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The Hakuna Kama Mama Project: Producing Technologies of Resistance to Maternal Mortality in East Africa

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Abstract

Giving birth can be a life or death matter for many pregnant women. As a consequence of the high rates of maternal death in many countries, death in childbirth has come to be understood as an unfortunate yet accepted part of the contemporary maternal health landscape. Globally, the high rates of maternal death comprise many overlapping historical and systemic features that are not always easy to disentangle. Adding to the complexity are entrenched approaches to maternal mortality that tend toward one-size-fits-all strategies, approaches that minimize or erase the specificity of local and regional differences. This trend is problematic as Western biomedical approaches often demand that women perform assigned roles and operate under systems not of their own control or making—ignoring long histories, behaviors, and cultural beliefs that have preexisted this moment and have supported women’s authoritative knowledge. As an intervention into this landscape, this discussion introduces an ongoing project, Hakuna Kama Mama (HKM), which expands dominant framings by populating the healthscape with localized understandings of maternal health because African women are often regarded as the objects of expert knowledge rather than the subjects of their own stories. The HKM project centers upon the participants’ subjective perspectives of motherhood in their daily lives because they are knowledgeable subjects who desire to be seen as capable, responsible experts—as mothers and hard-working contributors to their community.

Keywords

African feminisms, PhotoVoice, Maternal Mortality, East Africa, Resistive technologies

Introduction

In a piece of Tanzanian folklore, a mother tells her children: “I am going to the sea to fetch a new baby; the journey is dangerous and I may not return.”

Giving birth can be a life or death matter for many pregnant women. As a consequence of the high rates of maternal death in many countries, death in childbirth has come to be understood as an unfortunate yet accepted part of the contemporary maternal health landscape. Yes, childbirth can be risky, yet most maternal deaths are preventable. There have been many efforts to understand and reduce the high rates of maternal death in communities across East Africa—and there have been some declines (Banda et al. 2017; Bwana et al. 2019; Fathalla 1991; Magadi, Zulu, and Brockerhoff 2003; Lund et al. 2014; Mlay 2013; Shija, Msovela, and Mboera, 2011; Shoo et al. 2017). However, “maternal health remains a serious global challenge in spite of decades of advocacy and investments in improving access to maternal and reproductive health” (Chi and Urdal 2018, 1).

Globally, high rates of maternal death consist of many overlapping historical and systemic features that are not always easy to disentangle. Adding to the complexity are entrenched approaches to maternal mortality that tend toward one-size-fits-all strategies, approaches that minimize or erase the specificity of local and regional differences. These approaches tend to be predominantly informed by the Western, largely male, biomedical establishment which relies on types and single normative models. This trend is problematic as Western biomedical approaches often demand that women perform assigned roles and operate under systems not of their own control or making—ignoring long histories, behaviors, and cultural beliefs that have preexisted this moment and have supported women’s authoritative knowledge (as midwives, attendants, and mothers-to-be) (Hodgson 2017; Maoulidi 2011).

Further complicating this terrain are well-intentioned interventions that tend to mirror the politics and economic interests of international development, which may be at odds with community needs and interests (Tong 2000). For example, dominant biomedical framings of maternal mortality in East Africa tend to overemphasize changes women must make in order to reduce maternal mortality. Many popular interventions encourage women to give birth in a hospital setting, but this advice all but overlooks the complex and rational reasons behind women’s choices not to give birth in medical settings. As such, understandings of maternal mortality are most commonly presented in terms of ratios, rates, or numbers. While these data are important as public health indicators, they fail to reflect important dimensions of the problem. How might we begin to advocate for understandings of maternal death that also include biocultural processes, that connect the epidemic of maternal mortality with larger issues of structural and epistemic violence and colonialism?

As an intervention into this landscape, this discussion introduces an ongoing project, Hakuna Kama Mama (“There is no one like/none other than mama”) (HKM), which expands dominant framings by populating the healthscape with localized understandings of maternal health. The HKM project was introduced in Zanzibar in 2014 as a creative intervention, connecting the work of the Tamasha la Nchi za Jahazi (Festival of the Dhow Countries) or the Zanzibar International Film Festival (ZIFF) and their Panorama programing (described herein). The project was the result of years of collaboration with various organizations, institutions, and individuals in the United States and Tanzania. In other words, HKM emerged out of relationships of trust and reciprocity over several years, many conversations, and many mistakes, which are central to successful collaborative, social justice–oriented research.

Zanzibar is a semiautonomous region located 75 kilometers off the coast of mainland Tanzania in an archipelago in the Indian Ocean. Zanzibar is made up of sixteen islands, and the two main islands are Unguja and Pemba. HKM was offered in Nungwi, a community at the northernmost tip of Unguja Island. Tanzania experiences high rates of maternal mortality, which at the time of the workshop were estimated to be at 454 deaths per 100,000 live births (United Republic of Tanzania 2011) (compared with nineteen in the United States, but as we know, these numbers are much higher for black women; Villarosa 2018). Nungwi, the location of the HKM workshop, experiences some of the highest numbers in the country.

