrespect and abuse of mothers by nurse-midwives. As Miltenburg (2019) states, many of these nurse-midwives do not have the power to change their

situation because they are themselves confronted with hierarchal power structures and gender inequality. She highlights that nurse-midwives in Tanzania often find themselves in the lowest ranking order of the health system, whilst men dominate other cadres, including positions of decision-making power. She argues that many nurse-midwives have themselves been subjected to degrading and disrespectful working conditions, compromising their ability to provide quality care.

Finally, I also talked to many experts in the fields of human rights, global health and international development, as I joined as a participant, as well as presented at 25 different conferences, seminars, workshops, and meetings. I both attended small human rights training seminars for midwives, as well as large conferences, such as the Partnership for Maternal, Neonatal and Childbirth Health conference in Delhi, India, which brought together representatives of UN agencies, national Ministries of Health, NGOs, private philanthropic foundations, and corporate sponsors to discuss efforts to reduce maternal mortality in low-income countries. During my fieldwork, I both conducted formal interviews, as well as had informal conversations with such experts, and joined the seminars as a participant observer. As MacDonald (2013) states, such seminars and conferences are also ethnographic sites - places to observe and participate in an international network of advocates, policy makers, and practitioners. All the different seminars, workshops, and meetings provided a sense of the different groups working within the global maternal health field, and informal conversations with 44 different experts gave me further insight into the subject matter of this PhD thesis.

Language and Translation of Interviews

I interviewed the research participants in the United Kingdom in English or Danish, whereas in Tanzania I conducted the interviews in either English and Kisby myself, or in Kiswahili or Kikusuma with the help of my translator. I was initially sceptical of using a translator since changes happen to language during the translation process (Squires, 2009). When a translator performs a translation, they translate not only the literal meaning of the word, but also how the word relates conceptually to the context. Therefore, when a poor translation occurs, the researcher may lose the conceptual equivalence, or find the meanings of the participants' words altered because of how the translator performed the translation (Gee, 1990; Fredrickson et al., 2005; Temple, 2005). However, on the other hand, I was also aware that my Swahili was not advanced enough to talk to mothers about very sensitive topics. As Umaña-Taylor and Bámaca

(2004) found, research participants often revert to their mother tongue when exploring emotive concepts; hence, richer data was attained when a translator was present. Overall, I found that my translator in Tanzania was very helpful assisting me in all the interviews where necessary in Kiswahili or Kisukuma, and she even conducted four interviews on her own. More importantly, my translator also helped me recruit my research participants through snowball sampling. The snowball sampling method in which one interviewee gives the researcher the name of at least one more potential interviewee. That interviewee, in turn, provides the name of at least one more potential interviewee, and so on, with the sample growing like a rolling snowball if more than one referral per interviewee is provided (Kirchherr and Charles, 2018).

Finally, I found that some words were simply not translatable. This has been a central concern for my research study; the ability to accurately 'translate' complex concepts such as 'human rights' cross-culturally and avoid defining events as 'human rights violations' when this perception might not have been shared by the research participants. In a similar vain, Temple (2005) questions whether non-native speakers conducting cross-language research can meaningfully represent the views of their research participants. She states that learning the language goes some way to address this problem, however, the cultural context and specific meanings attached to the concepts interpreted in the analysis may be lost when reproducing answers in an English text. She therefore suggests including words in the original language where there is no direct English equivalent in order to ensure that the cultural context and research participants' understandings of concepts remain visible. Therefore, some words in Kiswahili have been added in brackets throughout the ethnography to preserve the meaning of the words as near to their original meanings as possible.

Data Analysis

The data sample included mothers of different ages, mothers with different childbirth experiences, and different expectations for their next childbirth. While each narrative was characterised by different nuances, there were marked commonalities, which helped establish a useful starting point from which to explore the shared concepts, behavioural practices, and knowledge among the mothers at hand, and the ethnography is presented in such a way as to show these similarities in relation to human rights standards. Even though attribute data was collected from both group of mothers, the focus was mainly on collecting 'cultural' data, as the focus was on the mothers' lived experiences and perceptions on topics such as motherhood,

childbirth, wellbeing, violations, accountability and justice, as well as whether there was a sense of 'empowerment' when claiming human rights and demanding accountability during the childbirth journey. Singer and Erickson (2011) state that most medical anthropologists work with samples, or subsets of the population in which they are interested in order to capture cultural data which reveal how people make sense of the world. Similarly, this research study was focused on two distinct subsets of the population 'disadvantaged' mothers in Tanzania and 'empowered' mothers the United Kingdom specifically to investigate the policy assumptions inherent in the human rights-based approach to maternal mortality. Singer and Erikson (2011) explain that in contrast to attribute data, cultural data does not rely on probability data, because shared and socially constructed nature of cultural data is not consistent with the assumption of case independence in classical sampling data. As Handwerker (2002) highlights, whereas attribute data requires probability samples, cultural data does not, because the shared and socially constructed nature of cultural phenomena violates the assumption of case independence in classical sampling theory. This assumption is often warranted with attribute data – your age is unrelated to mine however, we participate in the same culture, so our understanding of aging or motherhood are bound together, because we acquire cultural knowledge through social interactions.

Once transcribed and digitised, data were transferred to NVivo, a software package that assists with the categorisation of data. Both the transcripts and the field notes were systematically coded in order to identify key themes. After establishing the most frequently occurring and relevant concepts, I developed a series of 'nodes' (collections of references about a specific theme) through which to 'code' (gathering references relating to a single theme) the data. Each set of data was coded into nodes, some of which were pre-programmed through word frequency queries and others of which were subsequently added as patterns emerged. Coding has been described by Charmaz as 'simply the process of categorising and sorting data', while 'codes' are described as serving to 'summarise, synthesise, and sort many observations made out of the data' (1983, pp.111-112). Coding the data thus provides a link between data and the process of conceptualisation (Bryman and Burgess, 2002, p.5). This process proved helpful in organising the large quantity of qualitative data, which I collected. It also allowed me to analyse data systematically, to record this analysis, and to crosscheck the quantitative data, as well as enable easy and systematic data searches and link building. As Maher et. al. states, a digital analysis software package such as NVivo does not fully scaffold the analysis process. It does, however, provide excellent data management, quantitative analysis, and retrieval facilities which support

the analysis and write up (2018, p.12). My research experience was consistent with these comments.

Document Review

Alongside interviews and participant observation, I carried out an extensive review of academic, legal and policy literature. While practitioners often rely on legal and policy documents as illustrative of legal and policy processes, Shore and Wright state that such documents can be treated as cultural texts and "narratives that serve to justify or condemn the present, or as rhetorical devices and discursive formations that function to empower some and silence others" (1997, p.15). With that in mind, I completed my extensive review of all the literature, legal and policy documents that are relevant to the concept of human rights in childbirth, as well as the human rights-based approach to maternal mortality. This document review helped me to devise a time-line of key events and actors, together with an overview of key concepts. Finally, I also conducted some archival research in order to fully understand the historical background to childbirth practices in the United Kingdom and Tanzania, as well as the colonial past.

Ethical Considerations

Approval for this research was given by the University College London's Ethical Approval Committee, the Tanzania Commission for Science and Technology (COSTECH) and the National Institute for Medical Research (NIMR). Below, I outline the ethical considerations which I identified, and describe the precautions that were taken in order to safeguard research participants' wellbeing during their participation in the study. All research participants received a Participant Information Sheet and a Consent Form in English and Swahili, which had been approved as part of the ethical review process. The Participant Information Sheet outlined: i) the purpose of the project; ii) the nature of potential involvement; iii) confidentiality protocol; iv) possible benefits and risks, and v) details of eventual research dissemination. It also clearly explained that participation would be undertaken on a voluntary basis and that the research participants had the freedom to withdraw from the study at any point, without giving a reason, and that any quotations used in research would be by reference to an anonymous name, instead of their real names. Subsequently, I asked if they had any questions about the project. All

research participants, who took part, were satisfied that they had received enough information. Written informed consent (signature or witnessed thumbprint) was obtained from all research participants. The Consent Form confirmed that the research participants understood the ethics procedure, how their personal data would be used, that participation was voluntary, and that they had received the relevant information about my research project. The Consent Form also asked for permission for the use of quotations, as well as the audio recording of interviews in the United Kingdom. Finally, I also informed the research participants that I would not be able to provide any legal or medical advice, given my role as a researcher. However, many mothers commented that they had found it helpful to talk about their childbirth experiences and some of them even felt a sense of closure from discussing the human rights violations they had experienced in childbirth. Finally, my research project was carried out in a manner that conforms to the Association of Social Anthropologists' (ASA) Ethical Guidelines for Good Research Practice.

The notion of 'Do No Harm' has been a strong consideration throughout my fieldwork. First of all, I anonymised both the research participants and research sites, so there is no potential risk or unintended consequences for the research participants. Furthermore, I wanted to pay special attention to doing no harm to especially 'vulnerable' mothers. Napier and Volkmann (2023) state that 'vulnerability' is by no means a static category and changes according to historical events and cultural determinants. Accordingly, I established a somewhat flexible category of mothers who were 'too vulnerable' to participate in my research. This included mothers who had recently lost an infant during childbirth – due to dealing with my own loss at the time, I appreciated that they would need to talk to family members or a therapist to process the painful emotions of loss, rather than a researcher. Furthermore, I often decided not to complete interviews with 'vulnerable' mothers in Tanzania, who were unemployed and ill, sitting isolated in dark, unclean rooms, often with their husbands or fathers hovering around, perhaps in an attempt to control what was said during the interview – such interviews would politely be ended early by me, under a protective pretext, as I did not deem it safe for the 'vulnerable' mother to describe her childbirth story in such close proximity to others.

Finally, the term 'mother' has been used throughout this thesis to refer to those who had given birth. It is acknowledged that not all people who have given birth identify as women, and it is important to acknowledge this, so this research remains inclusive.

Reflections on the Methodology

A limitation of the research study is that it is not based on direct observations of disrespect and violations during childbirth, but rather on the experiences and perceptions of the mothers undergoing them. Vitzthum found an inconsistency between maternal recall when systematically observing breastfeeding whereby mothers under-reported frequency and over-reported the duration of breastfeeding. (1994, pp. 554-556). Objective measurement of 'human rights violations' in childbirth is challenging due to normalisation or subjective ways of interpreting the situation, which can lead to either under - or overrepresentation of the problem (Savage and Castro, 2017). Hence, I also conducted document review of the academic, legal and policy literature on the subject matter, and found examples in the media. Finally, I did participant observation in maternity clinics to observe healthcare worker-mother interactions and captured inconsistences in maternal recall when conducting participant observation among mothers in both Tanzania and the United Kingdom.

In the course of my own fieldwork, I was in greater proportion a 'participant' as a mother myself, rather than 'just' an observer. Although participant observation is widely used as a research method in medical anthropology, researchers adopt differing degrees of participation and/or observation. Davies argues that the ethnographer "may rely on literally being an inconspicuous bystander; or they may take the opposite approach and reduce reactivity by participating as fully as possible, trying to become invisible in their role as researcher if not as human participant" (2008, p.7). In fact, I found that it proved very useful having personal experience of both midwife-led and obstetrician-led childbirths during my fieldwork years, so I could ask the mothers relevant and sensitive questions. As Brown and Casanova (2009) argue, my position as a female researcher and a mother undoubtedly assisted in my ability to connect with the mothers who I interviewed for this research, as motherhood enables the building rapport between the researcher and research participants who are themselves mothers. However, the complexities and inconsistencies in maternal recall should be considered while interpreting the findings of the current research study.

The first part of my 'informal' ethnographic research was conducted in the United Kingdom where I gave birth to my two children. Then my 'formal' ethnographic research took place as I lived in Tanzania with my family, and then the final part was done as we returned to live in the United Kingdom again. Even though I was born in Denmark, I spent most of my childhood

and adolescent years in Tanzania, Zambia and Lesotho, and I have had my 'home' in the United Kingdom for the most of my adult life. Van Ginkel (1998) states that there are benefits to conducting 'anthropology at home,' such as being able to speak the language and easily establishing a 'natural' rapport with research participants, as well having an existing knowledge of daily routines, symbols, and value systems. In contrast, Ohnuki-Tierney (1984) argues that it might be difficult to maintain both an intellectual and emotional 'distance' from research subjects when conducting 'anthropology at home.' The necessity for 'distance' from research participants in order to attain 'objectivity' is derived from the concern that the data collection might be influenced by his or her own culture. Hence, Brewer states that "a proper balance must be found in the dual role as part insider and part outsider, and to participate while also reflecting critically on what is observed and gathered while doing so" (2000, p.60).

Whilst I retained the advantages of doing anthropology 'at home,' my identity as a Danish mother provided me with the necessary 'distance' to conduct my research reflexively and avoid taking familiar cultural patterns for granted. Weston argues that "every situation carries its exoticisms, in so far as the exotic is always defined in relation to a set of assumptions held by the observer" (1991, p.224). However, despite my many years of living in the research setting, speaking the languages, as well as my identity as a mother, which all made me feel like an 'insider,' I am ultimately from a different cultural setting to the one in which my research participants operated. Conversely, I still felt that like I was doing anthropology 'at home,' not because of the research locations, but due to my new identity as a mother and full embodiment of motherhood. Finally, I felt as if my ethnographic fieldwork to some extent became embodied research, due to my bodily experience of childbirth at the beginning of my research period, and finally, due to my 'sensitised embodiment' (Rivedal, 2022) as a mother taking care of two children whilst trying to conduct research among other mothers.

Reflexibility and Cultural Awareness in Research

Ethnography as a qualitative research method has evolved to increasingly encourage researchers to become reflexive about their own presence in the field (Brown and Casanova, 2009). As I began my research, I found myself reflecting on why I felt so passionately about this particular subject; a subject that has only become conceptualised as a human rights issue during my own lifetime. In this regard, I recalled an article written by Melissa Parker, who taught me about cultural relativism during my undergraduate studies in social anthropology.

Parker (1995) asked herself a similar question after returning from fieldwork in northern Sudan: why did the topic of female circumcision evoke such intense emotions and opinions? Consequently, she traced the historical genealogy of the topic, highlighting that the women's movement has had an immense impact. After the sexual revolution took place in the 1960s, sex became perceived as separate from reproduction and with this increased focus on the quality of the sexual act there was a shift in the emphasis from the vagina to the clitoris in the representation of women's sexuality. Consequently, the examples of female circumcision generated fear about female castration among Western feminists. However, Parker argues, even though many in the West make sense of themselves in terms of their sexuality, this cannot be considered universal, as such ideas might be perceived as amoral and even bizarre in other parts of the world. Hence, she argues that we need a more reflexive approach in our research which appreciates that such an intense emotional response to female circumcision, should ultimately be understood in relation to our own concerns within our own particular historical and cultural context, instead of being viewed as representative of the reality experienced by our research participants. Fundamentally, as Papadopoulos and Lees (200) highlight, without reflexive and culturally competent research methods, researchers tend to impose own beliefs and values onto research participants, which leads to invalid research data.

As I travelled to London, Dar es Salaam, and Delhi to participate in a number of international conferences and seminars about maternal health and human rights in childbirth, I realised that these spaces and platforms were all full of women like me, middle-class, educated, and privileged women, who had experienced childbirth, and were therefore emotionally attached to the topic. I felt strangely in unison with all these other women in our common concern about maternal death and human rights in childbirth. At the same time, it made me wonder whether this particular arena somewhat serves as the last bastion for 'second wave' feminists, after 'third wave' feminists have deconstructed the common notion of 'womanhood' identity. As known, 'second-wave' feminists and radical feminists, such as Daly (1973; 1978) and Rich (1977), emphasised a shared 'womanhood' identity, based on the idea of women's shared oppression by the patriarchal system. In opposition, 'third-wave' feminists argued that such a homogeneous, essentialist, and ahistorical conception of 'womanhood' contributes to power-laden and damaging cultural stereotypes about women (O'Reilly, 2012).

Whilst it has since been acknowledged by most 'second-wave' feminists that early analyses were too narrowly constructed from the lived experiences of white, middle-class, educated,

heterosexual women (Zinn and Dill, 1996), many remain frustrated by the deconstruction of the idea of 'womanhood' which might have effectively dismantled their common platform for action and change. As Deveaux argues,

> Isn't it necessary, both for reasons of personal affirmation and political efficacy – in order to make rights-based claims, for instance – to assert the existence of the 'categories' of women, lesbians, and gay men? And how does a group or an individual simultaneously resist and identify and mobilize about it for the purposes of empowerment and political action? (2014, p.240)

Consequently, as I participated in a number of international conferences and local seminars, which had a focus on human rights in childbirth, I posed the question whether these spaces somewhat also serve as a newfound platform for 'second-wave' feminists to further their idea of a united experience of 'womanhood,' or even a common experience of 'motherhood' in opposition to the so-called patriarchal dominance? Indeed, various conference material and mainstream articles on childbirth I came across strongly romanticised the revival of a feminist childbirth platform. For example, Olorenshaw's (2016) article 'Feminism has Focused on the Boardroom, but it is Time to Remember the Birthing Room,' highlights the importance of reviving feminism during childbirth. Storeng (2010) describe similar tendencies in relation to the Safe Motherhood Initiative, which was led by a group of women who participated in the civil rights and women movements of the 1970s, translating into very strong ethical beliefs about childbirth. Thus, it is not inconceivable that the human rights-based approach to maternal mortality represents another re-found cause for 'second-wave' feminists, and their daughters, to protect the 'victims' during their 'patriarchal' biomedical childbirths. All of these above considerations are issues that I took into account throughout my research, so that my own historical and cultural context in relation to childbirth was not automatically imposed on my research participants, the mothers interviewed in Tanzania and the United Kingdom.

Chapter Two

Fieldwork Sites and Research Subjects

This chapter describes the two research sites and the research participants. The first section of the chapter provides an overview of Tanzania as a research site, as well as the Sukuma mothers, as the main group of research participants in Tanzania. Then an overview will be provided about the United Kingdom as a research site, as well as the English mothers, as the main group of research participants in the United Kingdom. These two different research locations and research participant groups where purposely selected as a comparative study. Since the human rights-based approach to maternal mortality assumes that 'empowered' women will automatically claim their human rights, this assumption is tested by purposely selecting two different research participants groups: a group of 'disadvantaged' and 'uneducated' Sukuma mothers in contrast to a group of 'empowered' and 'privileged' English mothers. Furthermore, the different research sites are selected to compare and contrast the different socio-economic, political, and cultural factors that might prevent mothers from claiming their human rights and demanding accountability in childbirth. Even though such an approach seems counterintuitive to the traditional, in-depth, rich description of a single ethnography, medical anthropology has from its beginning been, as Foster and Anderson state, "...the cross-cultural study of medical systems and ... the bioecological and sociocultural factors that influence the incidence of health and disease now and throughout human history" (1978, p.1). Medical anthropologists have increasingly studied and created comparative frameworks for making sense of health-seeking, medical pluralism, and medical syncretism (Singer and Erickson, 2011). Even more so in the subfield of the anthropology of reproduction, where comparative ethnographies showed the different ways that pregnancy, childbirth, and the postpartum period has been managed physically, but also socially constructed in unique ways within different cultural contexts and historical periods (Jordan, 1978).

Part I: Fieldwork Among Sukuma Mothers in Tanzania

The first part of the chapter describes Tanzania as the first fieldwork site of this research study, and provides an overview of the research subjects, who were mainly mothers from the Sukuma ethnic group.

Fieldwork Site: Tanzania

Tanganyika gained independence from Great Britain in 1961, and Zanzibar followed in 1963 as a constitutional monarchy. In Tanganyika, Julius Nyerere, an idealistic socialist leader, established a one-party political system that encouraged national self-reliance and rural development. In 1964, a popular uprising overthrew the Sultan in Zanzibar and expelled many of the Arabs and Indians who had dominated the isles for more than 200 years. Later that year, Tanganyika and Zanzibar combined to form the United Republic of Tanzania, but Zanzibar retained considerable autonomy (Ingham, 2023). The population of Tanzania has grown rapidly from an estimated 12 million in 1967 to 67 million. For administrative purposes, Tanzania is divided into 26 regions, 21 on the mainland and five on Zanzibar. Ninety-eight districts, each with at least one council, have been created to further increase local authority. In 2007, there were 114 councils operating in 99 districts; 22 are urban and 92 are rural. There are around 120 or more ethnic groups. None of these hold a dominant position, as effective efforts at 'nation-building' after independence, which included the promotion of Swahili as the national language, helped Tanzania to avoid serious ethnic conflict (Heath, 2010). Around 80 percent of these communities follow patrilineal marriage practices, whilst the remainding approximately 20 percent of communities follow matrilocal and matrilineal marriage practices (Duncan, 2014)

The Constitution (*Katiba ya Jamhuri ya Muungano wa Tanzania*) which was adopted in 1977, established the form of government. It was amended in 1984 to include a Bill of Rights. The 1992 amendments to the Union Constitution implemented a multiparty democracy in Tanzania. According to the Constitution, if the President comes from the mainland, the Vice President must come from Zanzibar, and vice versa. Members of the Cabinet, including the Prime Minister, are appointed by the President.

The Healthcare System in Tanzania

The Ministry of Health, Community Development, the Elderly, Gender, and Children (The Ministry of Health) has the overall responsibility for the health services and defines healthcare priorities for the country. The Government of Tanzania developed a national health system after independence which was committed to providing the population with free access to health services. To meet the health needs of the rapidly growing, largely rural population, the government structured a referral pyramid health system to send people from a local first point of contact to increasingly specialised, more centralised facilities; this multi-tiered decentralised health system continues to operate to this day. The first local point are community health posts at the village level. Most village governments employ two or more health workers commonly known as village health workers. After short training, they run a community health post providing health education and care for minor ailments. The next level of referral are dispensaries which are run by a clinical assistant and a nurse, offering basic outpatient curative care to between 6,000 and 10,000 people. The next level up, health centres are staffed by clinical officers supported by nurses, reaching up to 50,000 people. Although intended to provide preventive care, health centres have 10–20 beds and provide reproductive health services and minor surgery. District hospitals offer inpatient services and outpatient services which are not available at dispensaries or health centres. There are 132 districts in Tanzania with populations ranging from 1.4 million people in Kinondoni district to 46 000 people in the most sparsely populated district of Mafia. Regional hospitals cover from four to eight districts. Although the range of services at regional hospitals is similar to district hospitals, regional hospitals are larger and offer more specialised care. Finally, there are four national teaching hospitals that provide complex healthcare, which requires advanced technology and highly skilled personnel (Kapologwe, 2020).

The size of the healthcare workforce (both health professionals and other healthcare workers) has declined in absolute numbers and relative to the size of the population. The decline in absolute numbers was especially significant during the 1990s when the Government of Tanzania retrenched the healthcare workforce and imposed an employment freeze – resulting in a loss of one-third of the healthcare workforce. It was estimated in 2006 that there were 29,000 staff working in government health facilities (an estimated 65 percent shortage) and about 6,000 staff working in private facilities (an estimated 86 percent shortage). It was

estimated that an additional 144,700 workers need to be trained and employed to ensure a well-functioning healthcare system in Tanzania (Kwesigabo et al., 2012).

The public health sector has been undergoing a number of reforms, whereby more than 6,000 healthcare facilities across the country are now responsible for their own program planning and financial management. (Songstad et al., 2011) Nonetheless, the health sector as a whole remains heavily dependent on external resources; since international development partners continue to contribute a significant amount towards healthcare expenditure, meanwhile the public healthcare spending continues to be low at 26 percent (MoHCDGEC, 2014). Finally, the Health Sector Strategic Plan (2021–26) lays out ambitious targets to achieve universal health coverage. The strategy recommends harmonisation of existing fragmented health insurance schemes into a mandatory universal health insurance (UHI) scheme, which provides all citizens with an entitlement to a minimum healthcare benefits package. In implementing the health financing strategy, the Minstry of Health decided to have long- and short-term plans for improving overall health insurance coverage (MOHCDGEC, 2018b). The Universal Health Coverage Bill of 2022 was tabled before Parliament in September 2022. The Bill is currently with the Social Services and Community Development Committee for further consultation (Sauwa, 2022).

Maternal Health and Mortality in Tanzania

The maternal mortality ratio in Tanzania is very high at approximately high 556 per 100,000 live births (See below table for comparison with other countries) with about 80 percent of deaths occurring during childbirth and in the immediate postpartum period (Tanzania Demographic and Health Survey, 2016). Maternal deaths are associated with both direct and indirect obstetric causes. The direct causes, include haemorrhage, hypertensive disorders, obstructed labour, and sepsis are responsible for about three quarters of maternal deaths worldwide. Meanwhile, the indirect causes of maternal death include the effects of pre-existing disorders, such as HIV, malaria, tuberculosis, mental diseases, epilepsy, and diabetes (WHO, 2018).

Dispensaries provide maternal and child health care, treat simple medical problems during pregnancy such as anaemia, and assist with normal childbirths. However, because of the shortage of healthcare workers, it is not unusual to find a dispensary especially in remote and

hard to reach districts having neither a clinical assistant nor a nurse; instead, such a facility may be run by health worker without any professional training commonly known as a medical attendant. Furthermore, the evidence shows that women continue to incur costs related to antenatal and delivery care, such as charges for equipment used by health professionals such as gloves (Mselle et al. 2019). Finally, there are hidden costs for attending health services, such as transport, which also could disincentivise visits to health facilities (Lambin and Nyyssola, 2022).

Research Participants: Sukuma Mothers in Tanzania

This section provides an overview of the Sukuma mothers as a research participant group (research participants are referred to as 'mothers' for the avoidance of confusion). For the purposes of this study, the majority of the research participants were 'disadvantaged', heterosexual Sukuma mothers, with one or more childbirth experiences. However, to reflect the demographics of the urban area in this research study, a few mothers from other ethnic groups were also interviewed. In terms of educational background, around 80 percent of the Sukuma mothers had attended primary school, whereas about 20 percent had completed secondary school, and about 5 percent had completed a university degree. The majority of the Sukuma mothers had given birth in a hospital, health centre or dispensary, whilst few had given birth at home or at a private clinic.

The Sukuma are believed to have first settled near Lake Victoria in the Mwanza region of present-day Tanzania during the period of Bantu expansion. They were long thought to be a subgroup of the Nyamwezi, who speak a similar language and share many customs, however, the Sukuma developed their own distinctive culture based on farming and raising livestock (Brandström, 1986). Prior to colonialisation, the Sukuma lived in farming villages, organised into loosely affiliated chiefdoms. They cultivated grain crops such as sorghum, millet, and maize and also kept cattle, which continue to be an important symbol of wealth. After the German East African Company took control of the area in 1891, the Sukuma were forced into commercial farms where they were expected to grow export crops such as tea and coffee. Subsequently, the Sukuma later excelled at commercial farming under British colonial rule and grew prosperous from sales of cotton, tobacco, and grain crops. Sukumaland continues to be one of the most important farming areas in Tanzania today (Heath, 2010).

The recent market commoditisation of land in Tanzania has pushed a lot of the Sukuma out of their landholdings and into urban areas to look for employment. As a result, many women have developed home-based activities in order to balance childcare responsibilities with income earning. The most common economic activities include preparing and selling beer or food, such as *chapati* and *maandazi* (donuts), hairdressing, or setting up *mama nitilie* stalls outside their homes for clients to sit and eat (Mbilinyi, 2023). Magongo and Corta argue that even though the 'de-masculinisation' of Sukuma men, due to their loss of land, has led to some sort of 'empowerment' of Sukuma women, as they now have their own independent income, they are at the same time forced to take on the responsibility as head of household. Without access to land, their low-waged employment and petty trade is often not enough for Sukuma women to support themselves and their households. Hence, rather than experiencing economic empowerment, many have instead become 'the managers of household poverty' (Platteau et al., 2005).

Most of the mothers interviewed for this research study were employed as low-wage, casual labour for *nakidi* (cash in hand) or engaged in petty trade, such as selling small quantities of crops or the aforementioned baked goods. A few of the mothers interviewed were employed in various bars, guesthouses, hotels, and nightclubs across the city. Lees (2021) describes how the neoliberalisation of the economy in the 1990s also led to a growing informal economy whereby sex has become commodified through monetary exchange, however, none of the mothers interviewed stated that they *actively* participate in the 'entertainment industry.' Finally, only very few of the mothers in this study owned their own small landholdings (*shamba*) where they would grow their crops to sell at the market.

At the beginning of my fieldwork, it was hard to establish the exact 'socio-economic status' of the mothers who I interviewed. As a starting point, I sought to derive their socio-economic status from their answers to my questions about their educational background and their occupation, as well as the size of their household and their access to land. It did offer some clues, when mothers stated that they had not completed their secondary school or when they stated that they were employed as domestic workers. Additionally, I would try to derive her socio-economic status from their home settings. As mentioned in Chapter One on methodology, I would interview the mothers in the privacy of their own homes, as this was often the most convenient for them, however, this would also provide me with some non-verbal indications of 'privilege' or 'disadvantage.' The 'privileged' Sukuma mothers in my research

study, for example, lived in big houses with a lot of domestic workers running around completing tasks for them, whereas the 'disadvantaged' mothers, who themselves often worked as domestic workers, had tiny, clean mud huts, surrounded by a lot of other women and their many children running around in their ragged clothes.

Howe states that whereas a lot has been written in relation to the measurement of socio-economic status in high-income countries, less has been written about this in low-income countries (2012, p.871). Kriel et al. argues that the economic approach to poverty that require quantifiable measures; income, expenditure or/and assets tend to ignore dimensions of poverty related to the lack of social support, social networks, aspirations, and social participation. Instead, she argues, the 'wealth in people' remains important in Africa and a key dimension of poverty is therefore an absence of access to extra-household networks (2014, p.3). Similarly, I found that even though I classified some of the mothers as 'disadvantaged' in terms of educational background and employment, some of these mothers revealed their strength and 'privilege' in their strong social participation in various social networks, including their neighbourhood, religious community, and kinship networks. In contrast, the 'vulnerable' mothers in this study, were unemployed or ill, sitting alone in dark, unclean rooms, and isolated from their social networks.

Part II: Fieldwork Among English Mothers in the United Kingdom

In this section part of the chapter, I describe the United Kingdom as the second field site in this research study. I provide a description of the United Kingdom, as well as the healthcare context, and finally, I describe the English mothers as a research participant group.

Fieldwork Site: The United Kingdom

The United Kingdom of Great Britain and Northern Ireland was created through unification of the Kingdoms of England and Scotland under the 1701 Acts of Union. The island of Ireland, also joined via a personal union, was incorporated under the 1800 Acts of Union, while Wales had been part of the Kingdom of England since the 16th century (CIA World Factbook, 2023).

The administrative structure of Greater London includes 33 separate boroughs, 14 of which constitute Inner London and the others Outer London (Morrill, et al., 2023). The research for this thesis took place in a borough in South East London.

The Healthcare System in the United Kingdom

The National Health Service (NHS), which provides comprehensive healthcare throughout the United Kingdom, was established by the National Health Service Act of 1946. The services provided are administered in three separate groups: general practitioner (GP) and dental services, hospital and specialist services, and local health authority services. GPs give primary medical care to a group of persons who register with them. These GPs operate their own practices but are paid by the government on a per capita basis, but their services are organised locally by an executive council. Hospital and specialist services are provided by professionals on government salaries working in government-owned hospitals and other facilities that are under the direction of regional authorities (Encyclopedia Britannica, 2023).

Historically, the poor and ill in the United Kingdom received healthcare from religious orders, in particular the monasteries. However, when King Henry VIII established himself as head of the newly created Church of England in 1543, he dissolved the monasteries, which was the main source of care was removed from ill and vulnerable people. It was not until 1601, under Queen Elizabeth I, that the Poor Law established alms-houses to care for the ill and disadvantaged, and a system of 'outdoor relief' provided benefits in kind to support the poor at home. During the 19th Century, attitudes towards the disadvantaged changed and the care provided by alms-houses was thought to be too benevolent, so austere workhouses were established, providing accommodation for the poor, orphans and the elderly. Although the different groups were supposed to be looked after separately, in practice this rarely happened, and everyone was housed in single, large institutions. Subsequently, as the anatomical/pathological basis of disease became better understood, healthcare was increasingly provided by other bodies, and hospitals were established for infectious diseases. Additionally, many voluntary hospitals were established, run by boards of Governors. Medical care was provided by visiting specialists who would, invariably, have lucrative private practices elsewhere. For economic reasons, such hospitals tended to focus on people with relatively acute problems who did not require long-term care. Meanwhile, primary and community care services evolved quite separately from the hospitals. (Greengross et al., 1999)

In 1911, David Lloyd George introduced the National Insurance Act, which legislated for a small amount to be deducted from an employee's wage in return for free healthcare. However, since this scheme only gave healthcare entitlements to employed individuals, efforts were made to launch a public healthcare system after the Second World War in which services were provided free at the point of need, financed from central taxation and everyone was eligible for care. A basic tripartite system was formed splitting the service into Hospital Services, Primary Care and Community Services. However, by 1974 there were concerns about problems due to the separation of the three primary areas of care, so drastic reorganisation efforts were implemented. Subsequently, the Thatcher years saw a restructuring of the management system, and finally in 1990, the National Health Service and Community Care Act was passed, which established independent Trusts to manage hospital care (Chang et al., 2015).

The state-owned industries in the United Kingdom were increasingly privatised during the 1980s under the Thatcher government which did not only extend to telecoms, transport, and utilities, but also the healthcare sector. The Public Private Partnership model has since allowed private companies to take over the running, at least in regard to non-clinical matters, and the ownership of NHS facilities. These new private providers have not been subjected to robust control to maintain accountability or high standards of quality. Harrington (2004) states that in order to maximize their returns, these private companies have cut back on staff and bed numbers. He argues that due to the partial private, contract-based delivery of healthcare, patients have begun to expect compensation where the treatment has been unsuccessful. The NHS Resolution (2023) report states that maternity compensation claims represent the highest value of clinical negligence claims. Two-thirds of the £13bn spent by the NHS in 2021-22 on negligence claims was related to maternity care. During the time period 2009-2020 a total of 6,914 successful compensation claims related to poor maternity care, costing more than £4 billion in compensation (Lintern, 2021).

Maternal Mortality and Health in the United Kingdom

The maternal mortality ratio in 2020-22 was 13.41 deaths per 100,000 live births. This is significantly higher than the maternal death rate of 8.79 deaths per 100,000 live births reported in the previous complete three-year period (ONS, 2023). Maternity services are provided by 136 NHS trusts in England. There are four broad types of settings for care in childbirth: at home, freestanding midwifery units, midwifery units and hospital obstetric units. Maternity services comprise approximately 1,970 consultants and 1,630 trainees working in the

Obstetrics and Gynaecology specialty in England. Data from the Health and Social Care Information Centre shows that in 2014 there were a total of 21,517 full time equivalent midwives working in maternity services based on a head count of 26,139 (National Maternity Review, 2016).

Research Participants: English Mothers in the United Kingdom

This section provides an overview of the English mothers in the United Kingdom as a research participant group. This research participant group is not entirely homogenous, however, the majority of the research participants interviewed in this research study in the United Kingdom were educated, white, heterosexual English mothers, with one or more children. However, to reflect the demographics of the London borough in which the mothers lived, a few mothers from other ethnic groups were also interviewed. Many of the residents in this London Borough were born in other parts of the world, so even though the majority of the mothers were English, some of the mothers were originally from outside London or even outside the United Kingdom.

The majority of English mothers in this research study gave birth at their local hospital which is a large district general hospital with more than a hundred beds. The hospital provides a full range of services, including emergency department, medical, surgery, critical care, and maternity services. The maternity department did not historically have a good reputation, as the Healthcare Commission's Review of Maternity Services found it provided inadequate training of its staff in core maternity skills, as well as failing to provide women-centred care, including the lack of choice of birth and lack of support for breastfeeding. Furthermore, several areas of poor performance were identified, which included poor integration of support workers, low data quality, insufficient involvement of obstetricians and midwives in antenatal care, untimely length of stay in hospital, and low levels of hygiene. Consequently, the hospital's Executive and Board agreed on an action plan to strengthen leadership and supervision, training, and stakeholder involvement. They agreed to reintroduce ward-based comments cards and become more responsive to comments and formal complaints. In 2019, the Care Quality Commission (CQC) report found that the maternity services at the hospital had moved up from "requires improvement" to "good."

A large proportion of the mothers interviewed in this research study could perhaps be described as a typical 'NCT mother.' Miller (1997) states that becoming a 'NCT mother' commonly

involves months of preparation, including attending costly National Childbirth Trust (NCT) classes, reading numerous books about childbirth, and listening to many comparative stories about other people's experiences of giving birth. Such mothers are more likely to choose a 'natural' childbirth without painkillers and insist on breastfeeding after birth. Even though they are too young to be called the 1960s generation, they have been influenced by feminism, so have often both attended university and have a period of employment before childbirth. In fact, most of the English mothers interviewed had similarly attended NCT classes, as well as pregnancy yoga and hypnobirthing classes. Furthermore, almost all of them had attended university and had a professional career. Most intended to have a 'natural' childbirth in a birth centre and hoped to breastfeed their infant. Finally, several of the mothers attended alternative medical treatments, such as acupuncture, osteopathy, and homoeopathy during pregnancy or after childbirth.

Several of the English mothers interviewed seemed to be influenced by the contemporary idea of 'intense mothering.' Hays (1996) argues that the idea of 'intensive mothering' has been dominating mothering in the West whereby the individual mother is responsible for child rearing, even when such child-rearing is labour-intensive, emotionally absorbing, and financially expensive, imposing unrealistic and unremunerated obligations and commitments on the individual mother. However, even though the English mothers were influenced by 'intense mothering' and were in some ways similar to the North London NCT mothers (Miller, 1997), there were also distinct differences, due to both their work commitments and ideological/political beliefs. Whereas several of the aforementioned North London mothers decided to stay home to look after their children after childbirth, most of the mothers in this research study either had to, or specifically chose to, return to work again. Furthermore, most of the English mothers interviewed in this research study could not afford to give birth at a private hospital, so in contrast to many North London mothers, had to have a 'public health childbirth.' Nonetheless, several of the first-time mothers would choose not to have a private birth, even if they could afford it, since they wanted to support the local hospital. The mothers, along with many of the other residents living in this London borough research site, appreciated the maternity ward at the hospital as it had been close to being closed down in the past.

All the research subjects had differing motivations for taking part in the research, some mothers were drawn by the perceived therapeutic effect of talking about their childbirth trauma, others felt they were contributing to academic research, some were simply hoping to meet other

mothers in the local area. In fact, it quickly became apparent that a large number of the mothers, who were interviewed in the focus groups, were hoping to bond with other mothers over their shared childbirth experiences, as well as finding new friends. Although several mothers enjoyed their maternity leave with their infants, some found themselves quite isolated without the social network that their work had previously provided them. Furthermore, a large majority of the mothers were not born locally and found themselves far away from childhood friends and family, so the focus group could perhaps be the starting point for new friendships. Finally, several of the mothers did take part in the research as they specifically hoped that their childbirth experiences and the resultant research could make childbirth better for future mothers.

Chapter Three

Human Rights Violations in Childbirth

This chapter provides an overview of the mothers' experiences of 'human rights violations' and 'wellbeing' in childbirth. Firstly, this chapter investigates the notions of 'violations' and 'wellbeing' in childbirth throughout history within their cultural context. Then this chapter investigates the mothers' own experiences of 'violations' in childbirth, as well as their perceptions of wellbeing in childbirth, in both research sites in Tanzania and the United Kingdom. The central focus of this chapter is to investigate whether the human rights-based approach to maternal mortality effectively captures the mothers' perceptions of 'violations' as well as their perceptions of 'wellbeing' in childbirth within their particular historical and cultural context. I consider whether the international human rights framework is equipped to deal with the power hierarchy integral to the biomedical context. Finally, the argument that the 'universalism' of the international human rights framework neglects the particular historical and cultural context of childbirth is explored.

Human Rights and 'Human Rights Violations' in Childbirth

The Universal Declaration of Human Rights (UDHR) was adopted by the UN General Assembly in 1948, legislating that "All human beings are born free and equal in dignity and rights." (Art. 1). However, since the UDHR is not legally binding, the process of drafting a legally binding instrument enshrining the rights of the UDHR started immediately afterwards. Initially, it was envisioned that there would be a single covenant, encompassing all the human rights, however, the ideological battle between the West and the Soviet Union bloc meant that the General Assembly eventually requested that two separate covenants be formulated. The International Covenant on Civil and Political Rights (ICCPR) outlined rights such as the right to participate in government and the prohibition of torture, whereas the International Covenant on Economic, Social and Cultural Rights (ICESCR) outlined social, economic, and cultural rights, such as the right to healthcare. Together with the Universal Declaration, the Covenants

are referred to as the International Bill of Human Rights. A series of international human rights treaties have since been adopted, which have all expanded the body of international human rights law. These include the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CTI), and the Convention on the Rights of Persons with Disabilities (CRPD), Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICMRW), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), among others (Smith, 2010). CEDAW protects a wide range of gender-based rights, including rights related to non-discrimination, gender-based stereotyping, prostitution, participation in public life, nationality, employment, education, health, economic and social benefits, special rights for rural women, equality before the law, and equality in marriage and family life.

A number of the international human rights treaties are relevant to protecting mothers in childbirth, including the ICCPR, ICESCR, ICERD, CEDAW, ICMRW, CTI and CRPD. The Maternity Charter draws upon the above human rights treaties, as well as regional human rights treaties including the African Charter on Human and People's Rights (African Charter), the African Charter on the Rights and Welfare of the Child (ACRWC), the American Convention on Human Rights (ACHR), and the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), to establish the rights of women before, during and after childbirth. Finally, there are a number of relevant, specialised human rights treaties, including the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, the Convention of Belem do Para, and the European Convention on Human Rights and Biomedicine. Thus, the Maternity Charter is anchored in international, as well as regional, human rights law.

The Maternity Charter firmly establishes that mothers have human rights in childbirth. Even though it ought to be self-evident that mothers should have human rights in childbirth, the arena of childbirth remains a 'battleground of opinion' (Harman, 2013). The discussion about childbirth issues often evokes an emotional debate about a 'natural' versus a 'biomedical' childbirth, a midwife-led childbirth at home versus a biomedical childbirth in a healthcare facility. As Hill states, "In spite of the huge appetite for positive change, there is still a huge amount of polarity in the childbirth world. Women versus the healthcare system. Midwives versus obstetricians. Holistic midwives versus obstetric midwives. Doulas versus doctors, among others" (2016, p.1). Thus, injecting human rights discourse into this childbirth debate, evokes even stronger emotional reactions, turning the childbirth arena into a 'childbirth

battlefield.' While Daviss and Davis-Floyd's (2021) celebrate the introduction of the notion of 'human rights violations' into the arena of childbirth, the obstetrician Tuteur (2016) reacts angrily towards the 'misappropriation of human rights language' for the purposes of childbirth, stating that such claims might jeopardise the relationship between mothers and healthcare workers in childbirth. Hence, the question as to when an event or an issue in childbirth can be categorised as a 'human rights violation' remains contested.

