FACTS AND EXPERIENCES REGARDING MATERNAL MORTALITY IN TANZANIA

How Can the Evangelical Lutheran Church of Tanzania (ELCT) Contribute to Saving the Lives of Mothers? The Case Study Of the Chagga Tribe

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Dedication

This work is dedicated to the following people:

Rindeni Mwanga, my dear husband for being understanding and supportive during the entire period of study. Dear, you really inspired and encourage me to move ahead. You mostly prayed for me in the times of need. You were very far in Tanzania but I felt your support. I really appreciate your encouragement and love that you showed me throughout the period of study. May almighty God richly bless you.

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My in-low family, Willium Mwanga and Dora. Your love, care and prayer, take me to accomplish this work. Thank you for the support and encouragement. God bless you all the time.

My other family members; Neema, Joshua, Happiness, Ebenezer and Gloria. Your tenderly care and prayer inspired me to go forward. I really thank you for the encouragement and support.

Abstract

The main aim of this thesis is to explore facts and experiences regarding maternal mortality in Tanzania and to assess if the church can do anything in the reduction of maternal mortality. This has been done in the Chagga patriarchal area where the ELCT- Northern Diocese covers

The collection of data was based mostly on questionnaires and interviews. People were interviewed orally using some questions to guide the interviews. An interview schedule was prepared with a list or set of questions or issues which were to be explored during the interviews. The theoretical framework consists of feminist theory and pastoral care concepts. The focus was on the factors that contributed to maternal mortality in Tanzania. Also the effects of maternal mortality to the society and to assess if the church can do anything to reduce maternal mortality.

The study revealed that patriarchal system that prevailing in the Chagga society is one of the biggest factors that cause maternal mortality in the study area. This is because most of the other factors are linked to the patriarchal system which affects the women and especially pregnancy women. On the other hand the women hold the lives of others in the society. This is due to the fact that, women are the main producers of the daily family economy; they are also the care taker of the all members of the family including elders and children. Therefore, when a woman die, it means many others in the society are affected too, specifically children. Unfortunately, the study finds the church to side with the Chagga patriarchal society in oppressing, disvalue, dishonor, and undermine women. There is yet no contribution from the church regarding the reduction of the maternal mortality.

The society where this study has been carried out seems to have a great believe that the church can heal its member spiritually and physically. From this idea, many people have been much disappointed to see the church side with patriarchal traditional social system that contributing to the highest number of maternal mortality in the respected society.

The church has to speak for and act upon the liberation of all at the place where there is any kind on oppression, discrimination and torture. The church has to act on what it preaches. The church has to speak openly where the society goes against Gods' will by hindering the freedom of others (women) and exalting men. Men have to be taught their responsibilities and the value of women so as to respect them. Thus the question of pastoral care has to go

beyond the spiritual boundaries and meet the physical needs of the society with the aim of bringing new hope and new life, physical and spiritual too.

Acknowledgement

Any academic work involves many challenges. It requires a lot of support and encouragements. A lot of people have played particular role that inspired me attain this degree.

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Abbreviations

CRR	Centre for Reproductive Rights,
CSPD	Child Survival Protection and Development
DDH	District Designated Hospital
ELCT	Evangelical Lutheran Church of Tanzania
ICD	International Classification of Diseases
KCMC	Kilimanjaro Christian Medical Centre
MCH	Maternal and Child Health
MDGA	Millennium Development Goals in Africa
MO	Medical Officer
ND	Northern Diocese
NTPI	Norwegian Tanzania Partnership Initiative
OPD	Out-Patient Department
TDHS	Tanzania Demographic and Health Survey
UMATI	Uzazi na Malezi Bora Tanzania
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	Children's Rights and Emergency Relief Organization
WCC	World Council of Churches
W.H.O	World Health Organization
M.O.H	Ministry Of Health

CHAPTER ONE

1.0 Introduction

1.1 Problem

It has been my belief through observing and through experience that, being pregnant and childbirth in most African countries, specifically Tanzania, is the same as playing a game of chance with life; either to live or to die can bear the same weight. From twice being pregnant and experiencing the hardness of poor services, carelessness and being ignored, I can testify that, mothers in Tanzania are dying from a death which can be easily prevented if proper measures are taken.

The traditional life that I am exposed to, in my Chagga tribe is a kind of tradition that ignores women, undermines them, and does not consider then as human being with all of their senses. The tradition favours men and puts them as heroes, kings above all other things in the society.

When we were growing up we had traditional teachings that were called "*Chagga Initiations and Traditional sex education."* In a Chagga language this education is called "*Mapfhundo*". During this traditional education women are prepared to become good mothers in their family and in society, likewise men to become a good father to their families and society. So, boys and girls were considered as a grown up after '*mapfundo'*. *Mapfundo* teachings are categorized in two main groups; '*Mregho'* for boys and '*shigha*' for girls. The cultural idea of female obedience and responsibility is important in this initiation. Although the women rite deals with gender issues, they do little to confer women's rights in sexual matters. This makes Chagga women submissive to men on the issue of having sexual intercourse even if a woman is not ready for it. This habit causes a lot of unexpected pregnancies. Likewise for men as leaders and the power of the family and society are also marked. The *Mregho* then prepare boys to become good fathers with the emphasis on their responsibilities to their family and to society. Men are taught to be strong, to be decision makers, not to be ruled by women, and to treat women as children because in Chagga understanding; women are grown up biologically but in real sense they are still children to some extent.

Some literature too has been written on this Chagga tradition and sex education such as Mbiti (1990: 118) which finds initiation rites to be a significant event in Chagga's lives. The initiation events mark the end of childhood and mark the introduction of adulthood. In that case initiation is the way for the Chagga to give informal and traditional education to boys and

girls. Similarly, Chamshama R (2011:30) in the different tribe, on her research on prostitution culture and church also finds that, in different cultures of Tanzania, girls' initiation rites are where women are constructed according to the specific community desire. She finds that, males and females are differentiated through rituals that affect the constitution of their physical matter. Girls are taught to be humble, respectful, subordinate to men, passive, submissive, and not argue against men. The teachings also prepare girls to be good wives. They are taught how to be humble and take care of their husband. It is more strongly emphasized that the girls be humble, gentle and submissive to their husbands. They use Swahili idioms like *"mumeo anapozungumza weka maji mdomoni usiyameze"* which literally means, *"When your husband is talking, you should put water in the mouth and not swallow it"*. This implies that the woman are not allowed to argue with men, rather they have to respect each and everything. Openly, it shows unequal treatment between men and women in society.

It is my personal experience too, that a lot of negligence in society and in the hospital exposes pregnant mothers to unnecessary danger. This has been my personal facts when I was pregnant, I called my doctor to inform him that I felt sick, he replied that he could not come to the hospital to attend me because he was at a New Year party. As I was trying to insist that I was in a serious pain, the doctor switched off his mobile. Then I had to call another hospital where I was not attending the clinic. Briefly, this was how it proceeded at the hospital I had to go to. The birth was through operation. In between the operation process, doctors and nurses started to be worried. They were asking one another what to do. They even called other doctors who were not there for more advice. So from a call I got some of their conversation. They were explaining my situation, among other issues I understood that I had lost a lot of blood and that I was in a need of a blood transfusion. Unfortunately, they did not check my blood group before starting the operation process and there was no power in the lab so they could not have a test done immediately. So it was not possible for them to help me. But I was aware of my blood group, so I just say hardly, lying with open operated womb on the operating table that, "my blood is B+". Then, they all come closer and asked, are you sure it is B+? I said "yes". Then one of them runs to blood store to take the blood. Hence, it was of self-awareness of the blood group I was saved. Although a lot of ethical issues also can be raised up from this environment; yet that was not much of my concerning in this paper. From this and such circumstances I see that the pregnancy and waiting to have a baby is a sorrowful time in my context because the surrounding environment is not supportive; in that manner the

death can occur anytime, anyplace due to mishandling, lack of care, and ignoring the pregnant woman.

Again as a pastor, I have been questioning myself on how can the ELCT contribute to reducing the rate of mothers who are dying during pregnancy and child birth? What is our mission as a church, specifically the ELCT-ND, as God's representative people, if we cannot help our society grow healthy physically and spiritually? When will the church cease to be silent, side with traditions setup which are to undermine women and does not care for women? That ignores others? That neglect to save the lives of mothers? These questions comes up as a result of day to day ministering people as a parish pastor and meet their life challenges in different aspects. I just consider the issue of maternal death as far as how I see it on my working boundaries. The issue of burials in most of Tanzanian areas is still under the churches operations. Most of the families opt to be served by the church in the time of death and burials of their family member. It is common to report to the church the cause of the death so as the church can keep a proper record for its late members. In most cases, where a woman died with the maternal related problems, they just write the reason as maternal related death. I was a bit unsatisfied with such a general answer so I mostly prefer to make further investigation on the reason of death. Then I tend to have a lot of doubtful accounts in most cases. The family remains pained and sorrowful and only thing that they can say is "*ndo hivyo kuzaa ni mawili, kufa ama kupona, huyu alishaandikiwa kufa"*. This literarily means, "*It is the way it has to be, to be pregnant is to choose among two things, either to live or to die, this one has been written to die in this way.*"

To justify the existence of maternal mortality in most African countries including Tanzania where this study has been conducted, the World Health Organisation (WHO) finds maternal mortality to be high where few women receive maternal care. Whereby death is a result of prenatal, unsafe abortion, delivery before the age of 18, pregnancy after the age of 35, malnutrition and the like. It is said that, every day, approximately 800 women die from preventable causes related to pregnancy and child birth. But 99% percent of all these death occur in developing countries. Young adolescents are at higher risk of complication and death as a result of pregnancy than older women. (WHO).

The World Bank (2012) clearly shows that, maternal death is one of the biggest differences between developing and developed countries. The maternal mortality ratio indicates that, in developing countries, there are 240 per 100,000 live births versus 16 per 100,000 live births in

developed countries. On 20th October 2003 in Geneva, WHO, UNICEF AND UNFPA found that, women in sub-Sahara Africa have 1 in 16 chance of dying during pregnancy and child birth compared to 1 in 2,800 chance of dying in the pregnancy and child birth for women from developed countries. But it is said that these death could be avoided if all women had the assistance of a skilled health worker during pregnancy and delivery.

In brief, those are the things that are on my mind which force me to work on the issue of maternal mortality in Tanzania. The following are my research questions.

1.2 Research Questions

- What are the factors causing maternal mortality in Tanzania?
- How does maternal mortality affect the life of the society?
- Can the ELCT contribute to reduce maternal mortality?

1.3 Objectives of the Study.

The main purpose of this study is to find out and to evaluate factors that cause maternal mortality in Tanzania; how does maternal mortality affects the life of the society and to investigate if the ELCT can contribute to reducing maternal mortality and then to suggest some ways forward to improve the situation.

1.3.1 Specific Objectives

- To investigate factors causing maternal mortality in Tanzania.
- To assess the impacts of maternal mortality in Tanzania
- To assess if the ELCT can contribute to reducing maternal mortality.

1.4 Motivation, Relevance and the Significance of the Study

Being a mother is one of the motivating factors. I have been passing through difficult experience during pregnancy and during the delivery period. I have expanded on it well in my Statement of the problem. I have also seen a lot of my fellow women in Tanzania experiencing hard situations during pregnancy and others have lost their lives because of pregnancy and delivery. Generally, being a part of the Tanzanian citizenry, seeing and

experiencing being pregnant as a danger zone is my main motivation that forces me to go through with this study.

Furthermore, being a pastor in the ELCT -ND is another motivation. This is due to the fact that the ND has a number of projects, including running some hospitals, but still more emphasis on the maternal department is needed to rescue the lives of mothers who are daily dying innocently during giving birth. I consider this as a tangible motivation factor since the ELCT-ND already has a medical centres. Also the question of pastoral care to the society can have great impacts on irrelevant cultural understandings. This is also the quest to the ELCT-ND as a church in the midst of a patriarchal structure of its society.

Another motivation factor is irrelevant cultural understanding. It is believed that in chagga tribe, (Chagga is a tribe in the Northern part of Tanzania and they specifically live where the field work has been conducted) when a woman dies it is not a big problem since a man can marry another woman. On the other hand it is shameful for a woman to marry another man when the husband has died.

Again, the feedback from some of my parishioners is another motivation factor. When I hear them say "*hukumu ya haki ni mbinguni*" which literary means "*the right judgment will be at heaven",* it is puzzling and wounding. Apparently one would think there no right in the world. Many women pass through a lot of difficulties due to the cultural setup surrounding them. Many of them too lost their life because they did not get enough care and social assistance. To me the term they used to say 'the right judgment will be at heaven' means that something went wrong. Then what comes in my mind is that, I/we/the church should find ways to liberate those women who are complaining and they have seen that no one in this world could save them from their suffering environment. The case here is that, if the church, that preaches the righteousness of God, could bring the real meaning of their life by helping the women at the Chagga society to see the possibilities and choices at hand in midst of their context. This made me think the church can make a difference in their lives. Hence, my interest is provision of pastoral care; in different ways such as teaching, rebuking, guide, and many more, which will speak the truth that liberates all people in the society and not laying side by side with the culture that tortures and kills women.

1.5 Methodology

This is a qualitative work. The qualitative research method aims to understand a particular situation, event, role group, or interaction Locke et al (2007). Also Marshal et al (1998) says

that, qualitative research engages in everyday life between researcher and respondents in a sense that the researcher interacts with respondents so as to acquire important information. The qualitative method is based on interviews and questionnaires. It is basically an exploratory process where the researcher gradually makes sense of a social phenomenon by contrasting, comparing, replicating, cataloguing and classifying the object of study Miles et al, (1984). Therefore, by using the qualitative method it will give me an opportunity to learn the facts and experiences that women went through during pregnancy and giving birth in the study context, also to assess if the church can contribute toward the reduction of maternal mortality in Chagga context.

At the same time, ethnography method has not left out of this work. Bryman (2008:402) shows that, ethnography is a research method in which researcher is immersed in a social setting for an extended period of time. The researcher makes regular observations of the behaviour of members of that setting, listens to and engages into conversations and interviews informants on issues that they are not directly enabled to observe. As a researcher I am a part and parcel of investigated content and context. I am born and raised up in the Chagga patriarchy society, but also I am the part of the ELCT-ND workers.

In collecting the data, the focus was on individual interviews, focus group interviews and documentary data. The questionnaires also have been used as a means of data collection. Gall describes that, questionnaires and interviews are used to collect data about phenomena that are not directly observable so as to test inner experience, opinions, interests, and the like Gall at el, (2007:228). The interview method helps the researcher to interact face to face with the informants. The method also allow the use of guiding questions as I prepared them, although it gives me the opportunity to subtitle and reframe the questions and to give more clarifications to the informants where it seems to be not clear.

Again Gall (ibid) shows that, an interview involves questions asked by the researcher and receiving oral responses by the research participants. The interview has to be recorded by the researcher. It is a basic mode of human interaction that researcher and interviewee use to communicate. It is both structured and purposeful, involving careful questioning and listening with the purpose of obtaining comprehensively tested knowledge from respondents on the investigated topic. He then shows that, questionnaires are the printed forms that ask the same questions for all participants in the sample whereby the respondent can fill out the questioners

at their convenience answer the questions in any order and make marginal comments or skip questions.

1.5.4 Challenges During the Field Work

The highest challenge I met on using questionnaire and interview as a means of data collection in this work is language. This is because the main languages of the respondents were Swahili and kichaga; kichaga is the vernacular language for the Chagga tribe whereby Swahili is a national language and most of Tanzanians speak it in a satisfactory manner, however many elders cannot speak Swahili. In the situation where the respondents fail to give the information through Swahili I opted to use kichagga so as to acquire what I intended in the field. It is good that the researcher speaks both kichagga and Swahili. On the other hand the project has to be developed in English. So I had to construe all the reports I collected from the field work from either Swahili or kichagga to English.

On top of that, most of the interviewees failed to keep the appointment. This was the biggest challenge I faced. This caused mismanagement of my time as a researcher and also increased unnecessary costs. So mostly I had to re-book the appointment with some of the informant as they forgot or they emerged to fulfil the first appointment meeting. Also there was a lack of openness among the informants; this caused me to re-interview some of the participants because they gave different information when they were alone compared to when the interview was done with more than one participant.

More than that, the hospital where I intended to do my research was not ready and they were not open to tell me so. They delayed to give permission later without any proper information. But because the ELCT-ND has more than one hospital, I opted to do my research in another hospital where I got much of the information that I was searching for the development of this project.

Another challenge was a lack of transparency among respondents. This was because some were defending their positions; also they were afraid about the confidentiality of what they said. In that case, some of respondents were rigid and reluctant to give accurate information. After the interview some of the informants returned and others called to confirm that the situation was not as they had reported. Some promised if I managed to find them and we meet at another place, out of their working place, they could be freer to express the reality of the situation. As far as my intention was to be accurate on the data I was collected, I had to re-

interview some of them at their time and at the convenient place where they were free to give true information.

In spite of all the challenges, I had to follow up without getting discouraged so as to get enough data for this project. Finally I came out with enough data to help me to produce this work.

1.5.1 Field Work Report

It was imperative for me to ensure that the process of data collection was appropriate and procedural. Hereafter, to collect valid and reliable information, I employed the steps that follow

1.5.2 Data Collection

For the data collection I selected one of the ELCT-ND hospitals, public institutions, men and women of the Chagga tribe, elders of the Chagga tribe, some leaders of the ELCT-ND, pastors, doctors and midwives, and traditional midwives. I selected to be at the hospital in part of my data collection because it was easier for me to meet with the pregnant mothers. Among other things I intended to hear from them was their experience during pregnant and child birth. I also interviewed midwives and doctors at the same hospitals concerning their work in regards to pregnant mothers and the situation of maternal mortality, particularly at that hospital.