To populate the maternal healthscape with a more comprehensive accounting of the barriers to motherhood, the HKM project foregrounds African women’s collective knowledge production as a cornerstone in understanding maternal death—as derived from the collective research practice of Photovoice (PV). The practice of PV, through a community photography and storytelling process, has resulted in the production of various media. These localized understandings form what I term technologies of resistance.

Drawing on examples from the HKM project, this article seeks to address the following question: How might resistive technologies, as produced by women in the communities most deeply impacted by high rates of maternal death, allow maternal mortality to be differently understood and approached? In this article I outline the case for what African feminisms and feminist approaches bring to the study of maternal mortality, especially in African contexts. I do so by first providing a brief overview of the HKM project, its methodology, and its methods, then I analyze select HKM materials. I conclude by asserting the significance of women as media creators by highlighting how this approach demonstrates the limits of top-down medical approaches in fully addressing maternal mortality.

Theoretical Frameworks: African Feminisms

To think through the many entanglements that make up the maternal health landscape in East Africa, one must, as Nigerian feminist scholar Oyeronke Oyěwùmí (2011) states, “start with Africa” (p. x). In this case, the project starts with African women and African feminisms. It is important to note, however, that African feminism is not monolithic; rather, it is dynamic and fluid (Akin-Aina 2011; Decker and Baderoon 2018; Lewis 2001; Makana 2018; Mbilinyi 2015; McFadden 2005; Mikell 1995, 1997). Nigerian feminist scholar Obioma Nnaemeka (2004) argues that one must speak in pluralities when talking about African feminism because it represents a diversity of approaches, standpoints, and theories emerging from the specificity of localized contexts, historical forces, and cultural imperatives, which can be at times conflicting and at other times complementary and supportive. Furthermore, as Amina Mama suggests,

> Feminism in Africa is extremely heterogeneous as it bears the marks of having been forged in quite diverse colonial contexts (British, French, Portuguese, Italian, Belgian, Spanish), and influenced by a multiplicity of civilizations, Islamic, Christian and indigenous, before being further shaped by an array of anti-colonial and nationalist movements. Since independence, feminism in Africa has been diversified by the range of political regimes (from multiparty, state socialist, capitalist, civilian and military dictatorships), not to mention the influence of the Cold War, various conflicts and other forms of instability. (2011, e5)

These descriptions of feminisms in Africa provide the rationale for adopting these theories when considering an expanded accounting of maternal mortality, one that centers the intersectional lives, experiences, and well-being of African women. Although there is limited literature on postcolonial feminist approaches to nursing research in Africa (Anderson 2000; Anderson and McCann 2002), African feminist perspectives are still underutilized.

Methods

African feminist standpoint theories advocate theorizing from the everyday lived experiences of marginalized women to make visible the barriers to motherhood as understood by the community that is experiencing a higher than average number of maternal deaths each year. Building on this framework, the HKM project is a community-based descriptive exploratory workshop in Zanzibar conducted using a qualitative research approach to explore the barriers to safe motherhood as envisioned by the participants. The goal of the workshop was to envision the barriers to safe motherhood as seen by those who live with these challenges daily, because most normative approaches rarely start with the knowledge or experiences of those most impacted by this epidemic. Further, the HKM project and the analyses of the media created by HKM workshop participants drew upon these theories to better explicate the complicated narratives that the participants generated.

In order to build this knowledge and access women’s rich experiences with motherhood in the HKM workshops, we adopted the PV method. PV is a participatory action research method (Mejia et al. 2014; Pérez et al. 2016) that emerges from feminist standpoint and situated knowledges on the premise that people are experts of their own lives (Alcoff 1991–1992; Collins 1990). The PV method employs photography and storytelling to raise critical questions and to address issues of power imbalances in research (Catalani and Minkler 2010; Graham et al. 2013; Molloy 2007). In communities grappling with historical inequalities and overlapping oppressions, observational research by outsiders can significantly skew findings, and this can lead to inaccurate views of a community, its assets, values, and needs. Using the PV methodology allows participants, through the use of cameras, to take photographs that raise critical questions through photographic techniques and community storytelling (Gubrium and Torres 2013). In the context of HKM, the participants used PV to define how they wanted to be represented inside and outside their community and country (Wang and Burris 1997). Such an approach might enable us to address more thoughtfully the issues of equity and structural, as well as epistemic, violence in maternal health care.

Reflexivity

Feminist researchers Richa Nagar and Susan Geiger (2007) argue that “rather than privileging a reflexivity that emphasizes a researcher’s identity, we must discuss more explicitly the economic, political, and institutional processes and structures that provide the context for the fieldwork encounter and shape its effects—an aspect that has often taken a back seat in reflexive exercises” (269). To model this, I provide a brief overview of the HKM collaborators and the larger nongovernmental organizations (NGOs) that provided the structural support necessary for the workshops. The HKM team included myself and ten students from my institution in the United States; thirteen members of the Mikunguni Youth Development Organization (MYDO) in Stone Town, Nungwi, community members, and another Tanzanian artist; and the Women Panorama coordinator and four Women Panorama staff.