Wilson questions the whole category 'human rights violation' as the concept is constructed around state involvement, in opposition to the category of 'common crime' which is a problematic distinction in itself, since such binary categories are not always hermetically sealed, static, or universal but "overlapping and mutually constitutive" (1997, p.141). Indeed, there are epistemic and phenomenological issues to take into consideration when conceptualising 'human rights violations' in childbirth. As Shabot (2020) asks, in what sense are 'violations' actually violations when not even epistemically framed as such by its own victims? While Shabot ultimately frames particular events in childbirth as 'violations,' even if these are not conceptualised as such by the Western mothers themselves, von Hollen (2003) and Strong (2020) engage in cultural relativism to conceptualise human rights violations against non-Western mothers as merely 'maternal gestures' and 'fierce care' instead.

The anthropology of reproduction has revealed to us that perceptions of what exactly constitutes 'violations' and 'wellbeing' in childbirth is fluid, changing throughout history and according to cultural context (von Hollen, 2003). Childbirth is a biological event which occurs within a particular historical and cultural context which is complex and multi-faceted; how a woman experiences birth will depend on societal values, viewpoints, and her fundamental belief system. Ideas and beliefs about matters, such as family, traditions, rituals, health, technology, gender, women's rights, and professionalism, capitalism, power, risk, 'surveillance', the concept of 'good' and 'traumatic' births, 'good' and 'bad' mothers, as well as 'human rights violations' and 'wellbeing' in childbirth will all have a bearing on the expectation and experience of childbirth for individual women (child, 2012; Kingdon, 2009). Thus, the starting point for this chapter has been to ask the mothers themselves to explain what constitutes 'violations' and 'wellbeing' in childbirth to them and then investigate their perceptions in relation to universal human rights standards. This chapter is, however, not meant to assess the mothers' level of knowledge of the provisions enshrined in international human rights law, but rather to highlight the mothers' own perceptions of what constitutes 'wellbeing' in childbirth.

Part I: Human Rights Violations and Wellbeing during Childbirth in Tanzania

The first part of the chapter provides the historical background and cultural context to childbirth practices in Tanzania in order to explore how the notions of 'human rights violations,' 'violations,' and 'wellbeing' are perceived within their unique historical and cultural context. Then I present the ethnographic data on the Sukuma mothers' own experiences of violations and wellbeing in childbirth. The childbirth experiences are categorised according to the international human rights framework as the mothers' own perceptions of violations and wellbeing in childbirth are considered by reference to their particular socio-economic, political and cultural context.

The Historical Background and Cultural Context of Childbirth Practices in Tanzania

This first section provides a historical background to childbirth practices and cultural context of childbirth in Tanzania. Beginning with the 'traditional' childbirth practices before and during colonisation through to the 'modern' childbirth during decolonisation to current facility-based childbirths attended by skilled birth attendants. Finally, the idea of human rights in childbirth, as well as 'human rights violations' in childbirth is discussed within the cultural context of childbirth in Tanzania.

The Pre-Colonial/Traditional Childbirth

There are limited historical records about childbirth in pre-colonial Tanzania. Even though there are accounts from the exploration of East Africa by Europeans during 1848-76 which put Kilimanjaro and the great lakes of Tanzania on the map (Bridges, 1973), their accounts do not provide information about childbirth practices, as it was not considered a 'male area' of investigation. The female explorer Katherine Routledge travelled to East Africa where she described the traditional childbirth customs of the Kikuyu. Routledge states,

> The child on its birth is washed and oiled all over by the attendants. (The placenta is carried out into uncultivated land, and some grain strewn on the ground; grass is cut and placed over this, and on the placenta is laid – the whole is then covered with more grass and grain strewn around) The father is not present and does not see the child for a day or two. The infant is placed in seclusion for four days after the birth, and five days after that of a boy (1910, p.147).

The Kikuyu are however now located in present day Kenya, not Tanzania. There are similar ethnographic accounts from Theodor Meyer and D. R. Mackenzie about the childbirth in

Tanzania, however, they were both missionaries, so they provide limited insight into pre-colonial childbirth practices in Tanzania. Finally, it is important to consider that there are more than 120 ethnic groups in Tanzania, all with their own set of traditions and customs, so it is difficult to generalise and establish a consistent overview of traditional childbirth practices in pre-colonial Tanzania.

There are, however, numerous ethnocentric representations of the imagined pre-colonial 'traditional' African childbirth. On one hand, there is the derogatory colonial description of the 'native' childbirth as 'uncivilised' and 'dirty' with an emphasis upon racial difference reinforced by social Darwinist theory. An example of this can be found in a letter written in 1927 by a colonial officer in Tanzania, who states:

> At present a native women is delivered in almost complete darkness in suffocating smoke in a foetid atmosphere in indescribable filth in a kennel or a hut. She is surrounded by cattle and sheep and goats and attended by women covered with dried sweat and dirt and clad in stenching skins. Confinement and labor in such conditions are almost unbelievable and yet in normal cases women are delivered as easily as peas are shelled (Allen, 2002, p.28).

On the other hand, there is the idealistic, almost quixotic, description of the 'traditional' African childbirth, used as a representation of what a 'natural' childbirth should be, without any biomedical intervention. Dick-Read, who coined the term 'natural childbirth,' believed that the art of natural childbirth had been lost, except among 'primitive' African women, stating:

> The primitive knows that she will have little trouble when her child is born….Natural birth is all that she looks for; there are no fears in her mind; no midwives spoiling the natural process; she has no knowledge of the tragedies of sepsis, infection and haemorrhage. To have conceived is her joy; the ultimate result of her conception is her ambition (1933, p.86).

Even though there are no records of Dick-Read ever delivering any 'African' childbirths himself, he conceptualised the 'African' childbirth as a 'natural' childbirth for Western women to aspire to. Wall has criticised such representations, as it amounts to nothing short of Rousseau's idea of the 'noble savage' in 'natural' childbirth, stout of character and strong of body, untouched by the evils of technological medical intervention, to which their suffering Western sisters are so unhappily subjected (1995, p.181). In fact, Dick-Read even claimed that 'primitive' women who died in childbirth did so "without any sadness...realizing if they were not competent to produce children for the spirits of their fathers and for the ethnic group, they had no place in the tribe" (1933, p.196). Both these representations perhaps reveal more about the authors' own worldviews, than actual pre-colonial childbirth practices.

Interestingly, despite frequent representations of the 'African' childbirth as 'traditional' or 'natural,' free from technology and biomedical intervention, c-sections were already professionally performed from 1879 in Africa. R.W. Felkin reports how alcohol was used in Uganda to semi-intoxicate the mother and to cleanse his hands and her abdomen prior to surgery. He would use a midline incision and apply a cautery to minimize haemorrhaging. He massaged the uterus to make it contract but did not suture it, the abdominal wound was pinned with iron needles and dressed in a paste prepared from roots. The patient recovered well, and Felkin concluded that this technique was well-developed and had clearly been employed for a long time (Dunn, 1999). Similar reports were available from Rwanda, where botanical preparations were also used to anesthetize the patient and promote wound healing (Sewell, 1993).

The Missionary Childbirth

The first hospitals and clinics in Tanzania were missionary hospitals and clinics. The first physician working through the Church Mission Society Missions arrived in 1877 and the Catholic White Fathers established a hospital in 1888. These missions were responsible for training medical personal, bringing midwives and maternity services to the rural areas. However, the first doctors and clinics worked in the country with one simple aim: to keep as many of a its own alive as long as possible. The extension of these services, first to the Tanzanian members of the church, and thereafter to Tanzanians in the wider community, was a secondary consideration. (Jennings, 2008, pp.42-43). Vaughan argues that direct evangelisation during medical work was rarely put into practice, since there was not enough time to do so. However, the concrete healing of the body ultimately took second place to the winning of the soul and the fight against the 'evils' of African society. For the missionary, she argues, if illness was the result of sin, much of it was perceived to stem from the 'evils' of traditional society. Suffering and sin were inseparable in medical missionary discourse and was nowhere more apparent than in the field of midwifery and childbirth. Disease, for the missionary, was essentially a social phenomenon, not merely pathological, affecting the individual who had been corrupted by sin (1991, pp.65-66). Hence, disease or death in childbirth for the missionary, was often perceived as a direct result of the 'failure of motherhood' (Allman, 1994, p.25).

Childbirth to missionary medicine, Dreier explains, was somewhat ontologically challenging, as childbirth was not a disease or about repairing a broken part of the body. Instead of a singular

medical focus on childbirth, the missionaries instead embraced the full mission of ‘making mothers’ of the Tanzanian women, ‘educating’ them in nutrition, hygiene, and infant care. The idea of ‘making mothers’ was infused with Christian imagery of motherhood. As a figure and role mother, Virgin Mary personified the ‘motherlike’ virtues of piety, purity, submissiveness, and domesticity. Missions generally felt that by 'making mothers' they were liberating women from the oppression of polygamous marriage, indiscriminate divorce, and exploitative agricultural labour. Finally, missions also tried to 'protect’ women from their husbands' pressure to seek medical services from local 'charlatans' (2019, pp.153-154). Bruchhausen explains that the missionaries ultimately believed that the Tanzanian mothers were a risk to their own infants, especially in regard to nutrition. In 1891, Dr Pruen of the British Church Missionary Society stated,

> It is always a surprise to me how babies in Africa could stand the treatment to which they were subjected. They are fed from birth upwards upon gruel in addition to their natural food. On theoretical grounds the majority of them should die from gastric irritation; but such does not appear to be the case, and most survive this utter neglect of the rules of physiology and dietetics. (2003, p.94)

Linking infant mortality to ‘inadequate’ nutrition implied that it was the mothers themselves who were to blame for the morbidity or mortality of their infants. However, even though these missionaries correctly reported that it was often the grandmothers that had to feed the infants whilst the mothers were in the fields – they failed to mention that it was the colonial hut tax that forced mothers to spend more time in their fields to grow additional cash crops, effectively forcing them away from their infants. For the colonial powers, taxing colonised populations in cash was a popular means of raising revenue and ensuring labour contributions to the overall colonial production. Similarly, these missionaries failed to consider that many Tanzanian mothers could not bathe their children daily due to the lack of water, nonetheless, continued to preach to Tanzanian mothers about the importance of hygiene – ‘cleanliness is next to godliness’ (2003, pp.94-100).

Childbirth ‘in the bush’ was, according to the missionaries, a ‘difficult and dangerous affair,’ as the life of both the pregnant mother and the unborn baby was in danger. The elder women who assisted with the childbirth came to symbolise the ‘evil’ that the missionaries were opposing in their work. Christian missionaries saw the elder women as the “repository of all that was dark and evil in African culture and social practices” (Vaughan, 1991, p.23), and therefore regarded with suspicion many of the local practices surrounding childbirth, initiation, and fertility. Early accounts of the ‘darkness’ of the birthing hut was positioned against the

white sheets of the missionary maternity ward. This was a place where mothers could give birth without 'heathen' elder women and where 'peace and cleanliness' reigned.

The Colonial Childbirth

Tanzania was colonised by Germany from 1880 to 1919 and subsequently colonised by the British from 1919 to 1961. The German colonial administration in German East Africa became particularly interested in questions of population and reproduction as a result of the Maji Maji War.[2] Consequently, they focused on the problem of 'under-population' and on the health of their subjects in order on secure a workforce of able-bodied men. Healthcare was extended to mothers so that they could give birth to healthy infants which ultimately would contribute to a larger workforce. German colonial administrators and healthcare workers assessed the childbirth-related practices they encountered, and categorised some practices as 'functional,' others as 'inappropriate,' but most of all, they noted 'deficiencies' in obstetric care. Hence, German obstetricians introduced the supine position, a widely accepted practice in Germany at the time in order to further 'improve' childcare and childbirth practices. Finally, it was suggested that the number of German medical doctors and midwives should be increased, nursing and midwifery training should be offered, more healthcare facilities should be built, and the influence of the 'pagan' beliefs should be eliminated through Christianity (Bendix, 2016, pp.99-159).

The fear of 'underpopulation' did not disappear with the end of German colonial rule in East Africa but rolled over as important an issue for the British colonial powers (Bruchhausen, 2006). The British colonial powers initiated a drive between 1921 and 1928 towards maternal and child health care to grow a large enough workforce to ensure economic development. Maternal and child welfare was perceived as a tool that might promote this, as the British colonial powers associated low levels of population with high levels of maternal and infant mortality (Jennings, 2006). Allen (2002) explains that following the Tanganyika Medical Report in 1921, the British Medical Administration focused on eliminating 'cultural superstitions' and practices surrounding childbirth, as well educating mothers in proper

[2] The Maji Maji war was an uprising in 1905 which spread over a considerable portion of south-eastern Tanganyika and was not finally suppressed until 1907. It led to a reappraisal of German policy in East Africa. The imperial government had attempted to protect African land rights in 1895 but had failed in its objective in the Kilimanjaro area. Similarly, liberal labour legislation had not been properly implemented. The German government set up a separate Colonial Department in 1907, and more money was invested in East Africa. A more liberal form of administration rapidly replaced the previous semi military system.

nutrition and sanitation practices in an effort to prevent infant mortality. By the end of the 1930s, women were increasingly comfortable with the notion of giving birth in healthcare facilities. So much so, that the Tanganyika Medical Report 1927-1938 reported an increase of total recorded healthcare facility births from 507 in 1927 to 3.532 at healthcare facilities across the country. It was a number of successful medical achievements, as well as the increased awareness about risks in childbirth, which helped promote trust, and therefore encouraged an increased number of pregnant women to give birth in healthcare facilities, rather than at home. However, this 'success' was mainly derived from the long-standing mission hospitals, as it remained difficult to encourage women to give birth in government healthcare facilities. The missions had often been attached to local communities for years before they introduced their healthcare facilities to pregnant women. Furthermore, the missions often spent much time to build trust and acceptance from their local communities, while offering education, health and evangelical services through a holistic vision encompassing both bodily and spiritual wellbeing (Miltenburg, 2018, p.17). By the mid-1940s, women had become quite amenable to the notion of maternity care in healthcare facilities "so amenable, in fact, that many maternity clinics in the Territory were experiencing overcrowding." (Allen, 2002, p.29). Consequently, during the early 1950s, due to economic constraints, the British colonial powers instead promoted a shift away from the hospital and towards training of village midwives to provide services at home in rural areas (ibid).

The Independence Childbirth

Following independence in 1963, President Nyerere and the Government of Tanzania invested heavily in public healthcare provision in rural areas as part of its *Ujamaa* development programme. *Ujamaa* roughly translates from Swahili as 'familyhood' with an socialist ideology based on Tanzania's precolonial past in which people were perceived as living and producing crops communally, at the same time as it was seen as a model for Tanzania's future development (Gooding, 2019). The first Maternal and Child Health Plan was launched in 1974, paying special attention to integrated services for women and children, through a chain of dispensaries and health centres. By 1978, around 90 percent of the population was situated at a distance of no more than 10 km from a public health clinic. Furthermore, a large number of rural health workers were trained to provide maternal and child health services in rural areas. As a result, there were substantial improvements, as maternal mortality decreased from 453 per 100,000 in 1961 to 167 per 100,000 in 1985 (Shija et al., 2011).

Due to Tanzania's economic recession in the 1970s and 1980s, the International Monetary Fund (IMF) and the World Bank instituted structural adjustment policies, which among others things led to reduced spending for the health sector (Tingire, 2016). Tanzania consequently witnessed the pursuit of economic growth through market liberalisation and the curtailing of state intervention, such as public healthcare delivery and welfare safety nets. The core of the neoliberal vision is the idea that markets freed from government interference can allocate resources in the best and most efficient way and thereby promote common goods, including healthcare (Coburn, 2000). For most Tanzanians, however, this led to worsened living conditions as real incomes declined, meanwhile healthcare services deteriorated (Lees, 2021). Private medical practice was reintroduced in 1991, cost sharing (user fees) was introduced in 1993, and community health funds (local insurance schemes) were established in 2001 (Lambin and Nyyssölä, 2022).

The Traditional Birth Attendant Childbirth

The first official training of Traditional Birth Attendants (TBAs) began in the 1970s, when the WHO described the TBAs:

> They are often part of the local community, culture, and traditions, and continue to have high social standing in many places, exerting considerable influence on local health practices. With the support of the formal health system, these indigenous practitioners can become important allies in organising efforts to improve the health of the community. (WHO, 1978, p.63)

According to Langwick, the concept of TBAs - *wakunga wa jadi* - did not exist in Tanzania before the 1970s. In fact, even though the Alma Ata declaration in 1978 recommended training TBAs in 'low-income' countries, the Government of Tanzania did not initially accept it, because this strategy was perceived as straining the already limited resources available to improve healthcare. However, the government was forced to adopt the structural adjustment policies, so the Ministry of Health eventually complied and the first TBAs were as a result recruited and trained in 1985 (2011, p.38). At first, the TBAs were perceived as respectful to local childbirth cultures on the one hand, meanwhile providing a link to the formal biomedical health sector on the other hand (Sibley and Sipe, 2006). However, despite some good evaluations of TBAs initially, specialists began to express their doubts about their effectiveness, since it was difficult to identify exactly whom to train and how to introduce new practices into existing routines (Fleming, 1994; Dehne et al. 1995; Bergstrom and Goodburn, 2001; Carlough and McCall, 2005). Consequently, the current WHO recommendation for

skilled attendance at childbirth (including doctors, midwives or nurses) explicitly excludes TBAs (WHO, 2004) and the Government of Tanzania has, consequently, banned TBAs from assisting mothers during childbirth (Pfeiffer and Mwaipopo, 2013).

Current Priorities in Maternal Health

In 2000, in line with the promotion of the MDGs, the Tanzanian government developed the National Package for Essential Interventions with specific attention for reproductive and child health. The follow up document, Reproductive and Child Health Strategy 2005-2010, included action on implementation of focused antenatal care, skilled care during birth (moving away from training of TBAs), obstetric emergencies, postpartum care, and family planning, as well as attention for prevention of harmful practices (such as FGM). During this time, other policy guidelines integrated elements of relevance for provision of maternal health services, focusing on health system strengthening, including attention for human resources, quality improvement and procurement of essential supplies and medicine. The National Road Map Strategic Plan to Accelerate Reduction of Maternal and Newborn Mortality in 2006, followed by the One Plan (2008-2015), the Sharpened One Plan II (2015-2020) guided policy direction for maternal health in Tanzania throughout the past decade and remain important in reference to the current state of maternal health (Miltenburg, 2018).

The mid-term review of the 'One Plan' by the Ministry of Health and Social Welfare in 2014 revealed an increase in the number of facilities across the country offering maternal health services, however, the shortages of healthcare workers and supply stock-outs compromised the quality of care. The report mentions that 'cross-cutting bottlenecks (...) include mismatch between policies/guidelines and implementation with gaps in accountability, inadequate resources, medicines, safe blood supplies and other essential commodities, equipment and infrastructure to support quality of services. In 2016, the One Plan II outlines renewed commitment of the government to maternal health and aimed to promote, facilitate and support in an integrated manner, the provision of comprehensive, high impact and cost-effective maternal healthcare services, "along the continuum of care, to accelerate reduction of maternal, newborn and child morbidities and mortality" (MoHCDEC, p.24). In 2021, the One Plan III was introduced, building on the foundation of the One Plan II. Quality of care continues to be the central focus of One Plan III, however, instead of a sole focus on improving the access to healthcare services, the emphasis has shifted to "targeting each individual client in a holistic manner" (MoHCDEC, p.34).

The Sukuma Mothers' Experiences of Violations and Wellbeing in Childbirth

The following part of the chapter constitutes the first set of ethnographic data from my fieldwork in Tanzania. First, the Sukuma mothers' childbirth preparations as well considerations in regard to what constitutes wellbeing in childbirth is presented. Secondly, the mothers' childbirth experiences are categorised according to the Maternity Charter to explore whether these correspond to the Sukuma mothers' experiences of what constitutes violations and wellbeing during childbirth.

The Sukuma Mothers' Preparations and Perceptions of Childbirth

Childbirth among the Sukuma has traditionally been considered a normal event and not believed to require any specialist knowledge as such but done home alone (Reid, 1969). During my fieldwork however, I found that most of the first-time pregnant Sukuma women I interviewed were planning to give birth in a healthcare facility, rather than giving birth at home. The first point of entry for low-risk pregnant women in Tanzania into the public maternal health system is the community-level dispensary, where they can receive examinations, seek advice from a clinical officer or a nurse, and gain access to medicines, medical supplies, and immunization services, if available. Some dispensaries are equipped for childbirth, however, for more comprehensive services or to consult a medical doctor, women must visit a health centre. The health centres serve several communities and typically offer a broader range of services than the dispensaries. Women who arrive at dispensaries or health centres with more complicated cases are sent to the district hospital or regional referral hospitals. Particularly challenging cases may be sent to one of a handful of specialised national referral hospitals in Dar es Salaam. (Center for Strategic and International Studies, 2015).

Exploring the decision-making process with regard to the choice of childbirth location with the research participants during the in-depth interviews revealed that advice was initially sought from their own mothers or aunties, or friends who had children already, but they also sought advice from their antenatal midwives and 'biomedical' information sources. The mothers in this study tended to take advice from relatives who had given birth in a hospital, where this advice was backed up by knowledge of 'biomedical experts.' In contrast, the relatives who had given birth at home did not seem to successfully influence their choice of childbirth location as there was a sense among the mothers in this study that knowledge about

the ‘safest’ childbirth had moved on since previous generations. For the majority of mothers in this study, ‘biomedical experts’ and medical doctors constituted trusted sources of information, relied upon by the mothers to dispense objective, accurate and scientific information about childbirth and how to manage risk in childbirth. The hospital was therefore perceived as the safest option. A Sukuma mother, Sungulwa, explained,

> *Naturally we want to give birth in hospital, because this is dunia ya kisasa (modern times). When you are born and grown up in the city, close to a hospital, then it is easy to get to a hospital. And we all know that it is the most safe to give birth in hospital.*

Orwa et al. (2019) have found that more mothers with a secondary school education in Tanzania gave birth in healthcare facilities compared to mothers without. They argue that the educated mothers were more willing to seek healthcare as their education has provided them information about the benefits from doing so. Furthermore, since these mothers have greater employment opportunities in urban areas, they are more likely to live in urban areas where they have access to health facilities.

When I asked the ‘disadvantaged’ and uneducated mothers in the focus group whether they were planning to give birth in hospital, many of the mothers would look at me and laugh as if it was a silly question, and answer that it was because it was now *dunia ya kisasa* (modern times). Some of the first-time mothers highlighted that they had chosen hospital to give birth, since it was perceived to be the safest birth location in the case of an emergency. In fact, it proved at first a bit difficult to find an urban-based mother who had given birth at home. We eventually met with a young, Muslim mother, Khaleda, who was whiling to talk about her homebirth. She lived in a big house full of domestic staff, who ran around preparing the house and garden to set up in preparation for Eid celebrations. We ended up sitting outside in her car, as she did not want her family to know about the interview. Before the interview even started, she spent a lot of time explaining, and positioning herself as a ‘modern’ and ‘educated’ woman. She explained during the interview that she would have never normally considered a homebirth, as she was not tha kind of ‘traditional’ person to have a homebirth. Khaleda explained,

> *It was during the time of the demonstrations…All the medical staff were demonstrating about their low wages, so I couldn’t give birth at hospital. I had to find a solution, so I contracted a childbirth helper. She was an old kind lady, who really helped me during*

> *labour, so it was a good childbirth. But I was embarrassed about giving birth at home. You know I have passed the secondary school exam, and now I have a good job at an airline company selling tickets there, so I am not the kind of woman that gives birth at home, I am educated and I know that I am safer in a hospital because there are nurses and doctors there.*

Several of the mothers spent a lot of time trying to position themselves as 'modern,' even if they had not completed secondary school, they would refer to the fact that they lived in a big, modern city, distinguishing themselves from the *washamba* (peasant) women – the peasant women who lived in rural areas and had never even been to school. These mothers would conceptualise *washamba* women, as 'backward' and 'uneducated' women, the kind of peasant women would give birth at home in a mud hut.

The idea that childbirth in hospital is the more 'modern' choice might to some extent be derived from the global biopolitical push to encourage mothers in low- and middle-income countries to giving birth in a healthcare facility attended by skilled birth attendants (MacDonald, 2013). There has been a strong national push to encourage mothers to give birth with skilled birth attendants both from the government and NGO sector in Tanzania (Saiboko, 2012). However, even before that, the British colonial authorities, had initially recommended that all pregnant women give birth in healthcare facilities overseen by skilled birth attendants (until the maternity wards became too crowded to effectively deal with the demand), which again a goal within the fields of international development and global maternal health (and again there is a problem with overcrowded maternity wards). Nonetheless, most of the first-time mothers in Tanzania did not simply parrot global maternal health discourse, since they had mothers, aunts and even grandmothers who had given birth in hospital. In fact, some of the oldest mothers interviewed in Tanzania discussed their biomedical childbirth choice with an affection of sorts, as if such choice embodied the vision of the former President Nyerere – bringing healthcare to everyone. As a Sukuma grandmother, Masele stated,

> *After our independence, it was the vision of Mwalimu to declare war on disease. Meanwhile Iddi Amin was killing his own people in Uganda, our Mwalimu wanted to help heal his people – us. And it helped, we could go to a clinic to give birth, so we no longer had to worry about our babies dying in childbirth, like we had experienced too many times in the past.*

Culture and traditional beliefs among the Sukuma mothers interviewed did not seem to prevent them from giving birth in hospital. Whilst some of the Born-Again Christian mothers denounced *uchawi* (witchcraft), many of the other Sukuma mothers in this research study both used traditional medicine and, at the same time, chose to give birth in clinic or hospital. Traditional medicine and healers among the Sukuma have been described by many (Brandstom, 1990; Bukurura, 1994; Wijsen and Tanner, 2002; Hinkkanen, 2009). Reid explains that the Sukuma believe that everyone is born with a *nzoka* in the stomach and that sickness can be avoided if the *nzoka* is properly accommodated. The *nzoka* will start to grumble and growl, if food is disagreeable, and if one eats the food anyway, the *nzoka* will have to vomit, making the person feel sick (1969, pp.131-136). Hinkkanen (2009) explains that the *nzoka ja kukinda* is connected to a sharp, piercing pain in the woman's lower back which causes the foetus to abort, and an untreated *nzoka ja buhale* (snake blocking the conception) is believed to cause 'a pregnancy that has gone to the back' and will not return until traditional medicine has been administered. If left untreated for too long, the *nzoka ja buhale* may lead to permanent infertility. Apart from the *nzoka*, Allen (2002) explains that many Sukuma believe that *uchawi* (witchcraft/sorcery) is another cause of fertility problems. She explains that *uchawi* is believed to be done by either blood relatives, envious neighbours, co-wives, past lovers, or former husbands. However, *uchawi* was only believed to be the cause if the woman has given birth before, or else her infertility could also be attributed to 'God's will' or that she had simply been born that way (pp. 139-140).

Allen (2002) has highlighted the socio-economic and cultural importance of fertility among the Sukuma, which Hinkkanen also links to ancestor worship among the Sukuma/Nyamwezi. She explains that infertility is a problem because a childless a woman will never become an ancestor, since the requirement for ancestorhood is for one to have grandchildren who will remember her as an ancestor. As she states, "As a sign of the deceased person's childlessness, no stone (s-n. shigo) will mark his or her grave and she/he will have no one who will remember him or her after death" (2009, p.63). Likewise, the problem of infertility was also a key concern for the Sukuma mothers in my research study. As a Sukuma mother, Ruth, explained she had been unable to conceive for a long time before her first birth, so she consulted her traditional healer to help her. Ruth stated,

> *You know, at the end of the day, children are the most important in life. But trying, and waiting, and waiting, and I got just got tired of waiting. So, I consulted the old lady*

(traditional healer), who said that we should think about the nzoka in your stomach, and you know, I did feel like I had had trouble with my nzoka in my stomach, so then we talked about what medicine to take to calm my nzoka in my stomach, so I would hopefully get pregnant quickly. Yes, you know, I am happy now that the medicine worked, so we now we finally have happiness.

Stroeken explains that both the traditional healers and their clients are used to a certain degree of failure, "when the ancestor's wrath was too deep or the witch's schemes too clever to counteract" (2012, p. 127). Despite the risk of failure, several of the Sukuma mothers described their healers as supportive and helpful during the times of heightened anxiety, such as during pregnancy, but also in the postpartum period. In contrast to the healthcare workers in hospital who were just with her in childbirth, Ruth stated, the healer supported her throughout her whole childbirth journey. Correspondingly, Stoller describes the supportive role of the healer among the Songhay. As Stoller highlights,

> Among the Songhay, the healer, who has the time and symbolic stature to inspire confidence, guides the client through the illness. The healer holds your hand and walks you through the twists and curves of the village of the sick. The healer attempts to set the world straight so that you might return to the village of the healthy (2004, p.56).

Childbirth can self-evidently not be categorised as an illness, however, the traditional healer, in a similar manner to Stoller's Songhay healer, took Ruth's hand, guiding her through the childbirth journey to arrive at the village of motherhood.

The Sukuma Mothers' Experiences of Violations in Childbirth

The following section highlights the ethnographic data from my fieldwork in Tanzania in which the Sukuma mothers highlighted elements of 'violations' during their childbirth. The research conducted for this thesis was as aforementioned not designed as an attempt to measure compliance with international human rights norms, nor to assess the mothers' level of knowledge of legal provisions enshrined in international human rights law. However, it was important to reveal whether the mothers constructed 'violations' in line with the international human rights framework, hence, the following section is categorised along these lines. For clarity, international human rights law was never the focus during the interviews, instead the mothers could freely discuss their childbirth experiences, as well as their childbirth journey. The Sukuma mothers experiences of 'violations' in childbirth were as follows:

i) Harm and Ill Treatment

Everyone has the right to be free from harm and ill treatment under Article 1 of the Maternity Charter. The right is anchored in the idea that the healthcare workers should not be allowed to physically hurt the mother nor her newborn. It emphasises that the mother and her infant should be taken care of in a gentle and compassionate way, and receive assistance when experiencing pain or discomfort. However, the majority of the Sukuma mothers in this research study described frequent experiences of violence, including hitting, pinching, slapping, and pushing, as well as disrespectful behaviour including shouting, berating, and threatening language. As Shida highlighted,

> *I got bad treatment from the nurses in all of my childbirths. They shout at you, they hit you, they push you, they ignore you. They shout at you if you do something, and they shout at you if you don't do anything. And the worst part it, they don't attend to you even when something goes wrong, they just blame you for it all going wrong.*

Human rights violations in childbirth in Tanzania are reported to be widespread, as women and their families have described disrespect and abuse (D&A) in childbirth, including physical abuse (beating, slapping and pinching), lack of consent for care, non-confidential care (e.g. lack of physical privacy or sharing of confidential information), undignified care (e.g. shouting, scolding and demeaning comments), abandonment (e.g. being left alone during delivery), as well as discrimination on the basis of ethnicity, age, or wealth (McMahon et al., 2014; Sando et al, 2016; Kruk et al., 2018; Mselle et al., 2019; Shimoda et al., 2020; Das et al., 2021).

Freedman et al. (2018) explains that physical abuse is prohibited by professional ethical rules in Tanzania, however, it has become accepted among healthcare workers to be physical with mothers during the second stage of labour, especially slapping on the inner thighs, as a way to deal with so-called 'non-compliant' behaviour. This physical exercise of power over mothers is often reinforced by verbally berating them with warnings that their behaviour (when not obeying orders) will kill the baby. Such actions have become routine behaviour across the healthcare system in Tanzania (Allen, 2002; Freedman et al., 2018; Strong, 2020) – what Sardan calls practical norms, "the various informal rules, tacit or latent, that underpin those practices of public actors which do not conform to formal professional or bureaucratic norms" (2014, p.29). As Freedman explains, it becomes both routine and unremarkable (normal) and a

pattern of behaviour (a norm) that functions in practice, informally, to enable the physical actions of health workers. Healthcare facilities, like any other organisations, develop cultures and microcultures that display (and allow) particular patterns of thought and practice (ibid). Thus, as Napier et al. state, "Without concerted efforts to explore, understand and challenge the interplay of overt and covert beliefs at work within organizational cultures, counterproductive biases and behaviours can persist" (2014, p.1).

Strong (2020) differentiates between 'fierce care' and the structural reasons for abusive care in the healthcare facilities in Tanzania. She describes 'fierce care' as a tool for the healthcare workers, which involves hitting the mothers during childbirth and telling them they are killing their babies, to ensure that mothers have a safe childbirth. The structural reasons for abusive care, however, is the local reality that the healthcare workers face every day, attempting to provide mothers with the access to a biomedical childbirth despite the consistent lack of resources. Furthermore, Strong describes how the nurse-midwives are weighed down by 'biobureaucracy' The anthropologist Matthew Kohrman (2005) uses the term 'biobureaucracy' to describe the growth of institutions that have emerged to advance the healthcare of ill bodies, and their associated policies, programmes, research, guidelines, etc. In the words of the nurse-midwife Martha,

> There are a lot of things that cause that state. The first thing entirely is the frustration she has (poor living conditions, low wages)…..Another thing is the harassment that she has gotten coming from the administration: maybe a person has a problem, she has gone there and encountered bad language from the administration: and she has transferred it to the patient. (Strong, 2020, p.85)

Strong describes how stressful the working environment is for the nurse-midwives, who are weighed down by 'biobureaucracy' whilst caught up as an intermediary between hospital administration and taking care of mothers in childbirth. In this connection, Gluckman (1949) provides an in-depth analysis of the village headmen in British Central Africa, which sheds some light onto the difficult dilemma of intermediaries – who take orders from above whilst accommodating the needs from those below. During British colonial rule, the village headman undertook an administrative role to report suspicious deaths, illness, and strangers, and to make sure that the residents kept the village clean. Hence, in his official role he reported to his superiors, whilst at the same time was expected by the villagers to represent, even though these were seldomly accepted by the colonial regime. Similarly, Strong argues that there is a global and national biopolitical push for women in Tanzania to give birth in healthcare facilities, yet there are not enough healthcare workers or resources to accommodate this in practice, hence,

the healthcare workers become struck in the middle as intermediaries, under pressure from both sides. Similarly, von Hollen describes comparable power dynamics in her ethnography about childbirth in South India where nurse-midwives and medical support staff (*ayahs*) were under immense pressure from top management, and as a result took their stress and frustration out on the most disadvantaged and uneducated mothers, taking advantage of the power accrued by the biomedical healthcare context. She stipulates that because the *ayahs* come from a similar class and cast background as these mothers, they were more inclined to resort to abuse and disrespect to establish social distance and authority. Comparably, Strong highlights that the target was mostly the mothers who looked poor or uneducated, whereby "the nurses might use derogatory language as a way of reminding her of the distance in their social positions and their resultant access to authority and power" (2020, p.86).

ii) Lack of Information and Informed Consent

The Maternity Charter states that mothers have the right to information, informed consent, and respect for their choices and preferences, including companion of choice in childbirth and the right to refuse of any medical procedure. Furthermore, the information should be provided in a manner and language that is understandable, accessible, and appropriate to the needs of the individual mother making the decision. Nevertheless, most of the Sukuma mothers in this research study stated that the health workers rarely provided information or asked for their consent. As a Sukuma mother, Mandwa, described,

> *My baby was the wrong way around, but the nurses never told me this was the case, instead they just kept on telling me to push and push and push. It was only when the doctor came, he told me, and then he turned my baby around and pulled it out. I would have liked the nurses to tell me that the baby was the wrong way around, then I would not have been so scared.*

Several of the Sukuma mothers in this study also said that various things were done to them without the healthcare workers asking for consent or providing information about the procedure. Since the mothers were not given any consent forms to sign or any information about the procedure, it was difficult to establish exactly what was done, and assess whether the medical interventions were necessary or even to blame for subsequent medical emergencies during childbirth. Some of the mothers interviewed seemed to suggest that the healthcare

provider administrated an IV oxytocin drip into them without providing any information or asking for their consent. A Kuria mother, Gati stated,

> *After I arrived at hospital the nurses inserted a drip into my arm. I don't know what it was as no one told me what it was, I just assumed that it was necessary. But my contractions became a lot faster after that drip, so the birth was over with very quickly.*

Some of the mothers interviewed seemed to suggest that the IV oxytocin was administrated to them because the healthcare workers wanted the birth quickly over with, so they would vacate their bed as quickly as possible. Shimoda et al. (2018) have found that some healthcare workers in Tanzania do not follow the oxytocin instructions and instead administer doses that increase the risk for dangerously strong uterine contractions. There are risks associated with using IV oxytocin to stimulate contractions, Boie et al. explain that these include contractions that are too long or too frequent (uterine hyperstimulation), which can lead to changes in the baby's heart rate and therefore the need for emergency caesarean (2018, p. 3). Nonetheless, it was difficult to know what exactly was in the IV drip inserted into the mother, since the healthcare workers did not provide information or ask the mother for consent.

iii) Lack of Privacy and Confidentiality

Everyone has the right to privacy and confidentiality under Article III of the Maternity Charter. This means that healthcare workers are not allowed to share the mothers' personal or medical information, including all records and images, without consent. However, most of the Sukuma mothers in this study stated that there was no privacy, as they could easily be seen or heard by others due to the lack of partitions. Moreover, the treatments administered could also readily be seen, and their personal information was occasionally discussed in front of others. Potential consequences from healthcare workers discussing their health status, as we know that the AIDS/HIV status of women within a healthcare context, as well in wider society, can lead to stigma (Vanable et al., 2006). Furthermore, some of the mothers described how medical students had been present when they gave birth, even though they had not been informed of it beforehand or given their consent but had instead gathered this from the conversations that they had over her head. Nonetheless, most of the mothers interviewed did not raise the lack of

privacy or confidentially as an issue of concern, but just framed it as something that was 'normal' within a healthcare setting.

iv) Disrespectful and Non-Dignified Childbirth Care

Every woman has the right to be treated with dignity and respect. Hence, no one is allowed to humiliate, verbally abuse, speak about or touch the mother in a degrading or disrespectful manner. However, the majority of mothers described frequent experiences of disrespectful and undignified treatment at the hands of the healthcare workers. A Muslim, and mother of nine children, Viyana recalled,

> *From the time I entered the hospital I was made to feel unwelcome, there was just hostility. They never greeted me. They were just busy talking to each other at the nurse station. They ignored my cries for help, so I in the end I had to give birth on the dirty floor. Once I was finished giving birth, a nurse came canc started shouting at me, ordering me to clean up after myself.*

The hostility and lack of hospitality by the healthcare workers seems to be at odds with the social expectations in Tanzania, where being hospitable and welcoming to guests is generally perceived as a paramount value (Fourshey, 2012). As Allen (2002) observes, she was received well as a guest by the healthcare workers in the healthcare facility during her fieldwork, since *wageni* (guests) are generally treated with respect in Tanzania. However, as d'Alessandro has observed in her ethnographic study, the healthcare facility was converted into the healthcare workers' social, privatised space, so the patients were perceived as intruders, making the healthcare facility fundamentally inhospitable for them. Sardan states that the common bureaucratic culture rooted in the colonial administration has encouraged healthcare workers to see the maternity ward as their space and the anonymous client, in particular the mother who has no pre-existing connection via kinship networks or social connections to the health workers, as "a nuisance, an inferior and a victim all rolled into one" (2015, p.418). In the same way, mothers are not perceived as *wageni* in healthcare facilities in Tanzania but instead treated with hostility.

Some of the mothers in this research study stated that there was one thing worse than being treated with hostility and disrespect by the healthcare workers which was to be completely ignored during childbirth. A Muha mother, Grace stated,

> *My first childbirth was terrible, I was crying and begging the nurses for help, but they told me, "Keep quiet!" and just left me alone. Only when the medical doctor came by, did I get help with delivering my baby.*
>
> *It was the same with my second childbirth, the nurses only arrived when this head was already out. After my birth I was totally covered in blood, and because I was so weak, I did not have the strength to even wash myself. The nurses did not care that I was totally covered in blood and did not help.*

Mselle et al. (2013) state that lack of equipment and high number of mothers per healthcare provider are all reasons why healthcare services are poor in Tanzania. Healthcare workers have reported how the shortage of resources has had an impact on their ability to care for women during childbirth, as they always have to prioritise high-risk women, which means that low-risk mothers are left alone in childbirth. The heavy workload of healthcare workers was recognised by most of the Sukuma mothers in my study, however, many highlighted that the reason they were abandoned in childbirth was not always because of too much work but sometimes because of *uzembe* (laziness). A Sukuma mother, Selema stated,

> *Yes, I feel sorry for those who are working hard, but they are not always working hard. During my childbirth I was left alone in labour, I could see them right there - just chatting – ignoring me on purpose. Even when I cried out for them to help me, they just ignored me, as if I was not even worthy of their attention. It was not because of too much work - uzembe.*

Similarly, Allan argues that it is not always due to heavy workloads that mothers in her study were abandoned by healthcare workers during childbirth. She states,

> …it isn't always because the nurses are overworked. I've observed births where at least five nurses are sitting around a table laughing and joking and virtually ignoring the laboring woman, maybe once or twice calling out to her to quit crying and making so much noise" (2002, p.189)

Several of the Sukuma mothers interviewed for this research study recognised that healthcare workers were overworked and that the healthcare facilities were under-resourced. Furthermore, several of them also recognised that when their childbirth constituted a genuine medical emergency, then the healthcare providers might 'not in the right state of mind,' so could not be blamed for disrespectful or even abusive behaviour. However, since so many of the mothers had more than one childbirth experience, they had personal experiences of inattentive or abusive healthcare workers when there were no medical emergencies and when the wards were less busy. Thus, even though the mothers did not specifically highlight their *'haki za binadamu'* (human rights) in childbirth, they emphasised that the humiliation of them at the hands of the healthcare workers was unjustified.

v) Discrimination and Inequality

According to the Maternity Charter, everyone has the right to equality and freedom from discrimination. Equality requires that pregnant women have the same protections under the law as they would when they are not pregnant. However, several of the Sukuma mothers interviewed for this research study described the prejudice they had experienced at the hands of healthcare workers. A young Sukuma mother described how she felt discriminated against by healthcare workers due to her young age when she became pregnant. Kabisi recalled,

> *My first pregnancy, I became pregnant in secondary school, and therefore unfortunately had to drop out of school…..When I went to the hospital to get advice about my pregnancy, the nurses mocked me and lectured about me about my foolishness of getting pregnant when I was young and was still in school.*
>
> *I had to return to the same hospital when I was nine months pregnant because I could only feel very few movements inside my tummy, but when I tried to tell them, I was just ignored by the nurses, but I was scared that my baby would die inside my tummy…. Then I could not feel any movements, so I went back to them, and I told them that I could not feel the baby moving. But again, they did not listen, they did not want to listen. So, they just sent me away.*
>
> *My baby was born stillborn.*

Tanzania adopted a discriminatory ban in 2017 which prohibited young pregnant girls from continuing their education in public schools. School officials would conduct mandatory pregnancy tests and routinely expel pregnant students. The requirement that they drop out of school, often also prohibited their return to school after they had given birth. The ban, and its associated negative discourse about pregnant students, has without doubt influenced some of the healthcare workers discriminatory behaviour against young pregnant women. However, after the death of the former President Magufuli, the Ministry of Education fortunately announced that the girls, who had dropped out of school because of pregnancy, could return to school.