Again I interviewed men in Chagga society so as to get their views on the question of a man's responsibility to their wife while pregnant. Traditional midwives were interviewed on how they handle pregnant mothers in their respective areas; how they treat the case of the pregnant mother in a situation where they see the risk of life of their client? On that particular group, I was also interested to know their level of education especially in maternal health.

The elders of the Chagga society were also interviewed with the aim of getting the traditional ideas of the Chagga perceptions on the issues of maternal mortality and how the patriarchal social setup has been influenced by the Chagga tradition life.

In order to have enough information, I also interviewed pastors on the researched topic in order to have an idea on whether the church can do anything so as to reduce the situation of maternal mortality. The leader of the main office of the ELCT-ND was also interviewed to know if there is awareness of the situation of maternal mortality and if there is any plan to

reduce the problem of mothers who are dying because of pregnancy and child birth. I also interviewed two medical officers (M.O) on the situation of maternal mortality in their areas. Generally medical officers supervise the hospitals in either regional or district levels. In order to investigate the agenda more accurately, I visited the birth and death registry in a district office so as to have the recorded figure of mothers who lost their life due to pregnancy related issues.

It was a great privilege during data collection that I managed to interview two families whose mother and wife died during child birth. I got their feelings and experiences on the discussed topic.

1.5.3 Field Notes

I had a notebook for taking notes during interviews. Prior to interviews participants were notified that the notes would be taking as the interviews progressed. There was no objection to the idea. Consequently, during interviews I took short notes in the notebook in order to counteract the risk of forgetting important details.

The information collected from the field was also recorded for the purpose of organising and making reference to it later. Reference to field notes was to enable the researcher to remember the details and facts in the study about the informants. Gall et al. (2003: 248) describes note taking as the usual method for preserving information. I kept information about the interviews which included age of participants, their position, and sex. Date time and place of interview were also recorded. I was also keen on nonverbal indications such as gestures and facial expressions and took note of them. The main benefit of note taking is that it facilitates data analysis. The data is within my reach. However, one of the shortcomings of note taking is that it can interrupt the efficiency of communication between interviewer and informant.

When questions deal with simple factual information, respondents typically expect their answers to be written and may appear upset if they are not. On the other hand, if respondents are asked to reveal sensitive or confidential information, note taking may distract them and prevent them from giving information they otherwise might have given. Gall et al. (2003: 248). I was conscious of this and in some cases there was a delay in taking notes until after the informant had left the site.

1.5.4 Method of Analysis

The analysis was treated as a form of narration based on the contribution from the interviewee. (Kvale 1996: 199) says that, "*an interview analysis can be treated as a form of narration, as a contribution of a story told by the interviewee"* in that sense, the analysis of the data in this project is more in narration form. The narration aims to bring the potential meaning through condensing or expanding of the report from the interviewee.

Also the feminist analysis was used in this work. It has been an idea of Potter (1996:146) that, the purpose of feminist criticism is the mapping and changing of the attitudes and conditions and the reformulation of a new language which is woman centred and free of patriarchal constrains and oppressions. On top of that the analysis is based more on a theoretical and conceptual fame work whereby the issue of feminism has been more elaborated.

The following table shows the participants during data collection according to their gender, occupation and date of interview.

Table 1: 1 List of Informants

INFORMANT NUMBER	GENDER	OCCUPATION	DATE OF INTERVIEW
Informant 1	Female	Home Mother	27.6.2013
Informant 2	Female	Home Mother	28.6.2013
Informant 3	Female	Home Mother	28.6.2013
Informant 4	Female	Home Mother	28.6.2013
Informant 5	Female	Home Mother	1.7.2013
Informant 6	Female	Teacher	1.7.2013
Informant 7	Female	Teachers	2.7.2013
Informant 8	Female	Teachers	2.7.2013
Informant 9	Female	Peasant	3.7.1013
Informant 10	Female	Shop keeper	3.7.2013
Informant 11	Male	Farmer	4.7.2013
Informant 12	Male	Peasant	4.7.2013
Informant 13	Male	Driver	4.7.2013
Informant 14	Male	Farmer	5.7.2013
Informant 15	Male	Farmer	5.7.2013
Informant 16	Male	Farmer	8.7.2013
Informant 17	Male	Farmer	8.7.2013
Pastor 1	Female	Pastor	9.7.2013
Pastor 2	Female	Pastor	9.7.2013
Pastor 3	Male	Pastor	11.7.2013
Pastor 4	Male	Pastor	11.7.2013
Midwife 1	Female	Midwife	12.7.2013
midwife 2	Female	Midwife	12.7.2013
Midwife 3	Female	Midwife	12.7.2013
Doctors 1	Female	Doctor	13.7.2013
Doctors 2	Male	Doctor	13.7.2013
Local midwives 1	Female	Local Midwife	19.7.2013
Local Midwife 2	Female	Local Midwife	19.7.2013
Local midwives 3	Female	Local Midwife	19.7.2013

Local midwives 4	Female	Local Midwife	23.7.2013
Local midwives 5	Female	Local Midwife	23.7.2013
Local midwives 6	Female	Local Midwife	23.7.2013
ELCT Leader 1	Male	Administration department	26.7.2013
ELCT Leader 2	Male	Financial Department	26.7.2013
ELCT Leader 3	Male	Health Department	29.7.2013
ELCT Leader 4	Female	Women Department	30.7.2013
ELCT Leader 5	Female	Projects Planing Department	30.7.2013
Elder of Chagga Society 1	Male	Farmer	1.8.2013
Elder of Chagga Society 2	Male	Farmer	1.8.2013
Elder of Chagga Society 3	Female	Peasant	2.8.2013
Elder of Chagga Society 4	Female	Peasant	2.8.2013
M.O 1	Male	M.O	6.8.2013
M.O 2	Male	M.O	6.8.2013
Family 1	Male	Teacher	9.9.2013
Family 2	Male	Peasant	13.8.2013

As it has been shown in the table above, I conducted 1nterviews with 45 respondents. The interview also considered both male and female. The interviewee provided the information that has been used to bring answers to the research questions.

Therefore, this study uses these methods in data collection in order to make sure that much information on the researched topic has been given from the targeted research collaborators. Also this method has been used in order to get feelings, opinions, views and insight of the general situation and understanding of facts and experiences of maternal mortality, the effect of maternal mortality, and to question the contribution of the ELCT-ND to reduce the situation. All these have been done to explore the reality of the situation where relies heavily on facts and human experiences.

1.6 Theoretical Frame Work

This study employs feminist and pastoral theories. Feminist theory is a significant theory which is applied globally to critique patriarchal practices in the society and in the church. In this case, many scholars and most African feminist scholars like Oduyoye (2001) and Kanyoro (2002), who look at the position of women in Africa versus patriarchal heritage, are of much help in this work. This thesis is based on the advocacy for the lives of women who are dying because of maternal problems, so I am using also the pastoral theory to assess critically if anything has been said in relation to maternal death as a pastoral concern. I selected these theories because of my ELCT-ND context; it has been seen that the death of women due to maternal issues, among other causes, and the brutal care that women received from the patriarchal system settled in the society is one of the biggest problems. On the other hand, the church has a great opportunity to educate the society on what is good and what is

not good to do. The church can go beyond the spiritual perspective to a physical dimension of caring. That is why I opted to frame this project on the mentioned theories abo.

1.7 Ethical Consideration

First, I wrote a letter to the general secretary of the ELCT- ND to ask for permission to carry out this research in one of its medical centre. Then I went to the selected health centre with the written permission. Then, I briefly explained to the officers the purpose of my visit in order to get though what I was aiming for.

During interviews and questionnaires I explained to the interviewees what the study is about and sought their willingness to participate in the study. I also let them know that the information sought will be for the academic purpose only and that they will remain anonymous unless there is consent to the contrary. Generally 40 out of 45 respondents were not willing to be known as an informant due to the fear of losing their jobs, and most of the women feared being beaten by their husbands or being accused by their fellow women for speaking about their husbands openly. Men were afraid not only because they will lose their jobs, but also it is of a great shame for the men to speak about women issues. But surprisingly some men were certainly agreed that the woman suffered due to the patriarchal social setup of the Chagga people.

1.8 Limitation of the Study

The study limitation was in the area covered by the ELCT- ND and its people who are the Chagga tribe. Although there are many health centres that are owned by the ELCT, one health centre that owned by the ELCT-ND was selected as a health centre case study. Also there are many dioceses in the ELCT, but this study will be limited only in the Northern Diocese. Also the researcher limits herself on feminist and pastoral care theories while doing this work.

1.9 The Position of the Researcher

The researcher's position as how this study is concerned is that of critical insider. This is because I have worked as a pastor in the ELCT-ND since 2008. I have seen numerous of mothers lose their lives during pregnant and child birth. I have also seen the ELCT-ND implementing more projects like establishing orphanage centres, hospitals, and elderly care centre. So, I want to investigate critically on the side of maternal mortality what has been done or what can be done to rescue the lives of mothers who are dying while pregnant and while giving birth; which actually I believe is the reason, among other factors, of having a

high number of orphans. It has been my conviction that much has been done to promote the life of mothers during child birth; hence, there is a need to strengthen services and to give education on cultural patterns that seem to make the problem bigger. Since the ELCT-ND owns some hospitals and it has the power to promote changes in the society by giving education and break the prolonged silence. It can be a good starting point, then as times goes by it will be the landscape of all other hospitals, Chagga society and Tanzanian community in a wider sense.

1.10 The Structure of the Thesis

This thesis has six chapters. The first chapter is in introduction. This chapter consists of the statement of the problem, research questions, objective of this study, motivation relevance and significance of the study, methodological approach, theoretical fame work, ethical considerations, limitation of the study and the position of the researcher, then structure of the thesis. The second chapter serves as background information about Tanzania and the ELCT, also background of the study area and its people; the Chagga people of Kilimanjaro. Chapter three serves as a literature review. In this chapter the related literature of maternal mortality has been reviewed. The focus was to see if the maternal issues have been taken into consideration as a church/pastoral related agenda.

Chapter four tells about conceptual and theoretical frame work. In this part, the concept of maternal mortality and maternal mortality in relation to contextual understanding has been clearly elaborated. The theories and concepts used in this work also has been clearly elaborated and its relevancy to this study. Chapter five presents discusses and analyses the findings. Finally, the last chapter will be the conclusion and recommendations. Basically, the conclusion and recommendation will be based on the research findings.

1.11 Summary

This chapter introduces the work; it shows why the study has being carried out and mapping how it has been carried out, its relevancy and it's importance. The following were the sub sections in this initial part, statement of the problem, research questions, aim and objectives, motivation and methodology. Also it presents, ethical considerations, the limitation of the study and it shows the structure of the whole work. In the next chapter the paper will show the background information.

CHAPTER TWO

2.0 Background

2.1 Introduction

This study was carried out at Kilimanjaro region, Tanzania, specifically in the area of the Northern Diocese of the Evangelical Lutheran Church, whereby most of the inhabitants in the area are the Chagga people. Therefore, I prefer to give a background of Tanzania which will brief explain its population, politics, geography and health policy. Then I will talk about the background of the study area, which will be the E.L.C.T and the Chagga people of Kilimanjaro. Generally, this part presents the general understanding of the area where this project has been conducted and the culture of the Chagga people.

2.2 The background of Tanzania and Population.

Tanzania is a country located in the eastern part of Africa. It is among the developing countries of the world. The name of Tanzania is derived from the name of two states named Tanganyika and Zanzibar that united on 26th April 1994 and form the United Republic of Tanzania. It is bordered by Kenya and Uganda to the north; Burundi and Democratic Republic of Congo to the west; Zambia, Malawi and Mozambique to the south and also the Indian Ocean to the eastern part.

The country is divided into 30 administration regions, where by 5 regions are in the island of Zanzibar and 25 regions are in the mainland Tanzania. The capital of Tanzania is Dodoma where the national assembly and some of the government offices are located.

According to the census of 2012 (United Republic of Tanzania) (URT) (2013), the total population was 44,928,923. This population contain more than 128 ethnic groups who each has its own language. The census result also shows that male population is 21,869,990, while the female is 23,058,933.

2.3 Politics

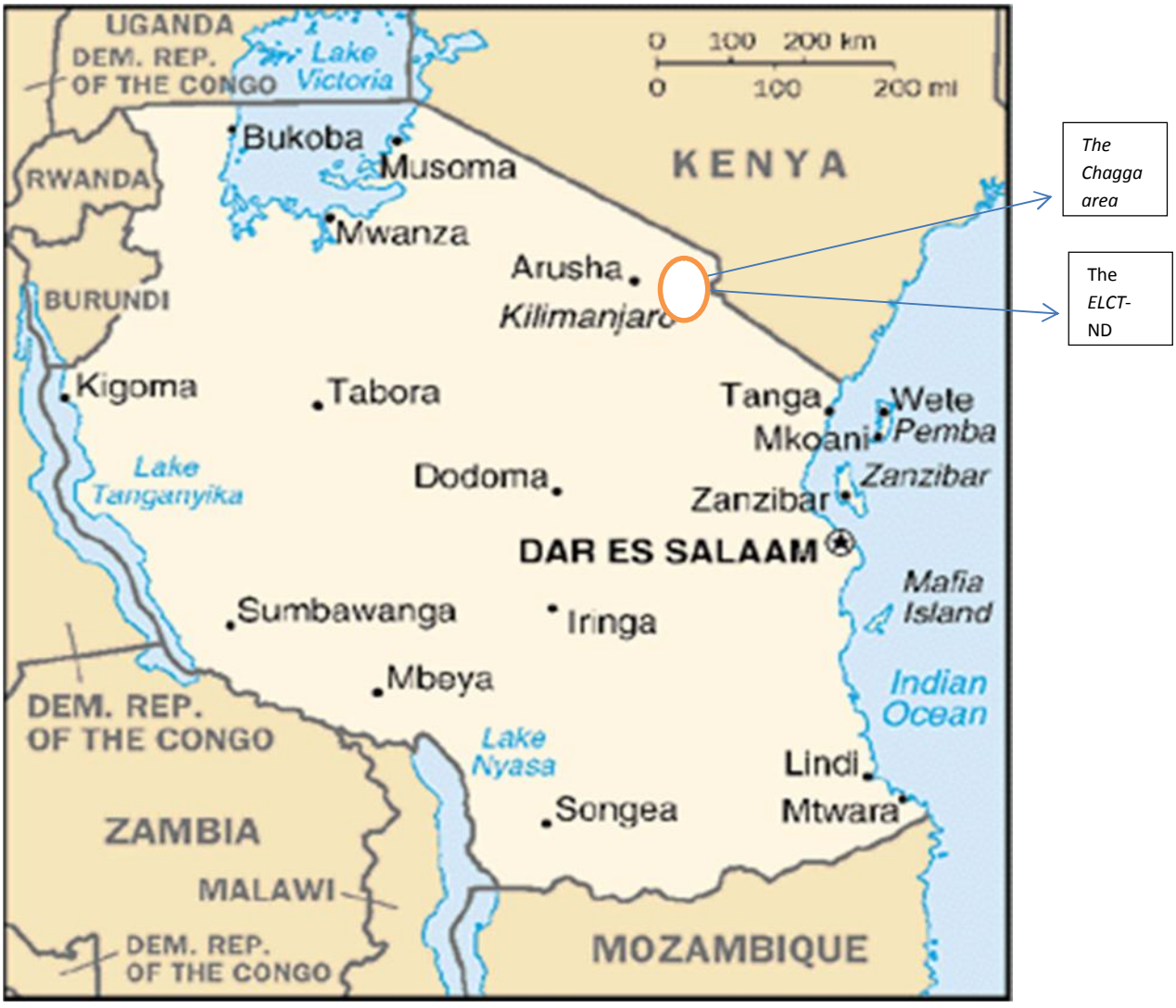
Tanzanian politics takes place in a framework of a unitary presidential democratic republic, whereby the President of the country has multiple tasks as a head of the state and as a head of the Government and also of a multiparty system. Executive power is controlled by the Government and legislative power is under both the government and the parliament.

Tanzania was a British colony up until 1961 where she attained full independence. By this time Tanzania was a one party state until the beginning of 1992 when the government decided to adopt multiparty system.

2.4 Geography

Tanzania is 947,300 squares Kilometre, and it lays mostly between latitude 1 north, 12 south and longitude 30 west and 40 east. She is mountainous to the northeast. Central Tanzania is a lager plateau with plains and arable land, the eastern shoe is hot and humid. She has a tropical climate and two major rainfall regimes. One is uni-modal; that is October and April and the other is bi-modal that is of October-December and March –May. Uni-modal is experienced in the southern central part of the country whereby bi-modal covers the North and Eastern part.

Fig 1.1 The Tanzania map



2.5 Tanzania Healthy Policy

Tanzania Healthy policy shows that it has a mission to facilitate the provision of quality and affordable basic health services, considering gender sensitive and suitable so as to improve health status to all citizens; Ministry Of Health (M.O.H, 2003). Between other objectives the reduction of the burden of diseases and maternal care has been given priority. Also, the policy shows that the Government will ensure that health services are available and accessible to all people in the country; including both urban and rural areas (M.O.H 2003).