As a multiethnic, North American–based, transnational, feminist womxn scholar with expertise in East Africa (Swahili language training, Fulbright Scholar in Tanzania, mother to two Tanz-American children, difficult childbirth, Muslim) who had witnessed many missteps (if not outright failures) of small and prominent NGOs—many rooted in misconceptions of gender, religion, culture, language, colonialism, and disciplinary boundaries—including my own, I was privy to many conversations about alternatives to status quo approaches to maternal health. It is important to note that at the time of these early conversations Tanzania and Zanzibar in particular were not on target to meet the Millennium Development Goals (MDGs) for reducing maternal mortality rates. Many resources (financial and otherwise) were being funneled into existing programs to assist in reaching the reduction targets and into programs and ideas with no past proven success or that had been inadequately assessed. It is in this context that this project was co-conceived, and a proposal was submitted to the ZIFF Women Panorama program for a workshop related to maternal mortality. The mechanisms for funding this workshop included direct support from my home academic institution, student donations, the Mikunguni Youth Development Organization (MYDO), and ZIFF Women Panorama program funds. Together we mutually agreed on a budget and who would cover what aspects of the budget and how.

The ten undergraduate students from my academic institution applied to this summer community-engaged research program and were interviewed and chosen by me to participate. The group is ethnically and racially diverse (but all born and raised in New Jersey), with nine females and one male from different academic departments (Women’s, Gender, and Sexuality Studies; International Studies; Sociology; Education), ranging from first year to senior class status. They all had a semester of informal Swahili language study, PV research training, and solar installation training. The group spent three weeks before the HKM workshop installing solar lighting in maternal health clinics in four different communities, including Maasailand on the Tanzania mainland, and Unguja and Pemba islands. Each of these clinics delivered more than

one-hundred children a month and either had no electricity or experienced significant energy insecurity. The solar installation experiences provided the students with critical clinic and community experiences in vastly different contexts from semiurban and rural indigenous communities in the lead up to the HKM workshop.

Our local partners included ZIFF, established in 1998, a well-respected arts festival that brings the entire East African region together through film and offers the wider community a variety of workshops, arts, music, and cultural events over the course of nine days. As an NGO, ZIFF hopes to serve as a catalyst for social and economic development. To meet this goal, ZIFF has created a number of Panorama programs: Women, Youth, and Community. These community-based programs in Stone Town and select rural communities offer focused Panorama programing on a specific topic each year. According its website,

> [ZIFF] has used the platform of the Women’s Panorama to highlight and address pertinent gender and social issues. The Panorama therefore becomes a medium of Women’s Power and Visibility. The Women’s Panorama commonly comprises of a series of workshops, seminars and symposia organized and centred on the visibility of women in and through the medium of cinema, the arts and the media. (http://www.ziff.or.tz/womenpanorama/)

HKM partnered with ZIFF’s Panorama program to offer a workshop in Nungwi. This was the very first time in the (then) fifteen-year history of ZIFF that a Panorama program was offered in this community. This was due in large part to the proximity of Nungwi to the main festival location of Stone Town. But it was also coupled with the (past) reluctance of Nungwi community members to align themselves with the festival, questioning the value of such a festival to the community. Nungwi has been deeply impacted by a glut of international tourism, environmental degradation, and stagnant economic growth leading to prostitution and child labor, a slow pace of development (lacking running water, electricity, refuse collection, indoor plumbing), and cultural changes. Because ZIFF promotes their Women Panorama programs as “forums to discuss social practices and policy questions curtailing women’s human and legal rights,” some of the goals the ZIFF promotes seemed at odds with some beliefs and practices in the community.

Despite initial apprehensions, the Women Panorama coordinator (a female Zanzibari resident) sought and was granted permission by the community to host a workshop, films, and events supporting motherhood, which was agreed would be of great potential benefit overall. A call was put out by the Women Panorama coordinator with the support of the local *shehia* (district commissioner). The participants were recruited and selected by the Women Panorama coordinator, and all participants were compensated for their participation in the workshop through funds my students secured through fundraising efforts in the United States. In advance of the workshop, we worked with Women Panorama and ZIFF’s director and staff to arrange the ground logistics (the workshop location, films, screens, sound system, generator, cultural events, water, food, and ground rules), and 120 participants were accepted. Ultimately more participants applied than could be accommodated.

We also partnered with MYDO, who were chosen for their organizational goals and expertise as well as the large number of young women who were active members. Most of these women spoke Swahili, Arabic, and English. Before the HKM workshops, my students hosted a PV training session for our MYDO collaborators, which consisted of seven young women and three young men, plus two members of leadership—two men and one woman. Most of the MYDO membership consists of younger adults aged sixteen to thirty, with a few older adult members. The training session included the details of the workshop: the goals of implementing PV, information about maternal mortality, and details about Nungwi. We also demonstrated the concepts in action, becoming familiar with the specific cameras and the technology, and anticipating problems that might likely occur in introducing the idea and taking photographs in this community. MYDO members facilitated a session on the Zanzibari history, culture, and customs.

Before we started the HKM workshops, the participants were informed about the topic of the workshop, the itinerary for the three days, and the importance of the workshop. Verbal and written consent was requested from all participants, and the workshop co-coordinators reminded them of their voluntary participation and their freedom to withdraw from the workshops at any point. We guaranteed confidentiality for the written information they provided and used pseudonyms on all collected data.