The Bowser and Hill (2010) report highlights that healthcare provider prejudice exists in many healthcare facilities which plays out as discriminatory behaviour against certain sub-groups of mothers based on race, age, HIV status, socio-economic and educational status, and ethnicity. However, none of the Sukuma mothers in this study reported any discrimination based on ethnicity or tribal affiliation. This, however, prompted me to begin the process of epistemologically questioning whether the mothers themselves would know whether they were discriminated against due to their ethnicity or tribal affiliation. Strong (2020) describes in great detail how some healthcare workers at the Mawingu Regional Hospital in Tanzania would discriminate against the minority ethnic groups who spoke Swahili less fluently. Similarly, Mtuy et al. (2022) highlight how many Maasai women in Tanzania have experienced discrimination during their antenatal visits, as healthcare workers would punish them for attending clinics late, by serving them last, charging them for free services or even hitting them. Thus, I tried enquiring about discrimination in a different way, asking whether there was positive discrimination based upon ethnicity or tribal affiliation, such as being Sukuma, however, this was dismissed entirely by some mothers with loud laughter. In the words of a Sukuma mother of five children, Kanana:

> *In all of my childbirths I have had one bad experience after the other because of bad treatment from the nurses. They ignore you and are rude to you….Then when your vagina tears afterwards, they do not stich you up or provide you with any medicine for pain relief, they just tell you to go buy a Coca Cola and tell you that will help.*
>
> *(Mother laughs loudly – an indication of my question being very silly)*

It does not help you if the nurse is Sukuma or from any other tribe or if you are Sukuma or you are from her tribe.

Similarly, several of the mothers stated there was no discrimination based upon religion. The aforementioned Muslim mother, Viyana, stated that the healthcare workers' 'bad treatment' had nothing to do with religion. Again, I began the process of epistemologically questioning whether the mothers themselves would know whether they were discriminated against due to their religion. Nonetheless, the consistent answer from the Muslim mothers in this study was that they did not feel discriminated against due to their Muslim faith. The Muslim mother, Fatima stated,

I gave birth in hospital. It was an awful experience…I would call the nurses for help, but they completely abandoned me in labour. I felt like a ghost, because nobody saw me and nobody wanted to see me or hear me……Only after my baby was born did the nurse arrive and cut the umbilical cord….I got bad treatment not because I am Muslim, they did not even know I was Muslim, and even if they did, they would not care.

However, a young Born-Again Christian mother, Kashindye, interviewed in Sengerema described the positive discrimination that she experienced due to her religious affiliation. Even though one would expect she would have experienced some sort of discrimination due to her young age and low social status, the fact that she knew her nurse-midwife through her church probably resulted in a positive childbirth experience. Kashindye recalled,

I was very lucky to have a good childbirth. I think I was very lucky that my nurse that attended to me in my childbirth turned out to be a woman that I knew from church, she is a Born-Again Christian just like myself, and I think therefore she looks on me as a friend.

Allen similarly found, during her fieldwork in Tanzania, that the mothers who knew the nurses personally would be treated in a better way during childbirth. She states, "the atmosphere on the ward was less hostile when the nurses knew the birthing woman personally, either as friend, neighbour or relative" (2002, p.197). Freedman et al. (2018) explains that even though such positive discrimination is not framed as a human rights violation as such, this favouritism can

be considered unequal treatment. She states that favouritism is rife in the healthcare system in Tanzania, as those with kinship networks or other social connections get preferential treatment, including access to scare commodities, such as medicine.

None of the Tanzania mothers in this study described any discrimination by healthcare workers in relation to HIV/AIDS status. This was probably because I took special care during my interviews not to stigmatise any mothers by asking them directly about their HIV/AIDS status – so it would only have been noted if self-identified by the mothers themselves, and none of the mothers did so. Instead, it was highlighted by some of the healthcare workers themselves as a valid reason for discrimination. A nurse-midwife I interviewed justified her poor treatment of disadvantaged, 'uneducated' mothers by labelling them as *mshamba* (peasant) and as potentially HIV/AIDS positive. The nurse-midwife Jackie stated

> *Then that mshamba woman comes into the hospital with absolutely nothing. They are supposed to bring plastic gloves. But she does not bring plastic gloves or anything, so what am I supposed to do? Then I have to use a plastic bag instead of gloves when examining those women and when delivering their babies. But this is not good for me, because they are so dirty, for all I could know, they could have AIDS, and they could give that to me.*

Bremnes et al. (2018) state that the nurse-midwives in their study from Tanzania constantly reported their fear of getting infected with hepatitis, HIV or TB due to the lack of protective equipment. They were convinced that if they had better and more available equipment, they would feel safer. More advanced equipment would also make it possible for them to monitor and follow-up patients more adequately and make it easier to determine which patients need their help the most. In fact, a study by Ndikom and Onibokun (2007) found that factors that influence behaviour were mainly fear of contagion, as well as irregular supply of resources like gloves and water. Further, Grellier's study on nurse-midwives' knowledge of HIV virus found that even though nurse-midwives are trained and provided with the technical knowledge about HIV, "it does not necessarily equip them to deal with many of the underlying issues, which in turn reflect on midwifery practice" (1995, pp.190–193). Unfortunately, most of the healthcare workers interviewed in Tanzania stated that they often did not have access to basic protective covering, such as plastic gloves or clean water to wash their hands.

There was consistent discrimination reported by the most disadvantaged and uneducated mothers in this study. Several of the mothers described the disrespect and contempt they had experienced at the hands of the healthcare workers during their childbirth. Allen has also highlighted that the educational and socio-economic status of the mothers in her study seemed to influence the healthcare workers' conduct toward them. As she recalls,

> During the twenty-two months of my fieldwork, I had ample opportunity to observe interactions between patients, their family members, and hospital staff. It soon became clear that different categories of people were treated differently. People who appeared educated, or those who were assumed to have wealth, such as the Arab members of the community or myself, received better treatment. Those without these symbols of modernity or who didn't know the proper way to behave in the modern setting of the hospital or clinic encountered many problems. Even though they had physically arrived at the hospital, they still did not have access to its resources (or to a limited extent only). They often had no negotiating power at all and… were often scolded and assumed to be ignorant. Nurses, on the other hand, garbed in their white uniforms and nurses' caps, served as the representatives of modernity and functioned as gatekeepers who decided who would be admitted hassle-free to the maternity ward. (2002, p.197).

There was often no effort made to hide this kind of discrimination by some of the healthcare workers in the little maternity clinic in Tanzania which I had been fundraising for. As a general rule the *washamba* mothers who arrived on bare feet were dismissed, whereas the mothers with fancy shoes were attended to, with a smile. Von Hollen describes the dilemma for such disadvantaged, uneducated mothers, as they are told to give birth in healthcare facility in order to be 'modern,' but upon entering the healthcare facility they were perceived as 'traditional,' and as a result dehumanised - *the other* - treated with condescension and disrespect because of their 'backward' status and their 'unmodern' practices.

Mead (1934) argues that our identities are created through our ongoing social interaction with others, as well as through our self-reflection about who we think we are in relation to these social exchanges, hence, our identity/social identity is dependent on others. Following on this, Beauvoir argued that women have always been positioned as 'the other' in relation to men. She states,

> She is defined and differentiated with reference to a man and not he with reference to her; she is the incidental, the inessential as opposed to the essential. He is the Subject, he is the Absolute – she is 'the Other' (1945, p.5).

Arendt (1963) describes how Jews were constructed as 'the other' - *the Untermensch* - during the Second World War. She explains how the dehumanisation process follows particular steps, whereby one first loses the right to have rights, then one's moral personhood, and finally one's

individuality. Likewise, Said (1978) uses the concept of 'orientalism' to describe how the West has constructed the Middle East, Asia, and Northern Africa as the 'Orient' as 'the other' to the West. Said argues that the West has been constructed as a 'superior,' hegemonic power in contrast to the inferior, less rational and exotic 'Orient.' Historically, Kronfeldner (2021) explains that the dehumanisation of 'the other' has often involved categorically denying some human beings membership in the humankind or in a graded form. The targets (whether as individuals or groups) often overlap with the targets of racism, sexism, classism, ageism, and meritocracy but has, more recently, broadened beyond the traditional focus on gender, races, and classes, to include refugees (Esses et al., 2001), disabled people (Capozza et al., 2016), LGBT persons (Fasoli et al., 2016), patients within healthcare settings (Luna et al., 2019), and disadvantaged mothers in childbirth (this research study).

vi) Lack of High-Quality Childbirth Care

Every woman has the right to healthcare, and no one is allowed to prevent this, according to the Maternity Charter. Even though I was not able to interview the mothers who have sadly passed away, I was able to interview a few mothers who had lost their infants in childbirth. Some of these mothers described the loss of their infant due to medical emergencies, but others described the death of their infants in childbirth a direct consequence of 'unhelpful' and 'untimely' healthcare providers. The first mother I interviewed in Tanzania, Bititi, was convinced that even though the death of her infant was due to a medical emergency, it was in part attributable to the fact that the healthcare workers had intentionally ignored her. Bititi recalled,

> *There were complications during my second pregnancy, so I rushed to my local clinic…..I could feel something was not right, because it felt wrong compared to my first birth, and then blood started flushing out of my vagina, so I was scared of dying and rushed to the clinic for help……I was crying for help, but the nurses did not come to help me. I could see through the window that they were just sitting there and watching TV. They decided not to help. Instead, a stranger helped me and tried to stop the bleeding, but couldn't, so he went to get a nurse, but it was too late, my baby was dead by that time.*

This childbirth experience was tragic for the mother, as she had to live with the pain of this loss every day.

The most depressing childbirth story, which I was told during my fieldwork in Tanzania, was told by Jelaa, who had been left infertile after her infant had died during her first (and last) childbirth. Initially, we talked to her niece, who lived in the same compound as her, but she came over to us after that interview had finished and asked us if I could interview her in person. Sometimes I would bring my boys along to interviews, so they could play with the children of the mothers I interviewed, but I remember thinking how grateful I was that I had not done so that day, feeling sudden guilt to have children when she had none. At first, I was hesitant to interview her as I had not planned to include childless mothers in my study, because they were categorised as too vulnerable to interview. Nonetheless, she insisted on being interviewed by me, so it would have been rude if I did not accommodate her request as a guest in her family's home. Before the interview began, she invited me into the house to have tea, with plenty of sugar. Then she took out a number of medical documents, including ultrasounds, and showed them to me, indicating that I could see from the documents that she was infertile. She then proceeded to tell us about her mismanaged childbirth. First, she had been ignored by the healthcare workers, then she had been scolded by them when trying to inform them of her deteriorating condition, and finally, they seemed not to know what they were doing during the emergency caesarean. After her birth, they all seemed to be indifferent to fact that her infant boy was dead and failed to inform her that the caesarean had left her infertile. She was particularly saddened by the fact that they had been so indifferent to the impact that had on her life; consequences that had destroyed the rest of her life.

After returning home, she tried for some years to get pregnant again but was never successful. First, her husband and his family thought witchcraft was to blame, so they repeatedly locked her in the house, rarely letting her out. Only after meeting with numerous traditional healers, and then medical doctors, it eventually became clear to her and her husband that she would never be able to have any children. As a result, her husband divorced her and she had to return to live with her parents. According to Sukuma customary law, her father had to return the bride wealth, so that her husband was able to take on a new wife, which left her new household considerably poorer. After her parents died, she had to go and live with her sister. Not only did she feel like a burden to her sister and her family but she was frequently accused by people in her new community of being jealous of other women because she was *ngumba* (barren), leading to her even being accused of witchcraft, while others regarded her as

bringing bad luck, and therefore shunning her. After I finished my tea, she looked at me and told me that being a childless mother is the greatest grief there is.

The Sukuma Mothers' Perceptions of Wellbeing in Childbirth

The above section has focused on the various 'violations' that the Sukuma mothers recalled having experienced during childbirth. Even though the majority of the mothers interviewed in Tanzania identified various human rights violations in their childbirth, a few of the mother could also describe positive childbirth experiences and could also identify what constituted 'wellbeing' in childbirth to them. The following list highlights the ideas of 'wellbeing' in childbirth for the Sukuma mothers.

i) Healthcare Workers, Medical Equipment and Medicine

When I asked the mothers at the end of the interview what they wished for which could have made their childbirths better, the majority highlighted that they wanted to be treated with kindness and stated that the healthcare facilities needed more healthcare workers, medical equipment, and free medicine. These mothers wanted competent healthcare workers, "who knew what they were doing" so that their infants remained safe, and their reproductive abilities remained intact. These mothers highlighted not only their fear of losing their infant in childbirth, but their fear of being left infertile after a medical procedure. Several of the mothers stated that they could endure the disrespect and abuse at the hands of healthcare workers but needed there to be healthcare workers to look after them. As a Chagga mother, Mary stated,

> *What is the point of going to a clinic when there are no doctors, no nurses, no medicine? At the end of the day, I will only have real happiness when I give birth in a hospital with good doctors, so I don't get messed up inside, when the medicine is there, when the equipment is there, so I can finally go home with my baby without worry.*

As mentioned beforehand, Tanzania suffers a major healthcare worker shortage. The total shortage of healthcare workers across healthcare facilities was estimated to be 56 percent in 2014, the shortage was in particular acute in district hospitals and dispensaries. It is estimated

that to achieve a 80 percent coverage rate for childbirths, assisted by a skilled birth attendant, there should be at least 25 healthcare workers per 10,000 persons. In Tanzania, even if all the healthcare workers were combined, the density would be less than 50 percent of the minimum required (Miltenburg, 2018).

ii) Childbirth Support

Many of the Sukuma mothers in this research study stated that they would have liked to have better support during childbirth, and if this could not be provided by healthcare workers, then they would have liked a family member to accompany them in childbirth. Chaote et al. explain that there have been some concerns about privacy, crowding in the maternity ward and introduction of infection, so birth companions have not been allowed in Tanzania (2021, pp.2-3). However, several studies have found that birth companions provide mothers with informational, practical, and emotional support and can serve as advocates for women (Bohren et al., 2017; Bohren et al., 2019). Chaote et al. did a pilot project in Kigoma, Tanzania, where mothers were allowed birth companions during childbirth. The mothers reported that they found that the birth companion improved their childbirth experience and, when the birth companions talked about their own role, they stated that it may have affected the healthcare workers treatment of the mothers, as they served as "witnesses to healthcare providers' behaviour and being advocates for women's rights and wishes" (2021, p.15). Similarly, several of the mothers interviewed stated that they would like to have a birth companion during birth, because a birth companion could help with emotional support during childbirth, but perhaps even more importantly, they could secure attention from healthcare workers in cases of emergencies, as well as provide them with water and food which they felt was hard to access during extended stays in healthcare facilities.

iii) Wellbeing and Support during the Childbirth Journey

After childbirth, many of the Sukuma mothers in this research study were privileged to have support from family members at home. Whilst the majority of the mothers felt disrespected and violated during their childbirth, they were happy to recall how their female family members were there to help heal physically and emotionally afterwards. As the Sukuma mother, Munde recalled, "I am happy that despite what happens in hospital, that you can finally go home afterwards, and then your aunties come to help, and we can talk, and they can help with the

housework." In fact, most of the mothers with very young infants had a relative next to them during the entire interview. In the case of Grace, who was visibly still upset about her childbirth, I was about to end the interview early, as I was worried that I might re-traumatise her by talking about her childbirth but then her sister began answering on her behalf, and she nodded affirmatively, when the information was conveyed accurately. Eventually, I began talking to her sister about her childbirth instead, and luckily, she could provide me with an example of a positive childbirth experience, with lots of care and attention, which had taken place in a rural clinic outside our urban setting.

Often, the mothers also received support from their extended family and wider kinship network. A few days after childbirth, when the stump of the umbilical cord has fallen off, it is customary for Sukuma mothers to have their infant celebrated within their wider kinship network. Traditionally, the father would name the infant in the *kufunya ng'wana* ritual. The celebration of *kufunya ng'wana* was accompanied by dramatic enactments - if the infant was a boy, men would perform acts of hunting or building, and if it was a girl, they would enact cooking or cleaning the pots. However, the father might hold off giving the infant a name, if previous infants had died in childbirth, since in the absence of a true name, evil spirits cannot maintain their hold over the infant (Schonenberger, 1995). Several of the mothers interviewed in Tanzania described the great joy and wellbeing derived from celebrating their infant's arrival with their extended family.

iv) The Childbirth Experience vs Life Circumstances

A large number of mothers interviewed in Tanzania were too concerned about their day-to-day life circumstances to think about their wellbeing in childbirth, let alone bring their human rights claims to court. If the mother and infant had survived childbirth and were healthy, the mother often had to quickly move on to daily concerns, including employment, housing, land, child custody, and education for their children. This was especially the case for the mothers who were heads of their household after the death of, or divorce from, their husbands. As a Sukuma mother, Kadala explained,

> *I go every day to the market and sell mandazi (doughnut), but it is not enough to feed all my children, to buy them all clothes, and pay for school uniforms: it is simply not enough, but what can I do? I have to keep on going!*

As mentioned previously, the market-based land policies in Tanzania region have pushed many Sukuma men out of their landholdings which in turn has resulted in many Sukuma women have becoming the heads of their households – pushing them into low-waged employment and petty trade. Even though this has provided many Sukuma women with access to an independent income, the low-waged employment and petty trade is often not enough to provide for their households. Furthermore, with divorce or the death of their husbands, several of the Sukuma woman are consequently faced the customary stripping of their assets and land (more about this in Chapter Five). As a Sukuma mother, Bertha stated,

> *When I was divorced from my husband, he took everything from me, and his relatives even came to help him take everything. They even claimed my little shamba (field) where I grew vegetables to feed my family, and to sell at the market, to buy clothes for my family. I was left with nothing. I tried to go to the elders but that was no help to me,*

Magongo and Corta (2011) state that without access to land, the low-waged employment and petty trade is often not enough for Sukuma women to support themselves and their households. It is, therefore understandable, that many of the Tanzania mothers focused on achieving long-term wellbeing for themselves and their children, rather than focusing on the momentarily childbirth experience.

Part I Summary: The Sukuma Mothers' Perceptions in Childbirth

The first part of the chapter presented the ethnographic data from Tanzania which found that the majority of Sukuma mothers, especially the first-time mothers, initially preferred to have a 'biomedical' childbirth in a healthcare facility. In relation to childbirth experiences, the data seems to suggest that the majority of the mothers had experienced human rights violations in childbirth, including: i) harm and ill treatment; ii) lack of information and informed consent; iii) lack of privacy and confidentiality; iv) disrespect and indignity; v) discrimination; and vi) lack of access to high-quality healthcare. Some of these were not conceptualised as 'human rights violations' but instead considered 'normal' such as the lack of privacy and confidentiality. Even though several of the mothers in this research study recognised that healthcare workers were probably overworked and under-resourced, many of the mothers

highlighted that the way in which healthcare workers sometimes disrespected, or even humiliated them, was unjustified.

The ethnographic data found that the majority of first-time Sukuma mothers hoped to have a biomedical childbirth in a hospital, because that was perceived as a 'safe' childbirth. However, many were faced with a different reality when giving birth in the healthcare facility as they experienced events which can be categorised as 'human rights violations' according to the Maternity Charter and conceptualised as 'undignified' and 'unjustified' by the mothers themselves. Even though some mothers described their positive childbirth experiences, this was mostly if they could draw upon their social connections or kinship networks or were deemed sufficiently 'high-status' by the healthcare workers. As Strong (2020) argues, healthcare facilities in Tanzania are currently being promoted as the only safe place for birth, so the high demand for a biomedical childbirth is deeply misaligned with the resources available, whether material, temporal, and affective. Hence, despite the geopolitical push to ensure that mothers give birth in healthcare facilities believed to lead to an overall reduction in maternal mortality (Filippi et al., 2006; Wendland, 2016; Danielsen, 2017), my ethnographic research found that the wellbeing of the most disadvantaged and uneducated mothers were not always guaranteed in the healthcare facilities. Rather, many of the most disadvantaged mothers in this research study reported that the healthcare workers intentionally avoided them, and even worse, made them the main target for disrespectful and undignified treatment.

Part II: Human Rights Violations and Wellbeing during Childbirth in the United Kingdom

The second part of the chapter provides the historical background to childbirth practices in the United Kingdom in order to establish how the notions of 'human rights' and 'human rights violations' are perceived within their historical, political and cultural context. I then present the ethnographic data on the English mothers' own experiences of violations and wellbeing in childbirth. The childbirth experiences are categorised according to the international human rights framework, but the mothers' own perceptions of violations and wellbeing in childbirth sit within their particular socio-economic and cultural context.

The Historical Background and Cultural Context of Childbirth Practices in the United Kingdom

This section outlines the historical background and cultural context of childbirth practices in the United Kingdom, beginning with childbirth practices during the industrial revolution, through to the increase in hospital births during the Second World War, the 'modern' childbirth to the revival of the 'natural' childbirth in the 1970s, and extending to debates surrounding 'natural' vs. 'biomedical' childbirths in hospital. Finally, the current maternal health priorities are outlined and the idea of human rights in childbirth is discussed.

The Industrial Childbirth.

Historically, childbirth was only attended by other women who might have been friends or relatives with childbirth experience. Once in attendance, these women would assist not onlywith the birth, but also with the care of the mother and infant postpartum. Subsequently, the mother would have a lying-in period for a month, which ended with a churching ceremony, marking the return of the mother to public life (Cassidy, 2006). The middle of the eighteenth century saw a shift from childbirth as a home-based event to a hospital-based event with the establishment of the first 'lying-in' hospitals (Squire, 2009, p.183). However, it was mostly the 'indigent' or unmarried mothers that would use them, as middle- and upper-class women continued to give birth at home. In fact, many of the lying-in hospitals were operated much like reform schools, as swearing, smoking, and drinking was prohibited. Women would be expelled for having lice or being rude, and their activities, such as eating, and sleeping were strictly scheduled (Cassidy, 2006). Cody highlights that the bureaucratic rules, clock-watching, and mandated acts of deference made the choice to deliver in a lying-in hospital appear as an unappealing and irrational choice. However, when lying-in hospitals are placed in the wider context of what was an extremely hierarchical and economically polarised society with high maternal mortality rates, impoverished women must have come such hospitals believing that they were improving their prospects. Working class women during the industrialisation were used to cramped conditions both at work and at home, so the lying-in hospitals could be perceived as both spacious and materially rich places. Cody states:

> At the British Lying-in Hospital, mothers were given petticoats and gowns during their stay, and their infants received two clean dresses per week on Sundays and Thursdays, a rare luxury for the poor….The hospitals offered women the traditional post-labor fortified caudle, gruel, and mutton broth, but for most of their lying-in they were offered meat, cheese, milk, porridge, plain caudles…..a varied and wholesome diet that exceeded the

> standards of many poor Georgians who rarely could afford meat other than fat bacon (2006, p.323).

Loudon states that, nevertheless, the lying-in hospitals had appalling mortality rates due to recurrent epidemics, including puerperal fever. She highlights,

> By choosing delivery in a lying-in hospital, women (although they seldom knew it) were exposing themselves to a risk of dying that was many times higher than it would have been if they had stayed at home in the worst of slums and been attended in their birth by no one except family and an untrained midwife. The lying-in hospitals were such a disaster that, in retrospect, it would have been better if they had never been established before the introduction of antisepsis in the 1880s (2000, p.59).

Cody states that the lying-in hospitals transformed the experience of childbirth in a different way, not so much by 'medicalising' birth through the use of forceps, nor by replacing female midwives with male-midwives in routine deliveries but by dramatically and immediately altering the epidemiological landscape. Approximately forty women were housed together for nearly a month each, because ten women were admitted and discharged weekly, so each new mother actually cohabitated with approximately seventy other women during her stay. She states, "These seventy women and seventy children, housed together in the same building, created a perfect opportunity for any disease introduced by a doctor, midwife, visitor, or mother to spread rapidly" (2004, p.38). In fact, after Florence Nightingale opened a lying-in hospital, she promptly closed it again as infection quickly swept through the wards and several mothers died as a result (McIntosh, 2017, p.41).

The 'Modern' Biomedical Childbirth

The twentieth century saw the greatest and most rapid advances in obstetric medicine and reproductive technology. In 1948, the newly established NHS assumed the responsibility for the health of everyone, including mothers and their infants. Due to the Second World War, many mothers no longer had proper homes in which to give birth, so they started giving birth in hospitals instead. By the 1950s, the debate shifted to encompass not just the physical setting of birth, home or hospital, but a host of ideas about risk and safety, as well as the management of maternity services under the NHS. The consensus among obstetricians was that the physical safety of mother and infant was the primary goal of the maternity services. This was best achieved, they argued, in hospital, where obstetricians could oversee the childbirth (Squire, 2009). In 1956, the Guillebaud inquiry found a 'state of confusion' in maternity services and a thorough review was subsequently initiated. Consequently, the Cranbrook report was published in 1959, recommending that 70 percent of all births take place in hospital. McIntosh explains

that the shift from home to hospital births was due to the overall technocratic belief in the greater safety of hospital births. The mothers themselves also wanted to give birth in hospital, so they had access to new reproductive technologies, such as foetal monitoring. However, the reality of their experience was often different from what they had imagined, and women found themselves "left alone in labour, and encouraged to accept interventions that they did not necessarily want or need" (2012, p.158).

In the 1960s, the hospital began to be heavily criticised as a site of childbirth, because mothers increasingly began describing their traumatic childbirth experiences. Sally Willington, who established the Association for Improvements in the Maternity Services (AIMS), complained about her childbirth in hospital, in a letter to the newspaper,

> In hospital, as a matter of course presumably, mothers put up with loneliness, lack of sympathy, lack of privacy, lack of consideration, poor food, unlikely visiting hours, callousness, regimentation, lack of instruction, lack of rest, deprivation of the new baby, stupidly rigid routines, rudeness, a complete disregard of mental care or the personality of the mother. Our maternity hospitals are often unhappy places with memories of unhappy experiences (Davis, 2013, p.114)

Similarly, Davis provides a collection of historical childbirth experiences from the 1950 to the 1960s, whereby many mothers felt that their 'biomedical' childbirth was akin to a giving birth in a factory. One mother recalled how all the mothers were waiting in rows in trolleys along the corridors before being taken into the delivery room, "just one in a sort of sausage machine" (2012, p.91). Hence, by the end of the 1960s, some mothers were increasingly disenchanted by the 'medicalisation' of childbirth or the so-called 'biomedical' birth, so began to demand control over their bodies, their experiences of childbirth, the location of births, and their choice of birth partners (Parry, 2008, p.788)

The 'Natural' vs. Biomedical Childbirth

The 1970s became characterised by rapidly developing technology and medicine for childbirth, which emphasised the role of the obstetrician on the one hand, yet a return to more 'natural' values on the other hand. The Peel Committee proposed in 1970 that the maternity services should no longer offer home births, instead advising a move to 100 percent hospital delivery and asserting that "the greater safety of hospital confinement for mother and child justifies this objective" (Davis, 2013, p.60). In opposition, an alternative 'natural' childbirth movement was forming that encouraged partner-assisted, intervention-free childbirth, assisted by midwives

rather than obstetricians, with childbirth taking place at home rather than in hospitals (Inhorn, 2006, p.357). This 'natural' childbirth movement was influenced by Dick-Read (1933) who believed that there should be minimal surgical and anaesthetic interventions during childbirth. Dick-Read argued that extreme pain during childbirth resulted from muscular tension caused by fear; pregnant women should therefore learn about the birth process and about breathing techniques and exercises to aid relaxation as a means of reducing their tension. Dr Fernand Lamaze introduced the 'Read Method,' later known as the 'Lamaze Method,' using distraction techniques to aid relaxation. Both men argued that the move of focus from the woman's 'objectified body' to her 'subjective state of mind' would help the birthing process (Cosslet, 1991, p.9). Dick-Read's theories also influenced Marie Mongan in the United States (US) to establish hypnobirthing courses, in which trainers train women to guide their bodies into a state of relaxation during childbirth. Finally, Prunella Briance launched the Natural Childbirth Association in the United Kingdom, heavily influenced by Dick-Read's theories, which later became the National Childbirth Trust (NCT) in 1961. The purpose of the NCT was to advocate for natural childbirth and began in the 1960s to lobby the Government of the United Kingdom, calling for "the rigorous assessment of new technology and an end to the overuse of interventionist techniques" (NCT, 2018). The NCT has since spearheaded the 'natural' childbirth campaign in the United Kingdom.

The 'Normal' Childbirth vs Women's Choices in Childbirth

During the 1990s, the 'natural' childbirth discourse spread beyond the small groups of campaigners and childbirth educators in the UK to policy papers and reports. That began with Lady Cumberlege, the Parliamentary Under Secretary of State for Health, conducting a review of maternity services. The resulting report Changing Childbirth (1994) insisted that maternity care should become more woman-centred, and that choice, continuity and control should inform maternity services. The report appeared, on the surface at least, to legitimise what advocates of 'natural' childbirth, or so-called natural childbirth activists, had said for decades, that the 'biomedical' childbirth was to the detriment of the mother. Nonetheless, the report did not promote the 'natural' childbirth ideology, but rather the right of mothers to choose the kind of childbirth they wanted. This was obviously a conundrum for the natural childbirth activists, as mothers could choose an elective caesarean (Raphael, 2010, p.348). In response, the natural childbirth activists highlighted the 'overuse' of caesarean sections as a 'global concern' - the solution was evidently that more mothers should have a 'normal' birth instead.

In 1999, the Maternity Care Working Party (MCWG) was set up by the NCT to raise awareness of the public health implications of rising caesareans rates, as well as to campaign for improvements in maternity care. The MCWG consisted of the NCT, AIMs, the Royal College of Midwives (RCM), the Royal College of Obstetricians and Gynaecologists (RCOG) and the Nursing and Midwifery Council (NMC). Meanwhile the WHO recommended that the caesarean rate should be between 10 to 15 percent, the MCWG highlighted that one in four maternity services had a caesarean rate between 20 percent and 29.9 percent (Carter, 1999). The rise in caesarean rates 'warranted urgent action' because the outcomes of a caesarean was often traumatic for the mothers. An additional conference was held where it was highlighted that greater efforts should be made to promote the concept of 'normal' childbirth, and that midwives and obstetricians should work together to achieve the goal of 'normalising' birth. Finally, the MCWP agreed the document "Making Normal Birth a Reality" which described a 'normal' childbirth, as "an unassisted vaginal birth without induction of labour, epidural or general anaesthetic, forceps or episiotomy" (Maternity Care Working Party, 2007). In 2005, the RCM launched the 'Campaign for Normal Birth,' stating that a policy of maximising 'normal' childbirth in the context of maternal choice was safe, and furthermore, that it offered short- and long-term benefits to mothers (Posser et al., 2018).

The Normal Birth campaign began facing criticism in the wake of the maternity scandal at the Morecambe Bay NHS Trust in 2015. The Morecambe Bay investigation found that the maternity services at the Furness General Hospital (FGH) were dysfunctional, as the clinical competence was substandard and that the midwives pursued 'normal' childbirth 'at any cost,' which led to the avoidable deaths of 11 babies and one mother (Kirkup, 2015. p.183). Consequently, the RCM dropped its Normal Birth campaign in 2017, but faced renewed criticism after the maternity scandal at the Shrewsbury and Telford Hospital NHS Trust. The Ockenden review of the maternity services found that more than 200 deaths of infants and mothers were avoidable, because midwives had been preoccupied with hitting the target of a low caesarean rate. Consequently, the Ockenden report recommended that midwives stop using total caesarean section percentages as a metric for maternity services in their attempt to achieve 'natural' childbirths (Ockenden, 2022).

The English Mothers' Experiences of Violations and Wellbeing in Childbirth

The following part of the chapter constitutes the first set of ethnographic data from my fieldwork among English mothers in the United Kingdom. First, the English mothers' childbirth preparations and considerations are presented, together with their perceptions of what constitutes wellbeing in childbirth. Secondly, the ethnographic data presents the mothers' experiences of 'violations' and 'wellbeing 'during childbirth in the United Kingdom. The childbirth experiences are categorised according to the international human rights framework, whereas the mothers' perception of 'wellbeing 'in childbirth should be situated within their own particular socio-economic, political, and cultural context.

The English Mothers' Childbirth Perceptions and Preparations in the United Kingdom

Women in the United Kingdom are offered the option of choosing whether a midwife or an obstetrician would care for them throughout their pregnancy and childbirth, as well as their place of birth, at home, a birth centre or hospital. The majority of the first-time mothers interviewed in the United Kingdom planned to have a midwife-led 'natural' childbirth in the birth centre at their local hospital. The birth centre was perceived as more comfortable and homely than the ward in the hospital but was still considered safe, as it forms part of the hospital maternity unit, with access to obstetric, neonatal, and anaesthetic care if necessary. In fact, several of these first-time mothers had done extensive research or discussed it in their NCT groups, proposing that the birth centre might be the best place for their 'natural' childbirth. Some of the first-time mothers had also attended additional antenatal classes and hypnobirthing classes, which had a similar emphasis on practising pain management skills, including positioning and breathing, as part of a curriculum which supported 'natural' birth and 'empowered' couples to make informed choices, which they felt helped them corroborate their choice.

The majority of the mothers interviewed for this study in the United Kingdom gave birth at their local hospital, however, some of them instead gave birth at hospitals at locations across London. Several of the first-time mothers had taken tours of the newly refurbished birth centre at their local hospital before their childbirth and described it as a 'homely' and 'humanistic' place, the access to alternative birthing aids, such a birthing stools and balls. Research has

found that birth centres are associated with beneficial outcomes for mothers (Overgaard et al., 2011; Sutcliffe et al., 2012; Scarf et al., 2018) and their experiences are often reported as positive when they were cared for by midwives in birth centres (Overgaard et al., 2012; Macfarlane et al., 2014). In fact, many of the mothers in this study who had had a straightforward pregnancy and who went on to have a midwife-led 'natural' childbirth at the birth centre, described it as the 'perfect childbirth.' As an English mother, Rose recalled,

> *When I gave birth there, I was not let down, as the midwives were wonderful and supportive, and helped me through the birth, and basically tucked me into bed after it was all done, and I felt so safe and supported. It was really a perfect birth.*

Even though many of the first-time mothers were confident about giving birth in a birth centre, they were reluctant to give birth at home. Here, narratives of 'risk' and the importance of having 'medical experts' nearby prevailed. An English mother, Edith explained,

> *I have considered home birth, as its… more homely…..It was important for me to have a natural birth without medications, and having my husband there with me…But I preferred giving birth in the birth centre because you can get transferred to the hospital ward, where all the doctors are, just in case something goes wrong.*

A few of the English mothers did have a hard time deciding which birth to choose. On the one hand they had received biomedical 'expert' advice, that highlighted the 'biomedical' childbirth as safe, yet on the other hand, they had accessed information about a 'natural' childbirth being less risky and 'humanistic.' As an English mother, Mel explained,

> *It is quite confusing to figure out what advice to follow, on the one hand you have all the books and your NCT friends telling you that the best thing that you can do for your baby is to have a natural birth, as its more humanistic and not so risky, as there are no interventions…*
>
> *On the other hand, you worry about whether the doctors are right, that maybe birth is safer in hospital. But then you worry that the doctors will end up doing all these things to you, just because that is what is most convenient for them, and because you are just a cog in the wheel, so they don't think about your wishes, and they are not even whiling*

to give it a chance, they just want it over and done with, even though it's one of the most wonderful, if not the most significant moment in your life…

But then on the other hand, you want to follow the doctor's advice, because it might cost you your baby's life if you don't.

Overall, the majority of first-time mothers interviewed in this research study decided against an obstetrician-led 'hospital' childbirth, and against a homebirth as well, but planned to have a 'natural' childbirth without medical interventions, as this was constructed as the 'perfect' childbirth.

The English Mothers' Experiences of Violations in Childbirth

The following section reviews the ethnographic data from my fieldwork in a London borough in which the English mothers highlighted either elements of 'violations' or 'wellbeing' during their childbirth experiences. It was important to identify whether, or in which ways the mothers constructed 'violations' in a similar manner to the international human rights framework. When I first started conducting fieldwork, I expected the Sukuma mothers in Tanzania to report a high number of human rights violations, but that the English mothers in the United Kingdom would report only a few. Nonetheless, several of the English mothers, a lot more than expected, had experienced violations, including serious harm and infant death, during childbirth. The following section presents my ethnographic data from the focus groups, and one-to-one interviews with the English mothers resident in an anonymous London Borough in the United Kingdom. The following list is categorised according to the international human rights framework.

i) Harm and Ill Treatment

Everyone has the right to be free from harm and ill treatment under Article 1 of the Maternity Charter. However, several of the English mothers described incidences of harm and ill treatment, as well as malpractice and negligence. An English mother, Diana, described the loss of her infant and the subsequent insensitive treatment:

I was not feeling well – preeclampsia – the hospital staff did not really take my situation seriously. After three days I was released home too early, because the medical doctor was late for a dinner party…….At home I felt poorly again, so I called them again, but they just ignored me and told me to get some sleep. So, I then rang the hospital again on the Tuesday, they said I could come to hospital, but would not be able to see me until 10.00 in the evening, so I should just stay home. But I later started bleeding so called the ambulance, and I was rushed to the labour ward. I was scanned, but my baby boy had no heartbeat.

I then had to give birth to my dead baby boy. They promised me that I would not be able to feel something. But it was very painful. I could feel everything. The morphine machine was broken and there was no anaesthetist to sort it out…..My baby boy eventually was pulled out – but only after he had been there for ages – he was just left half in, half out. I was so aware of it. It was awful……They were not very sympathetic, it was all very much robotic motions.

After the death of my baby, instead of a side room, I was placed in the postnatal ward. On one side of me there was a mother of twins, and on the other side there was a mother celebrating her birth with champagne going off….I could hear new-born babies crying all around me….I even had a temp nurse ask me if I needed a wheelchair to go see my baby in the neonatal ward – she mistook me for someone else. She said: "Would I like help feed my baby?" But my baby was in the morgue….It was like a catalogue of errors.

In some other cases, some mothers described the harm and pain they suffered during childbirth. By way of example, an English mother, Madeleine, could feel intense pain during her caesarean, despite her anaesthetist being convinced that she had passed the block test. She recalled the events as follows,

I was induced at (….) Hospital on Good Friday…..Two nights later, a midwife put me on a machine, the consultant checked on me, and he said that you have to have an emergency caesarean……But when they cut into me, I could feel it, and I was screaming, I was thinking, the baby is going to die, and I will die, but at least I won't be in this pain, so just kill me, kill me, kill me…..

(Mother crying too much to continue the interview and pauses. When asked whether she would like to stop the interview she says no and continues.)

The consultant and the anaesthetist were arguing, and the anaesthetist was saying you have to stop, but the doctor was saying, the baby is not breathing. I said, knock me out, knock me out…..When I woke up, there was a baby besides me, but I was not sure whether I was alive or whether the baby was alive. And I remember looking at the clock and thinking if that clock is not jumping about like it would in a dream, if that clock is true then I am alive, and this is my baby….But I was just left there, none of the midwives chatted to me, none of them seemed to know. I woke up in the ward, but no one was there to explain anything to me. I texted (my husband) and it turned out that they had sent him into a side room, and he had been thinking that our baby was not alive, that I might not be alive. After the baby was born, no one had thought to go out to (my husband) and say your baby is fine, your wife is fine…..The anaesthetist did come later to try to explain what had happened, but afterwards nobody else came to talk to me. I called the buzzer, saying, look, can you help, I couldn't really move, can I have a bottle (of formula) because the baby needs to eat. The midwife said to me that I had to do it myself, but, but, but I couldn't move……I was not sure that any of the midwives knew what had happened to me. But they were just not interested. They did not care.

Harries and Ayers (2011) have investigated some of the factors that make childbirth traumatic for mothers, which include: i) feeling invisible and out of control, ii) feeling trapped, and iii) inhumane treatment, which in some cases also result in post-traumatic stress disorder (PTSD) with symptoms of increased agitation, and intrusive re-experiencing their childbirth. Even though PTSD is outside the scope of this study, there were some of the English mothers who stated that they had frequent uncomfortable flashbacks to their traumatic childbirths, such as Madelaine, who would have nightmares about her childbirth for several months afterwards.

ii) Lack of Information and Informed Consent

Even though the majority of mothers interviewed had their right to informed consent respected when it concerned major medical procedures, such as caesareans, several mothers stated that healthcare workers seldom sought consent when it was small procedures or examinations, such as vaginal examinations or membrane sweeps. An English/Polish mother, Julia said,

The night shift midwife came to me and did a membrane sweep on me without me even giving her my consent. I felt that it was very intrusive, and I felt almost violated. I don't understand why they don't just ask you before they do something to you.

Several of the English mothers interviewed also described how no information was communicated to them, and decisions were made over their head. An English mother, Elizabeth recalled,

My baby's heart rate began to drop when I had contractions, and a doctor was called, and a whole team arrived. The doctor was concerned and did everything possible to monitor my baby. I knew that these doctors had my baby's life's importance as a priority. Whilst inside me, my baby had 2 needles put in its head to monitor the oxygen levels in the blood and a tag clipped to her head to measure her heart beat…..I was continuously told to stop pushing, as the baby's heart rate dropped, but I could not do that, as I was in so much pain…..My baby finally came into the world screaming her head off at 1.10am on Wednesday 28 January 2009 - the cord was wrapped around the neck, which was understandably swollen…..I was beginning to wonder if there was a problem, had they noticed that the baby had a serious syndrome??! Why the delay? You would think that given my notes stated that there was a possibility my baby could have a syndrome, someone could have reassured me.