Tanzania has also created a number of organs which deal in promoting the general welfare of mothers. Those organs are Maternal and Child Health (MCH) and Uzazi na Malezi Bora Tanzania (UMATI). The Ministry of Health work together and will continue to cooperate with all organs and institutions which show interest in health care promotion. From this stands, non-government organisations including the ELCT-ND have a lot of effort in promoting good health to Tanzanians. This is due to the fact that there are lots of health centres which are owned by these private organs, and the government recognise them. The ELCT-ND also has many health centres too and they have engaged in lots of critical health problems in those centres.

Despite the effort played by the government and the other organisations in the prevention of the high maternal mortality, it is still seen as the big threat.

2.5.1 Structure of Health Services in Tanzania

The structure of health services at various levels in Tanzania are as follows. It has a bottom up structure. That is the services start at the community level up to the referral level which is the highest level of hospital services in Tanzania. Below is how the health services structure in Tanzania looks.

- Village/ Community Health Services
- Dispensary Health Services
- Health Centre Services
- District Hospital Services
- Regional Hospital Services
- Referral/ Specialized Hospital services

A) Village Health Services

This is the lowest structure of health care in Tanzania. The aim of the village health services is to provide fundamental preventive services which can be offered at home. The village government elect two health workers who are responsible for the health issues at a village level. Short training is provided to them before they start providing services. Then they have to take care of the village health cases primarily and forward them to the dispensary services level.

B) Dispensary services

This is the second stage of health services in Tanzania. There has been long term objective to have at least one dispensary in every village. The dispensary aims to serve 6000 to 10000 people, and to supervise the village health services. A dispensary aims to have an out-patient department (OPD), MCH, and one maternal room with at least two beds. A dispensary also shall have three qualified staff who are a Medical Assistant, Public Health Nurse or Midwife Nurse and Rural Health Assistant.

C) Health Centre Services

A health centre is expected to care for 50,000 people. It should have the following qualified staff; Assistant Medical Officer, Rural Medical Aide, Senior Nurse, Midwife Nurse, Public Health Nurse, Health Officer, Assistant Laboratory Technician, and Pharmaceutical Assistant. The services in the health centre are similar to that of the dispensary but the health centre offer more specialised services than that which have been provided at the dispensary level.

D) District Hospital

Each district should have a district hospital. For those districts which do not have a Government hospital, the government will negotiate with religious organisations to designate voluntarily its hospital to act as a district hospital; that is District Designated Hospital (DDH). The district hospitals have a good mix of qualified stuff and different specialities and experiences. It should have enough facilities too. The hospital is responsible for planning, organising and supervising all health activities in the respective district.

E) Regional Hospital

Every region shall have a regional hospital. However, regional hospital shall have specialists in various fields and offer additional services which are not offered at a district hospital level. At the regional level the expectations of the service is of higher of expertise compared to that of district level.

F) Referral/Consultant Hospitals

This is the highest level of hospital services in Tanzania. Currently there are four referral hospitals; Muhimbili Medical Centre in the eastern zone, Kilimanjaro Christian Medical Centre (KCMC) in the northern zone, Bugando Hospital in the western zone and Mbeya Hospital in the southern highlands zone. In addition to the medical services, the referral hospitals provides preventive care, teaching and research services.

2.6 Background of the Study Area and Its People

2.6.1 The Chagga People of Kilimanjaro

Chagga people live in Tanzania on the slopes of Mount Kilimanjaro. They are also called Chagga or Wachagga. Historically, the Chagga belonged to different clans (groups of people from common lineage) ruled by *mangi* (chiefs). The area was divided into independent chiefdoms. The chiefs sometimes warred with each other. Other times, they formed alliances to try to increase their power. After Tanzania won its independence in 1961, the system of chiefdom (mangi system) was abolished (Lyimo 2013). The main language spoken by the Chagga people is Kichagga. The Chagga speak various dialects in different districts. Despite these differences in dialect, the Chagga people can understand each other. However all Chagga people speak Kiswahili, the national language of Tanzania. Kiswahili is the language of instruction in primary schools and in work-places. English is the language of instruction in secondary schools and institutions of higher learning (Materu 2007).

Moreover, each Chagga family has its own homestead which is known as kihamba (the plural of this word is vihamba (Lyimo 2013). In other words, kihamba is the name given to the land along the slope of the mountain Kilimanjaro where the Chagga live and grow coffee and bananas. Kihamba land is owned by males, not by females and is only inherited by the sons, not by daughters when the father dies. Banana is the main food for Chagga people. Coffee is the main cash crop cultivated in the kihamba. Coffee was introduced in Kilimanjaro in the 1920s by German settlers, Husu, (1999). Therefore, coffee and banana are the main crops

cultivated on kihamba for consumption and for business. This agrees with Fleisch (1998) who says, "*Wachagga are efficient both in agricultural and business*" Husu (1999) shows that, Chagga are among East Africa's wealthiest and most educated people. They were one of the first tribes in the area to convert to Christianity. This may have given them an advantage over other ethnic groups, as they had access to education and health care as Christians.

This implies that the Kilimanjaro region has the highest concentration of secondary schools in Tanzania and the highest enrolment rate. The Chagga are highly educated and the most economically successful ethnic group in Tanzania.

Again, Chagga people lived a community system. In that manner, they have four unique aspects that bind the individual to the structure of the community. These aspects are namely as clan, age group, blood pact (*mma*) and neighbourhood. These are regarded as the main communal ties that promote the unity of the community. These primal ties define an individual who is an individual only in a community. As Laurent Magesa (1997) emphasizes, that relationship is authoritative. When people meet for the first time in the Chagga community, their greeting is used to seek how they relate to one another. This involves remembering their ancestors. For example, one could say, 'my name is A, my grandfather was B who was circumcised together with your grandfather' or 'I was circumcised together with your uncle' etc. The communal life is the central aspect of the community and identity in which one is identified with others in communal acts such as circumcision for boys, girl's initiation rites (*maphfundo)* and many more.

2.6.2 Chagga Initiations and Traditional Sex Education

Mbiti (1990) finds initiation rites to be a significant event in a Chagga's live. The initiation events mark the end of childhood and mark the introduction of adulthood. In that case initiation is the way for the Chagga to give informal and traditional education to boys and girls. Boys and girls are considered a grown up after '*mapfundo*'. *Mapfundo* is the special period when girls and boys are given traditional sex education. The teachings are categorized in to two main groups. '*Mregho*' for boys and '*shigha'* for girls. The cultural ideas of female obedience and responsibilities are important in this initiation. Although the women rite deals with gender issues, they do little to confer women's rights in sexual matters. That is why Chagga women are submissive to men on the issue of having sexual intercourse, even if a woman is not ready for it. This causes a lot of unexpected pregnancies. Likewise, for men their role as a leader and the head of the family and society are also marked.

2.6.3 Marriage and Giving birth in Chagga Understanding

In Chagga families, family life starts with marriage. Most of the Chagga families are polygamist. The main purpose of marriage is the bearing of children. In this vein, men are the centre of social reproduction as well as agent of successful reproduction. They have a concept which links to the male teaching during mregho which says that "*nguvu ya mto ni mawe*" which means "*the power of the river is stones*". The stones here mean the children. So men are encouraged to bear as many children as possible because this is where his strength will be measured. Steel (1999) assert that in Chagga tradition if a woman does not have the ability to become pregnant and bare children, she is cursed. They call it *"mbaka"*or *"kidengo"*; which means curse. When a woman of this type dies, they bury her body in the corner of the farm. She cannot be buried at the same place with the other dead members of her family. This is because the society believes she can spread her curse of infertility to the other family members. On the other hand, if the man is infertile they have to hide or to cover their shame because it is shame for the whole family. Then, his wife is advised to have sexual intercourse with another member of the family; mostly preferably the father in law, so as to bare children for her husband and cover his shame (Marealle, 1947).

2.6.4 Pregnancy and Maternal Death in Chagga Understanding

The social setup is structured in a way that maternal mortality is inescapable situation. If you are safe after delivery then you are privileged but if death happens it is the normal thing that happens to mothers. Because of this idea, there are sayings which make the value of woman while pregnant to be seen as unworthy. For the men whose wife died for the pregnancy or pregnancy related issues, they comfort him by saying that *"Nyi kitsawa charesa mfiiko"* which means that *"it is a tin lost the cover so it is easier to replace it"*. Traditionally Chagga people put water in a tin which can be covered by a banana flower or husker pipe from maize. These types of tin cover can be replaced as many as possible since they are costless and easy to find. So the easiest meaning of this Chagga saying is that, women are costless and are easy to replace when one is lost.

"*Usiwe lege lege wewe ni Mwanamke*" this a courage phrase which woman use to tell their fellow pregnant woman; especially young woman. It means, "*You are a woman, you have to be strong"*. From this idea, most of the women tolerate the pain while pregnant for a long time. Just try to be strong as other women. Thus, sometimes pregnant women bear unbearable pains due to the fear of being seen as not strong. At the same time there is no experience of

going to the hospital while in the early months of the pregnancy. In this situation there is a high risk of woman dying during the early stages of pregnancy, where most of these deaths are not even reported as a maternal death. The relatives and neighbours are just gathered for the burial and things end there. So, the data that are recorded official as maternal death are not covering the reality of the maternal mortality situation in the Chagga society.

2.6.5 Women and Education in Chagga

When the family opt to educate girls there is still a challenge in some areas of this study. They said that "*ukimwelimisha mwanamke umeelimisha mke wa mtu,* that means "*if you educate a woman you educate somebody's wife"*. The Chagga knows that education is key to a good life, but have a perception that if you educate a girl, and that girl gets married to another family, the husband's family will benefit from the education that the girl gets from her original family. Due to that notion, many families opt to give education to boys who they believe will stay with the same family, even after he gets married. Hence, many girls are not receiving good education in the Chagga area. This idea forces most of girls to get married while too young and with poor education.

On the other hand, most of girls also conceive while they are too young or while they are still at primary school. (Most primary school girls are under 14 years). This is because, most of families have started already to expose them to their proposed husband. At that age, most of girls have poor education and no education about pregnancy. It was very sad, (though interesting) that a girl of class six (13 years) become pregnant; and when the school matron inform her the girl said "*Please matron, do not tell my dad I am pregnant until I complete my studies"*. She had more than one year before she completed primary school. This means that the girl was not aware about the duration of her pregnancy and the due date. Bhalalusesa, (2011) finds that, more than 3000 primary school girls are expelled from school annually in Tanzania due to pregnancy. She said that, the mentioned figure might be lower than the real figure due to the fact that, many girls drop out themselves from school after realising they are pregnant, and before they start to show to avoid social stigma.

2.6.6 Social Economic Development

Economically, the Chagga are considered to be the most progressive tribe among other tribes in Tanzania. This is due to their effectiveness in education, Christianity, utilization of land, stable income from coffee production and also social solidarity of extended families, clan up to the whole society, Steel (1999).

Moreover, the Chagga have a long tradition of helping each other with economic status. The help goes in a way of giving one another animals like cows, goats, pigs, and many more with the agreement that, the first born from that animal should be given back to the owner. This has been a core way of raising one another's economy in Chagga tradition. This helps many families to have their own cows, or goats, or pigs, and hence to raise their economic situation.

Nowadays, the Chagga economy started to shake because there is no coffee production anymore. This is because the coffee market was not stable so the farmer use a lot of money to produce coffee and the price became lower and lower. The consequences of the decline of the coffee market are that many families have failed to educate their children in secondary and in higher education, whereby many children now migrate from rural to urban areas to look for a job.

2.7 The ELCT – Northern Diocese

E.L.C.T Northern Diocese had been established by Lutheran mission work from the Leipzig mission. Germany sent missionaries who first settled at Nkwarungo Machame in Kilimanjaro region in 1893 (Materu 2007). After their settlement at Nkwarungo, they spread out over Kilimanjaro and Arusha in the Northern part of Tanzania. Shao (1985) indicates that these missionaries were not alone in Kilimanjaro; they were working alongside Roman Catholic missionaries who had already been there since 1890.

According to Materu (2007) the meeting of Lutherans and Catholic missionaries in Kilimanjaro caused some misunderstanding and conflict among them due to the fact that each of them competed for the Kilimanjaro region with the desire to occupy as big an area as possible. In this case, Sundkler (2000) indicates that, in 1894 the German administrator, Captain Johannes stepped in and divided the country (region) into separate Catholic and Lutheran regions, with each group agreeing to strict principles of non-interference in the other's territory. However, the agreement of no-interference did not last long after the departure of the foreign missionaries. Lutherans explicitly made it the mission of the church to expand in areas where there was no Lutheranism. It was very clearly stated in the church plans to make areas without Lutheran Christians, including areas dominated by the Catholic Church, as mission areas where Lutheran missionary services were to be concentrated (Materu 2007).

The missionaries established various social services in Northern Diocese, which included education, and health services etc. In line with this concept Mwaluko affirms, "*Missionaries*

agencies have been engaged in education, health and social welfare development in Africa particularly Tanzania for several centuries" (Mwaluko, 1991).

Most of the members of the E.L.C.T Northern Diocese are Chagga people. In the 1960s when the first seven churches merged to form one church, (the E.L.C.T), the Northern Diocese was dominated by the Chagga people and the other three major tribes which were Pare, Maasai and Meru. As time went on, the number of Christian increased, and people demanded services from the church. These paramount reasons led the Pare in the Eastern part to claim its own diocese, followed by Arusha, and later in 1991 Meru established their own diocese. Therefore, the Northern Diocese as understood in 1963 can be now be traced to the Pare Diocese, Arusha and Meru Diocese, each with one main and dominant ethnic group.

2.8 The ELCT and Health Strategies

The Evangelical Lutheran Church of Tanzania (ELCT) contributes to the health services in the country by running 23 hospitals and more than 150 primary health care institutions, corresponding to about 15% of health services in the country. The motto of the Church health institutions is to give quality services to all. That brings a big challenge to the economy of all these institutions. After the health sector was opened to private institutions, the church hospitals lost many patients who are able to pay, and the poor were left to them as well as to government hospitals. Some hospitals have got DDH (District Designated Hospital) status and their economic situation is better, because the government covers a big part of the running costs. That should be the situation of all church hospitals in the present market situation. http://health.elct.org/.

This implies that, among the strategies of helping its members, the ELCT puts emphasis on the health services. It promotes good health to the whole society that it serves. This has been given a priority from primary health care. In doing so, the ND, where the study has been carried out, has a primary health education programme from the congregational level. The primary health education gives education on a balanced diet, hygienic life, caring of sick people at home, first aid service, just to name a few. Furthermore it runs 4 hospitals and 17 dispensaries. Retrieved from http://health.elct.org/.

Apart from that, every August, in all congregations the ND teach family health issues. Through that programme many health topics have been covered such as diabetes, cancer, pressure, and diarrhoea, just to mention a few.

2.9 Summary

The chapter presents the background information. In doing so, it considers the following points, the background of Tanzania which also shows the Population, Politics, Geography, Healthy Policy, Social Economic Development; specifically where the study has been carried out, The ELCT – Northern Diocese, The ELCT and health strategies. The detailed background of the Chagga people of Kilimanjaro was also well presented .The subsequent chapter will present the literature review.

CHAPTER THREE

3.0 Literature Review

3.1 Introduction

This part focuses on the reviews of related literature on the maternal mortality and the concern of pastoral care for women's health; specifically on maternal health. It gives an overview of maternal mortality as a pastoral care concern. It also shows the need of pastors to be aware of the social setup he/she serves so to be able to speak out on those bad settings and help to reduce the risk of mothers dying while pregnant or in childbirth.

3.2 Women Health and Maternal Mortality

Jansen and Stephen (2008) define maternal mortality as the death of a woman during pregnant, during delivery or within 42 days after pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or intensified by the pregnancy, but not from unplanned or negligible causes.

WHO also define maternal mortality as the death of women during pregnancy or 42 days after child birth. Moreover, the tenth revision of the International Classification of Diseases (ICD-10) shows that, maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Although the ICD-10 added also the 'late maternal death', which includes maternal deaths occurring between 42 days and one year after termination of pregnancy.

I also agree with Phiri et al (2006) that, "*women's health is more at risk than the health of others. Indeed the issue of women is multi-faceted and includes not only the physiological, but also the psychological, social and economic dimension, among others"*. This idea is true and it applies differently according to the context. As this work looks on maternal mortality can bring some different face on the developing and developed countries and on how the health of the women is at risk. This is due to the fact that the social setup, health care, the economic situation, accountability and responsibility of health workers and many more are different from one context to another.

Gebremedhin (2002: 95) says that, women are vulnerable to psychological and reproductive health problems as well as general health problems and issues concerning family planning and

community support. Women's physical vulnerability is higher than that of men due to women's sexual and reproductive role. He then finds the poverty as the leading course of poor health care; the major victims of poverty and the poor health care are the women and children.

Chodzaza (2008) in her research of quality care rendered to women with major obstetric complications in Malawi, shows that there is a lack of transportation which forces women to use traditional care to serve themselves because of the difficult in reaching the health centre. Lack of ambulances is also often an issue. In general she finds that immediate emergency transportation is a problem, also the shortage of staff in most of the hospitals, lack of awareness, and a failure to recognise a danger sign among pregnant women which is due to the illiteracy and low level of education.

The result of the research done by Mæstad (2007) on rewarding safe motherhood in Tanzania shows that, during 2004, Tanzania Demographic and Health Survey (TDHS) has shown a reduction in the under-five mortality ratio over the last 10 to 15 years. However there has been no reduction in mortality within the first five weeks of life, neither in the maternal mortality ratio. Due to this fact the Norwegian Tanzania Partnership Initiative (NTPI) put more effort into addressing this challenge so as to reduce maternal mortality in Tanzania. The main aim of this initiative was to attain the 4th and 5th Millennium Development Goal on reducing child and maternal mortality.