HKM PV Workshop

The HKM workshop participants ranged in age from sixteen to sixty-eight; they were mostly older women and young women, although there were about ten young and older men in attendance over the three days. The workshops were held at Nungwi school during a school break. English is the official language, but most Zanzibari people are Muslim and speak the national language Kiswahili, and translators assisted the group.

Over the course of three days, more than 120 participants engaged in PV as they discussed, wrote, created, and imagined together, in Swahili and English. We worked in large groups, small groups, and individually. Most of the time the group was split into three smaller subgroups of approximately forty participants.

Each group occupied a different classroom along one wing of the school. Zanzibari classrooms are typically constructed of cinder block or coral rock, configured as rectangles with a tin roof on exposed beams. There are window openings on one side of the rectangle; the opposing side consists of two larger openings facing the courtyard. The doorway to the classroom has no door to close, and the windows have no glass or screens. Each classroom has a large chalkboard at the front and long wooden benches and desks (figures 1 and 2).

Figures 1 and 2. Hakuna Kama Mama Photovoice workshop participants in action. (Photos by Marla Jaksch)

During the first full day of the HKM PV workshop, we facilitated a discussion on motherhood and barriers to safe motherhood. This day also included brief training about PV and cameras, and we provided access to the digital cameras (donated for the project) and other materials to record and represent the participants’ everyday realities as

related to our group conversations about motherhood. After the large group had been broken into smaller groups of approximately forty individuals, these were further divided into ten groups of four, who shared responsibility for the cameras. Each group had several hours to document using the camera, then had time to review and select a few images to be printed. Using small portable printers, we printed each selected photograph. Of those that were printed, each person selected two to discuss, and each participant wrote about one. Throughout the workshop, participants wrote short stories, and they took more than 600 photographs.

On the second day we asked participants to introduce an image and text to foster a critical group discussion about personal and community issues and assets. The facilitators translated and recorded comments on the public chalkboards (figure 3), and others took detailed notes and recordings of the discussions. At the end of the first two days the facilitators reviewed the materials across the groups, and they discussed the areas that emerged from each group. To guide the work of the next day, a plan was then made for areas for further discussion, such as themes that had emerged or questions that the work had provoked.

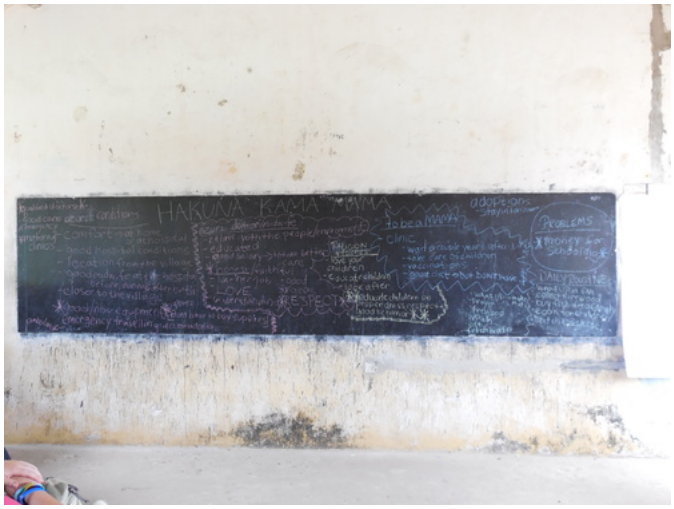

Figure 3. Wall of Challenges. (Photo by Marla Jaksch)

On the final day the participants co-curated a public exhibition of their work to which the community was invited. The participants also requested that members of the local hospitals and maternal and public health NGOs be invited. It was also decided that the exhibition should be shared with people outside Zanzibar, including in the United States.

As we collectively worked to organize the exhibition, a few significant themes emerged: (1) space, power, and autonomy; (2) respect; and (3) resilience. The results of their envisioning through PV concluded with the group describing their media creations as “technologies of resistance.” Localized knowledge about barriers to safe motherhood was produced collectively through photography and storytelling, designed to expand and shift the narrative regarding maternal death to one that centers their expertise and sees them as smart, capable, and loving experts and contributors to their community, along with calls for greater accountability for those typically empowered to improve women’s conditions. The goal of the exhibition was to reach and teach community members, policy members, and those in positions to make effective, informed change rooted in the needs, interests, and experience of the community members.

The next section presents the results of the HKM project connected to the themes I have outlined. Given the amount of materials collected, I will focus on what was collectively decided to be the most important information to share.

Technologies of Resistance: Space, Power, Autonomy, Respect, and Resilience

African geographer James Ferguson (2006) has described the concept of a place-in-the-world as a “categorical system within which countries and geographical regions have their ‘place’—understood as both location in space and a rank in a system of social categories” (as in the expression, “knowing your place”). This includes bodies made synonymous with places being located in the same categorical space/style. By centering our workshop to begin with Zanzibari women, in their community, we begin to challenge the concept of African women’s “place-in-the-world.”