The lack of information made a lot of mothers worried as they did not know whether the wellbeing of their infant was compromised.

iii) Lack of Privacy and Confidentiality

None of the English mothers in this research study reported that healthcare workers violated their privacy nor breach confidentiality at any point during their childbirth journey – during pregnancy, during nor after childbirth. There was one mother who stated that the healthcare provider told her to get undressed in a room where the windows had no curtains, however, she did not highlight it as a concern.

i) Disrespectful and Non-Dignified Childbirth Care

Several of the of the English mothers in this research study stated that they had experiences from their childbirth journey, whereby one or more of the healthcare workers had been disrespectful or lacked empathy. An English mother, Camilla stated,

> *I felt an overall lack of empathy and support from the midwives……Even though I was being very polite and respectful throughout my time at the hospital, the midwives were just very indifferent to any of the concerns that I had…..It felt as if the midwives felt that my presence was an inconvenience to them. Eventually they just left, and I was abandoned in labour until they realised, I needed an emergency caesarean……It was an awful experience.*

Some mothers even highlighted threatening behaviour from the healthcare workers. An English mother, Emma, recalled,

> *The women in the bed next to me kept ringing the buzzer. She had given birth that morning and I could see that she was in a lot of pain, she was in agony, I could tell it was genuine, that she really needed help, but instead of helping her, the midwife said to her: "Do I have to throw this at you for you to stop ringing it?" The buzzer, she was going to throw the buzzer at her. That was the level of care I was surrounded by. Then I later overheard that they eventually got a doctor to her, and she had had a litre and a half urine stuck in her body.*

Several of the English mothers highlighted that healthcare providers seemed to be very disrespectful and unsympathetic, especially when there were shortages of healthcare workers, however, some mothers stated that many healthcare workers were unsupportive even on non-busy days.

iv) Discrimination and Inequality

The research participant group of English mothers were for the purposes of this research mostly homogenous, since most were white, Christian(ish), heterosexual, middle class, educated and so-called 'empowered' mothers. However, since the English mothers were from a wide age range, a few of the younger mothers mentioned that, at times, had felt discriminated against

due to their young age, especially during their first childbirth. A young, English mother Jennifer, explained:

> *I was kinda young when giving birth for the first time, so my painful contractions were dismissed by the midwives, my wishes were kinda brushed over, as they thought they knew what was best for me, whereas second time round, I knew what I wanted, and even though I was still young, they knew that I had given birth before, so they did not just instantly dismiss the issues that I raised or any concerns I had.*

Childbirth as a time of intense vulnerability was a sentiment expressed frequently by the first-time English mothers who I interviewed. These mothers felt vulnerable because they had never given birth before, so they did not know what to expect. Despite the apparent vulnerability of first-time mothers, several mothers stated that they felt like the healthcare workers generally framed first-time mothers as a 'nuisance' instead of being more empathetic and providing the additional support which they needed. A first-time, English mother, Evie, recalled,

> *When I told my midwife that I was in lot of pain because of my contractions, she turned towards the other midwife in the room and said over my head, "She doesn't know what pain is, she has never been in labour before." And comments continued like this throughout my birth, instead of providing support, they constantly dismissed my concerns and fears as a nuisance.*

Vedam et al. found mothers aged 24 old or younger reported more disrespect and abuse during childbirth compared to mothers over 30 years old. They found that physical abuse was uncommon but verbal abuse and failure to respond to requests for help were the most common types of reported mistreatment; rights to information and autonomy were also disregarded. Overall, first-time mothers were twice as likely to report mistreatment (2019, p.8).

Even though it was not possible to identify any negative discrimination based on nationality, there were cases of positive discrimination during childbirth. By way of example, an Irish mother, Erin, had an Irish midwife during childbirth. Even though it was near impossible to get access to the private postnatal room after childbirth, the Irish midwife informed her that she would 'do her a favour' and get her into that room - unlike all the other healthcare workers that the Irish mother had spoken to, who had done nothing to help. Similarly, a Spanish speaking

Venezuelan mother, Rosa, described her childbirth experience as very positive, since she was surrounded by Spanish-speaking healthcare providers. She stated,

> *I had preeclampsia so I had to stay in hospital for quite a long time before giving birth. Luckily, I could stay in my own private room the whole time, and the staff were all so very nice to me, especially the Spanish speaking nurses. Luckily, also some of the doctors that met me were Spanish speaking so they could explain everything to me very clearly, so I could understand everything and knew what was happening all the time.*

The case of the abovementioned mother illustrates the benefit of healthcare providers being able to adapt to mothers linguistically and culturally during childbirth. Sen et al. explain that communication is severely tested when healthcare providers do not speak the same language as the mothers who seek care. In their ongoing qualitative research, they found that healthcare providers, who had to ask people who knew the language of migrants to serve as impromptu translators, often sensed that their instructions were not delivered in the spirit in which they were intended. These barriers can create distance between healthcare providers and women. Even well-intentioned providers get frustrated when mothers and their attendants cannot fully understand their medical advice or instruction (2018, p.11). In contrast, if the healthcare providers can linguistically and culturally accommodate mothers during childbirth, trust will develop between mothers and healthcare providers, with the mother experiencing a greater sense of wellbeing during childbirth.

i) Lack of High-Quality Childbirth Care

Even though I was not able to interview those mothers who have sadly passed away, I was able to interview a few mothers who had lost their infants in childbirth, as well as infants who had suffered brain damage during childbirth. Often the death of the infants, as well as the brain damage resulted from delay in the care or abandonment in childbirth. An English/Turkish mother, Zerah, stated,

> *My childbirth at hospital was awful because we couldn't get hold of our midwife, so my whole birth was delayed……When she finally came, she was too slow, and it was too late, my daughter was limp and so dark when born, so I instantly knew that something was wrong. The midwife insisted that everything was fine, even though I knew in my heart that something was wrong……At the development review they realised that*

something was wrong. So, we got referred to the specialised children's unit, Evelina, at St Thomas Hospital and they ran a number of tests that confirmed that my daughter has cerebral palsy.

A few of the mothers interviewed described how their infants either died or suffered brain damaged during childbirth. The mothers described the immense pain of losing their infants or facing a lifetime of taking care of their brain-damaged child.

The English Mothers' Perceptions of Wellbeing in Childbirth

The above section focused on the range of 'violations' which some English mothers recalled experiencing during childbirth. Even though the majority of the English mothers interviewed for this research study identified various human rights violations in their childbirth, a few of the mothers also described positive childbirth experiences, so were able to identify what constituted 'wellbeing' in childbirth to them. The following list highlights the ideas of 'wellbeing' in childbirth for the English mothers.

i) A 'Natural' Childbirth as Wellbeing and Biomedical Childbirth as 'Violating'

Several of the English mothers stated that they had a genuine sense of wellbeing during their 'natural' childbirth, whilst a few of the mothers in contrast highlighted their 'biomedical' childbirth as 'alienating' and 'violating.' Foucault (2008) and Kleinman (1978) have illustrated how the biomedical health system is reductionist and alienating which has led to many feminist scholars to draw similar parallels to that of the biomedical childbirth, describing it as reductionist and alienating, as well as even 'violating.' Martin (1989) found when examining medical books that the dominant metaphors in biomedicine for the delivery of babies comes from industrial production. In this biomedical cultural model of birth: i) the doctor is portrayed as the manager in the childbirth process; ii) the uterus is portrayed as the machinery of reproduction; iii) the mother is talked about as a kind of labourer, hence, she is said to be 'in labour' during the birthing process; and iv) the infant is the product. Furthermore, Oakley (1989) argues that the biomedical discourse frames the female body a machine, where the obstetrician is a mechanic and the pregnant woman a broken-down car. The garage is the hospital providing the tools to fix the malfunctioning parts. Similarly, Hunter (2006) maintains that the biomedical childbirth operates on the basis of 'three Cartesian principles' whereby the

mind is separate from the body, that the body can be 'fixed' like a broken machine, and that the 'science' of medicine and disease are based on logic and reasoning rather than on emotion and on sociocultural context. Finally, Davis-Floyd argues that in the West, the dominant beliefs and practices surrounding birth are based on the 'technocratic model' of reality, inherited from the Enlightenment whereby "the machine replaced the organism as the underlying metaphor for the organization of man's universe," (1992, p.44). She argues that a technocratic biomedical childbirth, is based on the domination of culture over nature, reproducing patriarchy by constructing mothers' bodies as weak and therefore needing male-controlled technologies.

Even though several of the English mothers in this study did find their biomedical childbirth traumatic, this was mostly in cases of unplanned caesareans or medical emergencies. An English/Danish mother, Lise, stated,

> *My first childbirth was horrible, as my daughter nearly died, and there were just so many stupid mistakes made, perhaps because it took place at four in the morning, so all the staff were probably agency staff, one of them was sleeping in the labour ward, half of the time my midwife was not there, the other midwife barely looked me in the eye, as if she hated me, and the other half of them couldn't speak English, and all the rest just didn't care.*

> *My second birth was a planned c-section at St Thomas Hospital, and it was just great. Yes, I know there is some stigma attached – you are too posh to push, whatever - And yes, it was scary to lie down in the operating theatre, getting ready for the doctor to cut open your stomach, it goes against all your rational thoughts, to do so. You know, I had to have an emergency c-section last time, so I basically just had to do, it was scary to convince yourself to do it the second time round, as it was voluntary. Anyway, it was great because the female anaesthetist just took charge, she introduced me to everyone in the operating theatre, she asked me questions, provided me with information about what was about to happen. She wasn't sweet and nice and kind, but she was supportive, had empathy towards my situation, she listened to the things I wanted, like skin-to-skin contact after birth. She was so professional, and I just felt supported and safe.*

Thus, even though the biomedical healthcare system is essentially dehumanising and reductionist, a biomedical childbirth was not in itself always experienced as 'violating' by the mothers themselves. Several of the English mothers in this study highlighted the fact that they

felt good about their planned caesareans, especially when they received information, when there was informed consent about the medical procedures, and when they felt that they had received supportive care from the healthcare providers. Overall, these mothers did not conceptualise a biomedical childbirth as 'violating' in itself. Thus, as Irvine states, the polarising dichotomy of framing childbirth as either 'medicalised' or 'natural' fails to capture the complex set of practices, outcomes, and perceptions that take place during childbirth. She argues that we need to destabilise the medicalised-natural dichotomy and accept that it is the mothers' own perceptions of their childbirth care which are the most important consideration (2021, p.204).

ii) A 'Natural' Childbirth as an Achievement

Several of the first-time mothers wanted a 'natural' almost 'pure' childbirth, with as little technological intervention and exposure as possible, as a 'natural' and non-technological pregnancy and childbirth was framed by the mothers as 'less risky.' Many of the English mothers in this study who favoured a 'natural' childbirth framed such a childbirth as almost 'pure' whereas a 'biomedical' childbirth was perceived as 'risky' and almost 'dirty.' An English mother, Elinor, stated,

> *I don't know where it comes from. I don't know where it comes from maybe from NCT, and TV and friends…It is definitely a white middleclass thing, you know, you should do these things, avoid drugs, avoid anything that is not natural, that is not organic.*

An English/American mother, Karina, even went a step further, resisting ultrasounds, as she was certain that such technological exposure was dangerous to her infant in utero.

The anthropologist, Mary Douglas, might provide an insight into why medical interventions and technology (which, in this research study, are focused on saving the lives of mothers and infants in childbirth) may be conceptualised as 'impure' and 'dangerous.' Whilst the 'purity' of childbirth in the 1950s was upheld through eliminating 'dirt' with the help of excessive hygiene and sterility, many of the English mothers in this study seemed to have been influenced to instead perceive the biomedical childbirth as 'dirty' and technology as 'polluting' the childbirth process – and ultimately as a danger to the childbirth process. As known, Mary Douglas states that dirt is "matter out of place" which implies two important conditions, "a set of ordered relations and a contravention of that order" (1966, p.44). She argues that there is no

such thing as absolute dirt, as no single item is dirty in itself, but only when it is outside a particular system of classification, in which it does not fit, is it perceived as dirty. She uses the everyday example of a pair of shoes, which are seen as dirty when placed on the kitchen table, but not when they are on the floor in the hallway. Similarly, natural childbirth activists do not frame technology and medical interventions as impure or dangerous when used to treat a heart attack; however, it is considered 'out of place' and not perceived as fitting in the childbirth context. As Mary Douglas explains, dirt is not an independent, objective attribute of something, but a residual category which is rejected from the normal scheme of classifications; it is considered impure due to its out-of-place-ness. This directly threatens the structure and process and, as a consequence, is perceived as disruptive, and dangerous.

Bledsoe and Scherrer state that the character of the 'natural' is arguably the guiding disciplinary question of anthropology. They highlight that since women in high-income countries assume a safe birth outcome, a healthy, living infant, the emphasis has shifted to the childbirth process itself. Since the 'natural' childbirth has become the goal, the mother perceives the medical interventions as a disruption to its the 'natural' process. Whilst childbirth is perceived as a natural process that should transpire at a pace and in a manner set by the birthing mother, preferably in her home with her family, the mother feels that she loses control of the birth, if the birth instead moves to the hospital instead, and the healthcare workers are perceived as attempting to supersede her individual rights, as the childbirth becomes subjected to technology and biomedicine. They state,

> Particularly feared are the medications that may make them loose control of their senses at the key moments in which awareness is needed. With blunted senses, they will miss the full range of emotions and the sense of achievement that they have been told should accompany their birth experience (2007, p.59).

The English mothers in this study who 'achieved' a 'natural' childbirth described the whole childbirth process as empowering and highly satisfying – the ultimate sense of wellbeing in childbirth. Elinor explained,

> *I remember when he was delivered without (an epidural) it felt like an achievement. Yeah, I did it without an epidural. Which I feel guilty about, and I feel silly, because I would never want anyone else to feel bad about having one but there is defiantly a sense of achievement. There was a thing in my head that said it would be better if you didn't, it would be a better story if you did it without it, so, it is just crazy that you focus on that*

when you should focus on whether you need pain medication. I would have had one, but there was defiantly a sense of achievement because I didn't…

This perception of a 'natural' childbirth as an achievement might be a result of our culture of achievement in the West. Brinkmann argues that the culture of achievement manifests through this institutionalised and collective desire to develop, implement and execute *'best practice'* in any field since we are always on the lookout for ideal *investments* (2010, p.17). Being an individualised, responsible human being that strives towards realising the *'best practice'* ideal applies not only to a work context but it becomes a way to live and perform in any given task, even with regard to the optimisation of relationships or the body. In short, one's worth and existence is constantly measured and depends on what you *do* as you *are* what you *achieve*. *What* and *how* to perform and achieve becomes the central question and the institutionalised ideals become the answer: one needs to perform in an *agile, flexible, adaptable* and *positive* way that allows the individual to be constantly on their toes, ready to disrupt oneself, change for 'the better' and achieve. Perhaps in a similar manner, the English mothers interviewed felt that they had to 'perform' during their childbirth – preforming in an *agile, flexible, adaptable*, *positive, and successful* way to achieve a natural childbirth. Petersen states that this leads to a constant self-surveillance of one's achievements and self-regulating measurements of how one has solved the day's task of being an industrious and responsible provider of *success* (2016, pp.53–60)

The dark side of a culture of achievement is, however, that those who are not able to achieve are perceived as 'losers,' as Petersen and Dilling state,

> Brutally speaking, the winners in the realm of this type of society are those able to internalise and live in accordance with these ideals. The losers, in contrast, are those who are not – those, who succumb to the pressure. Thus, a culture of achievement is born (2022, p.378)

This sense of failure was reflected by the English mothers in this study who 'failed' to 'achieve' a 'natural' childbirth and instead had to have a 'biomedical' childbirth. Similar to the research of Kjerulff and Brubaker (2018), who investigated the mode of childbirth delivery in relation to women's postpartum feelings about their first childbirth, the mothers who had an unplanned caesarean delivery were significantly more likely to report feeling disappointed in comparison to those who had a 'natural' childbirth.

The feelings of disappointment and failure even extended to the time period after childbirth, because some mothers in this research study felt excluded from their NCT groups after childbirth. The NCT childbirth preparation courses are well-known for providing childbirth information, as well as the chance to, as Cathy stated: "Buy yourself a white, middle class, yummy mummy friend.' Nonetheless, as the NCT course had such an emphasis on the importance of a 'natural' childbirth being the best kind of birth, this translated into two groups of mothers, those mothers who had 'achieved' a natural childbirth, and those who had failed. As the English mother, Kate, stated,

> *I did not fully understand my own feelings after birth, why I felt like such a failure, why I felt shame. I felt like I had let down my son by not being strong enough, I felt like I had let him down by being induced and having to have an emergency caesarean….Even after birth I felt like a failure and felt like an outsider in my NCT group, as all the other mothers had a natural childbirth, and were running around playing in the park with their newborns while I was still lying in bed recovering from the operation…..I felt like they were the shining, happy people, and I was dirty somehow….I don't know whether it was all in my imagination, but I felt excluded from the group.*

The feelings of failure often went hand in hand with feelings of isolation and loneliness, since several of these mothers were not born in London, some not even from in the United Kingdom, so their family or childhood friends often lived far away. Their feelings of failure were thereby compounded by the loneliness of being dislocated from their previous lives, identities, and relationships, and confined to their homes by the mothering role (Taylor et al., 2021), with the memories of their traumatic childbirth, meanwhile struggling to connect with others due to the fear that they would be seen as falling short of the ideal 'Good Mother.' Miller (2005) states that contemporary constructions of the 'Good Mother' are found everywhere in the popular discourse, influencing women's lives, as well as their childbirth experiences. For those becoming mothers for the first time, these include an expectation that their bodies are designed to reproduce and that they will be able to deliver naturally.

iii) Pain as a Violation or Wellbeing in Childbirth

Pain or the elimination of pain was a central element to many of the English mothers' sense of wellbeing in childbirth. Whereas the Sukuma mothers did not seem to focus on the pain in

childbirth, or simply attributed pain to the *nzoka* in their stomach, the majority of the English mothers were consumed by either the lack of pain relief or the ability to tolerate pain in childbirth as an 'achievement.' On the one hand, there were mothers in this research study who wanted pain relief to eliminate pain in their childbirth, whereas other mothers embraced the pain. The mothers who refused pain relief, embraced pain as 'empowerment' and the ultimate sacrifice in childbirth. Interestingly, pain in childbirth did seem to serve a special sacrificial function for some of the mothers in this study. A Catholic Italian mother, Julia, described the joy of pain and sacrifice during her three childbirths:

> *I had a natural birth every time. Yes, it was very painful, but I wanted it this way. I feel that I am somehow giving my body and this pain is a gift to my children in birth. I can't explain it, but I want to show my children how much I love them and how much I am willing to sacrifice to them. I am giving them life, it is painful, but I am giving this as a gift to my children in childbirth.*

Wall (1999) explains that even though in the West we are taught that pain is a warning message, something to be avoided at all costs, pain is a matter of behaviour, and its manifestation differs among individuals, situations, and cultures. He highlights that pain involves our state of mind, our social mores and beliefs, and our personal experiences and expectations. Morinis (1985) states that the *ordeal* i.e. the direct sensory experience of pain has traditionally been considered to be a by-product of the rite of passage. In fact, there are several ethnographic examples of the cultural function of pain as part of rites of passage rituals, including the Tikopia (Firth, 1916), the Arunta (Spencer and Gillen, 1927), Nuer (Evans-Pritchard, 1940), and the Tsonga (Junod, 1962).

The concept of the rite of passage itself was coined by Van Gennep who saw society as a house with rooms and corridors in which passage from one to another is dangerous. Danger thereby lies in the transitional states, simply because transition is neither one state nor the next, it is undefinable. The person who must pass from one to another is himself in danger and emanates danger to others. The danger is controlled by ritual which precisely separates them from their old status, segregates them for a time and then publicly declares their entry to their new status. Their old life is left behind, as they are reborn to the new life. Van Gennep recognised the importance of childbirth as a rite of passage for women, stating:

> The ceremonies of pregnancy and childbirth together generally constitute a whole. Often the first rites performed separate the pregnant women from society….They are followed by rites pertaining to pregnancy itself, which is a transitional period. Finally come the rites of childbirth intended to reintegrate the woman into groups to which she previously belonged, or to establish her new position in society as a mother, especially if she has given birth to her first child (1960, pp.41-43).

Bohannan (1953) describes how the women of the Tiv in Nigeria have traditionally scarred their bodies, with different scars symbolising different ages and particular functions, like enhancing female fertility. Pain therefore serves an important function, shaping, and revealing the identity of women, as well as signifying the difficulty gone through to receive such markings. This was important especially for women, who wanted to show potential partners their ability to handle pain, which they needed to withstand a painful childbirth.

On the other hand, several other English mothers in this research study, did not view pain as key to their transition to motherhood or wellbeing during their childbirth but instead insisted on pain relief during their childbirth. A British/Polish mother, Magda, described her frustration as her request for pain relief was resisted during childbirth:

> *I had contractions during the whole night, and they just continued for a total of 42 hours. When we finally went to the hospital in the middle of the night my contractions unfortunately started slowing down. I think this made them worried, as they started doing sweeps on me. Then after 30 hours of contractions. I just passed out on the bed as I was tired, and I was in pain. (Mother pauses, and has agonised look on her face). When the morning midwife came in, she did a new sweep. She was actually the first one to tell me that my baby was back-to-back, so they informed me that they had to put me on oxytocin to get the baby out…..But when I started the oxytocin the contractions became even more painful, but when I finally asked for an epidural, instead of giving it to me, the midwife said to me: "Why not persevere?" This [comment] made me so angry. I can't handle any more. I have had contractions for so long, and the baby is back-to-back, and I am on oxytocin, so why should I not have it? Why did she question this? But I finally got it. Let me tell you, the epidural was magical.*

Scarry states that the inexpressibility of the experience of severe pain engenders the very destruction of a person's self and his or her world. She states, "Intense pain is also language-destroying: as the context of one's world disintegrates, so the content of one's language disintegrates; as the self-disintegrates, so that which would express and project the self is

robbed of its source and its subject" (1985, p.35). In fact, a number of the English mothers in this research study felt that some healthcare workers had a bias towards a 'natural' childbirth and, therefore, only reluctantly provided pain relief. An English mother, Lily stated,

> *After one hour of contractions, I asked the midwife for pain relief, but she looked at me with utter contempt. She begrudgingly examined me and said that I was only 2-3 cm dilated and 'not being in labour,' there was no pain relief she could give me other than paracetamol. At this moment I cried in sheer fear that if I was not even in labour then I was surely going to die since the pain was so awful and unbearable. Absolutely no reassurances were given to me that this was the worst it would be, and she just walked out of the room, and left me to cry…….I begged to be examined an hour later as I wanted pain relief. My midwife casually advised I was eight cm dilated and it was too late to have any pain relief, other than gas and air!! I was so upset, I could only sob.*

Tuteur (2016) highlights that the natural childbirth activists who promote 'natural' childbirth continue to argue against pain relief and state that getting an epidural can kick off a 'cascade sof interventions' in which one medical procedure leads to another until the mother in childbirth 'has lost all her agency.' Tuteur states that there is no real advantage to avoiding pain relief in childbirth, since it is not the epidural that offsets this process, but rather the process itself which is designed to avoid life-threatening complications for the mother and infant in childbirth.

The debate about pain relief in childbirth highlights how ideas of 'wellbeing' and 'violations' are dependent on the historical and cultural context of childbirth, as pain relief has been constructed as either 'oppressive' or 'liberating' for mothers throughout the last century. Historically, Sewell explains, all operations in hospital were conducted without anaesthetic before the 1800s. It was not until 1846 that William T. G. Morton used diethyl during an operation to remove a facial tumour. The medical application of anaesthesia then rapidly spread from the United States to the United Kingdom, except in obstetrics, as there was opposition to its use, based on the biblical injunction that women should suffer in atonement for Eve's sin. In 1847, James Young Simpson nonetheless administered diethyl ether to a mother during childbirth, so some obstetricians subsequently began to recognise its potential, though many others continued to argue for the moral or 'medical significance' of pain. In 1847, Dr James stated,

> Pain during operation is, in the majority of cases, even desirable; its prevention or annihilation is, for the most part, hazardous to the patient. In the lying-in chamber nothing is more true than this: pain is the mother's safety, its absence her destruction sin (Sewell, 1993, p.61).

Thus, it was not until Queen Victoria had chloroform administered in her childbirth, that all opposition to a pain-free childbirth was finally silenced. She did not agree that pain in childbirth was a moral or physical necessity and instead popularised pain-free childbirth, not just as a possibility, but as a right. However, as chloroform was expensive, it remained only accessible to the middle and upper classes (Cleghorn, 2021).

In the early 1900s, a women's hospital, *Frauenklinik*, was set up in Germany where the obstetricians offered women *Dammerschlaf* (Twilight Sleep), an injection of morphine and scopolamine, so they could fall asleep during childbirth. Even though the body was effectively awake, pushing and delivering the infant, the mother would not remember anything after waking up. The Twilight Sleep was hailed as a miracle drug for childbirth and demanded by many women, such as the suffragist Mary Ware Dennett and Francis Carmody, who stated: "If you women want it you will have to fight for it; for the mass of doctors are opposed to it" (Cleghorn, 2021, p.194). Subsequently, the use of Twilight Sleep in childbirth spread across the United States, after the National Twilight Sleep Association (NTSA) successfully petitioned hospitals to provide it to pregnant women.

By 1958, Twilight Sleep had become standard in childbirth throughout the United States though it was increasingly being conceptualised by mothers as 'violating.' An anonymous letter sought an investigation into the "tortures that go on in the delivery room. (Schiller, 2016, p.108). Whereas the *Frauenklinik* had been a well-run hospital for wealthy, pregnant women, the reality of Twilight Sleep in the United States was another as women were often left alone for hours, restrained to their beds. Often, the dose was not enough to abolish the mothers' memories of a childbirth being semi-conscious, restrained and in excruciating pain, entirely at the mercy of her male obstetrician. Even if not intended, the Twilight Sleep transformed childbirth into a pathological process that required operative and drugs interventions as the norm, not the exception. Since scopolamine could only be administered in healthcare facilities and by obstetricians, most of whom, were at the time, male, the once female, feminist-promoted Twilight Sleep became the foundation for the biomedical childbirth. As Schiller states, the reaction to this brutal treatment of mothers in the Twilight Sleep childbirth propelled the "feminist figuring of childbirth, which sees the system as controlling, and the promotion of 'natural' birth, as a way to reclaim and empower" (2016, pp.108-109).

Part II Summary: English Mothers' Perceptions in Childbirth

The final part of the chapter described the historical background and cultural context of childbirth practices in the United Kingdom, as well as the English mothers' perceptions and experiences of violations and wellbeing in childbirth. Whereas the many of the Sukuma mothers in Tanzania only have limited childbirth choices, the English mothers experienced 'the burden of choice' in childbirth. The majority of the English mothers in this research study initially preferred a 'natural' midwife-led childbirth in a birth centre. My ethnographic data showed that the mothers interviewed in the United Kingdom, reported human rights violations during childbirth, which included: i) harm and ill treatment; ii) lack of information and informed consent; iii) non-dignified care and disrespect; v) discrimination; and vi) lack of high-quality healthcare. Overall, even though fewer of the 'educated' and 'empowered' English mothers in the United Kingdom experienced human rights violations compared to the Sukuma mothers in Tanzania, an unexpectedly high number of English mothers did experience human rights violations in childbirth, as well as infant death and infant brain damage.

The ethnographic data revealed that the majority of the English mothers who gave birth in birth centres had positive childbirth experiences and experienced a sense of wellbeing during childbirth, meanwhile, many other mothers felt unsupported and disrespected during unplanned 'biomedical' childbirths, especially in the case of medical emergencies. Many of the 'human rights violations' were conceptualised in similar ways in both Tanzania and the United Kingdom, due to the power hierarchy inherent to a biomedical childbirth. However, ideas of 'wellbeing' differed according to the cultural context since a 'natural' childbirth was embraced as an 'achievement' by several of the English mothers but something to be avoided by many of the Sukuma mothers.

Chapter Discussions, Comparisons and Conclusions.

In this final part of this chapter, I focus on comparing and contrasting how the mothers in Tanzania and the United Kingdom experienced and perceived 'violations' and 'wellbeing' during childbirth within their particular historical and cultural context, by reference to the international human rights framework.

The Sukuma mothers in this study initially conceptualised the biomedical childbirth as a 'good and safe' childbirth, however, after giving birth in a healthcare facility, the most disadvantaged and uneducated mothers unfortunately often experienced human rights violations, as they became conceptualised as 'the other' – an easy, dehumanised target and outlet for the healthcare workers' stress and frustrations. As Strong (2020) argues, even though the global biopolitical agenda to reduce maternal mortality rates has promoted healthcare facilities in Tanzania as the only safe place for birth, the high demand for an obstetric-led biomedical childbirth is deeply misaligned with the resources available, whether material, temporal and affective. Similarly, the research data shows that several of the Sukuma mothers interviewed in Tanzania did not get the biomedical childbirth they had envisioned and hoped for. Even though these mothers did not always conceptualise particular human rights violations as such, they did nevertheless describe numerous examples of humiliating treatment by healthcare workers.

Whilst many of the first-time English mothers were heavily influenced by the naturalistic fallacy – if something is 'natural' it must be good, several of the first-time Sukuma mothers had over-hopeful ideas about a 'biomedical' childbirth. The English mothers in this study who managed to 'achieve' such a 'natural' childbirth birth often felt that they had a positive childbirth experience, whereas those who had 'failed' often highlighted several human rights violations in their childbirth. This is not to say that the mothers in this study did not 'objectively' experience human rights violations when they said they did, however, their emphasis on what constituted 'wellbeing' and 'violations' was influenced by the biomedical context of their childbirth, as well as their historical and cultural context.

Several of the English mothers experienced a 'burden of choice' in childbirth, or at least in theory, between an obstetrician and a midwife, a 'natural' vs. a 'biomedical' childbirth, and so on. Fannin (2012) highlight that the burden of choosing wisely in the domain of childbirth is not simply an effect of the expansion of 'procreative techniques' or other innovations in prenatal genetic surveillance but is instead part of a broader transformation of the ethical responsibility for reproduction into a concern of each and every individual mother. She argues that this new configuration of power maintains Foucault's insights on the transformation of the population into the target and medium of biopolitical power, yet reaffirms the fundamentally novel character of the governmentalising state where "liberty itself becomes an indispensable element to governmentality itself…To not respect liberty is not only to exercise the abuse of rights in relation to the law, but above all to not know how to govern as one should" (2008, p.

351). Thus, the mother is not treated as an entirely passive object, but, instead, as a 'reasoned subject' whose decisions to make use of or reject the technological monitoring and pain relief demonstrate her efforts to achieve a measure of rational self-determination and autonomy (Martin, 2007, p.186). However, due to the ontological conflict between biomedical 'experts' and 'natural' childbirth activists in regard to what constitutes a 'risky' childbirth, it is difficult for mothers to make a 'reasoned' decision. Biomedical 'experts' will state that medical intervention should happen as soon as there is the slightest risk to the mother and infant, while natural childbirth activists state that waiting longer is better, as it is the rush to prevent risk in itself that too often leads to unnecessary medical interventions which, in turn, is 'violating' of the mother in childbirth.

Both the Sukuma and the English mothers' own experiences of 'violations' did not always overlap exactly with that of 'human rights violations,' as framed by international human rights law. However, both groups of mothers highlighted the importance of dignity in childbirth and stated that the humiliation they experienced in the hands of the healthcare workers was both a 'violation' and unjustified. More worryingly, the most 'disadvantaged' and 'vulnerable' mothers seemed to be conceptualised as 'the other' by the healthcare workers - an easy, dehumanised target for the stress and frustration of the healthcare workers. Thus, this chapter illustrates that international human rights protection for mothers is vital, especially for the most 'disadvantaged' and 'vulnerable' mothers, because childbirth is a 'vulnerable situation.' As Khosla et al. state "Human rights standards are an important accountability tool for recognizing and protecting the human rights of women during childbirth in facilities, and for supporting health system reform to prevent mistreatment in the future" (Khosla et al., 2016, p.131).

Whilst this thesis has found that international human rights protection needs to be universal and set in stone, the notion of wellbeing in childbirth, however, needs to remain flexible and responsive to the needs of the mother. The ethnographic data revealed that a one-size-fits-all approach to childbirth is not appropriate, as the notion of wellbeing is dependent on its particular historical and cultural context. By way of example, pain is perceived as empowering to some mothers, whilst others find pain relief instrumental to their wellbeing in childbirth. Hence, as Napier et al. (2014) state, subjective definitions and experiences of 'wellbeing' should be incorporated into healthcare delivery and, unless these are taken into consideration, the childbirth might be experienced as traumatic, or even 'violating' by the individual woman.

Chapter Four

Human Rights Claims in Childbirth

Research into human rights violations during childbirth is important (Chapter Three) but it risks reducing the individual woman to, simply, a 'suffering birthing body' (Malkki, 1996; Fassin, 2011; MacDonald, 2013) and a 'victim,' rather than an agent (Redhead, 2007). The singular focus on women as victims ignores their active agency when attempting to access rights, as well as the use of rights in their everyday lives (Merry, 2006). This chapter focuses on how international human rights law might be translated into human rights claims in practice by exploring the ethnographic data on the Sukuma and the English mothers' own lived experiences of claiming human rights during childbirth. The first section provides an overview of the 'empowerment potential' of the human rights-based approach to maternal mortality. The rational-linear, cause-effect, policy assumption inherent in the human rights-based approach to maternal mortality is questioned, and the concept of 'empowerment' is unpacked by drawing in the agency/structure debate from the social sciences, as well as the anthropology of resistance. The second part of the chapter outlines the Sukuma and the English mothers' own lived experiences of claiming human rights during childbirth. The research focus is on whether mothers (agents) were able to exercise their agency in childbirth within a biomedical context (structure), as well as the 'pragmatic' considerations of the mothers to keep themselves and their infants safe.

The Empowerment of Mothers to Claim Human Rights in Childbirth

The UN Technical Guidance on the human rights-based approach to maternal mortality states that the human rights-based approach "is premised upon empowering women to claim their rights, and not merely avoiding maternal death or morbidity" (para. 12). The approach "identifies rights-holders and their entitlements and corresponding duty-bearers and their obligations and promotes strengthening the capacities of both rights-holders to make their claims and duty-bearers to meet their obligations" (para 10). Accountability is central to the

human rights-based approach, which requires individuals, including women from vulnerable or marginalised populations, to be aware of their entitlements with regard to their sexual and reproductive health, and that they are empowered to make claims grounded in them. (para. 67). The vision of such an approach is that women are 'empowered' to become 'change agents' using human rights as a tool to achieve social and political change, claiming their rights with the result of improving maternity services, with the ultimate aim to overcome maternal morbidity and mortality (Hawkins and Newman, 2005). However, even though such a vision is admirable, the question remains, how exactly are mothers empowered? And even if they are 'empowered,' can we automatically assume that they are able to, or even willing to claim their rights within a biomedical context?

'Empowerment' as a concept originally got its impetus from the civil rights and feminist movements during the 1970s. Batlilawa explains that the idea of 'empowerment' can generally be traced back to the social justice movements that fought for social change during the 1970s, but specifically by adopting Paulo Freire's idea of 'conscientisation.' His active teaching method sought to make individuals become aware of their own situation, so that they could obtain instruments that would allow them to make choices and become "politically conscious" with "the means to transform the world that surrounds him" (2007, p. 9). However, the term 'empowerment' really began to take root among feminists within the international development field during the 1980s, and finally gained full prominence in 1994 during the International Conference on Population and Development held in Cairo. The following year, the Beijing UN Conference on Women took place with a specific focus on 'women's empowerment', and by the end of the 1990s the term 'women's empowerment' had become well established (Calvès, 2009). However, we still lack a common definition of 'empowerment' across various institutions, organisations, and NGOs, and that epitomises the general frustration with the term. As Siddiqi (2007) states, the concept of 'empowerment' has become so diffused and diluted that it seems almost impossible to implement in the field.

Rowland argues that the main reason that 'empowerment' is such an ambiguous and contested concept is because the root concept, power, is itself disputed (1995, p.101). Even though many different social theorists have sought to describe the concept of power, different ideas about power remain. As we know, Marx proposed that the ruling class holds all the power during the historical stage of capitalism, using it to exploit the working class (Draper and Haberkern, 2005) whereas Weber defined power as something that an individual has in a social relationship, so

that s/he can achieve his or her own will even against the resistance of others (Rubinstein and Maravic, 2010). Meanwhile, Bourdieu (1977) argued that power is ascribed by the social institution (e.g., healthcare facility) within which the agent is associated. His theoretical concept of 'habitus' is described as a set of learned 'dispositions' and inclines individuals to act and react in certain ways. Through a myriad of processes (e.g., medical education) an individual acquires a set of 'dispositions' that become second nature and embodied. These dispositions generate practices, perceptions, behaviour, and attitudes which reflect the social conditions within which they were acquired. Moreover, Bourdieu's (1999) concept of doxa further elaborates his notion of habitus, whereby agents subconsciously accept and internalise attitudes, knowledge, beliefs, and values of the institutional without knowing they are doing so – taking these for granted. According to Bourdieu when individuals interact in 'the field,' it shapes their practices, perceptions, and attitudes. Hence, habitus can change over time as well as positions of power, as they are determined by the distribution of different kinds of capital, such as economic, symbolic, social, and cultural capital. Finally, Giddens's (1984) structuration theory is an attempt to build a bridge between the structural analyses (in the Marxist tradition) and more agency-centred traditions of sociology (e.g., ethnomethodology, Goffman, Garfinkel). He introduces the notion of 'the duality of structure' to indicate that 'structures, as rules and resources, are both the precondition and the unintended outcome of people's agency.' Hence, agents are free to act, but draw upon and replicate structures of power through their actions.

Foucault argued that power is neither held by an individual (agency) nor a class group (structure) – in fact, power is not 'held' at all. Instead, it is dispersed and subject-less. Rather than wielding power, subjects are discursively constituted through power, so it is their actions that contribute to the operation of power. Furthermore, since power is ubiquitous, and appears in every moment of social relations, the operations of power are not departures from the norm, but rather are constantly present. Foucault highlighted,

> Power is everywhere: not because it embraces everything, but because it comes from everywhere. ... Power is not an institution, nor a structure, nor a possession. It is the name we give to a complex strategic situation in a particular society (1976, p.93).

In this way, power remains diffuse rather than concentrated, embodied, and enacted rather than possessed, and discursive rather than purely coercive which is the basis of network theory (Latour and Woolgar, 1986). However, even though power is often formulated as negative;

repressive, prohibitive, or exclusionary, power can also be positive and productive. Foucault states,

> We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact, power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production. (1976, p.194)

Foucault observes the element of resistance in relation to biopolitics, stating "where there is power, there is resistance" (1979, p.93). McGee (2016) explains that a number of anthropologists have argued that the study of resistance, provides a better platform to understand power and how existing power relations are challenged (Scott, 1989; Wright, 2016). Anthropological studies of 'resistance' encompass large scale, long-term group opposition to dominant forces (Taussig, 1980; Comaroff, 1985; Gadgill and Guha, 1995), small scale 'everyday forms of resistance' (Scott, 1989; Sivaramakrishnan, 2005; Adnan, 2007) and finally the 'avoidance' of hegemonic relationships (Baaz, 2023) which provide an insight into what goes on 'below the waterline' as the less visible informal norms, beliefs and practices, and the interplay between structure and agency (Pettit and Acosta, 2014). McGee states that the notion of resistance was originally understood as a range of agency-based responses to dominant forces but, over time, the understandings of power informing these evolving perspectives on resistance have become less structural, more post-structural, and implicitly or potentially open to notions of structuration. She argues that if empowerment begins where individuals are able to imagine their world differently, resistance and empowerment overlap considerably. She states, "By enhancing people's appreciation of their agency and diminishing their fears of the negative consequences of taking action, acts of resistance prepare the terrain for shifting the boundaries of what is possible" (p.115).

Lock and Kaufert state that women have experienced an increasing appropriation of their bodies as a site for medical practice, particularly in connection with the 'medicalisation' of their childbirth journey, however both 'medicalisation' and 'power' are ideas that must be grounded historically and culturally, as must agency, power, and resistance. They highlight the importance of looking at the 'microphysics of power' (Foucault's idiom) and its operation in everyday life. They argue that women are not "passive vessels, simply acting in culturally determined ways with little possibility for reflection on their own condition" (1998, p.2). However, due to the circumstances of women's lives, women have had to learn not to resist but rather how to use what is available which means that their reality and habits are often

grounded in pragmaticism. Smyth also uses the concept of 'pragmatism' in her examination of the strategies that women adopt as they enter motherhood, stating that 'women who inhabit a pragmatist role are guided [...] by the demands of the particular situations they find themselves in as they go about mothering' (2012, p.115).

The next part of this chapter presents the ethnographic data collected among both the Sukuma and the English mothers, exploring the mothers' agency, avoidance, and resistance in the 'microphysics of power' during childbirth, as well as investigating how wider social-economic, political, and cultural factors either enabled or prevented mothers from claiming human rights, as well as their 'pragmatic' ways to keep themselves and their infants safe in childbirth.

Part I: Sukuma Mothers' Human Rights Claims in Childbirth

This first part presents the ethnographic data on the Sukuma mothers' human rights claims in childbirth. The first section describes the efforts to 'empower,' or, rather, the 'failure' to empower the Sukuma mothers in this research study though awareness-raising and human rights training. Then the ethnographic data is presented which reveals the socio-economic, political, and cultural factors that either enabled or prevented the Sukuma mothers from claiming their human rights in childbirth. The last section discusses the ways that mothers pragmatically managed to get their needs met by healthcare providers, as well as resisted human rights violations in subsequent childbirths.

The Empowerment of the Sukuma Mothers in Tanzania

There are a few UN organisations, bilateral agencies, and NGOs in Tanzania that support social accountability initiatives and human rights-based approaches to address human rights violations in childbirth. These initiatives often place women at the centre of the accountability process, 'empowering' women to conduct community scorecards, citizen's hearings, social audits, social monitoring, community maternal death reviews, among others. These initiatives support women to, as Boydell et al. state, "voice their needs and make claims to their entitlements and hold those responsible for the provision of quality services to account" (2019, p.2). The central principle to both is that rights-holders should hold "the duty-bearers (including the government and/or service providers) to account for their actions" (Squires et al., 2020). The theory of change stipulates that individuals and communities are 'empowered' and

somehow muster the countervailing power required to change the behaviour of healthcare providers and decision-makers (Fox, 2015; Boydell et al., 2019).

During the interviews and participant observation in Tanzania, I found that some of the mothers had been influenced by NGO awareness-raising campaigns and information about human rights in childbirth. As aforementioned in Chapter Three, several of the mothers in this research study emphasised the importance of giving birth in healthcare facilities with skilled birth attendants, however, none of them had heard anything about claiming their rights in childbirth. There were several reason for this. First of all, several of the mothers had actively decided not to attend any awareness-raising training seminars. While some of the mothers had been invited to, or previously taken part in various NGO awareness-raising seminars, most of them decided against it, because it involved many hours of work which was not compensated. They felt sorry for the rural women in the villages that were forced to participate: herded together like cattle by the village headman to participate in unpaid projects, seminars or focus groups, whenever there was a new *muzungu* NGO in town. Even if there were opportunities for participating in training seminars that offered per diem, these opportunities were almost always given to others – it was stipulated that it might be the relatives of the village headman or locally hired project workers – but never the village women themselves. In fact, a growing body of research finds that 'community-driven' projects are too often captured by local elites (Platteau and Gaspart, 2003; Mansuri and Rao, 2013; Fox, 2015) that per diems are often given out as 'top up salaries,' as well as to strengthen patronage ties (Marten, 2022) and that many 'empowerment' programmes are in fact disempowering, because contributions are expected from women, often leading to increased labour burdens and the perpetuation of 'female altruism' (Chant and Sweetman, 2012) which is especially problematic in Tanzania where so many women are the responsible breadwinners as heads of households.

Another reason that the Sukuma mothers in this study might not have been informed about any concrete methods to assert their needs or claim their rights in childbirth is because this particular aspect is missing from most of human rights-based approaches and social accountabilities initiatives in Tanzania. While the mothers in the United Kingdom have access to numerous childbirth preparation courses and prenatal information material about childbirth choices, empowerment, and asserting their rights in childbirth, most of the Sukuma mothers in this research study had only been exposed to information about the importance of giving birth in a healthcare facility with a skilled birth attendant. Even though the UN and WHO have

offered practical guides on how to apply the human rights-based approach to maternal mortality, this is solely aimed at health workers, health policy makers, national human rights institutions, and the judiciary, neglecting the women themselves as agents. In fact, even though the UNGA Follow-Up Report (2020) on the UN Technical Guidance on the human rights-based approach to maternal mortality, states that it is critical to engage directly with women themselves in efforts to prevent and treat maternal mortality and morbidity, there are no concrete, practical solutions offered; the UN Technical Guidance only goes as far as recommending that women should have access to relevant information "to enable their decision-making in matters affecting their health, pregnancy and childbirth" (p.15). In contrast, the following section focuses on the mothers' lived experiences of claiming rights and asserting their needs in childbirth. Even though there is a focus on the socio-economic, political, and cultural factors that might prevent the mothers from claiming their rights in childbirth, there is equally also a focus on the 'pragmatic' methods employed by the mothers to avoid human rights violations, if not during their first childbirth, then their subsequent childbirths.