Chodzaza (2008), in her research again shows that, Malawi is among the countries with the highest maternal mortality in the world. The findings show that, the number of maternal mortality has increased from 620 per 100,000 live births in 1992 to 1,120 per 100,000 live births in 2000.

Furthermore, United Nations (UN) article13 (2003) reports that, lack of access to health services and especially life serving care is among other reasons for the death of women experiencing complication during pregnancy and child birth.

In his research about Maternal Death in Rural areas Kigoma Tanzania, Semboja (1990) finds that, delay is among the factors that cause a high number of maternal deaths in Tanzania. In his project he viewed delay concept in 'three phases' when emergency care is needed. The first phase of delay was failure by the woman, her husband and family and possibly the traditional birth attendant to recognize the dangerous situation at home, when immediate transport to a higher level of care (hospital with adequate facilities) may have been life-

saving. The second phase of delay concerned transportation and facilities; there may be no ambulance or other transport vehicle available, and roads may be in poor or inaccessible condition. The third phase delay occurs when the health care facility personnel, as a rule in the hospital, were not prepared to act immediately when a patient in need of emergency treatment arrived. Semboja found delays to varying degrees in each of these three phases became a cause of maternal mortality.

Semba at el (ed.) (2008) in their article on Maternal Mortality in Developing Countries show that, while developed countries have made enormous progress in bringing down the huge death rates associated with pregnancy, women in developing countries continue to face a very high risk of death and disability as a result of pregnancy. The article also shows the risk of a woman dying as a result of pregnancy or child- birth during her lifetime is about 1 in 6 in the poorest countries compared with about 1 in 30,000 in Sweden.

Semboja's work (1990), on the study of maternal death in rural Tanzania shows that, while the causes of maternal mortality are many; social economic development is of greater importance in lowering maternal mortality than the provision of health services, although both are interrelated. In his research Semboja shows that, among 873 respondents on his study 560 of them are living under the poverty line in a sense that their income could not enable them to meet their basic needs such as food, shelter and clothes. In this situation it is obviously the problem is bigger for health care and particularly for the maternal care; so the result of the poor living condition is higher number of maternal mortality.

Massawe (1996) find that anaemia is reported to affect 56% of pregnant women in developing countries. It is again reported that in Africa the estimated prevalence in pregnant women is 50-60% (WHO, 2009.)

Again Phiri (2006) finds that in life, especially within Africa, there are many challenges that produce enormous pain, suffering and indignity. Life situation like these cause hard life experiences for Africans to face and especially women. She also shows that, in doing theology, experience is a legitimate source. The primary concern in doing theology to African women is not a method, but is life and life concerns for them and their peoples. In the context where the experience is patriarchal system; where women are beaten, raped and denied their rights, the choice is to do theology in the light of the female experience.

In relation to what women experience from the maternal issues, the Conventional of all Forms of Discrimination Against Women and its Optional Protocol (2003) shows that, the annual global estimated death from pregnancy related causes is close to 600,000 deaths while eight million cases of disability result from such cause.

According to Child Survival Protection and Development (CSPD) (2009), the low feeding frequency affect the health of pregnant women. Pregnant women should eat at least four times a day for adequate nutrition. However, in many areas in Tanzania women eat less than three times in a day, and they eat what is available; no matter how fewer nutrients the food contains. This poor diet affects the health of mothers and the baby she carries.

On top of that, goal five of the Millennium Development Goals in Africa, (MDGA) progress and challenges from the improvement of maternal health. The report from the goal shows that, WHO and UNICEF estimate that more than half million women in developing countries die from complications of pregnancy and child birth and it has been the leading causes of death and disability among women of reproductive age.

The report also shows that, in Sub-Sahara Africa alone complications during pregnancy and childbirth cause the death of approximately 250,000 women each year i.e. about one every two minutes. The countries with the highest maternal mortality ratio include; Rwanda, Sierra Leone, Burundi, Ethiopia, Somalia and Chad. The continent is also home to seven of the twelve countries with the highest number of maternal deaths in the world i.e. Ethiopia (46,000 per year), Nigeria (45,000) Democratic Republic of Congo (20,000), Kenya (13,000) and Sudan (13,000), Tanzania (13,000) and Uganda (10,000). The above mentioned seven countries account for one- third of all maternal deaths in the world.

Then MDGA finds that, accessibility to maternal health care and to health facilities in general still poses a big challenge to many governments in Africa, especially within the rural populations which accounts for the majority of the people. This problem is further compounded by the high poverty and illiteracy levels characterized in these areas.

There is consensus that the proportion of births attended by skilled health personnel; doctors, nurses or midwifes is very closely correlated with maternal mortality and, therefore, access to care by a skilled health provider at childbirth, when obstetric complications are more likely to occur, greatly reduces maternal mortality.

There is also a need to educate the communities on the importance of wider spacing of pregnancies, proper nutrition, and prenatal care. The MDGA focus shows that, between 1990 and 2015, three quarters of the maternal mortality ratio has to be reduced.

3.3 The Church and Maternal Mortality

It has been seen that, the church has dealt with other issues that can be related to the empowerment of women such as violence against women, marriage issues, and gender equality but not directly concerning maternal mortality as a church concern**.** However, it seems that, the church understands that a maternal issue is a problem that faces many women especially in Africa**.** The World Council of Churches (WCC) has a good plan on the issue of maternal mortality but nothing has been implemented. The plan says that, there is a need to improve maternal health, and the goal was the accessibility to maternal health care and to health facilities. The (WWC) also is aware that the health care and health facilities still pose a big challenge to many governments in Africa especially within the rural populations which accounts for majority of the people. This problem is further compounded by the high poverty and illiteracy levels characteristic in these areas, Abuom, (2004)

In reviewing the church and maternal mortality, it seems some church beliefs and teachings support the number of women who dying due to maternal mortality. To insist this, Rovner (2013) report that, Roman Catholic hospitals put women at risk in a sense that, they cannot perform abortion even if there is a pregnancy complications which bring the woman life at risk. However, in general, the researcher finds no literature directly on the issue of reducing of maternal mortality as a church concern; where the church acting on the reduction of maternal mortality. Together with this gap, I try to give some ideas that will show the church has to be very concerned with maternal mortality issues and has to prioritize the health and the lives of women in any way possible.

3.3 Religion and Health

It is well known that religion is a spiritual healer. This does not deny the physical care of its society. That is to say religion has a parallel concern to its member; that is spiritual and physical concerns. Dykstra, (2005) explained it clearly with a parallel reflection that midwives and ministers have much in common. They have long history of being valued as healers. He continued saying that, "we *are colleagues with great affinity, both in the practice of tending to birth, the physical and the spiritual kind, and in our involvement as a part of healing team in hospital"* (201). This was how Dykstra put it that the ministers are co-workers in the hospital

context. In most cases in Tanzania, ministers are healers not only spiritually or in the hospitals, but rather in the community, where people live. Instead of calling the ambulance or medical professional person, when a person in the community needs medical help, (which is long process with lots of demand) the church ministers and pastors are always being called. This is because the society believes that, church ministers and pastors have a physical support for a sick person too.

Tanzania and in many African contexts the religion is taken into high consideration and is a very serious institution that people consider as a moral director, as present in any situation; specifically the hard situations in life. Anything that has any relation to religious issues matters a lot. The translation of the bible is merely on day to day life experiences. In support of this reality, Phiri (1997:80) wrote that, "…*the majority of Africans (again particularly women) who read or listen to the bible view it as a source of inspiration in their daily life and not as a document under scientific scrutiny"*. This made religion a model of instruction in African communities. That makes it easier for religious leaders to change the societies in any element that makes mothers suffer and lose their life due to patriarchal social setup of the society.

3.4 Maternal Mortality and Pastoral Care Concerned.

This part will be approached by showing the function of pastoral care whereby its function if performed accordingly to pregnancy mothers, will have a positive effect. This has its reality from Stones (1996) idea of pastoral care that has been understood historically that pastoral care embraces the helping acts so as to provide healing, sustaining, guiding, and reconciling of troubled individuals; peoples whose difficulties occurs within the context of ultimate meaning and concerns. This idea of pastoral care applies too to the issue of pregnant women especially when they meet difficulties because of social barriers that hinder their access to good and accurate social needs.

Generally in Africa, the health of women has to be the pastoral care concern. Pastoral care is among essential roles of pastors in the ELCT/ND. The society understood and takes it very seriously that pastors are servants of God, and they are working in the physical world on behalf of God himself. Taylor (1989) makes it clear that, pastoral care has to help people meet various crisis and changing situations which come about their lives. That includes both physical and their personal relationship; to sustaining people in times of difficulty, frustration and sorrow. This shows that, in any situation that faces the life of people in a society, the

pastoral care has to take its part and direct fair and appropriate ways on how to bring up a healthy physical and spiritual wellbeing in society.

As it has been mentioned above, that in doing theology experience is a legitimate source. Therefore, in doing theology where women have died from maternal issues, where the patriarchal system is dominant, where the orphans are daily increased, the concern is not a method but the life experience and how to come out of such bitter experience.

3.5 Summary

This chapter presents literature review. The related literature has been reviewed so as to see how other ideas of the maternal mortality and if the church can do anything to contribute to reduce the situation. The following sub topics has been presented under this chapter; women health and maternal mortality, the church and maternal mortality, religion and health, then maternal mortality and pastoral care concerned. The proceeding chapter is about the conceptual and theoretical frame work that has been considered under this study.

CHAPTER FOUR

4. 0 Conceptual and Theoretical Frame Work

4.1 Introduction

This chapter focuses on the main concepts and theoretical considerations used in this project. In doing so, the chapter will discuss the feminist theory and pastoral care concern relating to the investigated problem. Then, at the end of this chapter the relevance of the feminist theory and the pastoral care concern to this study will be explained

4.2 Feminism Theory

The feminism theory has been used globally as a special mechanism to make changes in patriarchal structured societies. It has been used to challenge the existing situation in many societies with the focus of bringing change where there has been any kind of women's oppression. Through feminist theories some studies have been conducted which identify gender inequalities in the church and in the society. In a situation like this feminists and especially women feminist should use feminist theories to point out their oppressions and to suggest ways to get rid of it.

Feminism understands that women from different backgrounds have not shared the same experiences. This is an accurate reality since the level of development is also different from different parts of the world. The women from the First World or developed countries are not sharing the same experiences with the women from third world or developing countries. In that sense, what feminists from the First World view as a social demand can be different from what feminists from the Third World consider at the same time. In this idea, Peet and Hartwick (2009:240) wrote that,

> "Feminism is made up of several diverse social theories, political movements and philosophies. Most of these adopt critical stance toward the existing social relations, especially gendered relations. Feminist theory looks at the origins, characteristics and forms of gender inequality in order to focus on gender politics, power relations and sexuality. Feminism is consciously political and activist. Its politics centres on immediate issues like productive rights, domestic violence, maternity leave, equal pay, sexual harassments, discrimination and sexual violence as well as such long term issues as patriarchy, stereotyping, objectification and oppression. Themes related to development include the inequality between genders, the disproportionate amount of work performed by women and yet the absence of women in development policy or group decision making-in general, all of this being attributed to the subordination of women. In its early response feminist political activism tried to create grassroots movements that crossed boundaries and brought together women from differing classes, races, cultures, religions, and regional backgrounds as group of suffering common oppression. As feminism developed, these universalism come to be seen

> as oppressive in the sense that, woman from different backgrounds did not share the same experiences. In this regard, especially modern feminism theory was criticized as being predominantly associated with the views of western middle class academia rather than emanating from third world intellectuals and activists. Increased emphasis was placed in different contradictions, and strategy rather than a unifying politics. We now have diverse feminist rather than unified feminist movements".

This is to say that feminism concentrated in a wide ranging system of ideas about life and human experiences with the focus of a women centred perspective. This is because in many patriarchal societies women experience negligence, dominance, oppression, and denial just naming the few. Konyaro (2002) and Oduyoye (2001) revealed that, African culture and Bible tradition are patriarchal and both have been used as a weapon to dominate women. In understanding the experience of female oppression, Oduyoye (1990) insist that, the church is made up of both men and women. Thus, the church and the society should promote the empowerment of women with the focus of raising the awareness of partnership and solidarity among men and women in the church and in the society.

Miller-Mclemore et al (1999) define feminism as a radical political movement that struggles to end sexist oppression. For them feminist does not privilege women over men, rather it has power to transform in a meaningful way. They consider feminism as more than a goal to achieve equal rights, individual freedom, economic and social equality. They consider feminism as a way to strive to eradicate sexism and related exploitative system and to allow those silenced to join the culture of speaking the reality.

Eriksson (1995) on his work on the meaning on gender in theology, he considers feminism as working towards with the common goal; to end male dominance over women. It claims equal value for the two genders. On top of that, he shows that feminism consider both natural and social world. It understands the world to be constructed differently by people who, in different social context have had different life experiences. Again, Oduyoye (2000) describes that feminism emphasizes the wholeness of the community as made up of male and female beings; that is to say, the male humanity is a partner with a female humanity. She emphasises this idea by showing that feminism is the word of all who are conscious of the nature of human community as a mixture of values, roles and temperaments that are divided into feminine and masculine. Feminist theory can be called the advocacy of women's rights of the movement for the advancement of women. She argues that in the contemporary time it is not a matter of feminists expressing the oppression of women and following the link of historical happenings,

political and economic changes, and biblical hermeneutics, but also it is a time to challenge the situation in the light of women's situations.

4.3 Women and Health

Gebremedhin (2002) shows health as a basic determinant of quality of life with its major effects in economic development and social progress. Women's health is multifaceted and there are many critical issues when talking about women's health. This is because of the biological nature and physical roles of reproduction. Access to health care is of a great concern. Women, in order to cope with their daily responsibilities, depend on access to effective health care. Gebremedhin (2002:95) says that;

> "Women are vulnerable to psychological and reproductive health problems as well as general health and issues concerning family planning and community support. Women's physical vulnerability is higher than that of men due to the woman's sexual and reproductive role. Women, including children, are the typical social groups characterised by very high rate of mortality and morbidity, resulting from interrelated problems of underdevelopment including poverty, low standard of living conditions, inadequate social services and economic infrastructures, illiteracy and a lack of access to basic educational and health care".

Okoto in her view of women's health also suggest that, health should be considered as a basic rights and a high social priority. According to her, health is a basic right and must be prioritized. This concept is true and has to underpin every societal consideration with a special consideration to women's health as she states that "*Women's health is more at risk than the health of others. Indeed, the issue of women's health is multifaceted and includes not only physiological, but also the psychological, social and economic dimensions, among others"*. (2006:98)

It is very clear that the health of a woman has to be much carefully considered in all of its aspects. It is not something to be ignored. Out of many reasons that one can give on the importance of women's health is that a woman has her life and the life of others. So if the health of a pregnant woman is at risk, it means also the life of the one she carries is at risk too. But also in the African context, a woman holds the life of others in the society because she is responsible for all family chores including of the assurance of the availability of food in a family level. Thus, when this work concentrates on the maternal mortality, it saves a lot by saving the life of mothers.

4.4 The Church and its Mission

The church is the body of Christ, with its emphasis on the organic growth, growth into Christ and the continuation of the mission and the ministry of Christ; to the people of God. (Greenwood 200). With this focus, the church of today has to continue doing the mission and ministry of God; healing, teaching, preaching and much more. This has to be done not only with a spiritual focus, but with a focus on the whole body; including the physical. The ELCT-ND has to follow the same direction to bring hope for the future life of pregnant mothers and to help society understand the value of women in full. While the society ignores the women, the church should not only accept them but also do its mission to the society and show how the women has to be treated with their "exceptional" gender roles. In order for the church to manage its ministry, Mugambi (1994) suggests that, the church in its ministry should work in full collaboration with local leaders in the society where it implements the call of Christian discipleship. He insists that the physical and spiritual aspects of the individual and the society are equally important, and the church ought to be cautious not to emphasize one aspect and leave out the other. Therefore if the church wishes to offer its mission and ministry in entirely, it has to consider the spiritual aspects and physical aspects as both of equal values. Both are equally important and of a great values for the development of the church and the society.

4.5 Pastoral Care

According to Pattison (2000), the term 'pastoral' is derived from the English verb 'to pasture' with the meaning of feeding in the field, pasture or meadow; relating to shepherds or herdsmen or devoted to raising sheep or cattle. It remained as purely an agricultural concept of rearing and keeping the flock until biblical times when the term become an analogy for the activity of leading and caring of God's chosen people. Again, Benner (1998) shows the term 'care' is originated from the Latin word 'cura' which depicts both the ideas of 'care' and 'cure'. Banner referring to both care and cure as the actions that are designed to support the well-being of something or someone in a sense that it will restore the well-being that has been lost.

Then, the definition of pastoral care according to Ramsay (2004) is a religiously based ministry of care offered by believer and religious leader. He indicates that, it is a concern shown for the needs of people in every walks of life, whether in the time of health or incurably ill, in joy or sadness, in good times or in bad times, pastoral care relates to people's needs.