Taking a cue from Nigerian feminist Oyěwùmí, we measured the impact of dominance of gender constructs, especially as it relates to gendered spaces, in African societies. The space of the workshop itself symbolized something very significant to the participants: outside of weddings or other cultural or religious festivals, the opportunity for women to meet as a group like this was rare, let alone to talk about something of feminist importance to them personally and collectively (figure 4). The very act of hosting the workshop, of physically making space to talk about motherhood, is a form of resistance to patriarchal and religious norms that shape the day-to-day lives of the HKM participants.

Figure 4. Workshop discussions. (Photo by Marla Jaksch)

Space is a critical dimension and an often overlooked feature in maternal health interventions—it is easily reducible to a location, stripped of history or significance. Many of the participants’ photos and comments highlighted the space of the hospital or clinic as being a site of verbal and physical abuse, of class- and race-based discrimination, and of detention, overcrowding, abandonment, and extortion. These descriptions of the clinic or hospital as a site or space of abuse were common throughout the workshops. The participants identified the space of the clinic as producing many issues that led to their being unable or unwilling to see it as a safe and empowering place.

For some participants the evocation of space and power was connected to the cultural and religious practices that women were expected to leave at the door of the clinic. The participants registered frustration that they were expected to let go of deeply held beliefs, practices, and values when visiting a clinic or hospital. For example, in a Muslim community in which strict adherence to gender segregation is critical, the dominance of male doctors has been problematic for many women and their families—especially for their husbands, who may well have complete control over a woman’s ability to leave their home and pay for prenatal visits. These aspects of care—of who is to expected make concessions and comprises, who has power, and who is blamed—were a much repeated story. For instance, one participant took pictures of a local clinic’s waiting room (figure 5). In another participant’s image, which she titled “No Privacy” (figure 6), she attempted to highlight the Muslim virtue of *al haya* (modesty, shyness) as it relates to maternal health care (Maoulidi 2011).

Figure 5. Recovery room. (Photo by Amina)

Figure 6. “No Privacy.” (Photo by Halima)

In our discussions about why many participants choose to stay at home to deliver (against the advice to deliver in a clinic or hospital), some spoke of distance and costs; others spoke about overcrowding at the clinics and hospitals where, except when delivering, you could expect to share a bed with at least one other woman in a room with several beds. Many preferred the privacy and modest comfort of their own homes, even if it meant returning immediately to their domestic responsibilities (Jaksch, field notes, 2014).

The overrepresentation of men in obstetric care in Zanzibar is deeply connected to the legacy of colonialism. However, the tensions regarding midwives and traditional birth attendants in Zanzibar started much earlier. Various stereotypes have negatively influenced care, and these were solidified by British colonialism in which racial and class-based hierarchies determined the provision of care. Clinics and hospitals in Zanzibar were segregated well into the 1950s (Maoulidi 2011). Prior to British rule, midwives in Zanzibar had been exclusively women, and they were held in high esteem as sources of knowledge and authority (Nzegwu 2006). However, the use of midwives was made illegal, and they were dismissed in favor of male elders, chiefs, and doctors, who therefore claimed authority over women and youth (Gonzales and Fourshey 2017; Hodgson 2011). Through their stories of abuse, the HKM participants revealed the legacy of these practices and connected the participants’ maternal health-related experiences to deeper, historical roots.

The participants voiced their interest in more female doctors, and also in doctors who had received “good training,” who could “relate with the people” and the “environment.” When pressed to define what it meant to have good training, the participants emphasized cultural and religious values that were important to the indigenous people of Nungwi—and they were especially concerned with the act of being treated with respect.

For many participants, an opportunity to speak their minds about their physical and social location was significant. Many religious and cultural practices—such as *al haya* and power relations—make it impossible for women to challenge the authority of a doctor (or men such as their husbands) without significant consequences. Mariamu’s photo (figure 7, Mama Nzito) engages the subject of her photo directly; instead of covering her face or looking down (as *al haya* practices dictate), her subject looks directly into the camera, while sitting in her home. This may not seem a radical image to viewers outside this community, but the sharp distinctions that demarcate private and public space rest at the door of the home. It should also be noted that Nungwi is a desirable tourist location. As such, women in Nungwi often find themselves as the

object of a foreign photographer’s gaze, and pictures of them are taken and circulated without their consent. The power that comes with the ability to take photographs, to direct the lens where she would like it, and to allow us to see the world as she does is a radical act that was not lost on the HKM participants.