The Sukuma Mothers' Experiences of Claiming Human Rights in Childbirth

The following section presents the ethnographic data on the Sukuma mothers' lived experiences of claiming their human rights in childbirth. The first section highlights the immense socio-economic, political, and cultural barriers that the Sukuma mothers in this research study faced when attempting to claim their human rights in childbirth. In order of challenges encountered:

i) Absent and Unresponsive Healthcare Workers

Several of the Sukuma mothers in this research study stated that it was difficult to assert their needs and claim their rights during childbirth because there were no healthcare workers around or that they were intentionally ignored – so it was simply impossible to assert their rights from someone who was not there. As Ha mother, Rose, explained,

> *I am originally from Kasulu in Kigoma but moved to Mwanza to work here. So, when I got pregnant, I decided to give birth here in Mwanza at (….) Hospital. When I arrived*

there, I would call the nurses for help, but they just ignored me and left me alone in labour.

When some of the Sukuma mothers tried to get attention from the healthcare staff, they would be ignored or, at best, told to wait, and, at worst, be shouted at for 'disturbing them.' A Jita mother from Sengerema, Regina recalled,

Since it was my first birth, I was very scared. I was in soooo much pain and asked the nurses to help me, but even though they were not busy, they kept on saying "later", "later", they kept on ignoring me. They only came over when the head was already out. Then finally a nurse came and pulled out my baby, but I was not happy about it because she didn't use gloves when pulling out the baby, and when I tried to tell her to wear gloves, she just got angry and started shouting at me.

The above statement points to the consequences that many of the Sukuma mothers suffer when they try to claim their human rights during childbirth, instead of healthcare workers becoming more responsive or supportive, as stipulated in human rights theory, it has exactly the opposite effect and further abuse is suffered. The research done by Mselle et al. describes how a high number of mothers have experienced neglect, abandonment, and long waiting times at healthcare facilities in Tanzania. Even if they asked healthcare workers for help, they would not receive a response, and if they insisted upon a response, they were labelled as 'troublesome' and would be told to stop 'bothering' them (2019, p.6).

ii) Abusive and Disrespectful Healthcare Workers

The majority of the mothers interviewed in Tanzania did not assert their needs or claim their rights during childbirth, and if they did, they experienced disrespect and abuse. A Sukuma mother, Kalugula, described how angry the healthcare worker became when she resisted an IV drip being inserted into her arm. She recalled,

I went to give birth at the hospital and when I arrived the nurse-midwife put a drip on me. She did not inform me why and never asked me whether it was okay to do it even though she could see how scared I was…..Afterwards my contractions became so fast and powerful, so I got even more scared, so I asked the nurse to remove it. That made

the nurse angry, so she just left me, and continued to ignore me. Meanwhile, I was screaming because the contractions were so painful, and it made me scared. Eventually, another nurse luckily came by - who helped me, and she shouted at the other nurse for ignoring me.

Shimoda et al. describes how the mothers in their study were too scared to raise any issues due to verbal threats, as well as physical abuse, in Tanzania. Healthcare workers occasionally ensured mothers' compliance through physical abuse, such as beating, slapping, kicking, or pinching them during childbirth, as well as verbal abuse, such as berating, threatening and intimidating them (2018, pp.5-6).

iii) The Fear of Reprisals

A large majority of the mothers interviewed were scared of the reprisals they would suffer if they tried to assert their needs or claim their human rights during childbirth. They were very scared what would happen to the welfare of their infant if they 'disrespected' the healthcare workers or even just 'bothered' them. A Sukuma mother, Bugumba, said,

I would not dare to contradict a nurse-midwife during birth, because she might then just leave me completely, and then what will happen? What if my baby dies because of that? But even if my baby doesn't end up dying during birth, what about in the future? What if I go back to the same clinic in a few months when my baby is sick? Or I have to go back to give birth there again with the same nurse-midwife or her colleagues, why should I get help? At the end of the day, there is no reason to help me if I was a headache last time, I was there.

The mother's statement echoes the research findings by Evans who found that even educated and otherwise confident mothers have explained that they did not dare complain about any poor treatment because they were anxious about consequently receiving even worse treatment from the healthcare workers (2014, p.2). In fact, Strong (2020) describes how healthcare workers in her study in Tanzania did not generally abandon a mother in childbirth but did so after proclaiming her to be non-compliant or otherwise difficult or unsuited to the norms of a biomedical childbirth on the account of her unruly behaviour. The healthcare worker would instead move on to another mother. Thus, claiming human rights during childbirth does not

automatically result in responsive and higher-quality care, as presumed by the linear-rational human rights-based approach to maternal mortality, but can result in unintended local consequences and potential risk to the mother and her infant.

The Sukuma Mothers' Experiences of Negotiating their Needs in Childbirth

The next section presents the ethnographic data on the Sukuma mothers' lived experiences and 'pragmatic' methods to ensure their wellbeing and safety in childbirth. The majority of the Sukuma mothers in this research study faced several socio-economic, political, and cultural barriers when attempting to claim their human rights in childbirth, as described above, but some mothers did manage to negotiate their needs during childbirth or future births. In order of techniques or solutions employed

i) Kinship Networks and Social Connection

Some of the Sukuma mothers in this research study drew upon their kinship networks or social connections to ensure wellbeing and safety in childbirth. Anthropologists have long described how women in Africa maintain large kinship networks that provide close bonds of reciprocity (Aldous, 1962; Caldwell and Caldwell, 1987; Clark et al. 2017). Modern Western political theory is built on the concept of the state: the state was viewed by European political philosophers as a necessary solution for creating order in modern societies (Bartelson, 2001). However, Shaw (2000) explains that many non-Western countries should be understood in terms of kinship networks, rather than the state-centric idea of the citizen-state contract. Whereas the state-citizen contract with its associated public welfare and healthcare delivery is taken for granted in the West, extended kinship networks and are often perceived as more reliable in non-Western countries. This was confirmed by several of the Sukuma mothers in this research study, for example, Anna, who stated that she always drew upon family members if she lacked necessary resources or if she faced a life crisis. However, kinships networks were not always reliable for the unmarried/divorced/widowed mothers in this study, as they sometimes were denied access to the kinship network of their children's father. Furthermore, due to the neo-liberalisation and the rapid urbanisation of Tanzania, some of the mothers' kinships networks were distant and less accessible. However, by way of a different example, the disadvantaged and uneducated Sukuma mother, Kwangu, was able to draw on her social

connections from her past employment in order to receive 'good treatment' in childbirth. Kwangu explained,

> *I worked as a cleaning lady at that hospital, alas I do not know everyone there, but I do know a lot of the people there. I stopped working as a cleaning lady at that hospital before giving birth, but I returned not long after to that same hospital to give birth, because I still knew a lot of the staff there, and I had been in touch with them before my birth, and many of the others also remembered me. I got very good treatment from the nurses there. I am happy to report that I had a good childbirth at that hospital, even though my friends here next to me are telling me that they had a bad births there, I cannot complain, because I had a good childbirth there at that hospital.*

In this way, even the most 'disadvantaged' and uneducated mothers proved themselves resourceful when drawing upon other networks, such as religious networks, and social connections to ensure 'good treatment' in childbirth.

ii) Change of Childbirth Location

Some of the more 'privileged' Sukuma mothers in this research study, who had had a negative experience during their first childbirth in a healthcare facility, decided to save up to have a private childbirth. One example is the young Sukuma mother, Kabisi, who had a stillbirth after she had been ridiculed by the healthcare workers for being pregnant as a teenager, eventually managed to marry a wealthy man, working in the mining industry. This enabled her to give birth in a private hospital. The Sukuma mother, Kabisi recalled,

> *After the nurses ignored me, just sitting there in the office, busy on their mobile phones, sending me away, and the baby as a result being born stillborn, I decided that I did not want to return to that place again, ever…I had a good childbirth experience the next time because I was in a private hospital. The midwife helped me, and she was so supportive and kind. Even though my baby was ill, he had inhaled some of the water from the womb, I was not scared, as it was good medical staff and they gave him oxygen, so he eventually was fine.*

These ‘privileged’ mothers are out of scope of this research, however, this example, shows that some Sukuma mothers do exercise agency in order to improve their childbirth journey the next time they get pregnant, whether this is a private hospital or at home.

Along similar lines, some of the disadvantaged mothers in this research study, who had suffered human rights violations during their previous childbirth(s), decided to change their childbirth location. For example, Viyana chose to give birth at home after experiencing disrespect and abuse. She said,

> *As I said, the nurses ignored my cries for help, hit me or shouted at me. And it was not much better in my two following childbirths, so after that I decided that I might as well just give birth at home, where it is clean, and nobody shouts at you.*
>
> *After that I had all my births at home, on my own. I just sit in my home, and I take care of it myself, and when the baby is born, I cut the umbilical cord myself, with a razor blade, and clean my baby afterwards by myself. I have even given birth to twins myself, where my son’s buttocks arrived before the head.*

As aforementioned, the global biopolitical effort to combat maternal mortality has had a singular focus on increasing the number of births taking place in healthcare facilities, ignoring the discussions about the quality of care provided (Cogburn, 2020), hence, many rural mothers continue to embrace homebirths. They complain about the poor state of maternity wards, low quality of the healthcare services, as well as negative experiences of the healthcare workers (Sialubanje et al., 2015). Several studies in Tanzania have found that mothers, who experienced abuse and disrespect during childbirth, were half as likely to want to return to the same facility to deliver their next child (Kujawski, 2015). As Miltenburg et al. (2022) state, as long as women in Tanzania have poor experiences in healthcare facilities, they will strengthen their self-efficacy and exercise agency in their decision to give birth at home instead.

Some of the mothers in this research study, such as Viyana, effectively avoided the hegemonic power dynamics within the healthcare facilities and thereby ensured greater wellbeing in their future childbirths by choosing to giving birth at home instead. Baaz et al. (2023) argue that the notion of ‘everyday resistance’ should be expanded with the idea of ‘avoidance’ as individuals actively avoid hegemonic relationships by staying away. As Napier (2013b) states, at times resistance is not enough, as one still participates and acknowledges the

hegemonic relationship, instead one has to ignore and refuse to participate altogether. However, even though the decision to give birth at home stands out as a prime example of the Sukuma mothers exercising their agency and avoiding the hegemonic relationship in healthcare facilities, there has been a proliferation of new, localised policies in Tanzania, which sanctions women for giving birth at home (Chimhutu et al., 2014; Strong, 2020; Cogburn, 2020). Thus, the socio-economic-political reality should not be neglected, as some mothers are effectively forced to give birth in healthcare facilities, instead of at home.

iii) Informal Payments/Bribes

Several of the mothers in this research study complained about having to pay for treatments and medicine, which are meant to be free. Marten (2022) states that public accusations about bribery among healthcare workers in Tanzania sometimes stem from misunderstandings about the constraints which limited resources pose to healthcare provision. For example, nurses in Tanzania are often villainised by the public because they often ask for money in order to get supplies that are necessary for their care but are meant to be free. The persistent lack of supplies means that the nurses have to procure them from private pharmacies, hence, a nurse asking a patient for money may, in many cases, not be evidence of bribery. However, some of the mothers in this research study used *hongo* (bribery) to their advantage. These mothers acted as rational actors, using bribery in order to ensure that they had a good and safe childbirth experience. Perhaps unconventional, but effective, these mothers would offer *chai* (a bribe) to healthcare staff. A Sukuma mother, Kinyogoli, stated,

> *I had heard from relatives that you don't get good treatment from the nurses, and that you should be careful what you say to them, because they will just shout at you, tell you to shut up, and slap your legs. So, I made sure not to say anything to them, I just gave the nurse TSH 15,000, so I didn't get any trouble from her.*

Furthermore, I did ask some of the mothers whether they wanted bribes banned from the healthcare facilities where they gave birth. A Sukuma mother, Nhondele, explained her reasons for not wanting bribes banned:

> *I was warned from another mother that if I did not give a bribe I would get really bad treatment from the nurses, so I have saved up for the bribe long time before giving birth.*

> *So, when I got contractions, I went to the closest government hospital. I quietly gave a bribe when I entered the hospital, a total of TSH 10,000. As a result, I got very good treatment by the nurses and I had a good birth…..I don't want bribes banned, because I won't be able to get good treatment from the nurses if I can't give a bribe in the future.*

As rational and pragmatic actors, the mothers recognised that bribery offers better access to maternity services within a healthcare context where demand seriously overwhelms supply.

Camargo et al. (2022) state that when they began their ethnographic fieldwork in Tanzania, they found that it was impossible to discuss treatment at public healthcare facilities without corruption emerging immediately as a central theme. Bribing was normalised to the extent that everyone knew that it was necessary to pay a bribe in order to obtain health services. The bribe was however seldomly a one-off transaction, but rather a first step towards creating a relationship between the patient and the healthcare provider. After the former President Magufuli clamped down on corruption, bribes were instead conveniently described as 'gift giving.' Although it seems that the gift often consists of money, both the patients and many healthcare workers frame the practice similarly as an acceptable, even a positive exchange. The gift, it is often said, is an expression of gratitude, hence the bribery did not disappear but rather adapted. They state that the informal payment or bribe thus morphs into a gift and it is justified on the basis of cultural and affective considerations. Similarly, my ethnographic data revealed that the 'gift-giving' emerged as a problem-solving strategy for the mothers in this research study - bribery offered a means to obtain easier access to a health system where demand seriously overwhelms supply.

Several of the healthcare staff that I interviewed during my fieldwork politely refused to talk about bribery or 'gift-giving,' however, during informal conversations, it transpired that many healthcare workers found it difficult to survive without receiving bribes due to low salaries – perhaps pointing to the root cause of their functionality. However, some of the wealthier healthcare workers also expect 'gifts.' For example, when I volunteered to help with the fundraising for the little maternity clinic, the medical doctor stated that there naturally would be a box installed in the maternity ward, so that mothers could "show their gratitude by putting little gifts into it." However, even though Mauss (1950) reveals the significance of gift-giving as a way to establish and maintain relationships - and that this research study found that

bribery/gift-giving benefitted some of the mothers, it ultimately means that the most 'disadvantaged' mothers, who do not have the resources to do so, suffer the consequences.

Part I Summary: Sukuma Mothers' Human Rights Claims in Childbirth

My ethnographic research found that the Sukuma mothers in this study had great difficulty asserting themselves and claiming their human rights in childbirth, due to: i) absent and unresponsive healthcare providers; ii) abusive and disrespectful healthcare workers; and iii) fear of reprisals. Some mothers had learnt from their own childbirth experience or the experiences of other mothers, to negotiate with the healthcare workers to get their needs met, or to take direct action to avoid human rights violations in subsequent childbirth. The mothers soon realised that if they attempted to assert themselves directly with the healthcare workers, they would suffer consequences, such as disrespectful and abusive behaviour from the healthcare workers or would just be ignored. Even worse, the mothers soon found out that there was a potential risk that their infants might suffer the consequences if they fell out of favour with the healthcare workers. Instead, they had to i) draw upon kinship networks or social connections; ii) change their childbirth location; nor iii) pay informal payments to the healthcare workers. Unfortunately, the most disadvantaged mothers had neither the required social capital, connections, or resources, so often had to give birth at home instead or return to a healthcare facility to face disrespect and abuse yet again.

The human rights-based approach to maternal mortality speaks about empowering women to claim their rights, but since it is aimed at policy makers, judiciaries and national human rights institutions, the individual woman seems to be left out of the equation. Perhaps the individual woman has been left out of any practical guides to the human rights-based approach to maternal mortality, because it re-directs the focus away from the right of the individual woman to choose a home birth towards choosing a childbirth in a healthcare facility, as this is in alignment with the global biopolitical agenda? If so, the human rights-based approach does homogenise mothers into the same group as thousands of other nameless individual mothers, separating them from their local particularities, into one grand narrative with one obvious solution: the adoption of the Western biomedical childbirth (Allen 2004; Berry, 2010; MacDonald, 2013). Perhaps the human rights-based approach to maternal mortality does not actively seek to empower mothers in childbirth, as it is more convenient to represent and reduce the individual

mother to a 'suffering birthing body' - a victim who should be saved in a healthcare facility by a skilled birth attendant, instead of an active agent with her own rights and agenda. Afterall, if the individual mother was truly 'empowered' and educated about her human rights in childbirth, she might just exercise her right to give birth at home.

The human rights-based approach to maternal mortality is based on the idea that if only rights-holders are informed or educated about their human rights, they will seek to 'close the gap' by standing up to claim their rights. Fox (2015) has, however, found that *information is not enough*. Specifically, impact evaluations have tested the proposition that local dissemination of service delivery outcome data will activate collective action, which will in turn improve service provider responsiveness. The studies found that there is no impact from information dissemination interventions (Banerjee et al., 2010; Keefer, 2012; Lieberman et al., 2014). This was confirmed by my ethnographic data, even if the Sukuma mothers in this research study were painfully aware of the gap that existed between what the kind of treatment they should receive, compared to the treatment they did receive, they soon realised that it would only result in potential risk to themselves and their infants if they did 'stand up and claim their rights.' In fact, my ethnographic found that we should be cautious when encouraging women to claim their rights in childbirth, since the persistent power hierarchy within a healthcare context, is not only very difficult to change, but can be dangerous to confront. In fact, many of the 'pragmatic' Sukuma mothers in this research study were astutely aware of this, so they instead drew upon their social status, kinship, and social connections, as well as their limited resources to secure 'good treatment' from the healthcare workers. Thus, the ethnographic data in this part of the chapter has revealed that, even though the human rights-based approach to maternal mortality highlights the importance of individual women standing up to claim their human rights, instead of merely "avoiding maternal mortality and morbidity" (UN Technical Guidance, para. 12), the focus of the 'pragmatic' Sukuma mothers was *precisely* on finding ways to avoid maternal and infant mortality.

Part II: The English Mothers' Human Rights Claims in Childbirth.

The second part of this chapter presents the ethnographic data on the English mothers' motivations to claim their human rights in childbirth, as well as the social factors and cultural determinants that prevented them from doing so. Firstly, the English mothers describe which avenues specifically encouraged and 'empowered' them to assert their rights in childbirth. Then

the social and cultural factors that prevented them from claiming their human rights during childbirth are explored, and finally, their 'pragmatism' and motivations are revealed, as well as their efforts to avoid human rights violations in their future childbirths.

The 'Empowerment' of the English Mothers in the United Kingdom

This first section of this part of the chapter describes the information sources that encouraged and 'empowered' the English mothers to voice their childbirth choices and actively claim their rights in childbirth. Almost all of the mothers interviewed in the United Kingdom had accessed the internet or attended various childbirth preparation courses which provided them with information about childbirth as well as the different 'childbirth routes' that were available to them. Additionally, they had also been exposed to various information material and childbirth preparation courses that encouraged them to assert their needs and rights during childbirth.

Whilst the human rights-based approach to maternal mortality is mainly targeted at health systems and women in middle- and low-income countries, human rights discourse has nonetheless trickled down to these childbirth preparation courses in the United Kingdom and were especially employed by organisations which promote 'natural' childbirth. Even though the human rights-based approach is vague as how exactly to 'empower' mothers themselves in childbirth, these childbirth organisations in contrast provide very concreate advice on how to 'assert your childbirth choices,' how to 'claim your rights' and 'how to be your own advocate' in childbirth. As an example, Lamaze International states that the way in which a mother can advocate for herself in childbirth is by educating herself about her various options in childbirth, asking the healthcare providers questions, role playing, bring along a support person and, finally, assert herself in childbirth when needed. As stated,

> Manners, niceties, and a kind tone of voice go a long way when working with staff and care providers. But when it's time to be direct, do so without apology (Lamaze International, 2023).

Several hypnobirthing courses have similar guidance notes available to mothers, stating that they will teach pregnant women about their rights in childbirth, and in additional AIMs has published an online book, which outlines concrete steps in order to be heard and assert needs in childbirth. Finally, the NGO BirthRights informs mothers about their human rights during pregnancy and childbirth. BirthRights highlights the superiority of the individual mother's rights in childbirth, even in cases of maternal-fetal conflict, also known as obstetric conflict,

when a pregnant mother's interests conflict with the interests of the foetus, which gives the mother the right to deny medical interventions, such as blood transfusion, emergency caesareans, etc.

The NCT has an extensive reach through its NCT courses, as well on the internet, both within mainstream and academic forums. The NCT website avoids the 'controversial' language of human rights, instead focusing on women's childbirth choices. The NCT has a number of academic writers who have conducted childbirth research which almost always appears to conveniently conclude that a 'natural' birth without pain relief is what is best for birthing women. Mary Newborn et. al. in their article "Has the medicalisation of childbirth gone too far?" first state that the arena of childbirth was traditionally attended to by female midwives until it was taken over by men who used 'destructive' instruments and medical procedures. They then go on to arguing that the medicalisation of childbirth has continued up until recently, and that women continue to be subjected to unnecessary medical interventions. They state,

> In many countries women who have straightforward pregnancies are subjected to routine intravenous infusions and oxytocin in labour. Women without obstetric complications are encouraged to have electronic fetal monitoring and epidural analgesia (2002, p.892).

Tuteur (2016) states that most of the discourse by childbirth activists found on the internet constructs the idea of the male, domineering obstetrician who wants to 'subject' birthing women to 'unnecessary' medical interventions, even though most obstetricians today are women who only want to carry out medical interventions in order to save the lives of the mothers and infants.

The majority of the English mothers in the study either attended NCT or NHS antennal classes. Several of the mothers had also attended hypnobirthing classes or pregnancy yoga classes. The NCT and hypnobirthing classes were mostly found useful by those mothers in this research study who had wanted a 'natural' childbirth, whereas those who had thought about opting in for either pain relief or planned caesareans were left somewhat alienated. An English mother, Celia, stated that a 'natural' childbirth was constantly highlighted in her NCT course as the best kind of childbirth. She recalled,

> *There was an unspoken consensus that a midwife-led, natural childbirth in a birth centre was PREFEREABLE to a birth in hospital with pain relief. And if caesareans were mentioned, it was instantly presented as something horrible. In fact, we did this*

role play with the trainer, all the others were lined up as pretend medical staff, and I was the mother having a pretend caesarean section. The scenario really scared me, as the process was presented as chaotic, overcrowded and disempowering. It's ironic, because in real life, it was my midwife-led birth that was chaotic and scary, whereas the female anaesthetist at my scheduled caesarean at St Thomas Hospital made me feel both well-informed, as she kept on telling me what would happen throughout, and she made me feel safe.

Some of the mothers found the hypnobirthing courses useful as they gave some practical tips to be used during childbirth, such as breathing and guidance for the fathers on how to help in childbirth. A white, middle class Swedish mother, Ingrid, stated,

I really do think that self-hypnosis is great, as it teaches you techniques to overcome anxiety and just relax. I also think the course was good because it gave my husband and I an opportunity to practice the childbirth situation, such as breathing, but perhaps more importantly highlighted that we needed to prepare our partners for the childbirth, how my husband could best support me during the childbirth, also how he could talk to the midwives about what I wanted, what we needed, and guided me in how to talk to the midwives and doctors, all of those things, and that was great.

Ingrid said that she found the course really great, because the instructor provided concrete examples on how to assert her needs and rights in childbirth, as well as instructed her husband to do the same. However, she also found that some of the instructor's statements made her feel bad about herself later on when she eventually had to be induced. She tearfully said,

The course instructor said that we should not let the doctor push us into having an induction, even if we were past the 42 weeks. Instead, we should just wait until the baby was ready to come out, you know, baby knows best….After 41 weeks I was induced because of reduced fetal movements…Instead of being happy that the induction probably saved my son's life, I spent so much time feeling guilty, almost as if I had failed my son by putting him through an induction. I know it does not make rational sense, but I keep on thinking that perhaps should have waited until he was ready to come out.

The most common reason for induction is a post-term pregnancy, a pregnancy that has gone beyond 40 weeks of gestation, because the placenta becomes unable to supply the infant with adequate oxygen, doubling the risk of stillbirth (Tuteur, 2016). The Sahlgrenska University Hospital in Sweden lead a research project which followed pregnant women beyond the 42 weeks; however, it was promptly stopped after five stillbirths and one early death. As Winnerholm et al. concluded, "induction of labour ought to be offered to women no later than at 41 weeks and could be one (of few) interventions that reduce the rate of stillbirths" (2019, p.11). However, the hypnobirthing trainer above, and numerous childbirth activists continue to frame inductions as 'unnecessary' medical interventions. The AIMs website states,

> Currently, women are being led to believe that there is a high chance that their baby will die if they continue with their pregnancy beyond 42 weeks. However, even those studies which appear to show a protective effect of induction before 42 weeks make it clear that the risks of continuing pregnancy beyond this point are extremely low (AIMS, 2023)

Even though these kinds of childbirth preparation courses and information materials frame their information as neutral and supportive of women's own childbirth choices, the human rights discourse they employ often seems to encourage pregnant women to claim their right – not to the childbirth they want – but specifically to have a 'natural' childbirth.

Some of the mothers interviewed in the United Kingdom found that when they attempted to get advice from their healthcare providers, whether midwives or obstetricians, or even their local GP, they found the medical staff reluctant to specifically offer advice on what kind of birth to choose. As a result, the mothers retreated back to their NCT friends for advice, or the above-mentioned information material to make an 'informed' decision. As an English mother, Cathy, stated, "It's almost like all roads lead to Rome – you have a right to make your own childbirth choices, but if you want to be the best kind of mum, have a natural birth." Douglas and Michaels state that mothers are currently influenced by the ideals, norms, and practices of 'New Momism' which seem on the surface to celebrate motherhood but sets unrealistic standards of perfection. They state,

> Central to the new momism, in fact, is the feminist insistence that women have choices, that they are active agents in control of their own destiny, that they have autonomy. But here's where the distortion of feminism occurs. The only truly enlightened choice to make as a woman, the one that proves, first, that you are a 'real' woman, and second, that you are a decent, worthy one, is to become a 'mom' and to bring to child rearing a combination of selflessness and professionalism that would involve the cross cloning of Mother Teresa with Donna Shalala. Thus, the new momism is deeply contradictory: It both draws from and repudiates feminism (2004, p.5).

Similarly, the natural childbirth activist information material relies on the feminist insistence that women have childbirth choices, that they are active agents in control of their childbirth, that they have rights and have autonomy. But here is where the distortion of human rights and feminism occurs. The only truly enlightened choice to make as a mother is the one that proves, first, that you are a 'real' mother, and second, that you are worthy to become a mother is to have a 'natural' childbirth. Thus, it both draws from and repudiates women's human rights in childbirth.

The English Mothers Experiences of Claiming Human Rights in Childbirth

In this next section, the ethnographic data covering the English mothers' lived experiences of claiming their rights in childbirth are presented. Firstly, the socio-economic, political, and cultural barriers, which prevented mothers from claiming their rights during childbirth are explored, and then finally, the 'pragmatic' ways that the mothers found to assert their needs are described.

During the focus groups and the one-to-one interviews with the English mothers in the United Kingdom, I first let the mothers describe their childbirth experiences. If some of the mothers highlighted elements of these experiences as disrespectful, abusive, violating, or traumatic, I would explore whether they were able to assert their needs, or in some way claim their rights directly or indirectly to remedy this. Even though the majority of the English mothers in this research study were 'empowered' and educated about human rights, with some of the mothers even having knowledge about the relevant legal protections, several of the mothers found it difficult to assert themselves and claim their human rights in childbirth. The following list outlines the main socio-economic, political, and cultural factors that prevented the English mothers from doing so. In order of challenges encountered:

i) Absent and Unresponsive Healthcare Workers

Several of the English mothers in this research study found it difficult to claim their rights in childbirth because the healthcare workers were unresponsive or just not there. A Canadian mother living in the United Kingdom stated that she was simply dismissed when she approached a healthcare worker about a suspected urinary tract infection (UTI). Claire recalled,

I was pregnant when I noticed a burning sensation when urinating. I called them and went for a check-up. When I was there, I proposed that it was a UTI, but the midwife totally dismissed it and didn't even bother taking any tests, she was completely unresponsive, she just sent me home.

I returned to the hospital when I felt the onset of painful contractions. First of all, there was no one at the reception when I arrived, and when a midwife finally arrived – my painful contractions were just dismissed, as the midwife said, "This is your first birth, so naturally you are going to be in pain."

I am actually quite sad talking to you about the whole thing because I had hoped to give birth at the birth centre, but instead I had to undergo an emergency caesarean in the ward because of my undiagnosed UTI. Yes, that's right. I had a UTI after all – if only that midwife had bothered to check it in the first place.

Furthermore, a few mothers stated that it was impossible for them to assert their rights in childbirth when there were simply no healthcare workers around. A Danish mother, Kristina stated,

I was two weeks overdue, so I had to be induced. The night midwife tried to give me some sweeps, but it did not do anything. She explained nothing to me, she just did it, she didn't even introduce herself. Since it did not work, she decided to give me oxytocin, I think, as again she didn't explain anything to me, she could barely be bothered to talk to me and just looked angrily at me.

I had never given birth before, so I had no idea what to expect, but when the contractions came, they were so scary and painful….I was alone in pain for hours, the midwife had just left me and I was just lying there for hours, with more and more extreme contractions. I could see on the monitor that it was extreme, but there was no midwife there to look at the monitor, to tell me whether I was okay. Then I started getting worried because I could feel that my baby's heartbeat started slowing down – I could feel it inside my tummy – I got so scared and started crying – I kept on pressing the button, hoping the midwife would come, but she never came. In the end my mother had to run out into the corridor to find someone – Another midwife came and pressed

the panic button – and immediately there were doctors all around my bed saying that they had to rush me into theatre to have a caesarean. I remember that I could see out of the corner that the doctor was telling the midwife off for not being there, and asking her where she had been. He asked her why she had abandoned me.

The Care Quality Commission's Maternity Survey (2022) found that 62 percent of the participating 20,900 women were abandoned during childbirth, so that they could not get the help they needed. Results were lower still for care in hospital after childbirth, with only 57 percent saying that they were 'always' able to get help.

ii) Physical and Mental Inability

Some mothers were not physically able to assert themselves, let alone even ask the healthcare providers questions or claim their human rights due to acquiring temporary and long-term disabilities during childbirth. A mother who had a spinal leak during childbirth, was subsequently unable say or do anything. The Irish mother, Sheila, explained,

I had a spinal leak during my childbirth, but it was not diagnosed until three days later. I was just lying there for three days. But I couldn't do anything, I couldn't sit up or hold my baby, and they were just happy to leave me there. Midwives kept on saying: "It is your fourth caesarean, so it all will feel different, it will get better, you just have to give it time."

Everyone was just happy that I was quiet. That I did not make a scene.

My mum used to be a matron at St Mary Hospital, so mum told them, there is no way that this is right. As soon as my mum told them: "I am telling you, this is not normal. I am qualified, and this is NOT normal". Then they took me back to theatre to do some tests. The doctor didn't even come, it was the nurses that came and said to me that they got the report from the doctors, and they were prepping me to go back to theatre. Then they straight away said spinal leak.

When I got into theatre, they were all there, and I was really crying. I was terrified, I thought I was going to die, I thought to myself: "Why am I going back here, maybe it

is more serious than they are letting on to me. Then I was crying and shaking. He was like, "We are not going to be able to do this if you can't stay still, we might damage your spine."

I was really scared. Then I don't remember nothing. I woke up four hours later. My back hurt for months. If this was my first, I would probably not go on to have another one….If my mum had not put her foot down, how long would I have been lying there for?

The physical and mental inability of some mothers to claim their human rights during childbirth highlights the extremely vulnerable position which women are in during childbirth. As Napier and Volkmann (2023) argue, vulnerability is complex and multi-layered, never static, but rather in flux, possessing a temporal component and which occurs on a spectrum. Furthermore, Pickles and Herring (2019) state that it is not so much the women themselves that are vulnerable, but in a situation that renders them vulnerable.

Stoller (2004) describes how everyone, during his illness journey to cure cancer, including his own medical doctor, stressed the importance of being your own advocate. Even though cancer and childbirth should not be compared as such, as childbirth is by no means an illness like cancer, he does highlight the important point that it is simply exhausting to be your own advocate. Furthermore, ideas about 'being your own advocate' and human rights discourse effectively transfers the responsibility from the healthcare provider onto the shoulders of the individual, which is particularly difficult for an individual in a vulnerable situation such as childbirth. Rose has coined the term 'responsibilisation' to describe the process whereby subjects are rendered individually responsible for a task which previously would have been the duty of another, such as the state (or healthcare provider). He argues that 'responsibilisation' as a technology of governance is deployed increasingly in advanced liberal democracies whereby "the problems of problematic persons are reformulated as moral problems in the way such persons conduct themselves and their existence" (2000, p.334).

iii) Authoritative Knowledge in a Biomedical Childbirth

Several of the second-time mothers stated that, whilst they had tolerated that their childbirth choices had been ignored during their first childbirth, since they felt that they did not know

what they were doing, they had a harder time accepting this during any subsequent births. As English mother, Iris, explained,

> *You know, I did not feel confident in my body's abilities during the birth of my oldest daughter. It was my first birth, and I did not know what I was doing, but after that (birth), I felt more confident that my body knew what it was doing. So when I went into labour with my youngest daughter, I was not so scared and I kinda had faith in my body, you know, my body knows what it is doing, that kinda thing.*
>
> *But even though I knew what I had to do and what I wanted, even though I did highlight my rights, my childbirth choices, even when I told them, it was as if they did not hear me. Even if I repeated myself, it was as if they chose not to hear me. Even when I told them about the things I was feeling inside, in my body, what was happening to my body, all the things that I could feel inside my body, it was just dismissed. Even though I told them that I was not a first-time mother, and that I knew what labour was like, what it should feel like, they were just not interested in my point of view. And that was when I started doubting myself and doubting my body's ability to do it again.*

Jordan describes how 'authoritative knowledge' is given priority within a biomedical childbirth context, whilst the woman's actual bodily experience is dismissed. She provides an ethnographic example from the context of a biomedical childbirth in which the knowledge of the healthcare workers is given priority over that of the embodied knowledge of the mother during childbirth. She states,

> Every effort is made to keep her from giving in to the overpowering impulse to bear down. She is asked to suppress the urge long enough for the physician to come in and pronounce her ready. The physician is paged several times but does not appear. Meanwhile, the woman is doing Lamaze breathing….The nurse makes every attempt to help the woman remain within acceptable behavioural norms by breathing with her in the Lamaze pattern. As time goes on, the woman's distress and pain become more and more pronounced…..The physician finally arrives, together with a male medical student. He examines the woman and declares that she is ready to push (1997, p.63-64).

Jordan identifies how everyone, including the obstetrician, the nurses, and the mother herself, work hard to maintain the definition of the situation as one where the obstetrician 'knows the facts' whilst the mother's bodily knowledge counts as nothing. Even when the mother's body has already gone into active labour, everyone upholds the idea that it is the obstetrician who should establish when the mother is ready and should start to push. Authoritative knowledge is

in this way an interactionally grounded notion, as everyone in the room works together to establish it as the truth. Even worse, the mother's knowledge of her own body is actively ignored by the obstetrician who establishes his professionalism by his impersonal attitude towards her. She states, "He treats her as an object, a performance that is made possible by the fact that others isolate and shield him. He never has to deal with this woman as a person" (p.70). Jordan's example shows how difficult it can be for mothers, not just to share knowledge about her own body, but even more so to claim rights during childbirth within a biomedical context, as biomedical knowledge is valued over that of the mothers' knowledge. As Jordan explains, within a particular domain such as the childbirth context, several knowledge systems exist, however, by consensus, some come to carry more weight than others. As Jordan states, "The power of authoritative knowledge is not that it is correct but that it counts" (p.28).

Recently, there have been attempts to make childbirths more woman-centred. Nimmon and Stenfors-Hayes (2016) nonetheless state that the idea of patient-centred healthcare is intrinsically difficult within a biomedical context since healthcare workers and, especially medical doctors are not able to 'share power' with their patients. They have investigated the interactional power exchange between healthcare workers and patients, and drawing upon the theory of Bourdieu, they illustrate how power is present in all interpersonal relationships. Power is neither positive nor negative but 'comes into being' when it is put into action through healthcare 'strategies.' These healthcare strategies are observable in that they are expressed through language; and language is tied to structures of power such as the social institution of medicine. Medical doctors can exert power by drawing on the legitimised institutional language of medicine that they are affiliated with by virtue of their qualifications and training. Therefore, even at the micro level of interaction, the very nature of the relationship between patients and medical doctors is asymmetrical. This unequal relationship is a product of medical doctors possessing legitimised and expert power meanwhile patients are reliant on medical doctors to provide them with the healthcare they need. Hence, mothers' will always struggle to communicate any knowledge of her own body, as well as her actively claim her rights during childbirth because the inherent power imbalance in the medical doctor-patient dyad is characterised by the medical doctors' possession of expert knowledge. With the benefit of this insight, it becomes clear how a biomedical context inevitably constrains mothers active rights claims in childbirth while enabling the dispositions, action, and perceptions of healthcare workers.

iv) Fear of Reprisals

Some of the English mothers in this research study stated that they did not assert themselves or claim their human rights during childbirth because they were worried that the health care workers would deny them or their infants the required healthcare as a result. A first-time English mother, Emelia, said,

> *After my emergency caesarean I was sent to the postnatal ward with my newborn son who was ill - suspected sepsis. The midwife had to give him antibiotics regularly through his cannular, it was awful because the night shift midwife kept on doing it wrong so my son cried and cried….So when the dayshift midwife came along and did it, and did it really well, I asked her whether she, or someone else could do it, instead of the nightshift midwife. But I should never have done that (mother pauses) the night shift midwife ran up to my bed and started shouting at me, saying that who was I to complain about her, and that she had fought in the Liberian civil war, and showed me the scars on her arms, and said that she was not scared of me…The problem is that I would normally have been able to handle a situation like that, but I was physically weak after my emergency caesarean, and I was worried about my ill baby, so I just froze…I didn't know what to say, as she was so physically huge standing next to my hospital bed and it was scary as she was shouting at me, and I was scared of being accused of being racist if I said anything about her, which is ridiculous since I am not racist at all, but I was just so physically vulnerable, trying to heal after my operation and emotionally vulnerable, because I felt that she somehow had the power over the health of me and my son, so I just kept quiet, and did not say a word to her or anyone else.*

Several of the mothers in this research study stated that their interactions with healthcare workers were not motivated by claiming their rights but, rather, influenced by the fear of reprisals in relation to their main concern: the welfare of their infant. In this connection, they perceived any 'negative' or confrontational interactions as potentially risky to the wellbeing and safety of their infant.

The fear of reprisals from speaking up was particularly a matter of concern for some of the English Black mothers interviewed, as Jackie stated,

I was in constant fear of being perceived as an angry Black woman during all my births as you know you will instantly be dismissed and ignored by everyone, you will just get frozen out.

Even during by second birth when I had to have an emergency c-section, and they didn't administer the anaesthetics properly, so it hurt, I refrained from saying anything, as I kept on thinking that they would do a really bad job of it, if I complained, so I kept quiet, kept on thinking about my baby, and was counting the seconds until it was over.

Ashley (2013) describes how the racist idea of the 'angry Black woman' highlights all Black women to be irate, irrational, hostile, and negative, which not only influences healthcare workers attitudes towards Black women, but also means that they refrain from expressing themselves due to the fear of the reprisals from healthcare providers. Crenshaw (1991) has drawn attention to the fact that Black mothers face discrimination on two accounts, both due to their gender and their ethnicity. Crenshaw coined the term 'intersectionality' within the legal field to describe how discrimination law has tended to treat identity categories separately, along a singular axis of discrimination, whereas in reality the various identity and political categories become compounded cases of discrimination. This is problematic for Black mothers in childbirth, not just because of the compounded discrimination they potentially face from healthcare workers, but also because of the compounded fear of reprisals.

In 2020, MBRRACE-UK investigated data on mothers who had died during or up to one year after pregnancy in 2018–2020 in the United Kingdom. The key findings from the report showed that there is almost four-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to white women. (MBRRACE-UK, 2022). In 2022, the NGO Birthrights followed up with the report 'Systemic Racism, not Broken Bodies,' which revealed the systemic racism within maternity care in the United Kingdom. The report described how many Black, Brown, and mixed ethnicity mothers often felt unsafe, were ignored, and disbelieved, were subject to racism by caregivers, were not given a proper choice or the means to give true informed consent, and were subject to coercion from caregivers, were regularly dehumanised and were disproportionately affected by structural barriers to care. Finally, the report also described how the most vulnerable migrants and refugee mothers faced discrimination in the maternity healthcare context, as well as racial profiling, "where

British-born Black and Brown women were asked if they need to pay for treatment based on their ethnicity or appearance e.g. skin colour or religious dress" (2022, p.74).

v) Undermining the Trust in the Mother/Healthcare Worker Relationship

Several of the mothers in this research study stated that they were worried about undermining the trust in their relationship with their healthcare worker during their childbirth if they highlighted concerns or asserted their rights in childbirth. The mothers described this as a mixture of their worry about challenging their authority and fear of reprisals but, at the same time their empathetic concern for the overworked and stressed healthcare workers. An English mother, Maria, stated,

> *I did feel sorry for my midwife as she was looking after three other women at the same time, and I didn't want to add to her stress. Also, I was worried that if I started getting stressed or agitated myself, then she would have even less reason to attend to me when I needed her, no one want to be around someone who is self-entitled, or too needy, and all that. I guess being assertive in that situation doesn't really work, because it just undermines your relationship with your midwife.*

The previous chapter (Chapter Three) has revealed the dichotomy of 'natural' vs. 'biomedical' within the field of childbirth which fails to capture the complex set of practices, outcomes, and perceptions that take place during childbirth (Irvine, 2021). Similarly, human rights discourse seems to create a dichotomy between the mother vs. the healthcare worker. Wilson states that human rights discourse relies on a Manichean dualism (violated/violator; powerless/powerful) which constructs its subjects as either innocent victims or 'human rights perpetrators' (1997, p.142). Cowan (2006) highlights that the strident moral absolutism of human rights discourse risks alienating those labelled as 'human rights perpetrators' as they may perceive their own concerns denied or misunderstood. Similarly, none of the healthcare workers who I interviewed in the United Kingdom or Tanzania were whiling to frame themselves as 'human rights violators' and highlighted that negligence is never done with criminal intent.

As I was getting ready to return home from Tanzania, I had dinner with a healthcare worker who personally knew Dr Jacob Kamanda, who had been charged for medical negligence after performing caesarean surgery. He stated, "That operation was done under such difficult circumstances. That poor man, he was never himself again after that court case. He just seemed to disappear and was just depressed all the time, he seemed to just fade away."