Collins (1988) and Lartey (2000) have the same idea that pastoral care refers to the church's overall ministry of healing, sustaining, guiding and reconciling people to God and to one another. Pastoral care practices focus on human problems and pastoral responses (Dunlap, 1999). This is a very essential idea as far as pastoral care is concerned. After focusing on human problems, the next step is the response toward the problem that may lead to the problems eradication and set the society free. Dykstra (2005) points out that pastors are unique among professionals because pastors are basically an agent of hope. In that sense when the society face problems and loses hope and sees no more life ahead, pastors have to bring new hope to such a society. This can be done by focusing on how people experience the particular context and the pastoral responses have to bring hope. Pattison (2000) adds that, "*pastoral care is the matter of doing not thinking"*, this is to say pastors have to see and then act upon what has been seen. The important point here is to act positively on negative situations. Take for example the context where this study has been conducted, women suffer and die because the social setup is not favourable to women, does not care for them and is too patriarchal; then, pastoral care has to find out a way to change the society's attitude toward the subordination of women and bring hope to the women and to the whole society. Moreover, Oden (1993) says that, good pastoral care does not ignore the bodily needs. To him, good pastoral care needs to pay attention to spiritual and physical comfort, economic necessity and progressive happiness. Following this idea, the church has to have a dual focus in its mission; spiritual and physical.

4.6 Pastoral Care in Relation to Midwife

However, Oden (1993) has equated pastoral care as a parallel professional with midwife. Oden considers that in a sense, both are helping in giving birth to a new life, the pastoral care midwife gives help in bringing new life in a spiritual manner while medical midwife does it in a physical manner. I critically side with Oden in his view of Pastoral care as a parallel professional within the context of where this pastoral care study has been conducted. With the view of this study, the work of pastoral care in relation to midwife has to be viewed differently; particularly as pastoral care is a midwife both in spiritual and physical attention. This is due to the sense that, mostly, maternal death occurs due to the patriarchal setup of the society and many other unethical issues. At the same time pastors are mostly trusted people in the society that they can bring about change. Pastors can use their position to teach the society and to direct people into more ethical conduct. In this sense pastors can work as a spiritual and as a physical midwife.

4.7 The Relevance of Feminist Theory and Pastoral Concerns to this Study

This study takes a women centred perspective. The feminist theory is relevant to this study because the study focuses on women's experiences in connection with pregnancy and child birth in the Chagga context, which puts their lives in threat of danger. In doing so, this theory will help in understanding and analysing the female experiences on the researched topic and then discusses how to bring about changes in the light of these experiences. The theory also will help answer the questions on; Why maternal mortality? Is there any system that favoured it? Is there any way that the situation can be changed? All these and other issues that have been raised in this study will be viewed and analysed, whether directly or indirectly, through a feminism view point.

Then, this study is multi-displinary. It has to do with maternal mortality and maternal mortality as a church concern. Because of that, it is also very important to view the pastoral ministry toward the society as how I explained above. The pastoral care deals with people's needs in every walks of life. Pastoral care has to do with 'care' and 'cure', and it has to support the well-being of people in every aspect of life, and many more. Considering that, this study tries to view the pastoral care as not only based on spiritual demands, but also physical demands on the society where it works. So it is very relevant to use the feminist theory to assess the issue of maternal mortality and to analyse, examine and discuss to what extent pastoral care has been helpful to the society where women are dying due to maternal issues.

4.8 Summary

This chapter presents a conceptual and theoretical frame work where the feminist theory and pastoral care have been explained from different views. These theories have been explained with their relevancy to the study of facts and experiences of maternal mortality. They have also been used in a broader sense in the discussion part of this work. The following chapter presents and discuss the findings. All the findings will be discussed with the view of feminism and pastoral concern as theories which have guided this work.

CHAPTER FIVE

5. 0 Data Presentation

5.1 Introduction

This chapter present the findings of the study. The focus of this study is the contribution of the church on the reduction of maternal mortality in Tanzania. The scope and limitation was in the area covered by the ELCT- ND, and one of its health centres mainly in the Chagga area where Chagga people live. Therefore, the data was collected within this area. I have been much concerned with the Chagga patriarchal social setup and wanted to evaluate what was the concern of the church in such prolonged silence for the makeup of a society responsible for the lives of mothers. I also considered the documentary data of maternal death from the public officers, which will show the situation of the investigated problem. All the findings were collected from different participants during the field work.

5.1 The Situation of Maternal Mortality in the Study Area.

The research findings approve that, many death pregnancy related issues have occurred in the researched area and some are recorded but others have not even been. This means that, not all cases, where there has been a maternal related death have been reported to the birth and death registry, which is responsible for such matters. This is because some women do not attend prenatal clinics in any health centre during their pregnancy. They sometimes attend to the local midwives. However most of the local midwives cannot read or write, instead they keep their memory locally. When the death of a pregnant women occurs within such environment, they just bury her quietly with no information of the causes of the death. Other women do not attend to any medical care while they are pregnant, whether at the health centre or to the local midwives; they just stay and wait to give birth. The M.O 1 affirms this situation by saying that,

We've had problem with receiving information. The information we have here is only for those mothers who attended the clinic and who come to deliver at the hospital. But we have a number of women whom since they've conceived they did not like to come for the medical check-up and others they just deliver at home. Some such women survive but others die. Most of cases like this ending up quietly in the village and the records are not kept. So the data we have here might be increased greatly if we received all the information of those mothers who died at home while giving birth or while pregnant.

So the following figure shows the number of maternal death in the study area per year and the reason for the death. The report covers the period of 2010 to 2012.

FIG 2: 2. The Report of Maternal Death in the Siha District from 2010-2012

YEAR	AGE	DATE OF DEATH	Causes
2010	21	22.1.2010	Anaemia
2010	36	10. 4 2010	Anaemia
2010	17	26.9.2010	Brain Failure
2010	43	18.11.2010	Pulmonary Arrest
2011	24	23.2.2011	Amniotic Embolism
2011	26	12.6.2011	Eclampsia
2011	32	20.9.2011	Severe Anemia (Hb3.1 G/Dl)
2011	35	26.9.2011	Anemia
2011	18	19.10.2011	Cardiac Arrest
2011	29	22.12.2011	Septicaemia
2012	37	14.3.2012	Post-Partum Haemorrhage (Pph)
2012	30	16.6.2012	Amniotic Embolism
2012	16	26.11.2012	Unsafe Abortion
2012	21	30.11.2012	Anemia

SOURCE: Siha District: Field data, (2013)

5.2 Factors Affects Maternal Mortality in Chagga Society

Lyatuu et al (2010: 1799) reported that, maternal deaths can be sub-classified into direct and indirect death. Direct deaths are those resulting from obstetric problems or from interventions, omissions, and incorrect treatment or from a chain of events resulting from any of these causes. While on the other hand the indirect deaths are caused by a pre-existing disease or disease arising during pregnancy, aggravated by the physiological effects of pregnancy. From here on, this work will be discussed with the consideration of both direct and indirect factors for maternal mortality.

5.2.1 Pregnancy as a Woman Issue

Many women respondents complain that they take care themselves while pregnant. Men are not responsible. Most men respondents agreed that the responsibilities of pregnant women are on women themselves. Traditionally, Chagga's are polygamist; in that sense many men run to their second wives. They are not responsible for taking care of pregnant wives. This is due to social setup of pregnancy as a woman's issue with the result that the responsibility of taking care of the pregnant woman remains in the hands of her fellow women. Informant 13 confesses that.

When woman conceives, she is no longer a helper, she is always lazy, and she complains a lot, she vomits many times. For me, I cannot stay at home with my wife while she is always

throwing saliva all the time like a snake; it is her duty to ask her fellow women wherever she faces problems about her pregnancy Where under the sun have you seen male dealing with women things? Our part is to facilitate the pregnancy. I am not a woman to be asked about woman matters.

It has not been normal for the men to take care of their wife during pregnancy up to the time she gets the baby. The situation has been much influenced by the social understanding of pregnancy as a woman agenda. Many men do not include themselves in the issues of caring for their pregnant wives. From the suspicious eyes, this has a great influence from the polygamy system in Chagga society. It creates a loop to men that they can easily move and be cared from one wife to another. The situation forces the women to take care of themselves from the moment they conceived up until they give birth. The situation tends to be a bit hard to the women due to the fact that, during pregnancy, the woman cannot easily manage to do all the other work she was doing before to generate her income. The situation prevents her from having a stable economy. Then, if the husband does not care, the woman might not have enough for the hospital and nutritious food. Simply, many women face a lot of difficulties, they kept quiet in accordance with the culture surrounding them, and at the end the situation may get worse and cause maternal death.

Another informant (17), a male, insisted that pregnancy was the woman's issue said that,

Men had never and will never conceive. Why should we think about pregnancy matters? Those are woman issues. They have to find the way to help themselves because they are the one who are pregnant. We men can give them with as many pregnancies as they want. But they should not bother us. It is really shame for the men like me to think and concentrate on the women's womb. Women are many, young and old; they can talk their own affairs.

Again on the same idea, informant 5 a female, while pointing her stomach said as follows;

This is my sixth pregnancy, none of them my husband was responsible for me. When I conceived I am no longer his choice. From the time I told him I am pregnant, I can count the days he will stay at home with me. For last two pregnancies I did not tell him anything until he realise I am pregnant himself. Imagine a man can come home a week after I got a baby, he do not know who help me, which hospital I attend, how much I pay, who was taking care of other children in my absence, who was doing all works here at home. When he comes home he just ask 'mama nani alikusaidia?' that means which woman helps you? Because he

actually knows that, is only woman who knows this path of pregnancy and delivery can help me. Then he can again ask, was it at home or hospital? That is the men we have.

Informant 15 critically emphasised that, the pregnancy is not only the woman agenda, but it is also shameful for men to talk or to discuss about pregnancy issues. He started the conversation by saying that,

Let us speak with a low voice so that other men will not hear me speaking of women things. It will be much shame to me. In fact, we men are not at all responsible for the issue of women tummy. I have not much to contribute because I have three children always my mother is the one who take care of my wife when she is in that status. I always told her to stay with my mother when she reaches seven months. I cannot help her with anything. No strong men can ever do that. It is our ways of life. To change it is hard. The women should deal with their pregnancy and help themselves. They know how it looks, how it feels, what they go through to have a baby. Then, why men on women matters?

Generally, the approach of leaving the issues of pregnant to the women themselves means it is not given any priority in cultural development goals. This is because most of the leaders are men; most of the people who are in decision making forums are men, therefore if the men, who actually can bring changes to the situations that the community encounter consider pregnancy as not their agenda; what would be the outcome? Gebremedhin, (2002: 111) says that, one of the most important cultural obstacles to woman's maternal health is the absence of discussion the pregnancy at the household level, particularly between husbands and wives, and between parents and children. This implies that, the issues of pregnancy have been left to the women and not as a family concern. This concern is not just local, it happens in other areas too; Eritrea for example, where Gebremedhin conducted a similar research, similar statement were pointed out as cultural obstacles to women's maternal health. He continues saying that, "*Pregnancy should no longer be a taboo topic in the house hold. Discussions about pregnancy and maternal health care should be a common occurrence at both the household and community levels" (*ibid*).*

Together with these ideas that is prevail in Chagga society, there are still men who affirm that pregnant women should have care, understanding and support. They have seen what women go through during pregnancy and child birth; they have seen also many women die because of lack of immediate help, they have seen a number of men ignore and avoid being involved in anything concerning pregnancy and childbirth. One of men informant 16 says that,

Even we men we do not know where we are from. The woman carried us too, nine month in the womb, they have been so patient and tolerate to raise us up. Today we men ignore to help them while pregnant and delivery time. For sure we are looking a curse. I can never allow my wife to feel bad, to feel I am irresponsible of anything specifically while she is pregnant.

The response from another man (informant 14), was also supportive to the women during pregnancy and delivery, although he is in fear of being mocked by his social peers. He says that*;*

It is not in a hiding manner, women suffer to die during pregnant and delivery. I always do not like this situation to happen to my wife. When she is having any problem, whether sick, heavy works, she need funds or anything that makes her comfortable and healthy I am ready to do. Although I wish not anyone else to know that I am helping my wife to that extent because I fear that if other men know, they might think women controls me.

This two men are models for the Chagga patriarchal society, rejecting social barriers that make men ignore and not care for women especially while pregnant, and they seem to be responsible and understanding. Although pregnancy is considered as women issue, they took it as their agenda too.

5.2.2 Replaceable Tin Cover

The death of women is considered equivalent to as to losing the tin cover. To replace the tin cover is easier where the study is conducted. Traditionally, the Chagga keeps clean water in the tin which is normally covered by a banana flower. Since there are lot of banana trees in the Chagga area, it has been very simple to replace the cover. The tin cover costs nothing, there are many of them and easier to get.

From this perception, when women die it has been considered as a tin losing its cover and to replace it is very simple. This causes negligence in the care of pregnant women in the Chagga society. This is because of the notion which stayed for generations that, women are replaceable.

During the interview, all women respondents said that, they will not remarry if their husbands died, but all men said they cannot stay without a woman in case their wife dies. This affirms that women are considered replaceable while men are not.

Respondent 13 says that,

The pregnant woman passes through many things. To live be a blessing and to die is normal. Women are many. To lose one is like to take a cup of water from the sea they will not finished. When one died another one is there to be married. The sorrow is there for a while but the solution is also there.

Then, on the same agenda of the women being considered as something that can be replaced, pastor 1 says that,

Men are not so concerned for their wives when they are pregnant because they are not raised to do so. On the other hand, women then are not free to tell their husbands what they feel because they are raised to worry them. Men are also raised to see women as something that can be replaced. The situation that makes men to be not serious on caring of their wives during pregnancy. In that case they are not much concerned of the women's health in any case. The situation like this makes women feel unworthy, not valued and hence denies themselves. Many women die because of lack of caring that comes from the system that is reluctant, silence, not responding to the men who are irresponsible to their own families; and that is the way they were raised, due to the patriarchal society and women do not have any one to speak for them.

These were the complaints from informant 6. She says that,

These men they know when we die they can marry again. They are not concern on our life. If you tell your husband that you feel sick is like you ask him do not come back home today. He leave as if he did not hear well. They always run their responsibilities. But if they are not allowed to have another woman when a wife dies, they could take care of the one they have. Many of the women death in our area are preventable. The word of consolation to men when a wife died encourage them to neglect us; that women are many, you will soon have another one, do not cry as a woman. Therefore, because women can be easily replaced, men are not, in any sense, bothering themselves for our health.

The concept of considering women as replaceable means the women are not valued among Chagga society. The situation might be associated with many things, such as patriarchy characteristic of the society, the culture of women being quiet and not allowed to argue with men which is based on the Chagga traditional sex education, polygamous system where men can have more than one wife, so that if the one dies the other wife/wives are there to cover the

gap, and many more. For these reasons, unless the social setting changes, women will have a greater challenge on battling maternal health, since if they die they can easily be replaced.

5.2.3 Beating of the Wife

The researcher finds that, women are beaten by their husbands as part of a social cultural landscape. Actually, not all beatings are regarded as a punishment against the wife. The beating of a wife, as how it has been perceived in the study area, can have several meaning. One of the society elders indicated that

The beatings of a wife indicate several things. The first one is that, it shows there is a strong man in the house and a man who can discipline is wife. A man who do not beat his wife is weak, he cannot control his house. Second thing is that, women cannot be taught by words only but by action; there is a Chagga saying that, 'mka ekelosho nyi rumbu phfo', which literarily means that 'a wife cannot be directed/instructed by mouth only, rather by action'; Then, in this situation action means beating. This phenomenon makes most of men to beat their wife so as to teach them not by words only but by actions, also to be considered as a strong man in his family. The third meaning is that, beating of the wife has been considered as symbol of love. This is due to the fact that, women are always busy and they do not have time to rest. When a husband beat his wife it means he loves her and he want her to have leave from a lot of work she had every day. When a man beat his wife he has to slaughter a goat and the wife would have enough food as she recovers. Again she will have time to rest because she is sick by being beaten.

In this line, nurse 1 confirmed that they received cases of wives who had been beaten by their husbands but the wives do not want to report it as the way it was. Then, the nurse says that,

Many women come here after being beaten by their husband. But they hide the truth so as to protect them. Sometimes they come over while bleeding and having lost a lot of blood. Still they deny they were beaten so as to protect and cover their husbands. This is very dangerous situation to pregnant woman. We had some who lost their life because of being beaten while pregnant. Some of them the baby died in the womb. At the hospital we report as anaemia case because she had a lot of bleeding after being beaten. But in reality the anaemia caused by being beaten.

Again, Informant 4 also has this to say,

If I stay for a month without being beaten by my husband I see it like a surprise. It is shame and painful but I had nothing to do. I try to tell my parents, they told me that's the marriage life and I have to tolerate. I also tell his parents they said they will warn him, but still there is no changes. He is too drunkard and he cannot control his feelings, anger, sexual feelings and others. Six months back I got miscarriage because of being beaten; now I am pregnant, I don't know if I will live or if I will die.

The above informants proved that women experience pains and torture from their husbands. No one to speak for them because beating of the wife has been regarded as the husbandly responsibility. Also some of the women feel unloved if they are not beaten. This is because for those women who have been beaten they can rest for a while from house chores. Although it is awkward because even if the woman is on this '*traditional sick leave'*, if I my call it so, the husband is not again responsible for the house chores. Other nearby women as mother in law, (the husbands' mother) will come to work for her daughter in law, if not; any other relative woman will take her part. situations like this has an impact for the 'beating of wives' not to be easily abolished among Chagga due to the reality that, during the time that the mother in law is working and cooking for her daughter in law she will also have a time to eat well and she will not have many responsibilities since she will only do the main house work. So it has been suspected that, sometimes the husbands' mother are advising their son to beat their wives so that they could have good food and some rests too while caring her daughter in law.