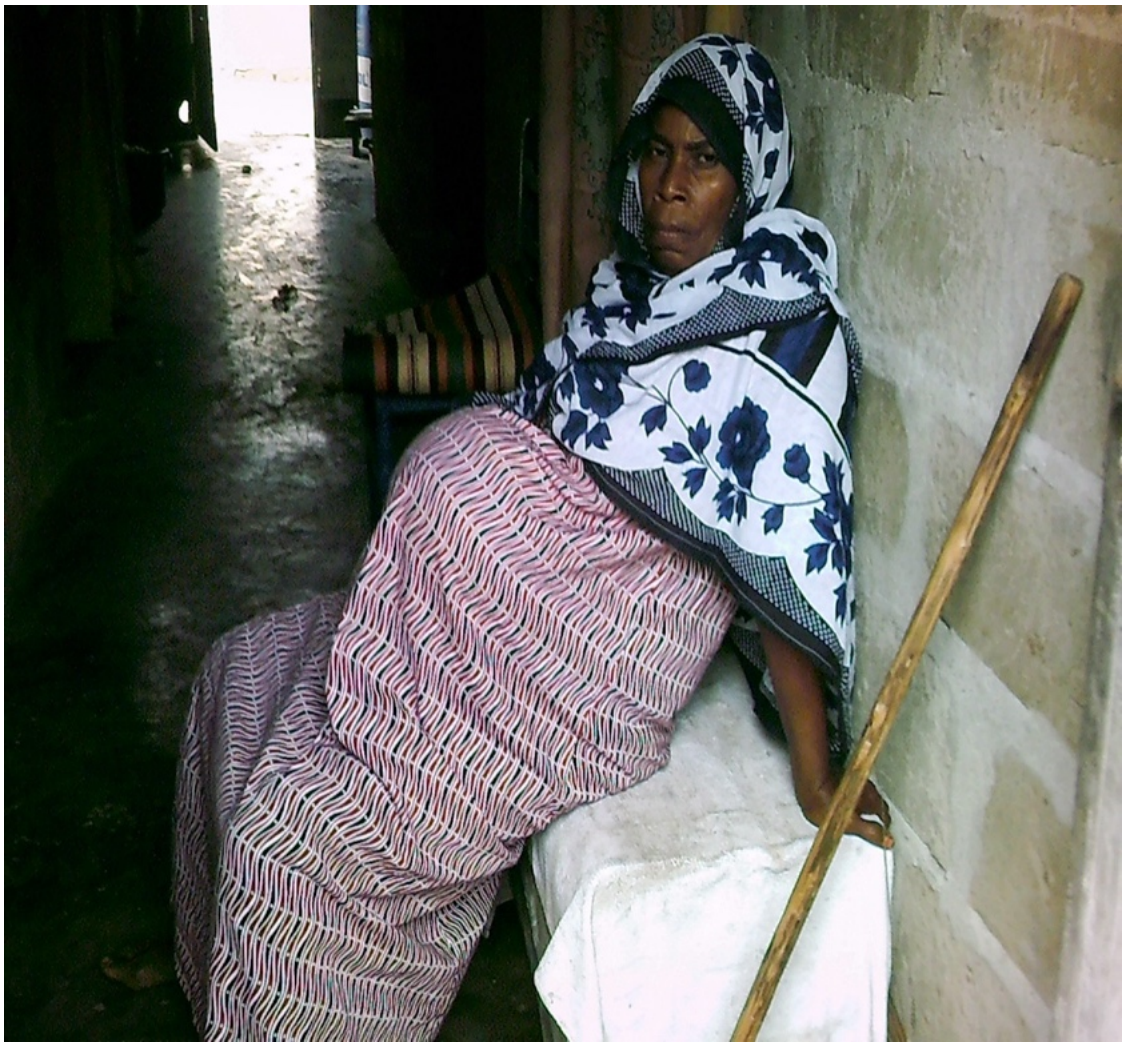

Figure 7. Mama Nzito (pregnant mother). (Photo by Mariamu)

The space of the HKM workshop allowed participants to speak back in a way that was safe but no less transformative. The themes of space, power, and authority captured the conversations, and nearly one-hundred photographs emerged of varying home conditions, including images of pregnant participants or community members engaged in very physically challenging domestic labor. For example, one participant stated, “Doctors should be made to visit us, to see our everyday life and conditions!” So for some of the workshop’s photographers, the goal of producing real representations of what their lives truly look like meant taking photographs that were less staged. In the photo by Amara (figure 8), we see a mama hard at work in her home, starting the day by cleaning her space: she does not look at the camera, nor does she pose or dress up for the picture.

Figure 8. Mama jobs in the home. (Photo by Amara)

One way we generated conversations about the images included asking the participants to use Post-it notes to attach comments on key words and photographs that were hung in the workshop rooms. Many Post-it messages were left on the “Mama is, Mama does” cluster of images. Most of the related photographs depicted women as strong, hardworking, capable mamas, contributors to their families and their communities. Typically the posted comments referred to the amount of work and different types of work that mamas engage in, regardless of whether they are pregnant or have other children:

> Mama is a person who fishes and returns from that work to continue with housework. (Juma)

Amina’s image (figure 9) shows a young woman engaged in the important daily work of women and girls on the island. Many images, like Amina’s, represented this work in important and positive ways, and others expressed empathy and love for their own mothers and the other mothers who work on their behalf:

> Mother farms, she leaves in the morning and returns tired. I help her with housework like cooking, washing the children. Mother is a very good person, I love her so much, she encourages and educates her children and she wakes up in the morning to farm for her children. (Leila)

Figure 9. Collecting wood. (Photo by Amina)

Leila’s comments highlight a lens through which we can see and value the work that mamas do and the impact of this work on their children and the community at large. The theme of work as it relates to mamas was one of the most commented upon and photographed. In Shehla’s photograph (figure 10) we see the profile of a woman in the process of farming or gardening.