When I discussed this case further, as well as the issue of mothers taking claims to court, he stated,

> *You have no idea how hard it is for us to hear a complaint from a patient – let alone being accused of malpractice. We try our best to help women in childbirth, to help treat patients. When we made a mistake, or if a patient complains about us, it turns our life upside down. From the outset, we are trying our best… We try to save the lives of our patients, and that is what we are here for.*
>
> *Yes, we need to learn from our mistakes, but at the end of the day, sometimes we make a mistake because these things happen when you don't have the right medical equipment, or because you don't have any other staff to help you at that time – we are trying our best to save lives in these operations.*

London argues that frontline healthcare workers are frequently unable to provide adequate access to care because of "systemic factors outside their control and because of management systems that disempower them from acting independently and effectively" (2008, p.72). Focusing on individual health practitioners' conduct divorced from their context in such a situation, London states, "frequently makes little headway and gives a human rights approach a bad name" (p. 73). Yamin (2008) argues that the use of human rights litigation for institutional and structural change should not be conflated with human rights advocacy which only seeks to identify a violation, an individual perpetrator, and a remedy, since most errors in the health system are rooted in institutional and systemic defects. She states that, even in cases of medical malpractice, a human rights perspective should focus not on the malpractice per se but on the system that condones wanton disregard for the mother's wellbeing. Even if human rights litigation might seem like a tempting tool to 'teach' healthcare workers a lesson, the traditional advocacy models seeking redress for individual cases of human rights are not enough to guarantee systemic change. She argues that rigid punitive remedies imposed upon frontline workers might become a disincentive for healthcare workers to handle obstetric emergencies (Yamin, 2013). However, even though Yamin highlights important points in relation to human rights litigation, she neglects the unintended consequences of transferring human rights discourse from the legal realm into the childbirth arena. If the concept of 'human rights violations' is transferred from the legal realm to the field of childbirth, it intrinsically necessitates the construction of the categories: 'victims' vs. 'human rights perpetrators.'

Daviss and Davis-Floyd (2021) advocate for moving the concept of 'human rights violations' into the arena of childbirth since it forces policy makers to wake up to the importance of childbirth issues. However, human rights discourse in the childbirth arena might have unintended consequences for healthcare workers. Even though some natural childbirth activists might not mind that male obstetricians are categorised as 'human rights perpetrators' engaged in obstetric violence, it is worth remembering that even midwives might end up labelled as such, since the tabloid press in the United Kingdom, does not shy away from a modern-day witch hunt of midwives. As stated by Hickley and Mitlin (2009), the abstract promotion of rights, often from a position of moral grandstanding, is more likely to aggravate than solve intractable social and economic problems and shaming and blaming can only take things so far. Cowan highlights that the strident moral absolutism of human rights discourse is counter-productive to relationships within a healthcare context in as much as these require "less self-righteous modes of relating that are also more attuned to moral complexity: listening, compromise and the creation of new solidarities and practices of co-existence based on recognition of an imperfect, shared humanness" (2006, p. 7). Not only is human rights discourse at risk of rendering the birthing mother a powerless 'victim,' but also frames healthcare workers as 'human rights perpetrators, which may ultimately undermine the relationship of trust between the mother and her healthcare worker in childbirth.

The English Mothers' Experiences of Negotiating their Needs in Childbirth

In this section we will look at the pragmatic ways in which the English mothers did manage to assert their needs and ensure wellbeing during childbirth. Some mothers in this research study had learnt from their own prior childbirth experiences, or particular social-economic, political, or cultural factors enabled them to take direct action to ensure their human rights were upheld during childbirth, so that they would have a good childbirth experience. These were as follows:

i) Mothers' Change of Childbirth Location

Some of the English mothers who had suffered human rights violations during their previous childbirth(s) decided to change the childbirth location for their subsequent childbirth. This included mothers deciding to have homebirths after having traumatic childbirth experiences in hospitals. A French mother, who had recently had a home birth, Celine, explained,

My first childbirth was a disaster. The hospital where I gave birth was supposed to be one of the best in the country, but I don't know, maybe they were too busy, and over-subscribed….When I arrived they did not believe that I was in labour, so they asked me to wait in the hall. But when I went to the toilet my baby's head was crowning out of my vagina, so my mother shouted for the midwife. When the midwife came she could not believe what she was seeing. She got hold of a wheelchair, and wheeled me to the ward, but had to go through the hallway, so the whole place could see my naked behind. It was quite embarrassing. Anyway, the birth happened, and luckily my baby was okay. But then again, they had no time to see us. Even my placenta was just lying there next to my bed for hours before the cleaning lady removed it. Anyway, all of these experiences made me to have a home birth when I became pregnant the second time. And I can tell you, it was a lot better. You know I gave birth right here on the sofa that we are sitting on. The midwife was nice, everything was calm, and it was homely.

Other mothers in this research study chose to give birth in midwife-led birth centres after having had a traumatic childbirth in hospital. A white, middleclass English mother Laura recalled,

My first childbirth had been very traumatic. The midwives at the hospital were just horrible. They treated me as if I was an inconvenience, and just said derogatory things about me over my head…..So when I got pregnant, I was very worried about giving birth again. But then we moved to this area, and we had a tour of (….) the birth centre, and I was pleasantly surprised, as it even looked like a hotel! So we booked the Centre for our birth…..My baby was overdue when my contractions began; so we called the Centre and they told us to come in…….I was in labour for 1,5 hours and it really hurt and I screamed; but the midwives were so supportive and caring and guided me through the whole birth…..After the birth there was no rush, they just tucked us in and gave us a cup of tea and a piece of toast, and it was just lovely.

Several of the English mothers interviewed had very positive childbirth experiences at the midwife-led birth centres. Finally, some mothers decided instead to give birth in a private hospital, as the Swedish mother, Jennie, recalled,

I did not want to go through such a horrible experience again, and nearly lose my child just due to some midwife's incompetence, and frankly laziness. She couldn't be bothered to support me; she couldn't even be bothered to be there. So when the emergency happened, she wasn't even there. So I decided never again! A private birth is very expensive, so we had to save up for a long time; but I told my husband that I was not having any more children, if I couldn't have a private birth…..Because it is also about what happens to you after the birth. They put you into a noisy and hectic postnatal ward. I had to recover from my emergency caesarean and my child had to recover from the illness; but we just did not have the required peace to recover…..And let me tell you, the private birth was perfect. The medical doctor explained everything to me, introduced me to everyone, listened to my requests, followed my instructions – such as skin-to-skin. And my private room was like heaven, so peaceful so I could sleep after the birth.

Again, the mothers who could afford private hospital are generally out of the scope of this research. However, the example is provided, to illustrate that mothers can be active agents who may not claim their human rights in their first childbirth, but eventually through the change of birth location, whereby they find a childbirth space that is more conductive to the rights and needs of the mother. A change of birth location, however, is restricted to the mothers that have the resources to do so.

ii) Biomedical 'Insider' Knowledge

Some of the English mothers interviewed were 'insiders,' as they themselves were nurses, midwives, or medical doctors, or had family members who were healthcare workers, so they were not afraid of challenging the 'biomedical authority' and asserting their rights within the healthcare facility. An English mother, Georgina, explained,

The medical doctor told me during the consultation that (the constant vomiting) was nothing, that it is normal for infants to have reflux. The whole time he looked at my husband, stating 'the facts' to my husband, barely looking at me, but still dismissing me when I tried to voice my opinion. Ultimately dismissing the fact that I knew in my heart that something was wrong with my baby, I could see my baby boy was physically weakening, almost shrinking, so I knew that we should do something….I think that if I

was just any other mother I might have accepted his medical authority on the matter, but because my father is a doctor, and because I am not scared of challenging his authority, or perhaps just because I know he is human, he makes mistakes, he doesn't know everything, so I went against his so-called expert medical advice, and luckily my husband supported me fully, helping me book an ultrasound at a private hospital –they found out that it was a volvulus, and luckily the great group of medical doctors there saved him – afterwards they told me that my baby son had just been a couple of hours from dying.

On the other hand, there were also some mothers who did not feel exempt from experiencing human rights violations during childbirth, even though they had a high status and biomedical authority. However, often the healthcare providers were unaware of this fact, so these mothers were not exempt from experiencing human rights violations during childbirth. This is the case for the English mother, Caroline, who gave birth at the same hospital where she worked as the Head of Human Resources. She stated,

My midwives did not know that I worked at the same hospital as them – and that I was effectively in charge of hiring and firing them. The reason I know that, is because they treated me without any care or consideration whatsoever. They ignored me. They dismissed everything I said. And I could see some of the other midwives doing the same to other women on the ward…..The first thing I did when I returned back to work was to fire the whole group of them; and I instead hired caring, supportive midwives in their place.

A number of the English mothers, however, did not like the direct confrontation, so instead of asserting themselves and claiming their rights during childbirth, they waited until afterwards, using the medium of a formal letter of complaint in which they highlighted their biomedical authority, as a means to validate the experience and complaint.

iii) Experienced Birth Companions

All of the mothers had a birth companion during their childbirth, such as their partner or mothers, whilst others had professional birth companions, such as private midwives or doulas. An English mother, Eve, stressed how good her husband had been in assisting her during

childbirth, since he communicated all her needs to the healthcare workers. They had had long conversation about what she wanted in her childbirth, and what he should do in various situations, if she felt that her needs were not being met. She was aware that she would be too focused on her contractions, the pain, and the birthing process in itself, so it would often it would probably be hard to communicate to the healthcare workers what she wanted, so he would have to act as her mouthpiece instead. Her husband, William, explained that a lot of preparation and conversations need to be had before the childbirth:

> *We had a lot of conversations before childbirth about what we wanted to happen during the childbirth, and what we would do and say if something went wrong - you need to do that especially when things start going wrong. If you don't, you end up not knowing what to do – because all the midwives and doctors use a lot medical jargon that you don't understand – meanwhile your wife is in so much pain that she can't tell you what she wants, so you just end up standing on the side-line, just feeling out of control. You need lots of conversations beforehand to clarify what we wanted and how we wanted the childbirth to happen.*

The role of fathers in childbirth has changed dramatically over the past century. From the 1970s onwards, a notable shift has occurred whereby the fathers, who did not originally have a place in the delivery room, are now not only expected to be present, but also to be actively involved (King, 2015). However, some of the fathers interviewed during this research expressed their feelings of inadequacy and inability to provide proper support to their partners in childbirth. The father, Elliott Rae, who has been mentioned in the media, has described how he developed post-traumatic stress disorder (PTSD) after the birth of his daughter. During the childbirth of his daughter her heartbeat began to drop, so she had to be resuscitated, which made him feel both helpless and out of control. He states, "I thought of PTSD as something only soldiers get after going to war, now I know it can be triggered for anyone who has had a traumatic life-changing or life-threatening event" (Brewer, 2021). Some of the fathers interviewed for this research study expressed similar feelings after a traumatic childbirth, as they were left on the side-line, feeling helpless and unable to provide support.

Even though several of the English mothers interviewed were grateful for their husbands' support, others stated that they felt that their husbands were both too inexperienced and unable to provide the needed help. Instead, these mothers stated, private midwives or doulas offered better support. A private midwife is a medically trained professional, a doula is

a ‘non-medical’ childbirth worker. The term ‘doula’ was originally coined by the anthropologists Dana Raphael, who used it to describe a non-medical worker who assists mothers during childbirth. The word ‘doula’ is originally derived from a Greek word, which refers to a woman “who comes to the home when a child is born, cares for the older children, cooks the dinner, bounces the fretting baby, and generally helps the new mother through the early postpartum period.” (1981, p.13). Basically, mothering the mother. Many of the first-time mothers were unaware of doulas or private midwives but more experienced mothers were aware that they could hire such help. A French mother, Venessa, praised her private midwife,

> *Our private midwife joined us a few months after the pregnancy was confirmed, and she was really lovely, and it was convenient as she did some of my antenatal checks at my home…I would have been happy, whether I had a doula or a private midwife, as I think either are great, giving me such great support during my childbirth……When my contractions started she joined me at the hospital, and it was really nice as I felt so supported, and she had a focus on my needs, which was very different to the midwives at the hospital, as they have other women to look after as well. And then she was there to help me when I took my baby daughter home, and I was totally clueless, didn’t know what to do, but she could help me.*

Private midwives and doulas were perceived by the interviewed mothers as offering both practical and emotional support during the whole childbirth journey, from pregnancy, through the childbirth process, to the postpartum period when the mother needed help with her infant. These birth companions seemed to have a similar supportive role to that of a healer among the Songhay, which was helpful, because some of them felt that the whole childbirth journey, from pregnancy to after childbirth, was a defragmented and impersonal process. An English mother, Anne, stated,

> *First of all, you barely know your antenatal midwife, as the health check-ups are often just done in a quick and mechanical manner, as if it is just something that she wants to get over and done with. And then you have to turn up and give birth with a midwife that you have never met before. So, you basically do not know the person that you are going to share the most important moment of your life with, you are just with a stranger….*

In 2016, the National Maternity Review's report, did make a clear recommendation that the NHS should roll out a midwife continuity of carer (MCoC) programme, since mothers would benefit from receiving support from the same midwifery team throughout their pregnancy - to ensure a relationship of mutual trust between women and their midwives. Maternity services and local maternity systems did make significant progress in establishing midwifery MCoC teams across the country, however, due to insufficient staffing levels, trusts are no longer expected to deliver such services (NHS, 2022).

iv) The Birth Plan

A few of the English mothers had made a birth plan before they gave birth. A birth plan is a record of what the woman would like to happen during her childbirth and after the birth. Women are often encouraged to discuss the birth plan with her healthcare provider, as it gives them a chance to ask questions and find out more about what happens during childbirth. Sheila Kitzinger coined the term 'birth plan' in 1980 and birth plans went on to being used in 78 percent of delivery rooms by 1993 (Suárez-Cortés et al., 2015). Several of the English mothers in this study said that they felt that the birth plan was a good opportunity to assert themselves and their needs during childbirth; however, many stated that the healthcare workers never even read it. A Danish mother, Kirsten, recalled,

> *I spent so much time researching, and planning, then I recorded exactly how I wanted my natural birth to happen. It is quite an exciting process actually, as it really makes you excited about giving birth, but I am sad to say that the midwife never even looked at it once.*

Kitzinger (1999) argues that birth plans are often ignored or ridiculed by healthcare providers, and that they might even be appropriated by the medical system to obtain compliance. But they can, however, be used constructively to inform, increase self-confidence, and build positive relationship. Thus, several natural childbirth activists and doulas encourage pregnant women to make a birth plan and share it with the healthcare workers, so they can effectively assert their childbirth choices before and during childbirth. For example, the doula Coleman states,

> If a provider insists on a treatment or plan you don't agree with, ask for a record. You can say things like 'can you please put in my chart that I do not agree with this plan and am asking for an alternative.' Make sure you ask to see the clinical

> note after it's written. Typically, they would rather work with you than risk writing that disclaimer and having something go wrong (Nunez, 2022)

This marks, as Bledsoe and Scherrer state, the rise of legal professionalism among mothers hoping to achieve a 'natural' childbirth. As they highlight,

> The birth plan is not a legally binding document, but its thrust is surprisingly parallel to one. It combines the languages of legal contract and medicine to maximize the chances of preserving control over the birth experience. (2007, p.67).

They state that even though the birth plan is not a legally binding document, women end up using it to assert her rights in childbirth, as a form of 'legalistic' weapon against the medical establishment. Even though, at face value, it seems that a birth plan is 'empowering' (as it highlights the rights and needs of mothers in childbirth), empirical evidence does not reveal a correlation between having a birth plan and a more positive childbirth experience. As Lundgren et al. state,

> In the birth plan group, women gave significantly lower scores for the relationship to the first midwife they met during delivery, with respect to listening and paying attention to needs and desires, support, guiding, and respect (2003, p.332).

Even if the birth plan seems to 'empower' mothers to assert their needs and rights in childbirth, research finds it erodes the relationship of trust between the mother and healthcare worker.

Finally, the employment of human rights discourse in childbirth plans to some extent envisions the mother as an agent who is in control of the childbirth process, even though the childbirth process is in itself often unpredictable and 'uncontrollable.' An English mother, Kathy, explained,

> *I guess I thought that my preparation could make me feel in control of my own birth. I wanted to be in control of it, maybe because in my work as a manager, so I have been in control all the time, managing complicated projects, and I thought that I could be in control of my own body and birth. But then when I gave birth, I had never experienced being so out of control in my entire life, I had never experienced that kind of pain. I thought I could manage my own experiences of pain in birth (with hypnosis), but it was so painful that I was about to jump out of the window.*

Some of the English mothers interviewed also felt that their birth plan had provided them with a false sense of security because their childbirth ended up being very different to the plan. Again, this reinforced the sense of failure for some mothers, and frustrated others, as they felt that they were not properly heard. Consistent with in the ethnographic data, Tuteur (2016) has also stated that even though natural childbirth activists believe that a birth plan is the key to having an empowering childbirth, such plans often cause disappointment because they establish unrealistic expectations of control in the childbirth process, even though childbirth is in itself unpredictable.

Part I Summary: English Mothers' Human Rights Claims in Childbirth

This section presented the socio-economic, political, and cultural factors that prevented some of the English mothers in this research study from claiming their human rights and asserting their needs in childbirth. My ethnographic research found that the majority of English mothers, who were mostly 'empowered' and educated about human rights, still found it difficult to assert themselves and claim their human rights in childbirth for the following reasons: i) absent and unresponsive healthcare workers; ii) physical and mental inability; iii) authoritative knowledge; iv) fear of reprisals, and finally, v) the fear of undermining the relationship of trust. However, there were ways in which some English mothers managed to assert their needs and claim their rights during childbirth. Some of the mothers had learnt from their own experience from previous childbirths or the experiences of other mothers, to take direct action, which included: i) changing the childbirth location; ii) biomedical 'insider' knowledge; iii) experienced birth companions; or iv) birth plan. The above actions however, had mixed results, as the birth plan for example lead to unrealistic expectations, whereas, changing the childbirth location seemed to work, as did bringing an experienced companion to the birth.

Even if the English mothers were prepared and 'empowered' to claim their human rights in childbirth, there was often confusion as to which rights to claim, not for ideological ends, but driven by the motivation of keeping their infants safe. On the one hand, these mothers were met with biomedical 'expert advice' which highlighted the 'biomedical' childbirth as safe; whilst on the other hand, the natural childbirth activists pronounce 'natural' childbirth less risky. The ontological conflict between the biomedical 'experts' and the natural childbirth activists' perceptions as to what exactly constitutes 'risk' in childbirth made it difficult for

many of the English mothers to decide what kind of childbirth they should choose, as well as which rights to assert during childbirth. Foucault highlights how biopolitics is intertwined with liberalism where "respect for legal subjects and individual free enterprise" (2008, p.317) is paramount. The interplay of forces between liberalism's will to freedom and the exercise of sovereignty over populations is thus a particularly modern problem. Rather than legislate over the existence of a living population, governmental power solicits self-management and the exercise of autonomy. The exercise of one's rights before the law require the articulation of claims to autonomy and corporeal self-determination, all hallmarks of the contemporary government of reproduction (Fannin, 2012). This 'responsibilisation' or transfer of responsibility from the state to the individual has been identified as a key component of biopolitical systems of governance (Rose, 2007).

Human rights discourse encourages mothers to go a step further, not only to take responsibility for the 'burden of childbirth choice' but also to take responsibility for their own actions and those of the healthcare workers during the childbirth. Mothers are encouraged to 'be your own advocate in childbirth' and to 'claim their rights,' as if they are some sort of auditor of the childbirth process. This 'audit culture' (Power, 1999) and audit technologies are theorised as instruments for new forms of governance and power (Shore and Wright, 2000) because audit technologies allow people themselves to check behaviours, so that governments in turn can withdraw from the responsibility of checking standards (Strathern, 2000, p.4). In the same way, as the individual mother in childbirth is rendered responsible for checking the behaviour of healthcare workers, the governments can in turn withdraw from checking standards. However, this is problematic, not just because the 'audit culture' inherent to human rights discourse transfers the responsibility for checking human rights standards from the state to the individual mother in childbirth, but also due to the ontological conflict between biomedical 'experts' and 'natural' childbirth activists with regard to what constitutes a 'risk' since this creates an ambiguity as to which standards should be upheld and which rights should be claimed in order to keep herself and her infant safe.

Chapter Discussions, Comparisons and Conclusions

This chapter presented the ethnographic data from the participant observation and interviews with mothers in both the Tanzania and the United Kingdom which focused on the mothers'

lived experiences of actively claiming human rights during childbirth. The chapter found that the Sukuma mothers in Tanzania had great difficulty asserting themselves and claiming their human rights in childbirth due to: i) absent and unresponsive healthcare providers; ii) abusive and disrespectful healthcare workers; and iii) fear of reprisals. Even though the English mothers in this research study had more capabilities and opportunities to claim their human rights in childbirth, the ethnographic data revealed that many refrained from doing so, due to: i) absent and unresponsive healthcare workers; ii) physical and mental inability; iii) authoritative knowledge and iv) fear of reprisals. The majority of mothers in both Tanzania and the United Kingdom found that the healthcare context was too restrictive to claim their human rights, so they instead had to find 'pragmatic' ways to assert their own needs and those of their infants, and to avoid potential harm.

Freedman argues that human rights has been a vital tool in repositioning maternal mortality in the public imagination and on the public health agenda. However, she states that "true transformation in the relationship between women and providers of childbirth services cannot be compelled by the operation of law" (2018, p.108). She argues that, to transform the relationship between women and providers, human rights-based approaches will need to go beyond articulation, dissemination, and even legal enforcement of formal norms of respectful maternity care. Instead, a deeper, more nuanced understanding of how power operates in health systems under particular social, cultural, and political conditions should be revealed, if such an approach is to effectively challenge settled patterns of behaviour and health systems structures that marginalise and abuse. She states,

> advocates need to understand how power – especially 'invisible' power – works in health systems. They need to examine the ways in which hierarchies of power permeate health systems and the marginalising, demeaning practices that go with those hierarchies are internalised, naturalised and/or normalised by patients and providers alike. With that empirical understanding as a foundation and human rights ideals as a guide, new approaches to social and institutional change can be created and implemented (p.108).

Whilst the power hierarchies are normalised by the healthcare workers, the mothers, who are painfully aware of these power hierarchies, do not claim their human rights, as they are ultimately scared that doing so might "kill the baby" (p.112).

The power hierarchy inherent in the biomedical context prevented most of the mothers in both Tanzania and the United Kingdom from actively claiming rights and exercising agency in childbirth. Nonetheless, this research found, similar to Lock and Kaufert, that women are not

"passive vessels simply acting in culturally determined ways" (1998, p.2), nor are they "inherently suspicious of and resistant to technological interventions" (ibid), instead, they were actively involved in finding 'pragmatic' ways to keep themselves and their infants safe. Even though the human rights-based approach to maternal mortality assumes an individual, autonomous actor who makes human rights claims for ideological ends, the mothers' main focus was to keep their infant safe in childbirth. Gruenbaum highlights that agency and resistance is not always employed for ideological ends, but is often 'pragmatic,' as women have to "manoeuvre within the changing patterns of constraints to their lives, trying to maximize their control over their own lives and the lives of their children" (1998, p.11). Similarly, this research study found that resistance and rights claims in childbirth were not done for ideological ends, instead the mothers had a 'pragmatic' focus on keeping themselves and their infants safe.

Childbirth is not something that women can do on their own; it is fundamentally co-operative in nature, involving a minimum of two bodies, the infant, and the mother, acting in conjunction with each other. However, the human rights-based approach to maternal mortality, similar to that of feminist scholars, risks employing an individualistic conceptualisation of the woman's autonomy, separate to that of the infant, as well as a singular focus on the rights of the individual woman. The singular focus on individual rights within the field of human rights historically stems from the conscious effort to move away from 'collective rights' or 'peoples rights' to the rights of the individual when the Universal Declaration of Human Rights (UDHR) was formulated. During this time the Soviet Union demanded an inclusion of collective rights in the form of minority rights in the formulations of the UDHR; that was, however, promptly blocked by the United States and other Western nations. Even though the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) both share a common Article 1 on the "right of peoples to self-determination" where self-determination is perceived as a right of peoples or nations, rather than 'collective rights.' Article 27 of the ICCPR states, "In those States in which ethnic, religious or linguistic minorities exist, persons belonging to such minorities shall not be denied the right, in community with the other members of their group, to enjoy their own culture, to profess and practice their own religion, or to use their own language." However, this is specifically perceived as the individual rights of members of groups, rather than 'collective rights' as such. Four of the international human rights treaties address specific groups: women, children, migrant workers, and the disabled. These treaties constitute of human rights along identity lines, which mandate group entitlements as necessary to the enjoyment of human

rights, and some have even established new human rights altogether. The Convention to Eliminate Discrimination Against Women (CEDAW) deals exclusively with the discrimination against women, however, again its focus is solely on the individual rights of the individual woman.

Feminists have from the beginning framed the individual mother as separate from her infant to separate womanhood from motherhood, so as to counteract the idea of 'fetal supremacy' and to accelerate the change of status of women and their opportunities (Tazi-Preve, 2013). In the United States, the Women's Health Movement (WHM) emerged, alongside the women's movement during the 1960s and the 1970s, with the primary goal to improve women's healthcare and reproductive rights, strongly influenced by the *Roe v. Wade* [1973] judgement. This has proved to be a longstanding 'battle' because conservative campaigns have continuously attempted to extend human rights to the foetus before childbirth. Such attempts to grant a right to life before childbirth seek to bestow rights on a zygote, embryo, or fetus, weighing this right to life superior to the human rights of the individual woman. In many cases, these measures aim to outlaw any procedure that terminates a pregnancy, as well as restrict access to in vitro fertilisation and contraception, which poses a significant threat to women's human rights (Center for Reproductive Rights, 2012). Even though the access to safe abortion is not a human right enshrined in the core international human rights treaties, the UN treaty bodies have often addressed this issue in their Concluding Observations[3] by recognising that restrictive abortion laws may force women to seek illegal, and hence unsafe abortions which threaten their lives (Zampas and Gher, 2008). Nonetheless, the Supreme Court in the United States recently overturned *Roe v. Wade* and ruled in favour of Mississippi's ban on abortions after 15 weeks, effectively ending the constitutional right to an abortion (Palaniappan, 2023). Thus, it continues to be an important priority for feminists to focus on the individual rights of women, instead of that of her infant, in order to counteract misguided ideas of 'fetal supremacy.'

Even though it is vital that 'fetal supremacy' does not compromise the rights of women, the importance of the infant to the mother in childbirth cannot be entirely dismissed. Even if

[3] See, e.g., Argentina, U.N. Doc. A/52/38; Azerbaijan, U.N. Doc. A/53/38; Belize, U.N. Doc. A/54/38; Belize, U.N. Doc. CEDAW/C/BLZ/CO/4; Benin, U.N. Doc. A/60/38; Bolivia, U.N. Doc. A/50/38; Bolivia, U.N. Doc. CEDAW/C/BOL/CO/4; Brazil, U.N. Doc. CEDAW/C/BRA/6; Burkina Faso, U.N. Doc. A/60/38; Burundi, U.N. Doc. A/56/38; Burundi, U.N. Doc. CEDAW/C/BDI/CO/4.

the feminist icon Simone de Beauvoir has stated that the infant "inflicts a harsh slavery upon her and it is no longer a part of her: it seems a tyrant, she feels hostile to this little stranger, this individual who menaces her flesh, her freedom, her whole ego" (1949, p.508), her views cannot be perceived as representative of mothers' standpoints, as she has never had children (Willsher, 2021). Human rights discourse and the policy assumption inherent inhuman rights-based approach to maternal mortality risks bringing with it a similar singular focus on the individual rights of the mother, as if the mother is an autonomous and separate entity to that of her infant. In contrast, this research found that the infant is *the* main focus of mothers during childbirth, and should be respected as such, even if that goes against the idea of the rights of the individual woman - inherent in the policy and practice of the human rights-based approach to maternal mortality. For example, when attending a human rights training session for midwives in the United Kingdom, the midwives were told to always focus on the individual woman's choices and rights in childbirth, even if this might have consequences for her infant, "since babies sometimes die, and we have to get used to that" (Fieldnotes, March 2019). However, such a singular focus on the woman's individual rights in childbirth neglects the strong mother/infant dyad relationship. In fact, this research found that the majority of the mothers in this study did not perceive themselves as autonomous individuals but strongly interconnected with their infant - a mother/infant dyad in childbirth. As Stroeken also highlights, for the Sukuma, a child's fate is "intimately connected with that of the mother until several years after birth" (2012, p.128). Correspondingly, most of the women in this study did not make childbirth choices or claim their rights for ideological ends but to keep their infant safe – as Schiller (2016) states, "Birth choices are not political statements." Thus, even if the U.N. Technical Guidance to the human rights-based approach to maternal mortality states that mothers should be empowered to claim their rights not for reasons of "merely avoiding maternal morbidity and mortality," (para. 12), this statement holds true in reverse - avoiding maternal and infant morbidity and mortality, is *the* main priority for mothers in childbirth.

Chapter Five

Demanding Justice After Childbirth

There is great motivation behind bringing human rights claims to court, at least in theory, as Baumgärtel states,

> There is something appealingly untainted in the idea of demanding human rights before courts. Having suffered harm, an aggrieved individual gets the chance to challenge the state apparatus before an independent arbiter resistant to the lures of power or politics. Manipulation will give way to justification and argumentation. Wrongs will be remedied in equitable manner. Justice will be restored (2019, p.154).

The previous chapter revealed that mothers were mainly preoccupied with keeping their infants safe, leading them to refrain from making rights claims in childbirth for ideological ends. This chapter explores whether the mothers in this study were finally able to demand accountability and justice after childbirth. The first section presents the international human rights instruments, as well as caselaw which has set precedent for mothers to take their human rights claims to court. Then the ethnographic data is presented to illustrate the Sukuma and English mothers' lived experiences of complaining/reporting human rights violations and seeking justice in court.

International and Regional Human Rights instruments

This first section provides an overview of the international treaty bodies and regional human rights courts which are available to mothers in respect of human rights violations experienced during childbirth. First of all, at the international level, there is no single international tribunal of human rights, but rather a number of UN treaty bodies which are relevant to human rights violations in childbirth These include the Human Rights Committee which monitors the International Covenant on Civil and Political Rights (CCPR), the Committee on Economic, Social and Cultural Rights that monitors the International Covenant on Economic, Social and Cultural Rights (CESCR), the Committee on the Elimination of Racial Discrimination that monitors the International Convention on the Elimination of All Forms of Racial Discrimination (CERD), the Committee on the Elimination of Discrimination against Women (CEDAW Committee) which monitors the CEDAW (Smith, 2010). Any individual mother,

who brings a claim that her rights have been violated by a state party under a particular treaty, may bring a communication before the relevant committee provided that the State has recognised the competence of the committee to receive such complaints and that domestic remedies have been exhausted first. Bond (2019) states that the ability to bring a complaint to an international treaty body offers victims potential compensation, remedies which may prevent future violations and an acknowledgment that their rights have been violated.

There are a few cases of mothers who have brought human rights claim to UN treaty bodies in order to demand accountability and justice for human rights violations in childbirth. The case of *Alyne da Silva v. Brazil* [2008] represents the first time a national government was held accountable for a maternal death. This case is also of significance because it was the first case on maternal mortality to be brought before the CEDAW Committee. The case concerned Alyne da Silva, a Brazilian woman of African descent who died from pregnancy-related causes after her local health centre misdiagnosed her symptoms and failed to provide her with emergency obstetric care in a timely manner. Her mother took the case to the CEDAW Committee, arguing that the national authorities had made no effort to establish professional responsibility, so she had been unable to obtain justice in Brazil. The CEDAW Committee established that States have a human rights obligation to guarantee women of all racial and economic backgrounds timely and non-discriminatory access to appropriate maternal health services. The CEDAW Committee made several general recommendations intended to reduce preventable maternal deaths, including the obligation to: (i) ensure women's right to safe motherhood and affordable access to emergency obstetric care; (ii) provide adequate professional training for health workers; (iii) ensure that private health-care facilities comply with national and international reproductive health-care standards; (iv) implement Brazil's National Pact for the Reduction of Maternal and Neonatal Mortality which includes the establishment of more maternal mortality committees to monitor maternal deaths; and (v) ensure women's access to effective remedies when their reproductive rights have been violated (Cook, 2013).

At a regional level, there are a number of regional human rights courts where individual mothers can bring claims about human rights violations in childbirth. All the regional human rights courts were set up as part of regional efforts to promote peace after the Second World War. In Europe, the European Court of Human Rights (ECtHR) deals with individual human rights cases under the European Convention on Human Rights (the Convention). In the

Americas, a dual model is in place, consisting of the Inter-American Commission and the Inter-American Court of Human Rights (IACtHR). Individual complainants have to submit their grievances to the Inter-American Commission first; thereafter, the case may proceed to the Inter-American Court of Human Rights. In Africa, the African Court on Human and Peoples' Rights (African Court) is an international court established by member states of the African Union to implement provisions of the African Charter on Human and Peoples' Rights (African Charter). Finally, there is the Southern African Development Community (SADC), which promotes women's rights through its own regional treaties, the Economic Community of West African States (ECOWAS) Court of Justice, and the East African Community (EAC) which bind member states to the principles of non-discrimination and gender equality (Bond, 2019).

In Europe, the *Konovalova v. Russia* [2014] case was brought to the ECtHR, highlighting women's right to informed consent in childbirth. The case concerns a Russian mother, Ms Konovalova who objected to medical students observing her during childbirth. She first filed a complaint with the hospital, but the hospital dismissed the complaint concluding that "[t]he treatment was carried out in the best interests of the mother and foetus" (paras. 17-19). Consequently, she brought her claim to court but the District Court dismissed her claim stating that the Health Care Act did not require the hospital to obtain written consent before allowing students to observe her childbirth. Finally, she lodged her application with the ECtHR alleging that the medical students' presence interfered with her right to privacy and subjected her to inhuman or degrading treatment (para. 1). The ECtHR found that Russia had violated her right to informed consent and held that the presence of medical students was a breach of Article 8 under the Convention. The ECtHR stated that the concept of 'private life' under Article 8 is broad and covers an individual's physical integrity. Thus, the presence of the medical students, as well as their access to the patient's confidential medical information constituted an interference with her private life (Dute, 2015).

In the Americas, the IACtHR used the concept of 'obstetric violence' for the first time in connection with the case of *Brítez Arce v. Argentina* [2022] defining it as "a form of gender-based violence, exercised by those in charge of health care for pregnant persons accessing services during pregnancy, childbirth and post-partum." Cristina Britez Arce was nine months pregnant when her ultrasound showed fetal death in utero. She was hospitalised to be induced but died of cardiac arrest. The court found that Cristina Britez Arce did not receive the required

medical treatment considering the several known risk factors of her pregnancy, nor did she have the necessary information on treatment alternatives. Instead, she was "subjected to obstetric violence" that ultimately lead to her death. Among other things, the court ordered the Government of Argentina to design a campaign to disseminate information on the human rights related to pregnancy, childbirth, and postpartum and on situations that may constitute obstetric violence. In fact, this is the first time a judicial ruling recognised the state's obligation to prevent obstetric violence by observing several human rights, including the rights to life, health, and humane treatment (Tames, 2023). Even though the IACtHR is inaccessible to both mothers in Tanzania and the United Kingdom, the case has practical if not legally binding significance because regional Courts will tend to look to each other' caselaw and judgements for guidance.

In Africa, the NGOs Equality Now and WAVES filed a case against the Government of Sierra Leone due to a discriminatory school ban on pregnant students. In 2019, the ECOWAS Court of Justice found that the policy amounted to discrimination against pregnant schoolgirls, and breached provisions of the African Charter. As a result, Sierra Leone reversed its policy and adopted a more inclusive education policy (Hodal, 2020). Subsequently, Equality Now and the Tanzania Women Lawyers' Association filed a joint case in 2020 against the Government of Tanzania at the African Court, seeking measures to overturn its discriminatory school ban on pregnant students in Tanzania. The case, brought on behalf of six Tanzanian schoolgirls who were expelled from school for being pregnant, claimed that the government's regressive policies violated the human rights of schoolgirls in Tanzania. The communication highlighted that Tanzania's national, international, and regional human rights obligations required it to eliminate all forms of discrimination against girls and women, to prevent and respond to violence against girls, including in schools, and to safeguard the sexual and reproductive health and rights of girls and women. In 2023, the African Court determined that Tanzania's policy to ban pregnant girls in school was discriminatory, however, ruled the communication inadmissible as the Ministry of Education in Tanzania had already overruled the ban after the death of the former President Magufuli (Moppert, 2023).

The above cases are significant, not only because they address maternal mortality and human rights violations in pregnancy and childbirth, but because they represent a shift in international human rights law from courts being restricted to the adjudication of 'first generation' rights to the courts now adjudicating the implementation of 'second generation' rights. The 'first

generation' rights include civil and political rights that are outlined in the ICCPR, such as the right to participate in government and the prohibition of torture. The 'second generation' rights are the social, economic, and cultural rights outlined in the ICESCR. Traditionally, it was argued that there are fundamental theoretical differences between first- and second-generation rights: that the first type of rights required governments only to refrain from certain activities, while the second requires positive intervention and policy implementation by governments. These second-generation rights were perceived as vague and non-justiciable. However, caselaw such as above, have changed this perception, as the courts instruct which policies such be implemented in practice. Hence, currently, under international human rights law, the state has the responsibility to *respect*, *protect* and *fulfil* human rights of everyone within the state. To *respect* human rights means that the state has a duty to refrain from interfering with the enjoyment of human rights. To *protect* human rights means that the state must proactively provide a system which prevents, protects from, and provides redress for human rights violations. To *fulfil* human rights means that the state must ensure that they are fully enjoyed through adopting appropriate legislative, administrative, budgetary, judicial, and other measures and policies. (Smith, 2010). The *Alyne da Silva v. Brazil* case illustrates how courts are now actively involved in not only providing redress and compensation, but directing states towards adopting appropriate legislative, administrative, budgetary, and other measures, which can ensure that mothers' human rights are upheld during childbirth.

Part I: The Sukuma Mothers' Accountability Demands after Childbirth

This first part presents the ethnographic data on the Sukuma mothers' accountability demands and search for justice after childbirth. Firstly, a brief overview of the justice system in Tanzania is provided, as well as official complaints and accountability mechanisms. Finally, the ethnographic data on the socioeconomic, political, and cultural constraints which the Sukuma mothers face when demanding accountability and bringing human rights claims to court is presented.

The Judiciary and Justice System in Tanzania

The Judiciary is the system of courts which interprets and applies the law in Tanzania. The judicial power is vested in the courts which consist of the Permanent Commission of Enquiry (the official ombudsman), the Court of Appeal, the High Court, the District Courts, and the

Primary Courts. The Court of Appeal consists of a chief justice and four judges. The High Court consists of a Head Judge (*Jaji Kiongozi*) and twenty-nine judges appointed by the president and holds regular sessions in all regions. The Primary Courts, which are courts with more limited jurisdiction, hear petty civil cases. The Primary Courts are the lowest courts in the hierarchy criminal, which deal with criminal cases and civil cases. The Primary Courts are established under the Magistrates Courts Act of 1984. Civil cases on property and family law matters which apply customary law and Islamic law must be initiated at the level of the Primary Court, where the Magistrates sits with lay assessors. Appeals of decisions of the Primary Courts are heard by the higher courts. The Higher Courts are courts of unlimited civil and criminal jurisdiction. The Court of Appeal of the United Republic of Tanzania is the highest court. Finally, there are specialised tribunals which form part of the judicial structure. These include District Land and Housing Tribunal, Tax Tribunal and the Tax Appeals Tribunal, Labour Reconciliation Board, the Tanzania Industrial Court, and Military Tribunals for the Armed forces. A party who feels dissatisfied with any decision of the Tribunals can refer the same to the High Court for judicial review (Manning and Kasera, 2020).

The English legal concept of 'justice' was imported to Tanzania during the colonial period. In contrast to the traditional norm of reconciliation in Tanzania, this concept of 'justice' was based on the 17th and 18th century state-centric Enlightenment theories of social contract and natural rights (Dancer, 2015). Since the colonial powers took over the criminal and administrative law, customary law was mostly drawn upon in civil matters, especially in relation to land and personal matters. However, customary law could not be applied in civil matters where customary law contradicted written (state) law. This legal pluralism was reflected in the judicial system during colonisation, as there were the courts of the colonial powers, as well as the local courts which predominantly applied customary law. Hence, throughout the colonial period, there were two distinct approaches to justice, and the unification of these were only consolidated after independence, and only partially consolidated, since customary law is still taken into consideration today (Sippel, 2022). In fact, the codification process of customary law in Tanzania can be attributed to the German anthropologist Hans Cory. He undertook the ambitious project of recording the local traditions and customs with regard to marriage, divorce, guardianship, and inheritance among patrilineal communities in Tanzania during the 1940-1950s (Cory and Hartnoll, 1945; Cory, 1953; Cory, 1955). Despite his impressive collection of data, Cory ignored the customs of matrilineal communities and only represented the views of male elders from patrilineal tribes, such as the Sukuma and Haya. His codification

project was, nonetheless, embraced after independence, perceived as an identity-forming feature in the 'nation-building' of the whole of Tanzania (Twining, 1963). As a result, his patrilineal, patriarchal construction and codification of customary laws became enshrined in the Local Customary Law Declaration Orders (CLDOs) and formalised in the Judicature and Application of Laws Act of 1961 (Dancer, 1997).

Tanzania has been at the forefront of African countries in terms of introducing some of the most progressive reforms on women's property rights, recognised through the Law of Marriage Act, as well as the Land Act and the Village Land Act of 1999 (Land Acts). However, even though the legal framework for women's rights in Tanzania is relatively strong, these national laws often conflict with customary law in practice. The rights for women in relation to divorce, child custody, maintenance, and the division of matrimonial assets on separation are all provided for by the Law of Marriage Act 1971, however, if a woman is married under customary law, she is unlikely to gain access to his property/land after divorce or death of her spouse (Bond, 2019). In *Scholastica Benedict v. Martine Benedict* [1989] the Court of Appeal denied a widow the right to inherit her matrimonial property. The widow sought the right to remain in the matrimonial home after the death of her husband, however, the court ruled, applying Haya customary law, that a widow can only inherit from her husband if there are no other male heirs and if he is the last surviving member of his tribe. The court subsequently ruled that the widow and her daughter had to leave their home.

Tanzania has signed and ratified a number of international human rights treaties, including the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social, and Cultural Rights (ICESCR), the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC). Furthermore, Tanzania has also signed a number of regional human rights treaties, including the African Charter on Human and Peoples' Rights (African Charter) and the Protocol to the African Charter on the Rights of Women in Africa (Maputo Protocol). As a party to these major human rights conventions, Tanzania has an obligation to ensure that its laws and practices are in conformity, yet customary law often clash with the provisions of these human rights treaties. For example, CEDAW provides for women's rights to own and inherit property without discrimination on the basis of sex, however, according to Customary Law (Declaration) Order No. 4 of 1963, women have no right to inherit the estate of their deceased

husbands. In *E.S. and S.C. v. United Republic of Tanzania* [2015] two widows were denied the right to inherit the estates of their late husbands. Subsequently, they were, along with their minor children, evicted from their homes by their in-laws. Despite appeals to the High Court, the Attorney General and the Court of Appeal, it was not until human rights organisations helped them take her human rights claim to the CEDAW Committee that they found justice. The CEDAW Communication (2015) states that the State party failed to revise or adopt legislation to eliminate the remaining discriminatory aspects of its codified customary law provisions with regard to widows.