Beating of wives has been also reported in to other parts of Africa. Although they might not report it in a relation to the maternal mortality. Meanwhile my concern is, if the women are beaten while pregnant, the consequence will be negative and some of them have lost their lives. In supporting this argument, Waruta (1994) shows that, many men think that, beating of wife is part of their husbandly rights and privilege if not obligation. Many women on their part seems generally to accept and their destiny and will often cover up for their husbands, even when they have hurt them badly. Hilinti (2013) finds that among Wanyaturu of central Tanzania, if a women is late to prepare food a man cannot be blamed of beating her. This affirms that in a different social setup in Tanzania and other parts of Africa, women can be easily beaten by their husbands. Many of such occasions happen when the woman is pregnant and most of women miscarry or die.

5.2.4 Poverty

Most of the informants whom I interviewed, the woman were said to be home mothers while the men were said to be peasants. In a real sense, these all fall in the same category that they do not have any work which will assure him or her to have enough funds for his or her life. Due to the social setup of the Chagga people, a woman can call herself a home mother, but a man cannot call himself a home father, so the men end up calling themselves peasants instead. Most of these home mothers and Peasants depend on the little they get from the small garden they have to sustain their life, whereby even to have daily food is not enough.

Informant 16 says that,

Ii is hard to get that money to take her to the hospital, if she have money she can go, but for me I don't have money to give the doctors. Many women deliver at home and no problem face them, why not her? There a lot of women who can help her and it is free of charge or just a small amount of sugar.

Then informant 7 puts it in that way,

It is not hard to deliver to the local midwives because if you don't have money to can pay her when her when you get, also you can pay her by instalment and the money is not too much as those at the hospitals. So I am not interested to go to the hospital while I can save some money if I deliver at home or at the local midwife's home.

Informant 11 insists that,

It is hard to allow your wife to go to the hospital while you do not have enough money, the hospital people asks if I have 'long leaves shirt' they ask in Swahili that 'umevaa shati la mikono mirefu?' At the same time they need another money to buy a lot of medicine. I know our mother did not attend any clinics and they bring us healthy to this world. Doctors and Nurses are thieves. My wife will deliver at home. Not at the hospital. I have a neighbour who attends many pregnant women than those corrupt people at the hospital. She will help my wife too.

Again, on this point informant 8 confess that,

I use more than my monthly salary so as to get services at the hospital. After giving the doctor extra money he calls a tax and they took me to a neighbour hospital where I find the same

doctor there and I was attended very well. That means if I had no money I would not get good service.

Informant 13 puts it in this way,

Due to the poor life condition, even doctors and Nurses are claiming more salary from the employer. But because also is hard for the employer to pay enough salary, doctors and Nurses demand extra money from the patients. They use a terminology 'vaa shati la mikono mirefu' which means that you have to pay more if you need good service. In a clear language that is a corruption; because that extra money will not have a receipt information, 'is you (patient) and a doctor' and the money will not go to the institution, rather to the person's pocket. Sometimes we wait to get enough money for the hospital and we find the situation also get worse. So we do not like not to attend to the hospitals but the situation forces us.

This has been affirmed by informant 10 that:

Doctors and nurses are not only corrupt money from the sick people and especially pregnant woman, but also they are working in a public and private hospitals while at the same times they run their own hospitals or pharmacy nearby. When the sick person has enough money to pay them they took them to their private hospital. Sometimes they tell us we have to buy a medicine in the pharmacy nearby the hospital and that is their individual business. So I have to sell everything I have to go direct to the private hospital, unless the story will be 'go and come tomorrow' to those government hospitals.

On this line, doctor 2 shows that,

If we get good salary we would be serious and committed at work and we hope our client would be satisfied. The problem is that we are working almost 24 hours, even I weekends, but what we get cannot even take us to half of the month. So when you see doctors, nurses running here and there, it is because of the life situation realities. We need also to have better life from our work.

Other research also shows the poverty as a cause of maternal mortality. In this line, Ronsmans, et al (2003) on their research on maternal mortality in the developing countries they find that, there is no doubt that the poorest countries suffer the highest burden of maternal mortality. The maternal mortality ratio is often quoted as the statistic that most clearly highlights the huge gap between developed and developing countries. The women's

lifetime risk of maternal death is almost 40 times higher in the developing world than in the developed world; and the highest maternal mortality ratios of 1,000 per 100,000 live births found in some regions of eastern and western Africa are as much as 100 times higher than those observed in some western countries. Moreover it has been observed that, globally, poorer women particularly see childbirth as a non-illness, where modern medicine has little to contribute. There is also evidence that poor families may be less willing to spend money on women's health. Jensen and Stephan (2008)

5.2.5 Poor Health Service and the Quality of Palliative Care

Through questionnaires and some of the interviews, respondents show that poor service is among one of the factors that cause maternal mortality. Respondents complained that, the services that are given by health workers to pregnancy mothers are very poor, to such an extent that most of pregnancy women lost their lives. Again, most of the pregnancy women who attended hospital were easily susceptible to infectious diseases because they were attended and deliver in a poor and not hygienic health conditions. Apart from that most respondents also shows that negligence among staff, few staffs harsh language from doctors and nurses, inadequate maternal and child health services (MCH), as well as poor medical care were among the factors which contributed to the maternal mortality.

Informant 1 in affirming poor services and the quality of palliative care as a problem and it leads to the maternal death, she explain that,

"I come here since 8:00 in the morning, a nurse tell us we have to wait because the measuring facilities are used for those admitted mothers. Now is 12:00 noon and we see her just passing here with no information on what is going on or what time will she come to attend us. We are here like slogan with our belly" she continued saying that,

"I was admitted at the hospital and we have to sleep two pregnant women in one small bed, the service was poor, we can see a nurse or a doctor once after two or three days. I stayed there for six days then I was tired, I did not even wait for the discharge because I see it as bed rest and I thought it was better to sleep on my own bed at home. Sometimes nurses say if we feel pain we have to follow them in a labour ward. At the same time when we go there we do not find them, either the watch keeper can try to walk in one office after another to find who is available. I was much discouraged when pregnant mothers who are admitted at the hospital help the fellow at the time of delivery because the doctor on duty was not seen."

On top of that Informant 4 says that,

The nurses come to me and told me to and buy gloves, I was not having any money so I did not manage to buy gloves and I was not attended. Then some friends visited me on the following day and I tell them about that, so they bought gloves for me. Still doctors and nurses use a very harsh language to me, the words that I cannot tell. (She starts crying and she does not like to talk any more).

5.2.6 Poor Means of Transportation

The research finds that, many pregnant mothers walk for long distance so as to access the hospital services. Then after all the walking when they reach the hospital they are not sure if they will get services or not. This situation force many pregnant women to refuse to go to the hospital.

Informant 3, with a great anger shows that,

I walk for three hours to get here, (at the hospital) and this is my second hour here I am still waiting for the service. I don't know what time will I reach home. Last month I come here and I went back home without being attended because it was too late for me to go on waiting. Sometimes this discouraging us. I feel like I am in a wrong track. Better I stay home.

Then informant 6 says that

I expected to get a baby after three weeks but I decided to come to the hospital a month before because last time when I was pregnant I was carried by local bed and before reaching to the hospital I deliver on the road, by God's grace I was saved but my baby died after half an hour.

Informant 14 explains that

Transportation is the big problem in our area. When a woman is pregnant and she got sick is hard, very hard. To carry her on a bicycle, sometimes in the night, it is dark no electricity, from here to the hospital we may use six hours. It is more than a punishment. You have to find neighbours to escort you and to help in holding back side of the bicycle. Because the woman is heavy and it is hard to control the bicycle in our rough road. At least if the hospital was closer it would convince me to see the necessity of the hospital. The nearer cervices we have, our local midwife is friendly to us and is affordable. Wherever we see the situation is serious

and critical is when we can try to go to the hospital, unless I don't see the importance of going there.

It has not been the choice of women to have such difficulties; even on how to get to the hospital. Many are using bicycles or local beds if the patient is in a serious condition. The reason is that there is no public transport to help them get to the hospital. At the hospital where the research has been done there was only one ambulance and the sick person has to pay for it. This also increase a load to them and especial the pregnancy women. However the hospital serves almost all the Kilimanjaro region which many people depending on the same ambulance in case of emergency. The situation on hardship in transport has also been reported, especially in the other parts of Africa too. Jensen and Stephan (2008:20) on their research of maternal mortality in developing countries, in the case of Malawi found that, many women live far from a hospital in an area characterized with insufficient roads and lack of public transportation to assist them to get to the hospital. In many rural areas there are not always available means of transport; transportation is bicycles, (which isn't the first choice for a pregnancy woman). It is difficult and dangerous to travel by night and during the rainy season the road condition is bad. In addition to the uncertainty of the time, the transportation problem makes it difficult for the women to reach the hospital before delivery.

Unfortunately, the women see the possibility of the church and the government to help them come out of the transportation problem and especially just when they are sick or during pregnancy. Some of the informants question this situation with a concrete reason when they were answering the question on if the transportation is a problem, and if they see any possibility that the church could help?

Informant 14, said that, *if the church can manage to have a number of hospitals, run big projects such as schools, universities, banks etc. it is also possible to have even a single ambulance to every district just to rescue the life of mothers and the babies who are walking long distance just to find the hospital.*

He continue saying that, *the church also can advise the Government to act on that. It is sad to see all ministers and many other government works owns most expensive cars and when we cried that we need transport at least to help the pregnancy women they send us a motorbike ambulance. Our roads are too rough, there is a lot of winds, sometimes rain; it is like they did not help; and for me is like to insult the women humanity whose these motorbike ambulance were exactly sent to help them. Again a sick person needs a health personnel but the*

motorbike ambulance can only take two passengers (the sick) and the driver. Sometimes the woman need confidentiality environment at the time of delivery, but in such motorbike ambulance no confidentiality. Although the women used it but it disvalue their humanity and some of the women refused to use it. (The Picture of the Motorbike Ambulance is attached at the Appendices)

5.2.7 Late Arrival to the Hospital

It has been observed that late arrival of the pregnant mothers in the hospital has been one of the biggest factors that cause mothers to die during delivery.

Nurse 1 says that,

Many pregnancy women are coming here at the last point. We can try our best to save them but most of them died. This is because most of them come while they had already lost a lot of blood and it has been hard to serve them. Others they are beaten and they hide it because is a shame and they do not come earlier for the check-up if they are injured. Again they know if they come with a case of been beaten by the husband, then the husband will be sued; also accordingly to how the society viewed it, it is a great shame for a woman to sue her husband in any circumstances. So many women in such situation hide themselves at home. On their late arrival, many reported a different case; they are not open to say they were beaten. They can report other stories like I fall down or something falls on me, all these is to protect their husband.

In insisting that late arrivals to the hospital as one of the factors contributed to the maternal death, another respondent, doctor 2 also says that,

These women know that hospital is important place when they see grave ahead of them. They come here while they cannot even express how they feel because they delay for a long time. Sometimes it's hard even to decide where to start as a doctor. This has been problem because as a doctor on doing investigation on what the problem is the patient could die. It is of a greater help if the patient come to the hospital as soon as she feels problem, because if she can explain a bit on how she feels it could easier the check-up process than if the patient is unconscious.

In addition to that, Informant 3 says that,

This is my first time to come to the hospital during pregnant, I had five children and I deliver all of them at home with the help of my neighbour who is a local midwife.

She continues to insist that, *I even not enjoy the hospital services as the one I use to get from home. Here I stay long so as to be attended, also they have a lot of questions and they don't have polite language. I even come here after having un-normal bleeding for three days.* It seems that, late arrival to the hospital is not always an accidental matter but because of the poor services at the hospital, it has been a last option. This affirms that, there is a problem at the hospitals. If patients opt to use traditional doctors while there are professionals ones, there must be a serious agenda behind it. Some has reported that, the language of the hospital workers has been so harsh and abusive toward women especially those who are pregnant, it has been well reported in the part of poor services as a factor which cause maternal mortality.

5.2.8 Women Workload

Many respondents argued that women workload contributed towards Maternal Mortality. Women in Tanzania have multiple roles and heavy workload and, therefore, do not have enough time for resting, self –advancement and recreation. This situation also affects pregnant mothers. Much of women's workload include bearing of children and their nurturing, taking care of the family, caring for the house, cleaning, cooking, keeping the animals, gardening, fetching water; and all other family chores. All these heavy workload results from traditions and customs or the marriage contracts stipulating that the wife must do all the work that is needed to save man, family members and children.

Doctor 2 says that

Sometimes we are forced to admit the pregnant women here not because they are sick or they need a medical attention; they come here and we recognise that they had not have enough time to rest which might be dangerous to their health. Many men in this area they cannot help their wife in home chores even when the wives are pregnant, many women overworked and the result is we have a number of miscarriage due to that. This is dangerous to women's health and especial pregnant women.

Informant 2 says that.

I always wake up before 5am and I had a time to rest after 11pm. My husband cannot even care that I am pregnant. I have to do all works at home. To cook, to clean, to take care the cows, pigs, chicken, fetch water, I carry firewood from the distances and a lot of other works

every day. I have to go to the market for food and other important shopping for the home use. If I fail to perform only one work, my husband slap me and he talk a lot, that I am a lazy woman. It is very hard, but I am a woman and that's the way of life here.

It is not easier for African women to choose what to do. She has to take care of all work at home. Men can choose to go out walking and take time for recreation but women cannot. Woman have to stay home working because the 'men' of the family or the husband or the parent will ask why all the home chores are not done well and on time. In this case, the division of labour seems to favour men and supress women. Simply, men do not want to work (especially domestic chores), which means women have no choice; they have to do all that men do not want to do at home and in society. Okoto observed how gender roles affect the life of women in Africa and she says that:

> In assigning roles based on gender, the theory of complementary plays a negative role for women in domestic ... allows a man to choose what he wants to be and to do and then demands that a woman fills the blanks. Generally, the woman has little or no choice in the matter; she has to do the rest if the community is to remain whole and healthy, (2006:94).

This kind of life makes women suffer; especially while pregnant and all works still is dependent on them. Some of the respondents also say that, some pregnant women arrive at the come to hospital dirty. It is not because they don't want to be clean, sometimes the labour pains started while she is still struggling to accomplish her duties and she could not even have time to take care of herself.

Nurses 4 says that,

We had a difficult time since most of women come here in a situation that the doctors cannot attend them since they are too dirty. The doctors told us to help them to be clean first. It is even worse that, many men cannot even help their wives to shower even if they are sick. They just say that women know how to help one another.

She continues saying that, *Last year a woman start a labour pain while she was cultivating her vegetables. She was having a lot of mud on her hands, legs and clothes, some neighbours saw her alone, lying down on the field and they helped her to get to the hospital. As we were washing her to be attended the woman stopped her breath.*

5.2.9 Early Marriage

Through interview and questionnaires many respondents suggested early marriage as among socio cultural habit contributing towards Maternal Mortality in the Chagga area.

The understanding of early marriage here is the situation whereby girls enter into a marriage contract below the age of 18. This situation does contribute to Maternal Mortality due to the fact that most of the women died because their bodies had not yet developed fully to handle the difficult of carrying the baby as well as the childbirth. This socio-cultural habit is very common, especially among the Chagga people.

My father was not interested to take me to school. Then my mother tries to help me with the school fees and some of other important school needs. Myself I was not happy with the conflict of my parents because of me going to school. Then I decided to get married when I was primary six with the age of 16 years. Now I am 24 years and I have four children.

Informant 3 was a woman if 17 years and she says that

My parents are very poor. We cannot have what we need at home so as to survive. Food clothes, education were really a problem. At the same time my parent were too drunkard. Why father always was insulting us; girl's children, what are you doing here, don't you see the men to marry you? This kind of life was not good. Home was not a favoured place to stay. So, I end up find myself a life partner and now I am married.

Another informant says that,

I was forced to get married after I know that I am pregnant. My parent, my neighbour my friends and even my school would not like to see me pregnant and I was not married. It was also hard for me to abort because also that is not allowed; I was worried if I abort and problems occur where will I hide my face? I was confused by a lot of questions and the last decision was to get married and to leave the school.

5.2.10 Poor Family Planning (*"every child born with his/her luck")*

The finding affirms that, some of the churches restrict their followers' use of family planning with the concept that it is not 'God's will'. Some of the respondents said that, poor family planning contributed to maternal mortality in Tanzania. They said that due to their church doctrinal, they are not allowed to use any contraceptives to prevent pregnant. Due to this kind

of teaching, many women cannot manage to plan when to conceive. They have to accept pregnancy as 'how God plan for them'.

Nevertheless, the socio-cultural pattern of the researched area is patriarchy, women do not have the rights to decide over the number of children, it is only men who have right to decide on that matter. This lead to maternal mortality as some women gets pregnant at an old age which is so dangerous to their health due to the fact that most of them experience problems such as labour complications.

Informant 9 says that "*It is sin to prevent pregnancy. And if I use any contraceptive my church will expel me. Even my husband does not like me to talk about contraceptives. He says God is the one who provide babies and we have to accept ii at any time he wants to give us. So I have to accept the reality"*.

Then informant 16 says that,

Why prevention! If your parent prevented you what would happen? We need to have as many children as how God will grant us. Every child born with his or her luck. Who knows the one you prevent would be the Tanzanian president. To prevent children is not our African tradition. We have to have as many children as possible.

5.2.11 Sexual Harassment

The research finds that, many women in Chagga conceived unwillingly. Most of them experience sexual harassment from their spouses. Due to the nature of where the study has been conducted, many women cannot say no to sex when her husband needs her for sex even though she is not ready for it. Sometimes the woman is forced to have sex on her conceiving dates whereby it is easy to fall pregnant. Nevertheless sexual harassment in the institutions and in the offices also causes unexpected pregnancies where by many girls conceived unwilling.