Figure 10. Collecting wood and grasses. (Photo by Shehla)

Many PV images depicted women in the fields, working at collecting food, wood, and other items to support their families. The related stories spoke to the challenges of mothers to find adequate food and the time to do it all (farm, cook, clean, and care for the family). For instance Alisha stated,

> Many mothers do small scale farming, my mother gets her basic needs like food from farming. As a child, I need to get my education paid for but my mom is unable to so because her salary is too small. My mom is very empathetic and she continues to look, she believes one day she will win. (Alisha)
>
> Mother depends on farming, agriculture is mother’s backbone as it is the ability for us to control our lives. These are the problems mother faces in the farming process:
>
> - lack of fertilizer in the field
> - water problems
> - basic services (adult education) (Mariamu)

Mariamu and Alisha’s comments bring awareness to the intersectional relationships between maternal mortality, maternal health, and women’s existing knowledge and skills—assets that can be leveraged to reduce maternal mortality in a more comprehensive way.

Relatedly, many participants commented on water as it related to barriers to motherhood. Since 1980, tourism has been on the rise in Zanzibar—especially in Nungwi, which is known for its pristine beaches. Zanzibar has also suffered from acute water shortages. Tourism is an economic sector that places high demands on water; and water scarcity is common in Zanzibar’s tourist areas such as Nungwi. The fundamental health determinants for a community are linked to sufficient amounts of safe water.

Among other things, water is essential for drinking, production in agriculture, daily personal and domestic hygiene, and sanitation (Lindstrand et al. 2010). As African eco-feminists have highlighted, global funding for institutional and infrastructure development of the water sector is largely in the control of men, but the essential providers and users of water are women.

A participant commented that, beyond some of the problems that others had noted, water is a key area that needs to be better considered:

> Other problems are the reduction of social services like water. My mom used to leave the home at 2:00 in the morning to find us water while thinking of her children at home sleeping. (Halima)

Similarly, Sabrina commented,

> During my childhood period there was no water in our village so my mother left in the middle of the night to search for water. She was forced to leave me while I was asleep. She was very tired as a result of carrying a bucket of water while thinking who will give my child tea and feed her at home. (Sabrina)

Collecting water is an energy-consuming task that impacts women’s ability to perform other domestic obligations. The participants were unanimous about the hardship that comes with being responsible for water. They all described collecting water as tiring and exhausting; at times, when they returned from collecting water to do other chores, they felt so tired that they did not know what they were doing. The women also stressed the concerns of having no other choice but to leave their children home alone while they collected water (Jaksch, field notes, 2014).

The modes of transporting water are gendered. Women and children do not use any mechanized transport (automobiles or bikes) but rather commonly walk to the location of the water source and back. This leads to health issues: general fatigue and exhaustion, headaches as well as neck, waist, back, and chest pains. As represented by Aisha in figure 11, and through the accompanying stories, women are capable and hardworking—and they are expected to collect water while they are pregnant and immediately after giving birth. In thinking about maternal health, many interventions neglect how the burden of providing water impacts mortality rates and ignore how salinity can lead to high blood pressure and hamper the ability to heal.

Figure 11. Collecting water. (Photo by Aisha)

Tanzanian feminist scholar Marjorie Mbliyini (2015) has written about the ubiquity and valorization of images of African women carrying incredible loads on their heads, suggesting this is not an image to celebrate—rather, given the health impacts and the inequalities that allow this to persist, we need to critically approach these representations. The representations of water in the HKM project presented complex relations to divisions of labor, of power and strength, and pride and inequality.

Another frustration the workshop’s participants expressed had to do with well-intended advice that was given to them but that was not at all related to their lived reality. In a community where women are the main domestic and outside labor, where there is no running water and minimal if any electricity, they did not receive reasonable suggestions for reducing their pregnancy risks and delivery complications, or for healthy postpartum care. None of the participants used the term “gender inequality,” but it was clear that they were expressing understandings of their status as both patients and as wives, and the ways many public health advocates expected them to change power imbalances (Adjiwanou and LeGrand 2014; Nnaemeka 1996). Zanzibari women are largely absent from maternal health policy making and have no decision-making authority at home, which places them in a precarious position should they take the advice of doctors over husbands or vice versa.

In preparation for the HKM workshop I spoke to many of the public health advocates in Zanzibar about top issues in reducing maternal death, yet not once did any mention of the doctors or nurses come up. However, in every group activity the participants expressed concerns about the behavior and ethics of those in charge of offering medical care. All the groups touched on what they felt was lacking in the care they received. For example, from our speakout about how we might address the issues relating to discrimination by doctors, nurses, and public health staff, the participants made the following statements: “They should like their job.” “They should be honest.” “They should treat people with love and understanding.” “I want to be treated with respect.” Clinics and hospitals are not necessarily safe spaces for pregnant and delivering mothers: the demands for respect also pertained to verbal and physical violence the participants reported receiving at the hands of clinic and hospital staff. A few participants spoke of being handled aggressively, slapped, and yelled at. Clearly this type of behavior presents serious risks to safe delivery.