Both Land Acts state that "The right of every woman to acquire, hold, use and deal with land shall, to the same extent and subject to the same restrictions be treated as a right of any man." (Land Act, 1999, p.26), however, at the same time the customary rules for land remain in force, consistent with the non-discrimination clause in the Constitution. For example, in *Lutabana v. Kashaga* [1981] it was held by the Court of Appeal that under Haya Customary Law a woman cannot inherit family or clan land. Between 1968 and 1988 the High Court and the Court of Appeal regularly adhered to the Local Customary Law Order (Declaration) No. 4 which upholds the patrilineal principle of inheritance that descent is traced through males. In fact, there was very little change until Justice Mwalusanya found Rule 20 of the Declaration discriminatory in *Ephrahim v. Pastory and Kaizingele* [1990] the rule prevented women from inheriting and selling clan land. Fortunately, several court cases have since been heard with more progressive judgements that uphold women's rights. In *Ndossi v Ndossi* [2002] Judge E. Munuo held that the widow was entitled to administer the estate on behalf of her children. The female judge referred to the Constitution which provides that "every person is entitled to own property and has a right to the protection of that property held in accordance with the law" (Bond, 2019). Furthermore, she held that Article 9(a) and (f) of the Constitution recognise human rights by requiring "that human dignity is preserved and upheld in accordance with the spirit of the Universal Declaration of Human Rights." However, despite such legal victories securing women's human rights in court, it remains difficult to safeguard rights for women in practice, as most cases ultimately never make it to court. As mentioned previously, disputes in regard to marriage, divorce, custody, inheritance, and land among patrilineal communities are often dealt with by the Village Councils. In fact, the Village Land Act of 1999 devolved substantial authority to village councils, and customary law often governs these bodies (Magawa and Hansungule, 2018).

Accountability and Complaints Mechanisms in Tanzania

The Public Service Act (2007), the Client Service Charter (MoHSW, 2018) and the Tanzania Health Policy (2007) all aim at improving the quality of healthcare services in Tanzania. The Ministry of Health has recognised that complaint mechanisms are integral to gaining an awareness of the patients' needs and enabling them to be incorporated into the planning and updating of health services. It is highlighted that effective complaint management may be an opportunity for the improvement of services and care, establishing a dialogue with, and increasing the trust of patients. Furthermore, complaints are perceived as providing a valuable source of insight into safety-related problems within healthcare organisations, the kind which are not identified by traditional systems of healthcare monitoring (e.g., incident reporting systems, retrospective case reviews). Thus, the ministry recognises that complaints provide healthcare facilities with important and additional information on how to improve healthcare (MoHSW, 2018).

The following section presents the ethnographic data on the mothers' experiences of complaining/reporting human rights violations they had experienced in childbirth, as well as their considerations in relation to taking human rights claims to court.

The Sukuma Mothers' Complaints/Reports on Human Rights Violations in Childbirth

Complaints have been identified as a valuable resource for monitoring and improving maternity services. As the Ombudsman states, complaints matter because feedback can help healthcare providers learn from when things go wrong and improve services as a result (2020, p.6-8). However, even though the majority of the Sukuma mothers had experienced human rights violations during childbirth, several mothers stated that they were reluctant to complain for the following reasons:

i) Ineffective Complaints/Reporting Mechanisms

The Ministry of Health recognises that effective complaints and reporting mechanisms are important in order to gain awareness of patients' needs, and that ineffective mechanisms have

a negative impact on healthcare services (MoHCDGEC, 2018). However, several of the mothers stated that they did not want to lodge a formal complaint, because they did not think that their complaint would not be acted upon anyway. A Nyamwezi mother, Malale, who had experienced a drunk medical doctor operate on her during childbirth, stated,

> *When I lived in Tabora, I gave birth to my first baby at (….) hospital. Unfortunately, I had to have an emergency caesarean, as my baby was too big. The operation was horrible because the doctor was drunk, so I was scared that he wouldn't even be able to complete the operation.*
>
> *He finally completed it, but so badly that I had to return after two weeks because blood was coming out of the wound, so I had to get it fixed*
>
> *I did not want to report it as nobody would listen to me, and even if someone would listen, nobody would do anything about it.*

Isangula (2022) has investigated whether complaints/suggestion boxes are a useful tool in Tanzania to improve healthcare facilities in Tanzania, since a feedback system is important in order to identify healthcare service delivery gaps. However, he found a number of limitations to the use of complaints/suggestion boxes at present. Firstly, there is generally no information available about how to use the complaints/suggestion boxes. Secondly, there are no pens or paper available to actually write the complaint. Thirdly, the patients feared reprisals if the healthcare workers saw them submit a complaint. Similarly, a few of the Sukuma mothers in this study stated that even if there was a complaint/suggestion box available, it was often placed out in the open, so they feared reprisals because the healthcare workers could see if they submitted a complaint.

Some of the Sukuma mothers in this study had no trust in the complaints procedure, because they thought that the same healthcare workers, who they complained about, would open the complaints/suggestion box, and as Malena stated, "they throw the complaint in the bin, or even worse, if they know it was you who did it, they never attend to you ever again." In theory, the complaints/suggestion boxes should be emptied on a regular basis by a person specifically responsible for handling complaints, such as a member of an integrity committee (MoHCDEC, 2018). However, Ahmed argues that the reason that a complaint often never goes anywhere is

linked to the person who receives the complaint. She states, "It is not only that complaints are received by the colleagues of the person whose conduct is under question. *Complaints are often received by those whose conduct is under question*" (2021, p.194). Finally, the Tanzanian NGO Sikika has found that only six of 28 hospitals have established complaints mechanism (Sikika, 2013).

ii) No Time or Resources

Even though the majority of the Sukuma mothers had experienced human rights violations during childbirth, several mothers stated that they did not have the time or resources to complain. If their infant was well and healthy, they just wanted to go home. A Malila mother, Ayiana, explained,

> *I decided to go and have birth in hospital instead of at home because I had problems with my blood during pregnancy. I eventually decided to go to (….) Hospital, because the other hospital has a bad reputation.*
>
> *My contractions began at night-time, so I decided to go the hospital and when I arrived, I asked the nurse to help, but the nurse told me, "Wait, wait", even though the nurse was just sitting down, resting, just ignoring me. She did not want to help…..Finally, a trainee nurse passed me and luckily came to help, but the trainee could not help me, because my baby was too big, so I needed to have a procedure. Luckily, the trainee fetched a nurse to help, and my baby was born, all healthy.*
>
> *I did not report that nurse, because I just thought to myself thank God that my baby is alive, now let's move on with our lives.*

The majority of the mothers interviewed in Tanzania did not have the time or resources to complain or even contemplate taking human rights claims to court, they simply wanted to go home. At home, during interviews, many of the first-time mothers were visibly affected by their traumatic childbirths but processed their traumatic experiences in the company with their female family members.

iii) Apologetic Healthcare Workers

A few of the Sukuma mothers who had experienced human rights violations did contemplate complaining, but decided not to, after they were approached by apologetic healthcare workers. In the words of a Nyiramba mother, Ruth stated,

> *I went to (....) hospital when I got contractions at night. When I asked the nurses for help, they said that my stomach was not big enough to give birth yet. I told them that I had contractions and that according to my antenatal card I was nine months pregnant. But the nurses insisted that I should wait. So, when my waters broke, I had to give birth sitting on the floor and my baby's leg fell down on the floor. Then a man luckily called the nurses and told them he would call the police if they would not come. So they finally arrived and started apologising, and they rushed to cut my vagina open to get my baby out….Afterwards I had to stay in hospital for a week because my son's leg was broken…..The nurses were then finally very kind to me and attentive, because they were worried that I would report them. But I could see how they treated all the other women in the hospital, very badly. But I did not report the nurses because they begged for forgiveness. Two nurses even came to me and begged forgiveness and begged me not to report them…Eventually I felt sorry for them, and I also just wanted to get home and focus on my son, so his leg could heal properly.*

However, Strong (2020) highlights that without a formal complaint from mothers themselves about the 'offending' healthcare worker, the medical officer in charge at the healthcare facility cannot initiate disciplinary proceedings, nor launch an investigation through the licensing body, the national nursing or medical organisation. Nevertheless, as the Sukuma mother, Malane stated, "everyone is too scared to approach the medical officer in charge, but even if they do, what can he do? Nothing." This is perhaps not far from the truth, as Strong (2020) highlights that the strict guidelines and complex protocols for disciplining healthcare workers in Tanzania mean that healthcare workers are guaranteed job security almost for life. Even if the formal proceedings are escalated to the regional medical officer (RMO) or finally to the regional administrative secretary (RAS), the offending healthcare worker is often simply transferred to another department or post, rather than dismissed.

iv) Fear of witchcraft

Some of the mothers in this research study stated that they were scared of reporting the healthcare workers because of *uchawi* (witchcraft/sorcery). The Muslim mother, Viyana explained,

> *I would never consider complaining about the nurse who delivered me because she has my placenta after birth. You know, they keep your placenta after birth, and you never know what they might do to it. If your nurse is angry because you complain about you, she might go awa and do uchawi to the placenta.*

A few of the Sukuma mothers in this research study explained to me that mothers would traditionally take great care to bury the placenta in a hidden spot after birth, so no one could get hold of it for the fear of *uchawi*. If *uchawi* was done to the placenta, the mother could either die or become infertile.

Whilst some of the Sukuma mothers in this research study perceived the placenta as both close to 'sacred' but also potentially dangerous to the health of the mother, some of the English mothers described the placenta as close to 'sacred' and 'pure' with potential health benefits for the mother. These English mothers believed that eating the placenta would provide them with extra strength or boost their milk production. Mothers consuming their placentas, *placentophagy*, encapsulated, cooked, and raw for the perceived health benefits, has been promoted by media personalities in the United Kingdom, as well as sold by companies for a profit. Coyle et al. (2015) have investigated whether the placenta is advantageous but found that the placenta is not sterile as one of functions of the placenta is to protect the fetus from harmful exposure to substances. As a consequence, elements including selenium, cadmium, mercury, and lead, as well as bacteria have been identified in post-term placental tissue (p. 673). Even though these ideas about the placenta might not be 'rational' Mary Douglas (1966) may provide us with some insight from her work on the differences between the sacred, the clean and the unclean – whereby matter is dirt out of place. Likewise, both groups of mothers perceived the placenta as matter out of place, neither mother nor infant, hence powerful, and almost sacred.

Scheper-Hughes and Lock point to the frequently encountered symbolic equivalence between conceptions of the healthy body and the healthy society, as well as the diseased body and the malfunctioning society, highlighting these as central foci for medical anthropologists.

They state, "In cultures lacking a highly individualized or articulated conception of the body-self…it should not be surprising that sickness is often explained or attributed to malevolent social relations (i.e. witchcraft), or to the breaking of social and moral codes, or to disharmony within the family or the village community" (1987, p.15). Thus, Viyana's fear about complaining about the healthcare workers due to her fear of *uchawi*, was probably interlinked with her fear of breaking the social code and causing disharmony. However, Viyana's fears were not completely unfounded since Allen (2002) has found that placentas from twin or breech births are considered among the Sukuma to be a very important ingredient in traditional medicines. These placentas are reportedly acquired from people who have access to them in the village or from nurses who work in hospitals and clinics.

v) Fear of Reprisals

The majority of the Sukuma mothers in this research study experienced human rights violations during childbirth; several of the mothers interviewed stated that they were too afraid of reporting or complaining about it for the fear of reprisals. Several of the mothers described the fear of immediate punishment if still in the clinic/hospital at the time, but some also described the potential consequences even after they had left the hospital. The Muslim mother Fatima stated:

> *If they knew it was me who complained, they would completely ignore me or be even more horrible to me next time I have to go that hospital. They might refuse to treat me or my sick child.*

Mafuta et al. have found in their study on social accountability in maternity services that women have remained reluctant in making rights and accountability claims due to, not only the absence of procedures to express them, but due to fear of reprisals (2015, p.11).

In the above section, we explored many of the 'pragmatic' reasons why the Sukuma mothers decided not to complain about human rights violations they had experienced during childbirth, fearing reprisals and adverse impact on access to healthcare provision for themselves and their children in the future. Despite their pragmatic reasons for not complaining, most of the mothers interviewed in Tanzania did in fact eventually complain, perhaps not to the healthcare providers or authorities, but to me. Almost all of the mothers complained to me in great details about the

injustices and indignity, which they felt that they had suffered during childbirth. Since Abu-Lughod (1990) criticises anthropologists for their romantic portrayals of resistance, with an almost over-eagerness to show how 'disadvantaged' people respond critically to local realities, I have been particularly mindful not to over-romanticise any hint of resistance by the Sukuma mothers in this research study. Nevertheless, I did find that several of Sukuma mothers did indeed exercise resistance and defiance towards their situation, their inadequate healthcare providers and the government by complaining about their childbirth experiences to me, instead of keeping silent. Courage was required to do so in the President Magufuli era.

The Sukuma Mothers' Access to Justice and Accountability Mechanisms

The following section presents the ethnographic data on the Sukuma mothers' motivations, as well as the socio-economic, poltical and cultural constraints that they faced in their attempts to access justice mechanisms at local, national, regional and international levels.

i) *Justice Mechanisms at Local Level*

At local level, none of the mothers interviewed in Tanzania would consider taking any 'childbirth issues' or associated accountability demands to the Village Council. Traditionally, there were three Sukuma courts: the *ntemi* (chief) court, the *banamhala* (the elders) court and the *ng'wanangwa* (the village headman) court. The *ntemi* court was a court, where civil cases were heard by the chief, while the *ng'wanangwa* court dealt with matters such as divorce, debts, assault or cattle theft, and finally, the *banamhala* court dealt with civil customary matters (Cory, 1953). At present, the Village Councils and the Village Land Councils are approached by many of the Sukuma to resolve disputes, in regard to divorce, adultery, custody, inherence, land ownership etc. However, with regard to conflicts or human rights violations in childbirth, the Sukuma mother, Nzwala, stated this was not traditionally something be considered by the Sukuma elders or the Village Councils, since childbirth issues would be considered issues for traditional healers.

The lack of human rights claims is often framed as stemming from the lack of awareness about human rights. For example, Starrs states that the reason that so few women in Africa take claims to Court is due "ignorance of their legal rights," (1997, p.12). Similarly, the OHCHR

Update Report (2018) on the UN Technical Guidance to human rights-based approach to maternal mortality states that the reason so few claim their rights, is due to the lack of awareness about human rights, hence, more awareness-raising is needed. In contrast, however, my ethnographic research found that the mothers' decision to refrain from bringing claims to courts was not due to 'ignorance' or even 'lack of awareness' about their human rights but based on a rational and 'pragmatic' decision-making process. The Sukuma mother, Anna, gained the custody of her son in court, but refrained from taking her human rights claim to court in order to avoid reprisals and ensure future access to healthcare. Anna explained:

> *I would never use the court to accuse a nurse or the hospital of anything. What if I have to go back to the same hospital again? What if one of my children get ill and I must go back to that hospital again? What if one of my daughters have to give birth there? At the end of the day, how do you think that the nurses will treat you or your children, if you report them? Do you think the colleagues of those nurses will attend to you? Never!*

Even though Anna had experience of winning the custody of her son in court, she was painfully aware that a short-term win in court might result in a long-term loss of healthcare provision.

ii) *Justice Mechanisms at National Level*

At national level, the majority of the Sukuma mothers in this study highlighted that it was difficult to bring their human rights claims to court due to the lack of resources, and legal representation. At present, there is only limited childbirth caselaw in Tanzania. In the first childbirth case, *Bashir Ally (Minor) suing by his next friend Fatuma Zabron v Clemensia Falima and two others* [1998] the Court of Appeal ended up dismissing the case, for insufficient proof that the cerebral palsy of the infant was caused during childbirth. In the second negligence childbirth case, *Mwamini Adam Ntengekaja v Urambo District Council Hospital* [2015] concerning Mwamini Adam Ntengekaja who was left infertile after the surgeon forgot a piece of cloth in her stomach during a caesarean operation. The mother had to have her uterus removed as a consequence of this medical malpractice and was left infertile. The Court of Appeal ruled in favour of the mother, establishing a clear breach of duty and awarding compensation. Finally, the most recent negligence case *Jamila Cosi v Muhimbili National Hospital* [2020] concerns a woman named Jamila Mbaraka Gosi who did not have her placenta properly removed following childbirth and as a result was left infertile. The High

Court found no evidence of negligence, with both the medical doctor and nurse being found to have discharged their duty of care. Harrington (2004) explains that the lack of caselaw relevant to medical negligence in Tanzania is due to the overall limited access to healthcare. In essence, since the mothers with riskier and more complex needs never reach the healthcare facilities, they therefore never end up injured in a healthcare facility, and thus, ultimately never take their negligence claim to court.

In neighbouring Uganda, there is rich caselaw in relation to human rights violations in childbirth. Take the case of *the Centre for Health Human Rights and Development and Ors v Attorney General* [2023] regarding the preventable deaths of two women, Ms. Nalubowa and Ms. Anguko, as example. When Ms. Nalubowa arrived at the hospital, the healthcare workers requested money and supplies, but the family did not have the amount requested, so when Ms. Nalubowa began bleeding, no one attended to her, and she consequently died. Similarly, when Ms. Anguko started bleeding, instead of attending to her, the healthcare workers just instructed family members to stop the bleeding with old pieces of cloth, and she eventually died. Ultimately, the petitioners challenged the Ugandan Government's failure to provide basic maternal health services in violation of: i) the right to health; ii) the right to life, and; iii) the right of women, under the Constitution. As a result, the court found that the state's failure to attend to a patient and the Government's failure to provide a clean and healthy environment violated the constitutional right to health. While the court acknowledged that the provision of services is often dependent on available resources, it held that this does not excuse the failure to provide basic lifesaving services that are free of charge. With this decision, the court acknowledged that access to proper maternal health care and emergency obstetric care is fundamental to ensuring women's constitutional rights to health and life.

Being informed of one's human rights is an important precondition to be able to claim them, but it is often not sufficient, since it is important to get help with legal advice and redress (Worm and Matimbwi, 2008). At national level, the Commission for Human Rights and Good Governance (CHRAGG) and the Legal and Human Rights Centre (LHRC) both receive and conduct enquires about human rights violations. Furthermore, the Legal and Human Rights Centre (LHRC), the Tanzania Women Lawyers' Association (TAWLA) and the Tanzanian Women's Legal Aid Centre (WLAC) are NGOs which do provide legal aid to women. The WLAC also has an outreach program, which includes sixteen paralegal units in urban and rural centres. Finally, Tanzania Media Women's Association (TAMWA) provides legal aid and counselling services to domestic violence victims, as well as a crisis centre in Dar es Salaam.

Merry and Levitt (2017) explain that NGOs are central to translating human rights into terms which make sense in their local communities. They state that human rights concepts must be *vernacularised*, or translated into indigenous cultural categories. The process of vernacularisation converts universal human rights into local understandings of social justice. Nonetheless, even if these human rights and legal organisations could help the Sukuma mothers in this study, many of the mothers interviewed remained reluctant to make contact with such human rights organisations, because they feared reprisals from the authorities. Most of the mothers in the focus groups remained reluctant even just discussing national human rights institutions, as doing so was deemed being critical of the former President Magufuli which could result in fines or prosecution.

iii) *Justice Mechanisms at Regional Level*

At regional level, Tanzania has ratified the African Charter on Peoples and Human Rights (African Charter) in 1986. The African Court is an international court established by member states of the African Union implementing the African Charter. Furthermore, Tanzania has also ratified the Maputo Protocol to the African Charter on the rights of women in Africa. This protocol specifically obligates state to "establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding," (Art. 14) and requires that healthcare provider training includes, not only technical aspects of care, but also focuses on the quality of care, including "non-discrimination, confidentiality, respect for autonomy and free and informed consent" (Art. 4). In fact, the Maputo Protocol is the only human rights treaty that explicitly mentions abortion as a human right, albeit with restrictions, by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the foetus (Art. 14). Nonetheless, the Penal Code in Tanzania only allows medical abortion in case the mother's life and health is threatened and is therefore more restrictive than the respective provision in the Maputo Protocol.

None of the mothers interviewed in Tanzania knew about the African Court or the African Charter. Even though several of the mothers found it positive that such regional human rights instruments existed, they wondered about the ways in which the African Court was different to the UN, and whether this court would have as much power as the UN. Some of the mothers stipulated that perhaps African institutions were better placed to deal with 'African problems,' but at the same time worried that they might accommodate the 'traditional' problems, rather

than confront and change them. A few of the mothers were concerned that perhaps these institutions favoured customary law, as well as men's concerns more than women's concerns, reinforcing status quo. Despite these concerns, women's rights are in fact protected by the African Charter. Article 18(3) specifically recognises and affirms women's rights and requires all African states to eliminate every discriminatory law against women and to ensure the protection of the rights of women. Nevertheless, the majority of the mothers interviewed in Tanzania felt that the African Court was out of reach for them, which was exacerbated in 2019, when the former President Magufuli withdrew the right of individual citizens and NGOs to directly approach the African Court.

iv) *Justice Mechanisms at International Level*

At international level, Tanzania has signed and ratified a number of international human rights treaties, however, even though many of the mothers knew about the UN, they did not know about the treaty-monitoring bodies, nor about the associated right of petition. When exploring the idea of using such a human rights mechanism to deal with their complaints, some of the mothers raised some problems. Firstly, several of the mothers seemed concerned by the fact that their name might be forwarded to the State, which they foresaw as only *matatizo* (problems/trouble). Secondly, a few of the mothers were astounded to hear that the outcome of the case was not legally binding. Finally, many of the mothers highlighted that they would probably need help with all the complicated papers, and this would be a financial burden to them, since none of them had access to the required resources or legal aid. Unfortunately, the high costs of legal consultation not only prevent the equal access and provision of rights, but also makes the legal route inaccessible to the Sukuma mothers most in need of protection.

In conclusion, none of the Sukuma mothers interviewed in Tanzania sought to enforce their human rights claims for accountability or justice mechanisms at local, national, regional, or international levels. Similarly to the finding from the research conducted by in Unnithan (2021), to several of the rural Sukuma mothers in this research study, the idea of claiming rights from the state, is as foreign a concept as the state itself. In fact, many rural Sukuma women perhaps think of their responsibilities towards their husbands and families, rather than in terms of their rights, as bride wealth has been paid on their behalf. Wijsen and Tanner highlight that most Sukuma women only have a few rights in practice. They state that if a so-called 'traditional' Sukuma woman, e.g., a wife of a subsistence farmer, would try to pursue her rights

individually at the local court, "would almost inevitably result in a beating from her husband, brother or father" (2002, p.133). They state that since her social existence and economic survival as well as access to her childbirth, depends on her being either the wife or daughter of a man, she would not risk these positions by acting on her own. They highlight that there should be at least five factors which she would need in order to have any success in using the law to uphold her independent rights as a woman. These would be strength of character, a social situation forcing onto such a woman the need for self-support created by events outside her control, some generally recognised qualifications giving her the possibility of social independence, personal wealth enabling her to be in some way independent, and, finally, indulgent and supportive male relatives, particularly her husband.

Even though Tanner and Wijsen do accurately describe the harsh reality for many Sukuma women, that somehow fails to capture the resilient characters of the urban mothers I interviewed in Tanzania. Despite their lack of privilege, several of these mothers seemed to be very resilient, as the heads of their households with independent incomes and wide social networks. As described previously by Magongo and Corta, many Sukuma women have moved into petty trade and causal labour which in turn has increased their control over the family's income, resulting in a shift of the traditional gender power dynamics. In fact, two-thirds of the mothers I interviewed were divorced or never married, out of their own personal choice, because they either considered the wedding too expensive, or because they did not find the father of their children up to standard. This does evidently not mean that the Sukuma mothers in this study were 'empowered' as the low-wages, lack of job security, and many dependants often made life a continuous struggle for them; however, they cannot be reduced to 'ignorant' victims. Instead, these mothers should be recognised as resourceful, 'pragmatic' women (Gruenbaum, 1998).

As a 'pragmatic' woman, the otherwise uneducated and disadvantaged Sukuma mother, Anna, did manage to access the District Court in Tanzania. Anna's daughter had both completed secondary school and a good job, so she had the required resources to help Anna take her custody claim to the District Court. As Anna explained,

> *So I told him (the solicitor) about the scenario, about how my former husband had taken my son to his mother's house after the divorce….but after hearing the full story he explained how difficult it was going to be because of the Sukuma customary law, but he said that we should try, and at least he told us what to do…….After two weeks I attended the court but again he (ex-husband) did not show up…..After some more weeks I went*

to court again he didn't show up again, so they gave him a final order - if he didn't show up then he will be taken by the police until the case is over, he will be in jail. So that time he finally showed up. In court he said that I was not doing a good job of taking care of our son. But luckily the court said that because our son is so young, he still needs his mother, but when he turns 7 years old, then they will open the case again if he wants to live with his father.

Then the court asked me how much I make per month and then they asked him how much he get per month, and he say TSH 600,000, so the court said that I had enough to send him to the government school and to pay for food every day, but the court told him that if it is not enough, then he should send me another TSH 150,000 every month. So finally, the court told him that he is not allowed to take my son away, and if he did that, then the court would punish him.

Anna's case proved relatively straightforward which is not often the case. The Sukuma are patrilineal and patrilocal, so traditionally the men secured primary entitlement to any offspring upon payment of bride wealth at marriage (Varkevisser, 1973; Wijsen and Tanner, 2002). Even though child custody is provided for by the *Law of Marriage Act 1971*, custody in Tanzania is as aforementioned, often dealt with by village councils in accordance with customary law. Finally, if mothers take custody claims to court, the process is often slow and might take years to complete. Thus, we can conclude that Sukuma mothers face huge socio-economic and cultural barriers when considering whether to bring their human rights claim to court, but also fear ever-present reprisals, so they are not simply ignorant, in the need of more awareness-raising, but quite 'pragmatic' with the survival/welfare of herself and the children resting on their shoulders.

Part I Summary: Sukuma Mothers' Accountability Demands

My ethnographic data in this chapter suggests that there were numerous socio-economic, political, and cultural barriers which prevented the Sukuma mothers from complaining/reporting the human rights violations experienced during childbirth. The main socio-economic and cultural factors included: i) ineffective complaints/reporting mechanisms; ii) no time or resources; iii) apologetic healthcare workers: iv) fear of witchcraft and, finally,

v) the fear of reprisals. These socio-economic, political, and cultural factors made it clear how difficult it is for the Sukuma mothers to make complaints, and even impossible for the Sukuma mothers to consider taking human rights claims to court as the justice and accountability mechanisms at various levels were explored. At local level, mothers preferred to take other matters, e.g., custody battles, rather than human rights claims, to court. At national level, human rights mechanisms seemed inaccessible due to lack of representation and resources, as well as fear of reprisals. At regional level, the mothers doubted the effectiveness of the regional human rights mechanisms and were worried about the replication of customary law outcomes. Finally, the mothers found the human rights mechanism inaccessible at an international level, again due to the lack of resources, as well as fear of reprisals.

The Sukuma mothers' lived experiences and perceptions of the justice, accountability, and complaints mechanisms at local, national, regional, and international levels, revealed that the mothers face immense socio-economic, political and cultural barriers when even contemplating demanding accountability and justice after childbirth. As the human rights-based approach to maternal mortality is increasingly promoted, particularly as a means of 'empowerment' for mothers in childbirth, the 'awareness of human rights' has been highlighted as a means to motivate and enable women to claim their human rights and demand accountability in childbirth. This chapter found, however, similar to Fox (2015), that information and awareness-raising is not enough. While awareness about human rights in childbirth is important, the human rights-based approach to maternal mortality does to not pay enough attention to the socio-economic, political, and cultural barriers to accessing the legal mechanisms. This is especially problematic in countries where justice and accountability mechanisms remain weak. An emphasis on an individual mother's ability to make a human rights claim moreover assumes that individuals problems are 'resolvable' through legal processes, even if healthcare concerns are linked to broader collective socio-economic, political, and political issues (Merry, 2003; Englund, 2004; Turbine, 2007). This is especially challenging in countries, such as Tanzania, where the legal system has been actively undermined by the former president Magufuli for years, shrouding human rights claims and accountability demands in the fear of reprisals.

Part II: The English Mothers' Accountability Demands after Childbirth

The final part of the chapter sets out the ethnographic data from the English mothers' lived experiences of lodging formal complaints, as well as demanding accountability and justice for human rights violations in childbirth. The first section provides an overview of the complaints and accountability mechanisms, as well as the human rights law instruments that the mothers have available to them in order to bring their human rights claims to court. The second section describes the social, political, and cultural factors which prevented mothers from demanding accountability, and finally, the mothers' own experiences of bringing human rights claims to court.

The Justice System in the United Kingdom

Over a period of almost one thousand years, the United Kingdom has built up a sophisticated legal system and body of laws. The foundation of the legal system is based on the concept of natural justice - an open hearing, an impartial court, giving each side an equal chance to state its case and to call evidence before a reasoned decision is made. However, it was not always like this since the legal system in the Anglo-Saxon times was originally a combination of local and royal government. Local courts were presided over by a lord or one of his stewards whereas the King's court, the Curia Regis, was (at least initially) presided over by the King himself. Until the end of the 12th century, guilt or innocence in criminal cases was determined through the process of 'trial by ordeal.' Under this system, the accused would undergo a painful and dangerous 'ordeal.' They might be forced to pick up a red-hot bar of iron, pluck a stone out of a cauldron of boiling water, or something equally as painful. If their hand had begun to heal after 3 days, they were considered to have God on their side, thus proving their innocence. King William II (1087-1100) eventually banned trial by ordeal, reportedly because 50 men accused of killing his deer had passed the test, and it was also condemned by the Church in 1216. Eventually the foundation of the modern justice system was built by King Henry II (1154-1189), who established a jury of 12 local knights to settle disputes over the ownership of land (Rivlin, 2004).

At present, the United Kingdom has three separate legal systems; one each for England and Wales, Scotland, and Northern Ireland. This reflects its historical origins and the fact that both Scotland and Ireland, and later Northern Ireland, retained their own legal systems and traditions under the Acts of Union 1707 and 1800. For the purposes of this thesis, we are focused on the justice system of England. The English court system is structured in the following way: i)

Criminal cases will start in the Magistrates' court, but more serious criminal matters are sent to the Crown Court. Appeals from the Crown Court will go to the Court of Appeal Criminal Division and potentially the UK Supreme Court; ii) civil cases will usually start in the County Court. Again, appeals will go to the High Court and then to the Court of Appeal – although to different divisions of those courts; iii) the tribunals system has its own structure for dealing with cases and appeals but decisions from different chambers of the Upper Tribunal, and the Employment Appeals Tribunal, may also go to the Court of Appeal (Ministry of Justice, 2023).

In 1997, the then Labour Government brought in the Human Rights Bill, which is based on the rights and freedoms set out in the European Convention on Human Rights (ECHR). The idea was to 'bring rights home' and enable citizens to take alleged breaches of the ECHR rights in front of the domestic courts. In 2000, the Human Rights Act (1998) came into force, which meant that all public authorities in the United Kingdom have to act compatibly with the ECHR. Even though it is unlawful for a public authority to act in a way that is incompatible with the ECHR (section 6 of the Human Rights Act), the courts do not have the power to set aside legislation on the grounds that it is unconstitutional or on the grounds that it violates human rights. This is because of a vestigial commitment to the doctrine of parliamentary sovereignty, as Dicey states "Parliament has … the right to make or unmake any law … [and] that no person or body [has] a right to override or set aside the legislation of Parliament" (1950, p.39). Fundamental rights protection in the law is therefore achieved by means of a very particular British compromise. If Parliament legislates in a way which is incompatible with the human rights found in the Human Rights Act 1998, the courts are tasked with interpretating the legislation in a way which is compatible with human rights. If it is not possible to interpret the legislation in such a way, the courts must issue a "declaration of incompatibility," which signals to Parliament that the legislation is incompatible with human rights, however, that leaves the legislation in force (Hanretty, 2020).

Complaints and Accountability Mechanisms in the United Kingdom

The NHS Constitution guarantees every patient in England the right to make a complaint about NHS services. The NHS is bound by a statutory complaints procedure, so any mother who is not satisfied with their maternity care can first complain to the responsible NHS Trust, to the General Medical Council (GMC) about their obstetrician, or to the Nurse and Midwifery

Council (NMC) about their midwife. If complaining to the NHS Trust, the Complaints Manager might invite the mother to the hospital to discuss the complaint (each Trust has a slightly different system, so the invitation may come from the Complaints Manager, the Head or Director of Midwifery or the consultant concerned). If following this meeting, the mother remains dissatisfied with the response, she can instead approach the Healthcare Commission to ask them to investigate and conduct an Independent Review. If the mother is still not satisfied that the complaint has been resolved, a complaint can be made to the Parliamentary and Health Service Ombudsman (Ombudsman). The Ombudsman will normally only look at a complaint after the local complaints process has been exhausted. Finally, the mother can decide to take her human rights claim to court (NHS, 2023).

There are a number of mothers and fathers in the United Kingdom who have received coverage in the media for lodging complaints and reporting human rights violations in childbirth. Rhiannon Davies and James Titcombe are examples of two parents who wanted to establish the truth about the deaths of their infants and as a result uncovered two of the worst maternity scandals in the United Kingdom. First of all, James Titcombe, who lost his newborn son Joshua as a consequence of failures in the childbirth care at Furness General Hospital, went through the NHS complaint procedure, complaining to the Trust, the NMC, the Ombudsman and even the Care Quality Commission (CQC) without any success because all of these complaints - and accountability mechanisms failed to thoroughly investigate the death of his son. As Titcombe (2015) explains, it was not until he convinced the coroner in Newcastle to open up an inquest that the significant failures in the childbirth care of his son were exposed, as well as failures in the care of other newborn infants. Consequently, the Morecambe Bay investigation was set up by the government's former health secretary, Jeremy Hunt, in order to examine childbirth concerns. A panel of experts, led by Dr Bill Kirkup, investigated the events from 1st January 2004 to 30th June 2013, and found that a number of serious failures in the childbirth care at Furness General Hospital had led to the avoidable deaths of 11 babies and one mother (Kirkrup, 2015).

Likewise, Rhiannon Davies had to complain repeatedly to uncover the truth about why her infant daughter, Kate, died after childbirth. Rhiannon Daviss gave birth to her daughter in a midwife-led birth centre in Ludlow which is a part of the Shrewsbury and Telford NHS Trust. In the weeks before the childbirth, Rhiannon Daviss had raised concern about a lack of fetal movement but was nonetheless not classified as high risk and still sent to a midwife-led birth

centre. When her daughter Kate was born, she was floppy and pale. She began to grunt, which is a sign of respiratory distress, but was not checked up on by the healthcare workers but instead just left in a cold cot. After she died, the Trust consistently gave half-truths instead of proper answers. Rhiannon Daviss tried in vain to establish the facts of her case, eventually being left no choice but threaten the coroner with a judicial review before an inquest into Kate's death was finally granted. Three years later, the hearing confirmed that Kate's death had been avoidable, and a follow-up investigation by the Ombudsman concluded that the child's death had been the result of serious failings in childbirth care. The independent reviewer Debbie Graham found:

> Shrewsbury and Telford Hospitals NHS Trust failed to fulfil its responsibility to establish the facts of this case and to establish accountability. Rather the Trust abdicated its responsibility to the Local Supervising Authority, an organisation with no accountability to the Trust and whose investigation was subsequently found not fit for purpose' (2015, p. 44).

Since more parents raised similar concerns, the former Secretary of Health, Jeremy Hunt, requested an independent review to examine maternity practices at the Trust between the years 2000 and 2019. The Ockenden Review (2022) found the failures there resulted in the deaths of 201 babies and nine mothers, as well as left several infants with life-changing injuries.

Finally, an example exists of a mother who has brought her human rights claim to court, and, as a result, changed the law. When Nadine Montgomery was pregnant with her son, she mentioned to her obstetrician that she was concerned about her body's ability to safely birth vaginally, as she was small in stature, whilst her infant was estimated to be large, due to her type 1 diabetes. Although Nadine Montgomery raised these concerns multiple times, her obstetrician chose not to discuss the option of a caesarean with her, as the obstetrician was of the opinion that caesareans should not be discussed because *"*then everyone would ask for a caesarean section, and it's not in the maternal interests for women to have caesarean sections" (*Montgomery v. Lanarkshire Health Board, 2015)*. Unfortunately, Nadine Montgomery experienced a shoulder dystocia during her birth, which eventually led to serious injuries to her and her son. After several complaints and appeals, Nadine Montgomery eventually took her case all the way to the High Court, which ruled in her favour, stating that clinicians must adopt a woman-centred approach to giving advice during pregnancy. The High Court held that the law required clinicians to have detailed and personalised discussions with women, which enables them to make their own decisions on the basis of information about 'all material risks.' This High Court decision redefined the standard for informed consent and disclosure.

Previously, the *Bolam test* in England was used to determine whether the healthcare worker's conduct would be supported by a body of clinicians. The *Bolam test* was affirmed in *Sidaway v. Bethlem Royal Hospital Governors* [1985] and others, although the ruling was not unanimous, with judges placing different weight on the patient's right to make informed treatment decisions versus the doctor's professional judgment in disclosing information. The Montgomery case firmly rejected the application of the *Bolam test* to consent, instead establishing a duty of care to warn of material risks (Chan et al., 2017).

The above examples have shown that despite great difficulties, mothers in the United Kingdom have been able to access complaint and justice mechanisms, and, as a result, have even managed to change the law. The following section presents the ethnographic data on the English mothers' lived experiences of lodging formal complaints and bringing human rights claims to court.

The English Mothers' Complaints/Reports on Human Rights Violations in Childbirth

The following section outlines the mothers' considerations as to whether or not to lodge a formal complaint or report human rights violations which they experienced during childbirth. Since the majority of the mothers interviewed decided not to complain, the first part explores the socio-economic, political, and cultural factors which prevented them from doing so. These are as follows:

i) Feelings of Exhaustion and Hopelessness

Some of the English mothers interviewed in this research study refrained from complaining due to feelings of exhaustion and hopelessness. These mothers even began doubting their own experiences, and as a result felt so hopeless that they were not able to complain/report anything. An English mother, Felicity said,

> *I planned a home birth for my first child, but everything went wrong as my contractions started slowing down, so eventually I was rushed into hospital, and I could feel that my anxiety and adrenaline kicked in, which made my contractions slow down even further.*

Instead of giving me support, the midwife just started screaming at me, telling me, or actually threatening a forceps delivery if I did not give birth within the next half hour…..After birth, another midwife started tucking the cord to get the placenta out, and when I said, "Please don't," she just glared at me and saying, "I am just following protocol." They were being so insensitive, and they had no compassion, but I never complained about them, because when I came home again, I started doubting myself, thinking that perhaps it was me that was wrong. I just started feeling hopeless about the whole thing (mother starts crying) so did not want to complain or even think about it.

Some mothers just wanted to move on from their birth and instead focus on their infant, and they felt too tired to move forward with a complaint or report the human rights violations which they experienced during their childbirth. As an English mother, Sarah, stated,

I have given birth both North and South of the river – both of them were just awful. In general, there was no empathy from my midwives whatsoever, in both places, they were just there, barely interacted with me and just did not care….But I never did complain because after your childbirth you just want to get on with it. And you are just too tired…And I was too busy with my newborn daughter.

Iwata et al. (2018) highlight the high levels of fatigue of mothers up to six months after birth, which diminishes the mothers' ability to both concentrate and communicate. However, the English mothers in this research study felt that it could even extend to one year after birth, as mothers struggled to return to work whilst also taking care of their infants during countless sleepless nights.

Rivedal (2022) describes the embodied experience of working mothers whereby the 'sensitised embodiment' of their maternal bodies is helpful to take care of their infant, however, also leads to exhaustion. She uses Merleau-Ponty's 'embodied consciousness' to highlight how the 'openness' of the maternal body to her child means that mothers have difficulty calming down, her body is always ready to take care of her child at night meanwhile having to perform at work the next day. Similarly, it was too much for many of the English mothers interviewed to even contemplate lodging a formal complaint which was coupled with the fact that mothers only have 12 months to make a complaint about the NHS from the time of childbirth.

ii) Fear of Reprisals

A few of the English mothers in this research study feared reprisals if they complained about any perceived violations in their childbirth. An English mother, Lara, who did complain about her childbirth experiences did fear reprisals from doing so. She stated,

> *I had a lot of complaints about the things that happened during and after my childbirth, and even though I am an educated woman, I was somewhat worried about complaining, because I ultimately worried that it might result in social services getting involved. You see, I co-sleep with my infant and toddler, and the official guidance is against that, so it did cross my mind whether they could somehow blacklist me or find things to use against me.*

The Children's Services have a legal duty to investigate situations where a concern has been expressed about the safety and wellbeing of a child, so they do work closely with both the police and healthcare workers. However, even though healthcare workers are obliged to discuss their concerns with the mothers, and obtain their consent before making a referral, both AIMs and BirthRights have been contacted by mothers who have been coerced into accepting interventions or antenatal tests by being threatened with Children's Services.

In contrast, there were some mothers who were convinced that no one would even look at their complaint, and even if they did, nothing would result from their complaint, so decided not to go forward with their complaint. As Diana stated, "I never complained about it because I thought to myself, what is the point? No one will listen." Finally, a few of the mothers still felt like a failure after their failed 'natural' childbirth, which deterred them from complaining. An English mother, Isabella, explained that she did not complain, even though she encountered disrespectful and unsupportive midwives:

> *I was in labour for three days until they eventually induced me and my waters broke. Luckily, the midwife who was responsible for the induction was very nice, and explained everything very well. But then I got a new midwife who was so disrespectful. Since I was having contractions every three minutes, I complained about the pain she shouted: It's called labour for a reason, love!*

When I started pushing in labour, my third midwife shouted at me that I was not doing it right, repeatedly: You are doing it wrong! You are doing it wrong! This made me feel like such a failure, like I was doing everything wrong, that it was my fault that I ended up having a caesarean.

So, when I was back home, I was too tired, and I felt like a failure so did not want to report my experience.