Doctor 1 shows that, "*many men are drunkard, meanwhile on their drunkard situation they are not ready make a consensus of having sexual intercourse with their wife, they just force it*. *From that experience, many women conceived without plan. Sometimes women having a young baby and she also exposed to that situation. So when she conceived the body is weak and the she is at the risk of her life during pregnant and delivery. Also, some women*

conceived while they're too old. These experiences touched women psychologically and physically, hence most of them died while pregnant or during delivery".

Informant 6 reports that, *I have a baby of six months, now I am pregnant four months ago, all this is because of the men who are dunk and they can't consider us women any more. They cannot hear anything we say but to fulfil their desire. Now he cannot help me, and if I die I die myself.*

Also one of the local midwives says that,

Women conceived when they're too old and they feel shame to go to the hospital. Most of them they did not plan to conceive, but because some men raped their wife without thinking what will happen, that always occur, a women of above 45 years to conceive. In that situation, the pregnant woman also afraid to go to the hospital because nurses also will insult her. So they prefer we local midwifes

Informant 12 reports that when he was explain how his daughter was ruined from having sexual intercourse for the promise of good result on her secondary national examination.

My daughter was in secondary school, few months before the national examination his teacher tell her to have sexual intercourse for the promise of giving her results for the coming examination. Then she conceived and it was shame for her with her 16 years to be pregnant. She decided to make abortion with the advice from her friends unfortunately she was not successful and we lost her in this way.

In addition informant 9 reported that,

I was looking for a job, my boss demand a sexual relation with me if I need to work in a good position. The boss was married and he doesn't like his wife to know me. I was not happy with the situation but I was forced to do so as to have a better job. As a result he ignore me after I conceived and I end up decide to abort. This was so hard because I did it locally since it was not allowed to do so. I was nearly to die but I was saved after a hard work from doctors.

There are different ideas brought up on sexual harassment as a cause for maternal mortality. Some women have been harassed sexually by their own husband and they conceived while too old. But also sexual harassment has been used as a means of corruption in schools and at work places. All these cause unplanned pregnancies. From unplanned pregnancy other things can occur such as abortions; where most abortions done in Tanzania, if not medically advised

are unsafe. Nevertheless, although the law allows safe abortion for unexpected pregnancy the cultural setup does not concur with that law. It has been reported that, based on the Centre for Reproductive Rights, (C.R.R) it is evident that mainland Tanzania's laws and policies are more expansive than most believe and the current legal and policy framework offers ample opportunities for increasing access to safe abortion services. (http://reproductiverights.org/en/document/the-legal-and-policy-framework-on-abortion-in-tanzania.)

5.2.12 Unsafe Abortion

It has been found that unsafe abortion is another cause of maternal mortality in the researched area. This is due to the fact that, most of the girls are afraid to be expelled from school and from home because of their pregnancy. It is also not normal to perform safe abortions due to the social setup and specifically the church beliefs. When girls conceive while at school from primary to high school level; automatically she is not allowed continue on with her studies. Also, it is shameful for her to be out of school because of the pregnancy. Because such situations, many girls use do abortions locally and most of them die. It has been my great concerned for the men who impregnated those girls where are they? Are they also expelled from school? Are they also having troubles within their families? The cultural setup considers it is the girls' fault. The school chased her, parents chased her, many people in the society point fingers at her; that makes many girls confused if they were in that situation. Boys are not counted on that. The study finds that most of girls are committing suicide due to this situation. Most of these deaths have not been reported as maternal death, this is because many of them occurred not at the hospitals, but rather at home or at the local doctors and it has been treated very confidentially.

Nurse 1 says that,

We have some reports of death due to unsafe abortion although not so frequently. Mostly we do not do abortion here unless it is medical recommended. So many do abortions illegally in a very local way and they can come here in a critical condition. So is not so easier to say this is big problem although it happens.

The social understandings also consider contraceptives as for adults, not for the teenagers, although many of the adolescents conceived because of the lack of knowledge and access of contraceptives. At the same time they hide and find local ways to abort. Together with this idea, Bhalalusesa, (2011) finds that, the pregnancy level among teens is much higher in

Tanzania and at the same time contraceptives are very prohibited for adolescents. On top of that, the report from informant 12 in the section on sexual harassment, whose daughter died, shows that, there are deaths that occur due to unsafe abortion.

5.3 How Does Maternal Mortality Affects the Life of The Society?

5.3.1 Encounter with Two Families Whose Wives Died Due to the Maternal Issues

It was of great opportunity that I was able to speak with the families whose wife and mother died during delivery. In one of the families, mother and her baby died, and in the other family, the mother died but the baby was saved. Both of the families expressed their grief of losing their loved one. The left husband confessed that, it was really hard for him to care for the children, though they were above two years. He complains that even to budget what to eat for a day was hard to him. He did not sleep for almost three months. The family economy has dropped. He saw everything in his family to be upside down; finally he decided to marry another woman where he sees life to be at least somewhat better. He says that "*it was not on my dream that one day my wife will left me. She was of much help to me and to my family, a thing that I understand more on her absence. He use Swahili idioms that "msiba usikie kwa mwenzio"* which literary means. *"It is not easy to get used to lose someone and especially the loved one"*.

However, in the Chagga context many men marry another woman when their wife dies, he too did the same. Although he married another woman, to him he says it is like he save one part but in another party remain a gap, this is because the children were moved to be cared by their grandmother. He moved them because the woman he married was not ready to care for those children. This situation pains him a lot but because he had to choose either a wife or children to stay with him and he decided to stay with the wife. The man also says that, he has to take care of her children at her mother's house by making sure they have food and other things to make them survive, at the same time he has to do the same in his home too. The situation makes him spend more than if the family was in the same house. This man says that, I did not understand the value of my wife when she was there. I was ignoring her most of the time she would talk to me about her health when she was pregnant. My perception is always women want to complain when they are pregnant. But after 9 months they get a baby safely. So I was not serious about her health. Now I understand how it feels, and how it looks like, the house without a wife. He also says that, I feel so sorrow because I cannot take care of my children

the way my wife was doing. Shortly, I will not miss my wife only but a lot of things in my life go in a way I do not wish.

The other family has a bit of a different experience. That is the family where the wife died and the baby was saved. So apart from condolences they have for the death of mother, the family also has another task to take care of an infant child and other children. Due to the social set up of Chagga people, taking care of babies is not male work; it is a female's work. The man says that, soon after the funeral he just looked for an orphanage centre where he can place his children. So, both of the babies are in the orphanage home centre. He says he just goes there once a month to visit them. He is explaining his sorrow in a way that he does not have someone to cook, to wash, to clean the house for him. He says a home without woman is dirty and disorganised. He uses a Swahili idiom which says that, "*nyumba ni mwanamke*" which means, "*Home is a wife"*. This is a famous saying in Tanzania which symbolizes that; woman has to take care of all the house work; washing, cleaning, and taking care of children, cooking, and much more. When looking closer to the explanation of the feelings of this man, it feels like he lost a machine, just property, something which was worked for him and not a life partner. This is not uncommon, but it is the way of how people live in this context; that the woman is there to work and toil for a man. This view is not far from that of losing a tin cover or replaceable thing as I explained above.

After this meeting with these families and having an informal conversation with them, I discover some important things which depict the effects of maternal mortality in Chagga society:

a. Increments of the number of orphans

b. Increments of street children

c. Lack of child care

d. Psychological torture for husbands and for the children

e. Lack of human resources, with a consideration that a woman is main producer at the family level.

5.3.2 Suffering of Children

From the findings some of the respondents show that, children have suffered in many ways when they do not have a mother. So the problem of maternal mortality extends to be a problem for the children in the society.

Informant 30 says that, *a number of babies suffered because of lost the problem of maternal mortality. Many of them are called orphans because their mothers are no longer there. The issue of taking care of the babies is a mother's task. So a number of orphans we have they have their father alive. But they cannot care for their own baby because it is not a male's work. Most of the children are taken to their grandparents were also the quality of care is not good. Men cannot cook, cannot wash, and cannot do shopping for his own children.*

Many women respondents say that, men can run from home and leave the children there. In this way, when a mother died, the children have to take responsibility for taking care of themselves. They cook, they fetch water, they wash, and do all other domestic chores. Respondent 4 say that "*it is impossible to depend on these kind men we have. When the mother dies it's difficult for the babies*".

Respondent 9 says that, *I am taking care of two children whose mother died. I feel like these children they have not a father. This is because his father is also needs my assistant for his daily survives. He cannot do anything to assist the life at home. Whenever he got little money, you will know by seeing him too drunkard. He can do nothing to assist the life at home. He is more than disabled.*

5.3.3 Dropping of Family Economy

Many respondents too show that, women are the main contributors to the family economy. This is due to the fact that little works at home gives the woman money to sustain her family with daily bread. From the interviews it shows that, many women work on their small garden where they can have vegetables for their family and the excess to be sold, and from that they can have some money for other family use. They also keep animals like cows, pigs, chicken where they can have milk and eggs but they can have a subsidiary and sell for other family needs. All this kind of works is women's wok so men cannot do for it is shameful to do a woman's work.

Pastor 3 says that,

Many families have a better life if the woman is healthy. Most women in our society are weak due to the maternal problem. It is worse when women die because many men if they are employed they just depend on their salary and they cannot do domestic works since it is seen as not respectable works, women works, and unplayable job. Many men are not responsible for their own home. Most of the family chores are merely known as women responsibility. In generally maternal mortality left some families in a highway life. They do not know where to start because they were not used to work while mothers can do everything. The mother is everything for the better life in family level and in society level at large.

In this line respondent 17 says that, *selling eggs, milking, taking care of children, washing cooking, and all other works at home, are women work. We men we are strong, strong to do those female works. If I find my son do such women works he cannot stay at my house. Those are girls work.*

Informant 13 says that,

My wife is everything here. When she comes from the market she can do the works that I cannot do for the whole day. Then she gives me money so that I can go out with other men. She is working and she is caring. I and my children are finished. She is everything to manage the life to move on here.

5.4 Contribution of the Church on Reduction of Maternal Mortality

This is central concern of this project; to assess the contribution of the church on reduction of the maternal mortality in Tanzania. The following are the findings through interviews and questionnaires about the contribution of the church on the reduction of maternal mortality. It was of a great challenge to collect data regarding the church and maternal mortality. Some of the informants see the positive contributions of the church but most of them feel that the church has done nothing to reduce the situation of mothers dying due to the maternal issues, but. Below are the views I got when asked the participants about their views on the contribution of the church to the reduction of maternal mortality in their area. The question was whether they think the church could do anything to reduce the maternal mortality.

Informant 10 says that, *the church built the hospitals where women's and other people can receive health services.* She insists that, *there is much that the church has done to help the life of mothers; to construct hospitals is not the work of the church if we would have a good welfare state. But the church constructs many more hospitals not only in this region but in the*

entire county, so as to rescue the life of mothers and others in the society. This is a positive focus of the church that's aim to help people physical too. Also the church educates doctors and nurses who are willing to save and to help women and all other people in the society.

Moreover, informant 22 also says that. *The church has a primary health programs which visits the families at their home and educate them about health issues. In this programme many families get education on health and especially the pregnant mothers. The primary health also teaches the families on many other health issues that are necessary for their general family health as cleanness so as to escape eruption diseases like diarrhoea and malnutrition. In this way the church has done a lot.*

The above ideas of the respondents implies that the church is doing something positive to help the pregnant mothers which will actually automatically reduce the number of mothers who are dying while pregnant or during the time of delivery. Their ideas also comply with the fact that the ELCT runs about 23 hospitals and 150 healthcares which corresponds to 15% of provision of Tanzanian health services. (http://health.elct.org/)

Then, informant 7 shows that, *the church is preaching on Gods loving and care. But its teaching is too theoretical. I don't see the real love among Christians whom we are a church member together. The church has to have different direction to deal with the problem we woman get from the way men treat us. We are like slaves, and the church knows, we are treated like we have an extra power that helps us to work. We are worthless, valueless, unrespectable creature. But the church is quiet. Imagine working like a slave while pregnant. Many women are dying because they tolerate working while they are very sick; men are exceptional creatures here. They are just there to direct women what to do but for them they can't do it. Unfortunately all of us men and women we belong to the same church.*

On the same line the other informant points that, *the church is failing to tell the truth. The truth about the difference we have; women and men. The focus of the church is not differing from that of tradition one that's why women are suffered everywhere, no relief even from the church side. If the traditional setup forces the woman to work hard the church do the same. So the church has not contributed enough especially on the social norms that leads to the maternal death.*

Some of the informants 2, 16, 26, 33, 36, 39 also show that, *the church focuses more on other issues but not directly on the lives of mothers who bring new life to this world. To have a*

hospital is one thing but to have qualified doctors and enough facilities that is another thing. The church has to improve the quality of services in their hospitals so as to help mothers who are dying daily. These informants show that, the church should be direct, specifically on the issues of mothers who dies and left their children suffering. And this can be done by having a specific goal to women in every way. Teaching the society to change its behaviour, having enough doctors, reaching those who are in the very interior of the village and be a role model in everything predominately with the purpose of ensuring mothers feels safe, physically and spiritually, in the hands of the church.

Some informants 19, 28, and 41 also show that, *the church is still silent on traditional issues which contribute to maternal mortality. The people who are too rigid about traditional the women's status, role, and dignity are also church members. Some of them are even leaders in different positions in the church. They see how women are dying because of different aspects but mostly the mistreatment they get from this patriarchy society. The church has to change its attitude on that of the traditional setup if it wants to focus on helping the women and especially to reduce the number of those who die due to maternal related issues. Most women are beaten; others are forced to sleep outside as a part of a punishment from their husband. In this situation, the church has done nothing*

Informant 2 and 8 says that, *the teaching about contraceptives as a sin against God is a big problem. Many women are conceiving without planning because they are abiding by their faith on the issue of contraceptives as a sin. At the same time, women are thought to respect their husband, so they cannot say no for sexual relationship even if she knows she will conceive and while she has a very young baby.*

These respondents provide information that can be divided in to two ideas. The first idea is that the church is not helping the woman and especially the pregnant woman on the question of social cultural patterns that affect them. Their view is that, the church is working side by side with the patriarchal social setup that has been for a long time seen as a cause of maternal mortality, although it is considered mostly an indirect cause. But the other thing from these informants is that, to merely have hospitals is not enough, the issue of quality care is more important. To have a number of hospital buildings without qualified staff, medicine, and all other facilities that are needed in a hospitals, is not important. Therefore, generally they see that the church has not contributed much to reduce the problem.

On the same line, Informant 4 shows that, *the church has to teach the society the proper way and not lie side by side with the traditional beliefs. It is difficult to say these are the traditional practices and these are the church practices. On the other hand the church is afraid to lose its members by telling them the truth. I say this because we can't get a proper answer when we take our concern to the pastors. My husband do not like to do any kind of work at home, he is drunkard, when he come home he is more than lion, he can beat me and all of my children, he don't care on my situation even if I am pregnant, he just say if I die there are lot of women to marry. I take this concern to my church many times but nothing has been changed. My pastor told me to be humble and respect my marriage. It is true to respect but sometimes it is dangerous because we can't replace our life. When we die the church enjoys conducting the burial services and say it's God's will. To me, many women's death due to maternal issues are human will not God's will.*

Moreover Pastor 3 says that, *the church might think that it is not its responsibility to save the life of mothers who are dying because of hardship in giving birth. But the church as a spiritual and physical healer starts from the time when Christianity was introduced to Africa. That is why mostly wherever you find the church there is also hospital or school. If in those days the missionary saw the need of taking care of people spiritually and physically why not today? We bury the woman who died when giving birth, but when looking at the cause behind it, most are related to the negligence the woman received either from her family or at the hospital. Can the church still be silence on such situation? Generally I want to say that, the church has to take its role as a caretaker of its member in every aspects of life. Women suffer and die. Men should be taught to work hard and the church can do it. Men can also think to love and care their wives. The church can also teach the importance of taking girls to school and to avoid exposing them to child marriage. All these may help to reduce the death of mothers in giving birth.*

Pastor 1 insists that, *it is easier for the church to organise the seminar that would educate the member of the society on how to care pregnant women. I say this because the church has all opportunity to do so. There are lot to tell the society about women's care. Women are working above their ability, women are beaten, women are not respected, and women are valueless in all aspects. In such situation there is no need for the church to go on looking and be quiet. She also suggest that the church can organise seminars to discuss the problem and to suggest ways of solve it. The church also can have marital seminars that can also teach on the importance of care as a wife and husband, the importance of helping each other in the*

family, the importance of work together. As I understand these and many more are the work of the church.

The three respondents above point out that it is the responsibility of the church to take care of the pregnant mothers in all their surroundings. They believe that the church can change the social attitude of people in the society where it works. They are aware that not all things that have happened to them and the society are of God's will. They see the church as hiding the truth. This is to say the church cannot only praying while pregnant mothers are dying, but it should also take some initiative actions toward reducing the problem.

In assessing to the contribution of the church on regarding the reduction of maternal mortality, the ELCT leader 1 shows that,

We have the centre for those babies whose mothers died while delivering. This has been our concern and we started from there. We have hospitals that those pregnant women can attend. These are our contributions as the church.

Then ELCT leader 5 says that:

Its real we had a lot of projects but unfortunately we had never thought on such projects. We have seen pregnant women are died but we focus more on the left children. It is a challenge to us now we had to think about saving life of those mothers too. There is a various ways we can approach that and I think we can make a difference on that.

The respondents from the church office take a consideration of having an orphanage centre as a starting point on addressing the problem. Also, having hospitals that the woman can attend as their contributions. But also they show that they have not yet focused directly on serving the pregnant mothers. This is indication that there is something that has to be done by the church so as to rescue the lives of mothers and their babies.

