The Quest for Trust in the Face of Uncertainty – Managing Pregnancy Outcomes in Zanzibar

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Abstract

High maternal mortality and morbidity and high levels of infant death have led to an intense feeling of anxiety and uncertainty over pregnancy and childbirth in Zanzibar. Faced with an unreliable system of public health provision of poor quality, women try to contain the dangers of this central female duty by actively searching for care that can be trusted. Their quest for trust includes strategies that acknowledge the need for contingency upon personal connections, especially in their encounters with the socially distant professional health services, despite the uncertainty this implies. Drawing on culturally relevant practices of secrecy and notions of morality, women try to increase their chance of a positive pregnancy outcome through an intricate process of testing the various sources of diagnosis and treatment.

Introduction

'Giving birth is like bingo', a young woman from my neighbourhood in Zanzibar Town told me. 'You have a 50/50 chance of survival.' This poignant statement reflects widely shared sentiments about the dangers and unpredictability of pregnancy and childbirth among Zanzibari women and defies claims in the field of public health that women are not aware of the risks of birth.[1] While the perceived risk of maternal death does not accurately reflect the actual risk of dying in childbirth, it nevertheless signals a situation in which maternal and child death is relatively common. The facility-based Maternal Mortality Rate (MMR) in Zanzibar was estimated in 1998 at 377 per 100,000 live births (UNICEF).[2] Main direct causes of death are unsafe abortions, eclampsia, haemorrhage and obstructed labour. The 2006 Reproductive and Child Health Situation Analysis shows that surgical deliveries are only available at the hospital level, however manual vacuum aspiration is not routinely available even in hospitals (Hussein 2006). The general lack of emergency referral is a major constraint to the availability of emergency obstetric care on the islands.[3]

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[1] Cf. Obermeyer 2000a for a critical discussion of this claim in Egypt.

[2] The 1998 study seems to provide the most recent verified numbers (e.g. the Ministry of Health in Zanzibar keeps referring to this number and study). The 1996 and 2004 DHS did not have adequate statistical sample sizes for Zanzibar to conclude MMRs. However, there are some newer numbers cited in some WHO documents (MMR of 362 for Zanzibar according to the Country Cooperation Strategy brief of 2011), and a 2011 update on MDG goals 4, 5 and 6 issued by the Ministries of Health for Tanzania mainland and Zanzibar suggests that 'available data indicates a fall in the maternal mortality ratio in Zanzibar since 1998 and a dramatic decline between 2008 and 2009 from 422 to 279', based on 'data from intensive surveillance of maternal deaths at all health facilities.' The methodology for these data, however, is not comprehensively explained.

[3] Zanzibar is a small island archipelago off the Tanzanian coast with a population of approximately one million people. The two main islands are small, and health facilities are in close reach compared to parts of the mainland.

A major public health strategy to improve maternal and infant health is focused on increasing women's use of biomedical antenatal care and delivery in a healthcare facility. And indeed, antenatal coverage in Zanzibar is good, with 99.4% of women attending at least once during pregnancy, and 48% visiting two to three times (NBS 2011: 129). 35.5% of women received two tetanus toxoid vaccinations and 89.5% of mothers were protected from tetanus during their last childbirth (NBS 2011: 133). The situation is thus better than in mainland Tanzania. Home deliveries have reduced from 63% in 1999 (NBS 2000) to 50% in 2004 (NBS 2005). According to the Tanzania Demographic and Health Survey 2010, 67.5% of women in Zanzibar's larger island Unguja delivered by a skilled provider (doctor, clinical officer, assistant clinical officer, nurse/midwife, MCH aide), but rates of health facility-based delivery vary considerably according to administrative region, ranging from 23% in Zanzibar North to 73% in Urban West (NBS 2005: 15). Postnatal care coverage remains relatively low at 36.2%, with disparity between Unguja (43.5%) and Pemba (23.7%) (NBS 2011:138). Abortion is the leading cause of admission in female general/surgical wards (MoHSW 2006), yet post-abortion care is not available in all health facilities. Induced abortion is illegal, though available against payment of a bribe, and the abortion case fatality rate is 2.2%.

While the increase of biomedical reproductive care use seems promising, quality of services is often poor, and the reputation of hospital care has suffered in recent years, with the introduction of cost-sharing models at a time of deteriorating health care conditions in the wake of economic crisis and structural adjustment from the 1980s (Lugalla 1997, Putzel and Lindemann 2008), characterised by staff shortage and constant lack of even basic medicines. Doctors sometimes openly admit that some of their equipment is of poor quality. In a conversation I overheard, for example, the government hospital Mnazi Mmoja's head gynaecologist advised a foreign visitor to bring her own intrauterine device (IUD), because the Chinese IUDs they use were sub-standard and often faulty.

Recent rapid privatisation of health services has resulted in an increasing range of choices, but also heightened uncertainty. After two decades of socialism, the ban on private medical facilities was lifted in the mid-1980s. Subsequently, private clinics, hospitals and pharmacies emerged all over the islands, but particularly in the urban centres. Privatisation turned health into a marketable commodity, a fact which traditional healers, who used to offer their services for free or a nominal fee, also recognised. As a result, today there is virtually no free professional health care anymore, neither in biomedical, nor in alternative health sectors (Beckmann 2010). The costs of private health care are prohibitive for a majority of Zanzibaris, but the quality of care is not necessarily better than in the public sector, where user fees have also been introduced in 2004. Moreover, the marketization of health has raised uncertainty about providers' trustworthiness, and diagnoses are often mistrusted as ploys to make money. De facto, neither public nor private health facilities offer optimal care; private hospitals often look nicer and staff tend to be friendlier, but few have surgical facilities and emergency cases are referred to the government hospital Mnazi Mmoja.