Collectively, the photographs taken, the supporting text that participants provided, and the ensuing conversations highlighted the participants’ desire to be seen as capable, responsible experts—as mothers and hard-working contributors to their community (figure 12). Most of the participants had assisted in more than five births, yet they were not seen as resources by the medical professionals and public health advocates in their communities, despite the acute shortages of trained medical staff. The PV images and stories in this section account for the participants’ shifting notions of motherhood, which mark a departure from much of what many in the Global North often see or hear about poor women in the Global South. Like poor women elsewhere, women in Nungwi have been conventionally regarded as the objects of expert knowledge rather than the subjects of their own stories. HKM methods center upon participants’ subjective perspectives of motherhood in their daily lives because the participants are knowledgeable subjects with singular, incisive insight into their own lived experience of motherhood that reflects hegemonic ideas as well as understandings that defy and exceed simple definitions or normative ideas.

Figure 12. Mama and baby. (Photo by Rehema)

Conclusions

HKM highlights how efforts that focus solely on obstetric care in a clinical setting do little to resolve maternal death, let alone account for what informs women’s choices and their ability and autonomy to make them. I have shared examples from a modest, community-based, African feminist intervention into maternal health—specifically maternal mortality—that seeks to challenge “development agencies and the experts who impose Western categories and technical knowledge that displace local knowledge and expertise” (Parpart, Connelly, and Barriteau 1997, 80). The project centers the deep, sophisticated collective analysis resulting from discussions and PV projects, providing a challenge to public health professionals who suggest that the solution to high rates of maternal death in Zanzibar can be reduced by giving birth in medical facilities. PV projects and the resulting conversations have revealed that many women are willing to forgo “expert” treatment at medical facilities because these biomedical spaces assign roles to expectant mothers, force them to cooperate under conditions not of their own making, and ignore the history, behaviors, and cultural beliefs that have supported them as mothers. In other words, women are being forced to give birth in unsafe biomedical places, and this is not just a matter of subjective feeling: Zanzibar’s main hospital suffers from extremely high rates of death in its facility (Herklots et al. 2017).

An additional goal of this discussion has been to place the technologies of resistance—the media productions of the participants—into a bigger context, thus situating the conversations about motherhood and awareness of the problems that mothers face and concretely linking them to poor maternal health outcomes. HKM does so by asserting that African women’s voices and experiences must be at the center of maternal mortality interventions if they are to be successful. Localized contexts are important because they are differently embodied, varied, disparate, and speak to the specificities that shape maternal health in their community (Adjiwanou and LeGrand 2014; Agyei-Mensah, Owusu, and Wrigley-Asante 2015; Anderson 2000; Anderson and McCann 2002; Herr 2014). This project understands African feminist frameworks as providing the grounds for interrupting ahistorical, generalizing, essentializing, culturalist, and racializing discourses, which have categorized people according to flattened-out gendered and racial categories and hierarchies (Jaksch 2014; Nnaemeka 2004).

African feminist work has challenged unitary notions of culture and contested images and representations of the essentialized, cultural Other. It is therefore crucial for challenging and adding to the dominant knowledge of and approaches to maternal mortality (McFadden 2018; Mama 2004; Oyěwùmí 2002). In addition to being a useful approach in the contexts outlined here, the adoption of African feminist epistemologies has a lot to offer beyond localized contexts, as the results of the PV workshops attest. Further, the participants’ work reveals the power gradients between patients and health care workers and within biomedical discourses.

In part, the creative media outputs created by the participants in the HKM project have complicated the victim narratives and served as a corrective to the overrepresentation of African women as hapless victims. The latter perspective has robbed them of their agency and, in turn, led to the devaluation of African women’s experiences—especially their acts of resistance. The construction of African women as lacking the capacity to create knowledge is a legacy of colonialism (Oyěwùmí 2003, 2011) that paved the way for (neo)colonializers to advance racist and sexist thinking. This perspective has allowed women to be stripped of their authority and decision-making abilities as midwives and healers (Hodgson 2017; Mohanty 2003) and has led to the nullification of women as a resource in solving the problems they face.

The HKM participants requested that we invite guests to the final presentation (figure 13) and that we to continue to share the maternal health data collected in Nungwi as a way to create space for rural communities in Zanzibar to speak about and represent with authorship their experiences and perceptions of motherhood. We have fulfilled our promise by hosting an exhibition of images and words at the gallery on our campus, and more than 200 people attended on opening night. Ultimately, HKM is meant to be a platform for the public health sector and various others to access the data and improve understandings, with the intention of using these research findings to coordinate future projects in Zanzibar that will put gained knowledge into action.

Figure 13. HKM community exhibit. (Photo by Marla Jaksch)

More specifically, the reframing and claiming of knowledges and space in this project will work to actively impact the quality of health services in the area and provide a critical lens for better analysis of outside health interventions. In this way, the participants are making demands and telling stories through resistive technologies embodied PV practices (Nagar 2014). In this way, the Tanzanian folklore shared at the beginning of this chapter is remade, and the return for women becomes possible. The results of PV work can viewed as a resistive technology that challenges normative, medicalized, top-down understandings of barriers to motherhood.

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