5.4.1 Women in the Church and Maternal Mortality

It is obvious that, many women expect the church to be against the culture that oppresses subordinates and weakens them and instead of help them to enjoy life in an equal society. Instead, they have seen that the church still walks together with the culture that oppresses them. In supporting this idea participant 8 says that:

Is it that the church does not see the way women are dying because of the surrounding environment? If a man beat a pregnant woman and the woman dies, still the church

continuing to be silence and accept that man as a church member; what is the expectation? The church is still preaching the gospel that favour men and kills women. This made women to have no place they can have relief to share their experience. If there is guiltiness on burying a number of women, we would have seen the difference, but the church fears to lose men as their members for telling them the truth.

Another respondent from informant 16 was that*:*

The church can help women if it takes her responsibility seriously; but because it favours men who are the warriors in this society, then it has been silent on the issues of women and maternal deaths for generations. When we complain about maternal death it is because the women has no one to care them, even the church opt to care for the burials only and not to save lives.

To support these ideas some literature has discussed on how the bible has been used in a patriarchal society to facilitate the system rather than to help women who suffer from oppression. Although they did not talk directly about maternal issues but generally I will view it in the eyes of a maternal perspective.

Pemberton (2003: 126) argues that all women in a patriarchal society suffer violence and oppression of many kinds that is legitimized by both religions and societies of which they are part. Religions sometimes oppressed women by applying some biblical patriarchal traditions. To support this view African feminist theologians like Oduyoye and Kanyoro (1992) state that women have been oppressed by biblical traditions, which has a patriarchal setting. In Africa women have been made quiet by a patriarchal system.

In supporting this Fiorenza (1993:315) affirms that,

> "Since the political and religion right recognizes that women's anger and fear constitute a potential revolutionary force when directed against patriarchal institutions, it manipulates these fears by quieting and redirecting them. They then employ biblical religion to inculcate the subordination. Women can fulfil their feminine vacation by living the ideal of true complementarities".

Fiorenza (ibd) added that a patriarchal system has also been influenced by the African religion which is tied with its culture. As Oduyoye (2001) says that "*It must never be forgotten that culture and religion are significant within African life that neither Muslim nor Christian in Africa can be totally free of the values that emanate from the traditional African Religion"* (Oduyoye, 2005:12) In understanding the experiences that African women went through she has this to contribute; women oppression is not only practiced in African religion but also in

Christianity through biblical interpretation and Christian theology as Oduyoye (2005:12) argues that: "*Unfortunately, Biblical interpretation and Christian theology in Africa have had the effect of marginalizing women experience"* Oduyoye (ibd) she further says that the Bible reinforces the traditional socio-cultural oppression of women, and Christianity has converted the African people to a new religion without converting their culture.

In Tanzania, most women are experiencing all the aforementioned torture and suffering which are influenced by a patriarchal system. It does not matter when or at what situation the woman experience these kinds of hardship in life: all of their life they are living by being oppressed and ignored by the social setup which favours men and forget the humanity of women. In that sense, when a woman is pregnant, men and the society neglect and ignore her, she continued to work hard, sometimes she does not have time to go to the health care or she is not allowed to go. Not only that but women are beaten while they are pregnant, they conceive when they are not ready due to sexual harassment, they are not free to prevent pregnancy by contraceptive means because of the notion that they have to have many children because every child is born with his/her luck. Those issues and many more have been killing women, especially while pregnant or during delivery or some days after delivery. In the midst of this kind of social setup, there is a church that preaches the righteousness of God.

5.4.2 Societal Expectation from the Church on the Issue of Maternal Mortality

In the way the respondents present their views, many depict the church as supporting agent in any suffering situation. Many of the participants in this research have seen the church has lost or will lose direction if the issue of a suffering society will not be its priority for bringing true liberation. The whole community expect the church to transform the situation; at the place where there is oppression, the church has to talk about liberation and act upon it so as to set the society free. The knowledge that the bible brings to the society is the service to the people. In that sense, it has puzzled many when they see the church that preaches the righteousness of the God to go on being silent in the cultural pattern which is causing women to die.

Society also expects the church to stand up for women in the midst of a harmful culture that idealizes men and exploits, ignores and subordinates women. In such a view, the work of the church would focus on the life of women and what they experience with the main agenda of setting them free. Since women are dying due to maternal mortality the society expect the church to be the first to see the situation and to act upon it in a way that will serve the interests of women.

Many in the investigated society again would prefer the church to tell the men the truth of loving and being kind to all people of God, including women. This is because if all men would know the love of God, they would stop undermining, disvaluing and to subordinating women. If that could be the case, then the women who are experiencing torture and hard life leading to death during pregnancy and delivery could survive.

5.4.3 Pregnant Woman in Dilemma

Form all the findings; I believe that the women in the Chagga society and similar societies are in a great dilemma. It has been difficult to find where they can find relief. I have seen that, many women conceived not with their willing but the husbands, yet he is not responsible, nor does he care for or understand his wife. Again, the churches, and social settings ignore women who conceive without being officially married, yet, the church and the society does not accept abortion or contraceptive for the teenagers, which are the group most affected by unwanted pregnancies and unsafe abortions. Pregnant woman are beaten by their husbands, yet still the church force her to obey the husband and the social setup is framed in such a way that it is a great shame to sue your husband. In the health centres the woman are insulted, and treated harshly, but still the woman are taught to be humble and tolerating so as to cope up with the Chagga social status. In this situation many of pregnant women suffered and most of them die. They are surrounded by difficulties in every corner of their lives. When they turn their eyes to the church, the church is less concerned with them and what they experience; rather the church is protecting men by telling the women to obey and not to argue with men because it is shame for a woman to talk about her husband, especially in a negative way. Most of the women are in dilemma because of such surroundings. During the interviews, I realised many of woman have been psychologically affected due to the difficulties they have been through while pregnant.

5.5 Summary.

The findings and discussion have been well placed in the fifth chapter. The aim has been to reveal the reality, the facts and the experiences that pregnant women go through in Tanzania; which have been as a catalyst for maternal mortality. The following sub title was discussed under this part; the situation of maternal mortality in the researched area, pregnancy as a woman issue, women as a replaceable tin cover, beating of the wife, poverty, poor health services and palliative care, poor means of transportation and geographical isolation, late arrival to the hospital, heavy workloads, early marriage, poor family planning with the believe

that every child comes with its own lack and unsafe abortion. All these findings have been discussed with the core concept of a patriarchal social setup in the researched area, which has been used to dominate women and privilege to men.

Again this chapter presented the effects of maternal mortality in the researched society, whereby the major findings shows that, there was an inner grief and pain in the life of the remaining family members, suffering of the children and dropping of the family economy since the women are the main producer in the family. Again, the chapter addressed whether the church could do anything to reduce the situation of maternal mortality. The following have been seen as a main point in this area; women in the church and maternal mortality, societal expectation from the church on the issue of maternal mortality, and pregnant woman in dilemma. The next chapter, I will conclude and present my recommendations for the whole work.

CHAPTER SIX

6.0 Conclusion and Recommendations

6.1 Conclusion

This work was about the facts and experiences that Chagga women experienced during pregnancy and childbirth. The great concern was to discover whether the church can do anything to overcome the situation. In order to reach the goal, I started by introducing my own experience and motivations for this research as a concerned mother and as a pastor. Also in the introduction part, methodological issues have been stated which bring clear information on a qualitative research procedure from the field work moment to how this work have been organised.

The major finding in this project was that the issues concerning pregnancy, child care, and domestic chores has been left to women while men are unconcerned with these roles. It has been a long term burden that women experience during their life time and many have died without finding a resolution. The social setting has been too patriarchal to the extent that it offers more opportunity to men and ignores women; suggesting they are worthless to the society. This is to say patriarchal system has been a motivating factor for maternal mortality in Chagga and similar context.

On top of that, the findings show that, the society is affected in a different ways due to the maternal mortality situation. In fact, women have already accepted it as part of their life, whereby if a woman is pregnant, it is as if she is already resigned to the possibility of death while life come as only a privilege or a gift. On the other hand, the children suffer due to the lack of maternal care. Again, since the women are the main producers in the family and social economy, then maternal mortality causes the decrease of the family's social economy.

Together with this the church shows no much contribution to the reduction of the maternal mortality. Very little have been done by the church in the situation of maternal mortality at the study area. Even in other areas, the church has been quiet on the issue of maternal mortality. There are no literature that have been written directly about maternal mortality as a church concern. This has been evident from the findings that, the church shows interest in the result on maternal mortality; that is the establishing an orphanage centre and not to deal with why orphans. In one way or another, the establishment of an orphanage centre in the area where mothers are dying because of pregnancy and child birth, without considering serving the life

of mothers first, is another way of implementing the growth if the issue. Above all, the society's hope for the church on the issue of the maternal mortality situation is quite different from what they received back. The society expects the church to be strong in telling the reality and to break all cultural barriers that make women suffer; instead, the church is silent and it side with the patriarchal social setup which has been driving factor that causing women to die during pregnancy and during delivery. Therefore, the following are my recommendations.

6.2 Recommendations

In this part I have suggested that, in order to break the social silence on the issues of maternal mortality, we must implement a new meaning of church roles toward this problem. In doing so, my recommendations will be based on what needs to change within the church so as to save the lives of mothers, specifically in the light of the findings that have been presented and discussed in chapter five above.

I agree that, the changes takes time but it has to be started and stimulated in order to achieve what is intended. From the presented data, critical discussion and theoretical considerations in previous chapters, there is no doubt that many women, not only those who are recorded, but also a number of others who have not been recorded are dying due to maternal issues. I feel obliged to take the question of maternal mortality in relation to the church mission to a point where each church/ each religion has to take a stand.

First, the church has to be the voice of the voiceless. Considering the situation and the position of women in the study area, the church has to speak for them. This will force the society to be aware and to understand the value, dignity and respect of women and their contribution to the development of the church and the society. This can be done in different ways, such us by promoting and valuing the work that women do in the church and in society at large. Then it can also be addressed during different seminars and sermons in the church. Again, since it is normal to have the pre-marital teachings when the couples opt to officiate their marriage in the church, the teachings can be made in such a way that, the man will understand the value of his wife.

Secondly, the church has to resolve the big problems, not just the little ones. The church should see the reason for having a number of orphans to the extent of establishing the orphanage centre is because many women are dying, and children lack care. I consider the orphanage centre as a very important agenda, but due to the reason of establishing it, and due to the nature of where the research has been carried out, the orphanage centre seems to me to

be small problem. This is due to the fact that, the orphans are the result of losing their parents. Unfortunately in data presentation we have seen that, the child can be entitled as an orphan because only a mother has died. This is because the question of child care is upon the women duties, not the duty of men. In such situation it is to say that if the child misses a mother, it means the child miss a parental care. Then, the big problem, which seems to be escaped by the church, and also seems to be as the reason for a number of orphans, is the issue of maternal death. So again, my concern is for the church to deal with the rescuing of mothers, and saving the women's life. This automatically will reduce the number of orphans but will produce greater care for the children and to the society at large. This can be done in many ways. I prefer to bring forward one way in the form of a challenge to the ELCT, Specifically Northern diocese that, if the diocese can own schools, banks, hospitals, different care centres for elderly and orphanage, why then should it not engage more in the issue of saving the life of mothers who are innocently dying while trying to bring new life in to the world? From within the church, I can see the possibility of having good services for the pregnant woman and save the women's life starting within their hospitals by using qualified staffs and facilities. The workers at the church hospitals can also be well paid to make them satisfied with what they get from being employed by the church. This is to say good payment will result in a good service as findings show poor payments leads to poor commitment and poor services among number of doctors and nurses.

Thirdly, the church can establish advocating groups for the problem of maternal mortality. The advocating groups can focus on both men and women who acknowledge the problem so that they can act as a catalyst for promoting behavioural change in the society. Although the findings in a large part show no care, no sympathy and no understanding from men to women during the pregnant period, there are some who are very responsible and acknowledge the problem. This can be done by empowering such people by giving them education and they can advocate in their day to day life as they are interacting with the other members of the society. It is my suggestion that, this can be as a point of departure toward bringing change and awareness of resolving the issue of maternal mortality.

Fourthly, the church has to focus on the church/pastoral ministry. When looking at the findings more closely, the church is supporting the cultural understanding on the issue of maternal mortality. That has been seen as a result of being silent on the issue of maternal death. This is due to the fact that, the church fears to lose members when it speaks the truth. That has been a reason why the church is silent in the midst of oppression, subordination and

killing of the women. This has never and would never be the calling of the church. The church at any cost, has to speak the truth and to rise up the liberated society, to take spiritual and physical care of its member and the society in a broader sense.

Fifthly, the church has to give education to the society concerning how maternal mortality can be reduced. This can be applied differently depending on the context. In the context where this study has been carried out the church has been acting as a medium of instruction and information giver to the whole community. The government leaders at different levels use the church leaders to give information to the community. This is because the highest amount of people attends the church mass every Sunday. At the church mass people are settled and communication is easier. This shows that the church can use the same opportunity to educate people about the problem of maternal mortality, which will slowly help the member of the society to value, respect, care and understand women especially during pregnancy and delivery periods. It will also help men to take responsibility while their wives are pregnant. This will start slowly but as time goes by it can change the social landscape of the Chagga society and all other similar societies.

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APPENDICES

1. List of Questionnaires and Interview Guides

A. To the Medical Officers, Doctors and Nurses

1. Sex.....
2. Marital Status (01) Single (02) Married (03) Divorced ( )
3. Are there any clinic services for the pregnant woman in your centre?
4. If yes, are there MCH services? .....
5. If yes, how many times do you provide MCH services in a week?
6. (01) Once (02) twice (03) third (04) fourth (05) More than four times ( )
7. How can you assess general attendance of this service?
8. What are your views in relation to responses of attendance to the MCH services? …….
9. Is health education provided to the pregnant mothers?.....
10. How do you evaluate the education offered?
    (01) Very appropriate
    (02) Appropriate
    (03) Inappropriate
11. This as a church's health centre, do you think the church has do anything to improve the situation of MCH?.....

12. Is there any death that occur in this centre due to maternal issues?.....
13. If Yes, What are the main causes of the death? .....

B. Individual Men

1. Age.....
2. Marital Status.....
3. 4. Do you practicing family planning (01) Yes (02) No ( )
4. What is your perception toward family planning?
5. 6. Have you ever heard about mothers' death during delivery period? (01) Yes (02) No ( )
6. 7 If yes, what were the causes.....
7. How many meals does your wife take during pregnancy? .....
8. What kind of food do you think should be taken frequently? .....
9. Does you get nutrition education for your wife when she was pregnant? .....

10. Who do you think should provide nutritious education? .....
11. Do you see any necessity for you to have education on pregnancy and delivery? .....
12. Can you explain briefly your opinion concerning death of mothers during delivery? .....
13. Is there any kind of food prohibited to be eaten by pregnant mothers? .....
14. If yes, what can you say about such prohibition? (01) Cultural and taboos (02) Medical ( )

C. Individual Women

1. Age .....
2. Marital Status .....
3. Occupation.....
4. How old were you when you had your fist pregnant?.....
5 What kind of food do you mostly prefer during pregnant period? .....
6 Why do you prefer such food? .....
7 Do you attend clinic during pregnant period? (01) Yes (02) No ( )
8 If yes, how many times do you (01) once (02) twice (03) three (04) four (05) More than that
9 What can you say about the service you got in the clinic (01) very good (02) good (03) poor ( )
10 What kind of services would you like to get during pregnancy?
    a. From your partner.....
    b. From hospital.....
11 Is the services you got satisfy you? .....
12 What do you say about the services you get from hospital? .....
13 Do you know any danger sign for a pregnant woman?
14 What is the relationship between you and your partner during pregnant?
15 What kind of work do you do while you are pregnant?
16 Where else do you attend to get health services apart from hospital?.....
17 Have you heard any woman died because of pregnant related problem?.....

Interview Guides

A. To the ELCT-ND Officers, Pastors and Primary Health Centre of the Diocese

1. Position
2. What is the church doing to help people who are in dangerous situation like sickness?
3. Why the ELCT established a number of hospitals?
4. How did ELCT manage to get the facilities for the hospitals?
5. How do you employ workers there?
6. Is there any motivation they got by working with the ELCT?
7. Do you have enough and qualified workers in all departments?
8. Do you think there is a problem of mothers dying during giving birth?
9. If yes, can you say why those dearth occurs?
10. Are there any social cultural patters you think is contributing to the problem of maternal death?
11. If yes, can you briefly mention some?
12. Do you think the ELCT has already done enough to overcome the problem of maternal mortality?
13. What else do you think that the ELCT can do to reduce the risk of mothers who are dying because of maternal problem?
14. Do you have anything you want to say that can contribute to show if the church can do anything for the reduction of maternal mortality?

B. To the Local Midwives

1. How do you feel to attend pregnant mothers in your area?
2. How often did you receive pregnant cases?
3. Where did you get training on how to attend pregnant mothers?
4. How long have you been doing this job?
5. What problem did you face during attending pregnant mothers?
6. How do you overcome/solve those problems?
7. Is there any death occur while helping woman during pregnant and delivery period?
8. If yes, where did you report those cases?
9. Do you get any payment for such a huge work you are doing?

C. To the Elders of the Society

1. Do you have more than one wife?
2. How do women be treated according to the Chagga norms?
3. How many children do you have?
4. Can the women remarry in case her husband died?
5. How about the men?
6. How do pregnant women be cared/treated in this society?
7. Is there a problem of women who are dying due to the maternal problem?
8. What is the status of men and women in your society?

2. Motorbike Ambulance