Some mothers described themselves as 'failures' after having to have a biomedical birth instead of 'achieving' a 'natural' childbirth, and this seemed to have affected their ability to report the human rights violations they had experienced in childbirth. As aforementioned, in a culture of achievement one's worth and existence is constantly measured and depends on what you *do* as you *are* what you *achieve*, hence, those who do not *achieve* end up feeling like 'losers' (Dilling and Petersen, 2021, p.378) and mothers might therefore turn critique inwards, instead of towards healthcare providers and wider society. In fact, Bauman (2001) has argued that in the realm of contemporary society, critique has become somewhat both privatised and disarmed, since instead of directing critique towards societal structures that stimulate unintended negative consequences for individuals, we tend to direct it towards ourselves and our own achievements. By turning critique inwards, we focus on small-scale critique whilst neglecting large-scale critique, making our critique societally impotent.

iii) Missing Maternity Notes

Some of the English mothers in this study were prevented from complaining or taking their claim to court, since their maternity records went missing. When a mother receives NHS maternity care in the UK, she should receive a set of maternity records at her booking appointment, which she then keeps with her throughout pregnancy and childbirth. Healthcare workers make a note of all the maternity care they provide in the records, including test and scan results. After the infant's birth and discharge from hospital, these records are retained by the hospital. An English/Turkish mother, Zerah, who was convinced that her midwife was responsible for her daughter's cerebral palsy due to the delay of care during childbirth, was not able to make a complaint or take her claim to court, since her maternity records went missing. As the English/Turkish mother Zerah stated,

I was not able to complain because you need your maternity notes, and when I asked for my maternity notes at the hospital, they told me that they had been lost. Then I tried talking to a No Win, No Claim solicitor to take my case to court, but again, she said that I needed my maternity notes, and that she could not do anything until I had my maternity notes.

To this day I am so angry and hurt. My husband does not know what to do, he asks me if he should find the midwife and kill her, but says that won't help me or my daughter…

A mother has the right under the Data Protection Act 1998 to get access to her maternity records after childbirth, however, if the individual mothers do not have access to their maternity records, then their cases cannot be investigated, and their claims cannot be taken to court. Similarly, James Titcombe describes how difficult it was to investigate his son's death after his wife's maternity records went missing. As Titcombe states, "This was the death of a child. How could the fact that critical records were missing, and that staff were unlikely to change their accounts of the events possibly be an acceptable reason not to investigate?" (2015, p.80). Instead of treating the fact that the healthcare providers had lost the maternity records as suspicious, that became the reason why all the complaints and accountability institutions decided against opening an investigation.

iv) Ineffective Complaints and Accountability Mechanisms

A few mothers stated that they gave up on complaining because they found the accountability mechanisms ineffective, and as a result, they did not feel listened to. A younger mother, Beth, who had had a traumatic childbirth, asked for a meeting with her midwife to highlight her concerns, but was instead met with healthcare workers, who seemed more interested in keeping her quiet – by saying what she wanted to hear – rather than addressing the problem. The younger, white English mother, Sue stated,

So, I thought that meeting was an opportunity to have my questions. But even though I asked the midwives a lot of questions about my birth, they did really not know anything and couldn't really give me any answers, it seemed they were just there to make sure I did not take my complaint further.

I wanted to further investigate this mother's assumption, so I contacted the healthcare providers at the hospital where she had given birth. When I turned up for the interview at the hospital, the Head of Midwifery looked confused at me, as the Personal Assistant must have arranged our interview by mistake. Luckily, the interview went ahead anyway, and the interview flowed freely, as the Head of Midwifery was excited about soon beginning a new job at another hospital. This meant that when I asked questions, honest, rather than official, answers were given. Hence, when I enquired about the abovementioned meetings, set up between the individual mothers and midwives, to talk about childbirth issues, it was honestly proclaimed, "we send a midwife to talk to the mums, you know, just to nip it in the bud" (Fieldnotes, April 2019).

Both Kate Davies and James Titcombe have themselves described their battles with various complaints and accountability mechanisms, which again and again proved ineffective and incompetent. For example, when James Titcombe (2015) approached the Nursing and Midwifery Council (NMC) about the incompetent midwives at the Furness General Hospital. The cases were given only little consideration or dismissed completely. The Professional Standards Authority for Health and Social Care (PSA) subsequently investigated the NMC's handling of the midwife matters at the Furness General Hospital which found that the record-keeping was very poor and lack of open, transparent communication, pointing to its misleading responses to bereaved families and its failure to disclose external reports looking at learnings from previous cases.

v) Taboo to Complain about 'Our NHS.'

Even though several mothers in this research study had experienced human rights violations during childbirth, the majority of them did not want to lodge a formal complaint, let alone take their claim to court. An overriding theme when conducting focus groups with the mothers in the United Kingdom was that while it was socially accepted to complain about their individual childbirth or an individual healthcare worker's behaviour, it was generally frowned upon to complain about the NHS. In general, many mothers began their childbirth stories with a general statement or disclaimer, which highlighted their appreciation of the NHS. Then they would express concern about the 'overburdened' and 'overworked' NHS. In fact, some mothers even highlighted how they refrained from complaining or taking their claim to court, as they did not want to be 'an additional burden' on the NHS, or a drain on the NHS. For example, an English

mother, Rose, did not want to bring her claim to court despite her son's brain damage resulting from complications during childbirth. She recalled,

> *When I arrived at hospital, I was examined and found to be nine cm dilated. I was immediately hooked up to a monitor. At this stage a wonderful midwife was on duty at the hospital - but she was just going off shift - thought something was amiss with my son. They subsequently discovered he was an undiagnosed breech - it turned out that when the previous midwife was saying I wasn't dilated at all, they were actually putting their fingers up my son's bottom and thinking it was my cervix. The Obstetrician was bleeped. They explained my son was breech, but that the Obstetrician on duty was very experienced in breech deliveries and they felt they could deliver him safely vaginally. I was given an epidural and gas and air and out into stirrups in the bed. Foetal and maternal monitoring showed us both to be tachycardic. My son evacuated his meconium in utero. Within a very short time, I was fully dilated, and we were trying to deliver him.*
>
> *Somewhere between 8.30 and 10pm, my contractions stopped, and people started to get concerned about the heartbeat and decelerations. I had an audience of about five to six people between my legs at any one time. Something I as unable to do anything about because my feet were in stirrups. The obstetrician did some kind of oxygenation blood test and said I had about ten minutes of pushing left before they would have to take me to theatre. In any event, we called it and went to theatre straight away for an emergency caesarean. My son was born in theatre - after some violent pulling around because his head was wedged under my ribcage - at 10.40pm. They struggled to get him out and he wasn't breathing on his own when he was born. A paediatrician was called to resuscitate my son and after what seemed like forever but was probably only about 15 minutes - they got him breathing and I saw him for the first time. He didn't go to PICU…..And we only found out months later that he was brain damaged – cerebral palsy.*
>
> *There are many unexpected expenses, and it would have been good with more support. Financial and emotional support. However, my husband and I we are civil servants interested in the common good, not being a financial drain on the NHS.*

The mother described that the trauma did not end with her traumatic experience during childbirth but continued afterwards as she felt it was almost impossible to get the emotional, practical, and financial support needed for herself and her son. She would have potentially received financial support if she had taken her negligence claim to court but decided not to as she did not want to be a financial drain on the NHS.

Several of the English mothers in this research study seemed to have felt that it was almost too taboo to complain due to the near 'sacred' status of the NHS. The Canadian mother, Claire, for example, who criticised her midwife for failing to treat her UTI - proceeded to tell the focus group that when she passes the local hospital, she always flicks her finger and says, "Fuck you NHS." However, instead of a sense of condonement among the English mothers, their facial expressions revealed upset/disgust/contempt, towards the 'crass' Canadian mother for her breaking the taboo and criticising the NHS. The term *taboo* itself is of Polynesian origin and was noted by Captain James Cook during his visit to Tonga in 1771, as the prohibition of an action based on the belief that such behaviour is either too sacred or too dangerous for ordinary individuals to undertake. The prohibition that is inherent in a taboo includes the idea that its breach or defiance will be followed by misfortune for the offender, such as lack of success in hunting or fishing, sickness, miscarriage, or death. In some cases, particular rules are the only way to avoid this danger, such as rules against fishing or picking fruit at certain seasons and against walking or traveling in certain areas (Steiner, 1956). Douglas (1966) highlighted that the notion of taboo is found in all societies, as all societies have different ideas about what constitutes taboo. Taboo, as rules of behaviour, are always part of a whole social system and should be analysed within their social context.

Melanie Phillips has stated that "the NHS sacred cow must be put out of its misery" but politicians remain reluctant to reform the NHS (Phillips, 2022). In fact, the British politician Nigel Lawson has famously stated that the NHS is the closest thing the English people have to a religion (Toynbee, 2018) which was clearly illustrated during the opening ceremony of the 2012 London Olympics. Numerous actors were dressed up as medical doctors danced around to swing music and hospital beds were arranged to spell out the letters N-H-S (Frayer, 2018) and as pictured below, a grand show of midwives among hospital beds and a sculpture of a giant baby.

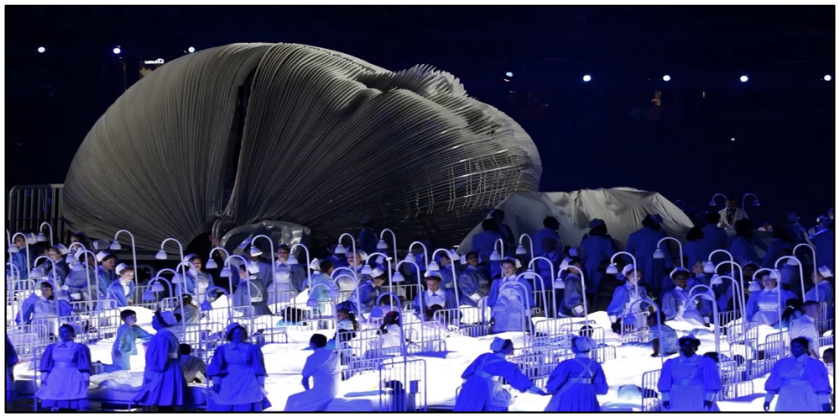

Image 2: NHS celebrated in the Olympics (Source: Jae C. Hong/AP)

This continued throughout the covid-19 pandemic as various events were organised to celebrate and show appreciation towards the NHS, such as the 'clap for the NHS' and children all over the country drawing rainbows to show appreciation towards the NHS (Mathers, 2020). The strong public sentiment towards the NHS has been clearly expressed by the former Prime Minister Tony Blair, who stated,

> The Conservatives don't understand why we created the health service. They don't understand it. The health service to me is a living, breathing symbol of what a decent, civilised society should mean in practice, helping people on the basis of their need not on the basis of their wealth. (Pearce, 2001, p.215).

Several of the English mothers interviewed seemed to express a similar sentiment and despite any of their individual negative childbirth experiences, they seemed to perceive the NHS itself as a symbol of healthcare for all, as well as a cornerstone of a fair and equal society.

vi) Authoritative Knowledge and Replicated Power Hierarchies

Several of the English mothers in this research study described their frustrations with lodging formal complaints, as they often felt that they had to 'formalise' very traumatic experiences. As Madeleine, the mother who could feel the pain during her caesarean, stated,

> *They need to understand, when they receive a letter of complaint, it might sound level-headed, but it is underplaying the trauma. I still have nightmare about it. About the pain, about nearly losing my baby.*

> *I think what made me decide to complain was, unless you point it out, people are quite happy just to continue as before. So, I wrote my letter of complaint to the chief*

executive, and cc'ed my local MP, and cc'ed the Department of Health, and my local GP. However, what doesn't come across in my letter is how awful it was. I was trying to write it in a very matter of fact way, so that they might do something about it, so not writing in an emotional way. But it had actually been so traumatic to me.

(The Chief Executive) enclosed the NHS complaints procedure, but I didn't take it any further, because I didn't want to dwell on it, because I had my child to raise. But there are still things that I would like to know.

Merry and Stern (2005) state that women often have to depersonalise very personal issues in order to seek resolution which acts as one of many deterrents for women using the legal process. However, some of the English mothers found that they even had to go one step further, as they did not only have to depersonalise their traumatic experiences, but they also had to formulate themselves in a 'rational,' 'scientific' and 'medical' manner in order for their letter of complaint to be 'taken seriously.' An English mother, Edith, who was an editor at a scientific journal, for example took special care to formulate her letter of complaint in a very 'scientific' and 'objective' way as she hoped that would finally get the message across to the management at the hospital where she gave birth.

Reader et al. (2014) state that a letter of complaint can provide unique insights into aspects of care that may not be easily captured through traditional quality and safety metrics (e.g., disrespect and dignity). However, there are a number of problems with how individual letters of complaint are perceived. Firstly, a letter of complaint is perceived as representative of an individual experience only, rather than a systematic investigation of failures. Secondly, such complaints are often just perceived as emotive, expressing anger, distress, and problems in interactions with individual healthcare workers, instead of addressing systemic problems. Third, such complaints are often perceived as individualistic, ignoring the wider system pressures influencing healthcare (e.g., workloads of the healthcare workers, policies), and thus, perceived as ignoring the crucial contributory factors leading to problems in the healthcare provision. Consequently, even though complaints can potentially indicate problematic trends in healthcare provision, in particular when considered in aggregate, the complaints are often not put forward to improve the healthcare provision.

A number of the English mothers attempted different methods to be taken seriously, such as cc'ing local councillors and the press, or emulating biomedical 'expert' language in their letters

of complaints. However, even when emulating the biomedical 'expert' language, they felt that their letters of complaints were ultimately dismissed as 'subjective' and 'emotional' individual descriptions of their childbirth experience and, thus, ultimately ignored. The experiences of these English mothers clearly demonstrated how they felt that they were met by an 'authoritative knowledge' power hierarchy, not only during their childbirth, but also afterwards when trying to access accountability mechanisms. Their feelings were corroborated somewhat by a former employee at the NMC who shared that the majority of the letters from individual patients "were thrown directly in the bin" (Fieldnotes, June 2019). Instead, it was the letters that described concerns which had already been raised by senior healthcare workers that passed the threshold and were therefore taken forward to the fitness-to-practise hearing. Thus, the power hierarchy of the biomedical healthcare context seemed to be replicated and reproduced in accountability mechanisms, with the 'authoritative knowledge' of healthcare providers positioned above that of the individual mothers.

The English Mothers' Human Rights Claims in Court

This part of the chapter outlines the motivations of the mothers to lodge a complaint or even take their human rights claim to court. Even though the majority of mothers interviewed in the United Kingdom decided not to complain/report the human rights violations after their childbirth, a few did, so we explored in both the focus groups and one-to-one interviews what the tipping point was for the mothers, that particular moment when they finally decided to lodge a formal complaint or take a claim to court. Finally, we explored whether the mothers achieved a sense of justice from their complaints and accountability demands. The findings were as follows:

i) Establishing the Facts of the Case

Several of English the mothers who did make a complaint, stated that it was important to them to know why things had gone wrong, so they could establish the facts as well as identify who was responsible for the mistakes. A young, English mother, Adrienne, stated,

I decided to go to hospital when I couldn't feel my baby move, you know, reduced fatal movements, so I went to hospital to do a scan, but when I arrived, there was no one around to do the scan. When someone finally did the scan, they decided that I should come into the hospital the next day for an induction….When I arrived the next day at the hospital, no one knew why I had come, no one knew about my induction, so I just ended up waiting in the reception. And when someone finally arrived, no one provided me with any information, everything just seemed chaotic.

When a bed finally freed up, they tried to break my waters. After that the midwife took me into another room, and three different doctors arrived at different times, asking me what kind of birth I wanted. So, I told them that I wanted a water birth with music playing. They got that organised for me, but they suddenly decided to do a caesarean on me. But then they suddenly discovered that my blood was low in platelets (thrombocytes), so a caesarean was not possible after all.

When I asked for more information about this, the midwife told me that her shift was going to end in 5 minutes, so she didn't have time to talk to me. Then a new midwife came, but she didn't even introduce herself, she just came into my room. And then suddenly a doctor came and said that they were going to do a caesarean. So, then I had a caesarean, and it all went wrong.

I just felt that everything was chaotic, and no one explained anything to me, so I decided to complain, because I would like to know what happened and why they decided to do the things that they did.

The Nursing and Midwifery Council's (NMC) code for standards of practice and behaviour for nurses and midwives state that that there is a professional duty to be transparent when things go wrong as "every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress" (p.150). Adrienne felt that there was no attempt to be honest with her in any of the subsequent correspondence from the Trust, it all seemed to be a cover-up. Adrienne hoped that by pursuing the complaint she would finally get some answers that she had been unable to get from the Trust beforehand, however, felt that she was constantly brushed aside as some sort of 'emotional' woman who did not have her facts straight.

ii) Lack of Apology and No Lessons Learnt

Some of the English mothers in this study stated that it was the injustice of the situation that motivated them to complain, and even take their claim to court, especially if no apology was offered, or if they felt that no lessons had been learnt from their mistakes. The English mother, Rosalind, said,

> *It wasn't until I had my second child at (….) Hospital that I decided to complain and sue them. I went back a year later hoping that lessons had been learnt.*
>
> *The care they gave me during the scan was fine, however, during the delivery there was no compassion – even though the anniversary of the death of my son was just a week away…there was no compassion, no sympathy, it was just robotic.*
>
> *When I sued them, I never actually got an apology in the end. They never admitted to causing the death of my son. They said that they were negligent in the care of me, but they never apologised to me, and I don't understand that.*

Several mothers interviewed stated that the delay in response and lack of an apology increased their sense of injustice. Similarly, in the case of a mother, referred to as Mrs J in the media, Mrs J eventually decided to take her negligence claim to court since she had waited for an apology from the Trust for more than a year after her infant died in childbirth. In this case, the medical doctors had failed to treat the pregnancy as high risk despite previous operations to treat fibroids and endometriosis which placed her at increased risk of uterine rupture. The mother highlighted that a timely apology would have allowed her to move on more quickly (Lydall, 2018).

iii) Infant Morbidity and Mortality

While the majority of English mothers in this research study decided not to complain, there was a clear tipping point for mothers – infant mortality as a result of complications at birth. As the English mother, Liz, stated:

They didn't listen to me, I told them that something was wrong, but they just didn't listen to me, they should have induced me sooner, but they didn't. So, there I was, left holding her cold little body, and I couldn't believe it, it really destroyed me. I look back now and think why did they not listen to me and take me seriously? At least they finally took me seriously after my negligence claim.

The mothers who had infants who were brain damaged, as a result of complications at birth, were also motivated to take their claim to court in the hope of justice, as well as financial compensation to help with the resulting increased support needs of the infant. Rose stated,

My partner and I felt that we had been very badly served by the NHS - the failure to diagnose Tom as breech, the midwife team's failure to listen to me, my own midwife's failure to even turn up, and the subsequent shock of what happened - so fast - during full labour had all provided reasons for us to feel somewhat short changed. We requested my hospital notes be sent to us. The hospital sent them to the wrong address - leaving my medical notes in the hands of goodness knows who, but their failure to acknowledge this or rectify it meant a delay of some weeks. Eventually the notes arrived, and we noticed that they had been changed from when we had read them cover to cover in hospital -when they leave them with you by your bed. This provided us with another reason to question what had happened. So, we complained to the hospital.

It took me six months to get anyone to listen to my concerns about my son properly – most stating "you're an over-reacting new mother." We were eventually referred to Consultants and at eight months Tom was diagnosed with brain damage - cerebral palsy. At 22 months old, he began to have uncontrolled seizures. During the course of the next ten years, his seizures nearly killed him on about six occasions - on life support, sedation, and ventilation. Managing the rest of his life and disabilities has clearly been a long-standing issue.

Pickles and Herring (2020) highlight that even though several childbirth cases might be brought to court under both negligence and human rights law, negligence compensation is ultimately of far greater practical utility. This can be attractive to parents of brain damaged infants as they face life-long support costs. Nonetheless, proving negligence in court which the usual standard for being awarded compensation, can be both very difficult and expensive for both sides.

Rinaldi et al. (2020) explains that it needs to be proven that the medical care providers owed a duty to the infant and that they were derelict in that duty and did not meet the proper standard of care. Furthermore, a causal relationship needs to be established between injury sustained by the child and the healthcare worker' breach of duty to the child. Hence, the mother in the case ultimately has the burden of proof. She must first demonstrate that she or her infant sustained a physical injury. Then she must prove that the attending healthcare worker was at fault. Finally, the mother must establish a connection between the injury sustained and the healthcare provider's negligent act or omission. All of this takes place as part of a process in which the individual has to undergo cross-examination. As Beech states, "The lawyers' objective is only to sue for damages and obtain a financial settlement. If you have a strong case, it is very likely to be settled out of court with no hearing, and a weak case will get nowhere" (2010, p.12).

iv) Achieving Justice?

Finally, the English mothers in this research study who had demanded accountability or taken their human rights claim to court were questioned as to whether that had provided them with closure or a sense of justice. Unfortunately, many of the mothers in this research study who had been through a formal complaints procedure, or had brought a claim to court, felt re-traumatised and eventually gave up, instead of achieving a sense of 'empowerment' or justice. As Rose, the mother of Tom, explained,

> *During the complaint procedure, we were not supported at all. We were actively blocked from having discussions with the midwife concerned but wrote to the Head of the Midwifery team with our concerns. We eventually got to a meeting with the Chief Executive of the hospital after several exchanges of letters with which we remained deeply unsatisfied. The meeting ended no differently. We felt that they lied and covered for everyone involved. They changed their story to suit whatever point we were making at the time. Eventually however, I did not have the emotional energy to continue. I needed to focus on what my son needed - which was a considerable time and energy investment to focus on a huge number of further diagnoses, appointments and subsequent emergency admissions - orthopaedics, neurologists, developmental paediatricians, physiotherapists, occupational therapists, then appointments relating to epilepsy and regular appointments for drug reviews….. We did not seek further legal*

advice, as we were emotionally drained and felt re-traumatised every time, we had to explain ourselves to a new person in the process.

Ahmed (2021) explains how problematic it is that the person who makes the complaint, who is often experiencing the trauma of the situation they are complaining about, ends up having to be 'the conduit,' as they have to hold all the information in order for it to be circulated, and to keep things moving, and they have to keep on making the same points to different people in the process.

The mother Seddon has blogged about her experience of being cross-examined as a witness in the NMC fitness-to-practise hearing of her midwife after her son was born stillborn. She describes the overall process as cold, complex, and impersonal. She recalls,

> I am 'Woman A' for the duration of the hearing. I no longer exist as myself. I'm a piece of evidence and am allowed to speak only when I'm asked a question directly. My husband is not allowed to support me while I am cross-examined, but my midwife is there, fully armed with her barrister and her family. I'm shaking with anger, with fear and distress. Her barrister cross-examines me for over two hours. It feels like an attempt to annihilate me. He blames, belittles, bullies, and tries to confuse me (Seddon, 2019).

Kennedy (2018) highlights how rape victims are often re-traumatised in court, as they are viciously cross-examined, have the burden of proof, and almost presumed guilty until proven innocent. However, mothers face perhaps even more pressure during cross-examination in court, due to the issue of compensation. The English mother Joanna explained how she ended up feeling prosecuted and re-traumatised in court, there being constant pressure to discredit her due to the issue of compensation. She recalled,

I was constantly re-traumatised as I had to explain everything again and again, I had to think and talk about the death of my son again and again, and obviously nobody believes you in court, they are trying to prove that you are lying and that you are just greedy, after the money, even though that is not your motivation at all, you just want justice for your baby son and things to improve for other mothers.

As an English mother, Elaine stated "it is basically a battle with highly skilled cross-examiner armed, who is focused on undermining your credibility. Giving evidence is daunting…and cross-examination is far more often traumatic than cathartic." Likewise, James Titcombe, the father of Joshua, described the complaints and accountability process, including the hearings,

as far worse than he could have imagined, because he felt that he was subjected to cross examination in a manner which attempted to discredit him. He said, "it just feels like a very unfair process that people can actually base a case and their arguments on trying to discredit a bereaved family and there is nobody there who is supporting the family or arguing or saying hang on a minute that's not true ... It was a horrible, horrible process and no wonder, no wonder, people don't want to go through it". (PSA, 2018, p.21) Similarly, Davies has described in an interview to the media how traumatic the process was for her, stating, "You re-traumatise yourself every time you touch it again" (Robertson, 2019). Finally, in the words of Joanna,

> *You know, even though I won my court case, I didn't feel like I won, because the whole thing was just awful, the court, the people, you are just traumatised again and again. You know, I even had someone say to me," Oh it's okay, you are still young, you can have another one." It was comments like that, oh my gosh, the effects of such a simple sentence on you lasts a lifetime.*

Hence, despite the initial hope of feeling 'empowered' from bringing their human rights claims to court, the English mothers in this research study instead felt re-traumatised - and rarely achieved a sense of justice.

Part II Summary: English Mothers' Accountability Demands

In this part of the chapter, I first presented the ethnographic data on the social, political and cultural factors which prevented the English mothers in this research study from complaining/reporting human rights violations. These main factors included: i) feelings of exhaustion and hopelessness; ii) fear of reprisals; iii) missing maternity notes; iv) ineffective complaints and accountability mechanisms; v) too taboo to complain about 'Our NHS' and finally; vi) authoritative knowledge and replicated power hierarchies. However, the tipping points for the mothers included: i) establishing the facts of the case, ii) the lack of an apology and no lessons learnt, and iii) infant morbidity and mortality. Finally, the ethnographic data revealed that several mothers felt invalidated or re-traumatised when they went through the formal complaint procedure or took their human rights claim to court, instead of achieving a sense of justice.

Even if individual complaints and claims are considered 'emotive,' they arguably provide healthcare providers with a convenient litmus test of their healthcare provision, and when combined, might offer an insight into systemic problems within the healthcare system. Nonetheless, the Ombudsman states that too many people do not complain because they do not feel listened to; so the complaints system does need reform for people to regain the confidence that their voices are being heard and being used to make improvements (2020, p.6-8). In the wake of the Morecambe Bay Trust, as well as Shrewsbury and Telford Trust scandals – where more than 200 infants and mothers died, it is concerning that individual complaints were consistently dismissed and intentionally ignored. As Lintern (2020) states, it is sobering to consider that while the Morecambe Bay Trust inquiry was taking place, systemic failures were resulting in unavoidable deaths of mothers and infants at the Shrewsbury and Telford NHS Trust, and no one apparently knew. Or if they did, no action was taken. He argues that in many ways it is the failure of regulatory organisations that is the worst part, as they should be the safety net to prevent death and disability. When they fail, we all suffer on a large scale.

Chapter Discussions, Comparisons and Considerations

In the final part of this chapter, the ethnographic data from both the English and the Sukuma mothers' lived experiences of complaining and reporting human rights violations in childbirth is considered. When comparing and contrasting the two groups of mothers within their unique socio-economic, political, and cultural contexts, it was revealed that not only did the Sukuma mothers experience immense barriers to attempting to assert their rights during childbirth (Chapter Five), but they also faced greater obstacles than their counterpart English mothers, if they attempted to complain about, or report human rights violations (Chapter Six). The Sukuma mothers not only lacked the support and resources to do so but the complaints and accountability mechanisms were also often missing oår inadequate, and the justice system inaccessible. Even though human rights exist as moral ideals, as well as legal entitlements to be claimed, awareness-raising about human rights does not necessarily mean that human rights are accessible or can be claimed in practice. As Turbine (2007) argues, a gap remains between theoretical declarations and the practice of rights-based approaches. Even though the uptake of human rights is not blocked by a 'cultural barrier,' it is nonetheless determined by differential

levels of state provision of the necessary political and economic conditions in which to exercise rights (Molyneux and Razavi, 2002).

Whilst the English mothers in the United Kingdom did have access to complaints and accountability mechanisms, as well as courts, they often felt either invalidated or re-traumatised in the process, rather than achieving a sense of 'empowerment' or justice. Cowan (2006) states that even though human rights evoke the notion of empowerment and social justice, the concept of human rights is simultaneously enabling and constraining, since it facilitates social and political mobilisation against mistreatment, – insofar as human rights direct political protests towards the established legal process which otherwise normalises and legitimises the exact same structural inequalities and power hierarchies. Therefore, even though Ahmed (2021) convincingly argues that we need to encourage the intersectional, collaborative, feminist complaints to dismantle racist and sexist structures, my ethnography revealed that when the English mothers attempted to voice their protests through the established complaints and legal processes, they faced invalidation or re-traumatisation, as both the complaints and justice mechanisms simply seemed to replicate and reproduce the 'authoritative knowledge' power hierarchy of the biomedical context. Even if the mothers attempted to replicate the 'biomedical' discourse to make sure that their complaint/claims were 'taken seriously,' they found their experiences and voices ultimately ignored or invalidated.

Chapter Six

Conclusions and Future Research

Over the past decade, the fields of international development, human rights and global health have increasingly converged, with the human rights-based approach as a common policy nexus to address disrespect and abuse in childbirth, as well as overcome maternal mortality. My primary research focus in this thesis has been to investigate the policy assumptions inherent in the human rights-based approach, superimposed against the lived experiences and local realities of mothers both in Tanzania and the United Kingdom. The research conducted for this thesis has explored the merits of placing human rights policy at the heart of childbirth: it examined the attempt to regulate and situate childbirth within the framework of international human rights law, whilst encouraging mothers to claim their rights and demand accountability during their childbirth journey. The line of enquiry taken was based on three central questions: i) Are the 'master narrative' and 'universalist' policy assumptions integral to human rights-based approach to maternal mortality relevant to the mothers' local perceptions of wellbeing and violations in childbirth; ii) Do the instrumental, linear-rational policy assumptions inherent in the approach correspond to the lived experiences of mothers claiming human rights in childbirth. iii) Did mothers experience a sense of empowerment and justice from demanding accountability for human rights violations in childbirth, or were there any unintended local consequences from doing so?

In Chapter Three, I analysed the mothers' experiences of violations and wellbeing in childbirth. The starting point for this chapter was to ask the mothers themselves to explain what constituted 'wellbeing' and 'violations' in childbirth to them and then I investigated their perceptions in relation to universal human rights framework. My ethnographic research found, as already highlighted by the anthropology of reproduction, perceptions of what exactly constitutes 'violations' and 'wellbeing' in childbirth is fluid, changing throughout history and according to cultural context (Jordan, 1978; von Hollen, 2003). As an example, whereas the Sukuma mothers did not seem to focus on the pain in childbirth, the majority of the English mothers

were consumed by either the lack of pain relief, pain as a sacrifice or the ability to tolerate pain as an 'achievement.' As Wall (1999) explains, even though we are taught in the West that pain is a warning message, something to be avoided at all costs, Morinis (1985) highlights that pain has traditionally been considered a by-product of the rite of passage. Hence, childbirth is a biological event, but the way that a mother experiences childbirth, and even pain in childbirth, will depend on societal values, viewpoints, and her fundamental belief system (Kingdon, 2009; Mcintosh, 2012).

My ethnographic research found that the wellbeing of the most disadvantaged and uneducated mothers was not always guaranteed in the healthcare facilities. As highlighted by Strong (2020), healthcare facilities in Tanzania are currently being promoted as the only safe place for birth, but the high demand for a biomedical childbirth is deeply misaligned with the resources available, whether material, temporal, and affective. The majority of the 'disadvantaged' Sukuma mothers in this research study experienced human rights violations during their biomedical childbirth, which included: i) harm and ill treatment; ii) lack of information and informed consent; iii) lack of privacy and confidentiality; iv) non-dignified care and disrespect; v) discrimination; and vi) lack of access to high-quality healthcare. My initial hypothesis and expectation from the ethnographic data was that it would point to a high number of 'disadvantaged' Sukuma mothers experiencing human rights violations in Tanzania, but only a few of the 'empowered' English mothers in the United Kingdom. Contrary to my expectations, many of the English mother had experienced human rights violations, including serious harm and infant deaths during their biomedical childbirth. The English mothers in the United Kingdom had experienced the following human rights violations during childbirth: i) harm and ill treatment; ii) lack of information; iii) non-dignified care and disrespect; iv) discrimination; and v) lack of access to high-quality healthcare.

Whilst several of the 'empowered' English mothers in this research study were highly educated and aware of human rights as a concept, the majority of the 'disadvantaged' Sukuma mothers only had access to primary education, and fewer still knew which specific human rights were relevant to the healthcare context. However, my participant observation and interviews both indicate that both groups of mothers shared a universal understanding of what constituted humiliation in childbirth. Hence, my ethnographic data also reveals, such as Miltenburg (2016) found in rural Tanzania, that the 'disadvantaged' mothers were aware when healthcare was substandard and could describe a range of ways in which the services could be delivered which would respect human rights principles. Even if they considered some human rights violations 'normal,' such as the rights to privacy and confidentiality, the majority of the

'disadvantaged' mothers found the humiliation suffered at the hands of the healthcare providers was unjustified.

My ethnographic data supports the human rights-based approach to maternal mortality proposition that a universal set of human rights protections for birthing women is vital because childbirth ultimately constitutes a vulnerable circumstance. My research study similar to that of von Hollen (2003) and Strong (2020) that childbirth can be an especially vulnerable situation for the most disadvantaged mothers, as healthcare workers can potentially misuse their position of power. The most disadvantaged mothers can potentially become perceived as 'the other' - an easy, dehumanised target for discrimination and outlet for the frustrations of overworked healthcare workers in weak healthcare systems. Meanwhile acknowledging that an international human rights framework is vital, this chapter argued such as Napier (2014) that a universal, all-fits-all approach to wellbeing in childbirth is not recommended, given perceptions of wellbeing in childbirth are dependent on the historical and cultural context of the individual mother. In the United Kingdom, most of the English mothers preferred a 'natural' childbirth, whereas the many of the Sukuma mothers in Tanzania hoped for a respectful biomedical childbirth. Instead, healthcare workers and providers need to be more flexible and responsive to diverse needs and should respond to their needs instead of their own agendas. At present, numerous natural childbirth activists, human rights scholars, international development and biomedical 'experts' all argue that they have been able to establish what is best, without asking the mothers themselves what they want. As Irvine (2021) states, it is ultimately the mothers' own perceptions of their childbirth care that are the most important. This chapter found that the main priority for the mothers was not the type of childbirth, but that their childbirth was safe for themselves and their infants. This conclusion seems obvious yet is too often ignored by the various actors that crowd the childbirth arena, focused on their own agendas, instead of that of the mothers.

In Chapter Four, I presented my ethnographic data on mothers claiming human rights during childbirth in Tanzania and the United Kingdom. My ethnographic research found that the 'disadvantaged' Sukuma mothers in my research study were not able to claim their human rights in childbirth due to: i) absent and unresponsive healthcare workers; ii) abusive and disrespectful healthcare workers; and iii) fear of reprisals. Likewise, the 'empowered' English mothers in this research study were unable to claim their human rights due to the following factors: i) absent and unresponsive healthcare workers; ii) physical or mental inability; iii) authoritative knowledge; and, finally, iv) fear of reprisals. Both English and Sukuma mothers

learnt from their own prior childbirth experiences or the experiences of other mothers and found ways to negotiate with the healthcare providers to have their needs met or took direct action to avoid human rights violations in future childbirths. There were more opportunities for the mothers in the United Kingdom to do so which included: i) changing their childbirth location; ii) having biomedical 'insider' knowledge; iii) having experienced birth companions; or iv) having a birth plan. In contrast, it was a lot more difficult for the mothers in Tanzania to take direct action during childbirth to assert their needs or claim their rights because they feared reprisals and were often reprimanded if they attempted to. Instead, they had to draw upon kinship or social connections, pay bribes, or find ways to change their childbirth location. However, some of the most 'disadvantaged' mothers often had neither the social nor economic capital. Thus, they avoided the healthcare facilities and gave birth at home, avoiding the unprofessional and disrespectful behaviour of the healthcare providers.

The chapter highlighted how the human rights-based approach and human rights discourse encourages mothers to take responsibility for the 'burden of childbirth choices' (Fannin, 2012) as well as actively claiming their human rights in childbirth, rather than just "avoiding maternal morbidity and mortality" as advocated by the UN Technical Guidance. That, however, effectively transfers the responsibility for 'auditing' the human rights standards from the state to the individual mother, so that governments in turn can withdraw from the responsibility of checking standards (Strathern, 2000). This 'responsibilisation' or transfer of responsibility from the state to the individual has been identified as a key component of biopolitical systems of governance (Rose, 2007). However, this 'auditing' or 'responsibilisation' burden weighs heavy on the shoulders of the individual mother, since it remains quite exhausting being your own advocate within in a healthcare context (Stoller, 2004), let alone in childbirth. Furthermore, this chapter found that it was often near impossible for the mothers themselves to actively claim their human rights during childbirth due to the power hierarchy inherent in the biomedical healthcare context. The 'authoritative knowledge' (Jordan, 1997) prevents mothers from communicating any knowledge of her own body, as well as her actively claiming her rights during childbirth due to the inherent power imbalance in the medical doctor-patient dyad (Nimmon and Stenfors-Hayes, 2016). Finally, the question remains whether there may be unintended consequences from encouraging mothers to actively claim their human rights during childbirth, if that undermines the relationship of trust between the mothers and their healthcare workers (Lundgren, 2003; Tuteur, 2016) or results in reprisals. My ethnographic research found that the human rights-based approach promotes a singular focus on the woman's individual human rights in childbirth, which neglects the strong

mother/infant dyad relationship. In fact, this research found that the majority of the mothers in this study did not perceive themselves as autonomous individuals but strongly interconnected with their infant - a mother/infant dyad in childbirth. Correspondingly, most of the mothers in this study did not claim their rights for ideological ends (Schiller, 2016) but had a 'pragmatic' focus on keeping their infant.

In Chapter Five, I presented my ethnographic data on both the Sukuma and the English mothers' experiences of complaining/reporting human rights violations after childbirth. My ethnographic data found that there were numerous social, political, and cultural barriers which prevented the Sukuma mothers in this research study from complaining/reporting human rights violations experienced during childbirth. These included: i) ineffective complaints/reporting mechanisms; ii) no time or resources; iii) apologetic healthcare workers; iv) fear of witchcraft, and, finally, v) fear of reprisals. The constraints that the Sukuma mothers faced in their access to justice points to the wider structural issues in Tanzania. Whilst awareness about human rights in childbirth is important, a human rights-based approach can be at risk of ignoring the structural and cultural barriers which mothers face when seeking to access a legal route. The emphasis on an individual's ability to make a legal claim assumes that the individual's problems are indeed 'resolvable' through a legal processes, even though such claims will always be interlinked with broader structural issues (Merry, 2003; Englund, 2004; Turbine, 2007).

Whilst it was easier for the 'empowered' English mothers in this research study to access complaint and justice mechanisms, many of them were reluctant to complain. Some of the English mothers found it almost too taboo to complain about the NHS, whilst others were overwhelmed by postnatal exhaustion (Iwata et al., 2018) or feelings of failure (Dilling and Petersen, 2021). As Bauman (2001) has argued, in the realm of contemporary society, critique has become somewhat both privatised and disarmed, since instead of directing critique towards societal structures that stimulate unintended negative consequences for individuals, we tend to direct it towards ourselves and our own achievements, such as 'achieving' a 'natural' childbirth. By turning critique inwards, we focus on small-scale critique whilst neglecting large-scale critique, making our critique societally impotent. Furthermore, some of the English mothers feared reprisals, whilst others were constrained by ineffective complaints and accountability mechanisms. However, the tipping point for the English mothers was the morbidity or mortality of their infant. In such cases, these 'empowered' English mothers sought to establish the facts of the case, requested that lessons were learnt, and demanded

accountability in honour of their infant. Even though such accountability demands by bereaved mothers offer important insights into potentially systemic problems within a healthcare context, the mothers found that such insights were seldom welcome. Their 'day in court' made many of the English mothers in this research study feel invalidated or re-traumatised, instead of achieving sense of justice.

In light of these findings, and before moving on to a discussion of a potential area for further research, it is worth once again posing the question whether a human rights-based approach to maternal mortality holds any promise or adequate potential to empower mothers during their childbirth journey, despite the various socio-economic, political, and cultural barriers identified in the thesis. First of all, this thesis revealed how important international human rights standards are for mothers and their infants in childbirth, not just because childbirth is a particularly vulnerable circumstance, but also because disadvantaged mothers can easily become a dehumanised target within a biomedical context. Furthermore, this thesis has also demonstrated how human rights serve an important function as legitimising discourse, vital in our current historical period and political climate, as women's rights are at a risk of sliding further down the political agenda (such as abortion rights). The importance of rights as a legitimising force (Merry, 2006) can be seen in the mothers' own statements about the importance of dignity in childbirth, as well as in the success various actors within the field of human rights, international development, and global health, have had in establishing maternal mortality as a human rights issue. However, the instrumental, linear-rational policy assumptions inherent in the human rights-based approach to maternal mortality does favour 'universalist' notions of 'wellbeing' which do not always correspond to local perceptions or requirements. Furthermore, the human rights-based approach to maternal mortality inherently promotes an 'individualist' conception of empowerment and individual human rights which may bring about unintended consequences. If the mother is perceived as an individual entity in childbirth, with individual human rights, the needs and safety of the mother/infant dyad can be easily misconstrued. This thesis has revealed that the mothers' attempts to negotiate and assert their rights during childbirth were never done for ideological ends, but rather as an attempt to keep the mother/infant dyad safe. Thus, the human rights-based approach to maternal mortality should take the strong mother/infant dyad relationship into consideration, as this was not only the mothers' *main concern*, but also their *main motivation* to claim their human rights and demand accountability in childbirth.

Future Research

This thesis has shown that the identification of human rights norms and standards relevant to childbirth has been an important step in establishing maternal and infant mortality as a human rights issue and in addressing human rights violations in facility-based childbirth. In the end, this thesis still leaves us with an important question: how do these mothers achieve justice? This question is especially important when considering mothers who have experienced the loss of their infants, who need answers to why something went wrong and who was responsible for the mistakes made. Therefore, more research is needed to identify the best ways to support mothers, so that they get their questions answered, as well as achieve a sense of justice without re-traumatisation. We should research what exactly 'justice' looks like for a grieving mother, and perhaps even alternative ways of achieving 'mother-centric' justice without the risk of reprisals and re-traumatisation.

Clark (2007) explains that most legal academics and human rights advocates talk in terms of 'retributive justice' and 'deterrent justice.' He explains that 'retributive justice' is based upon the idea that 'human rights perpetrators' must be punished, to make them accountable and give them what they supposedly deserve, and 'deterrent justice' holds that punishment is necessary, not simply because perpetrators deserve it, but because it will discourage others from committing crimes for the fear of sanction. On the other hand, 'restorative justice,' Johnstone (2002) explains, has evolved around the idea that crime is, in essence, a violation of a person by another person (rather than a violation of legal rules), that in responding to a crime our primary concern should be to make offenders aware of the harm they have caused, to have them understand and meet their liability to repair such harm, and to ensure that further offences are prevented: trough form and amount of reparation from the offender to the victim. Finally, measures should be taken to prevent re-offending, which are decided collectively by offenders, victims, and members of their communities through constructive dialogue in an informal and consensual process and that efforts should be made to improve the relationship between the offender and victim and to reintegrate the offender into the law-abiding community. As highlighted in this thesis, the mothers both wanted lessons to be learnt and their questions answered, outcomes which the traditional justice system does not always offer them. Additionally, even if restorative justice is perceived as 'soft justice,' it does, nonetheless, force the offenders to acknowledge the humanity of the victims through the process of demonstrating

how the offenders have hurt them. As found in this thesis, the most disadvantaged mothers became the 'dehumanised target' in the healthcare setting, so perhaps the restorative justice process, which encourages offenders to learn from their mistakes and generate greater empathy towards their victims, could help prevent future dehumanisation and violations from taking place? In conclusion, the question for future research could be whether restorative justice could encourage healthcare workers to learn from their mistakes, whilst ultimately offering mothers, who have experienced human rights violations in childbirth, a sense of closure and 'mother-centric' justice.

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