Much has been written on the precarious nature of maternal health delivery and the complex choices between 'traditional' pregnancy and childbirth care and hospital-based, biomedical care (Obermeyer 2000a, 2000b, Roth Allen 2002). This paper deals with women who are generally invested in a belief in the superiority of biomedical care and have financial resources to pursue it, but who still face significant uncertainties and try to navigate different options in the quest for establishing trust and reducing the dangers of pregnancy. It explores a semantic field which includes the notions of uncertainty, trust and secrecy. These notions link people's practices and beliefs to a context of increasing privatisation of health services, which acts as an additional recourse to older known ways of curbing dangers and enhancing wellbeing.

The data derive from several years of ethnographic fieldwork in Zanzibar and mainland Tanzania since 2004,[4] during which I lived with a local family in Zanzibar Town. The case studies I present are of two sisters from an urban family, which originates from the Hadhramawt in Yemen and belongs to the trading middle-class. They are well-educated, having left secondary school after completing form four and undergone some vocational training. Both work in the family business, are part of a large family network of traders, and have access to cash resources for health care expenditure.

Uncertain Outcomes

Children are highly desired in Zanzibar and regarded a blessing, and it is expected that the first child will be conceived within the first year of marriage, followed by subsequent births ideally spaced by several years. Successful reproduction is closely connected to reaching full social status, and childless women – and men – are pitied. For women particularly, the ability to bear children cements their position within a marriage and the wider community. A lot is at stake in ensuring reproductive success. When visiting a woman who had had several stillbirths, her visitors barely enquired about her health. Instead they tried to comfort her by saying she should not worry about her husband marrying another woman – surely he loved her enough to excuse her sub-fertility. The preference for multiple children is reflected in a consistently high total fertility rate for Zanzibar of 5.1 births per woman (National Bureau of Statistics 2011: xix).

At the same time, pregnancy is widely regarded as very dangerous, the time of danger culminating in childbirth and the postpartum period. Common rhetoric portrays pregnancy and childbirth as a highly precarious process whose outcomes are never certain and that often ends in death: 'You either die or you don't, you can never be sure,' '*Uzazi hamna uzoefu*, there is no getting used to giving birth, you can never predict how it will end,' and 'Having children is dangerous. These days, many women die in childbirth,' women (and many men) often commented when talking about childbirth, expressing the extreme unpredictability and anxiety associated with this central female duty. Everybody can recount relatives,

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[4] Substantial fieldwork periods include an initial 15 months stay from July 2004 to October 2005, and regular follow-up visits of varying lengths in July/August 2007, May to October 2008, December/January 2010, June to September 2011, and August/September 2012.

neighbours, or friends who experienced childbirth-related crises, including maternal death, stillbirths, and infant death, and these stories are often discussed among women. In the space of three months in the summer of 2011, for example, in my immediate surroundings, one neighbouring woman suffered her third late-term stillbirth in a row due to pre-eclampsia, one of my host sisters experienced severe post-partum haemorrhage and the other needed an emergency caesarean section, as did an employee of the same family, one of my key informants had a miscarriage (and a late-term stillbirth a year later), and an old family friend's daughter suffered severe complications and lost her baby four days after birth. At the same time, the wife of a prominent doctor in Zanzibar died giving birth in one of the island's private hospitals despite her husband's presence, a case that was often discussed to underline the unpredictability of a healthy pregnancy outcome, even under qualified medical care – but also to highlight the poor state of biomedical health care in the islands.

Visits to the maternity ward do not help to dispel these concerns. On one of my visits in August 2011, the antenatal ward is full of women walking around or lying in beds, moaning and praying in pain. It is hot and there is an acrid smell of blood and body fluids. The fans are switched off and the windows closed, because nobody wants to catch *upepo*, 'wind', which is believed to bring chills and illness. Relatives are not allowed inside and are constantly chased away, even from the hallway outside, but cats go in and out, and there are no mosquito nets to protect the women from mosquitos and flies. Two women are bound at their hands and feet to the beds, one has her baby delivered right there, with just a partition placed in front of her bed. Several women have bloody catheter bags hanging from between their legs, some bursting full, but nobody bothers to change them. There are moans and screams, prayers and calls for the doctor: 'doctor, doctor, help me!', and several younger women cry for their mothers. The woman next to me just lies on her back and breathes heavily, she seems to be unconscious. The one next to her wails loudly: 'what have I done, please just kill me! You are my elders, why are you behaving like this?' and then keeps repeating '*salaam aleikum'* (a common Islamic greeting that translates as 'peace be unto you') again and again. 'She has become mad from giving birth,' my informant says quietly: 'to give birth is a great challenge (*mtihani*), you can easily become mad, or get a heart attack.' The atmosphere is tense; patients are scared and relatives want updates on their loved one's progress, but few dare approach the nurses who are stern and unforgiving to those who bother them with questions. 'At night it's especially bad,' I am told, 'the doctors are cruel at night! They beat their patients if they're unruly, and tell them to carry their own bags to the delivery room. If the woman says: "I can't", they shout: "you can't? Yes, you can!"' On the other hand, staffing levels are constantly low. During the night of Mamu's crisis (see below), for example, the nurses claimed they had delivered almost 80 babies. 'We are tired,' a nurse exclaimed, 'of course you get impatient!'

Common perceived dangers around childbirth and the postpartum period include excessive blood loss often connected to anaemia (*upungufu wa damu,* lit. 'reduction of blood') during pregnancy, fever (*homa*), fits (*kifafa* – lit. epilepsy, but in terms of pregnancy it refers to pre-eclampsia and eclampsia, the most common

causes for perinatal mortality worldwide[5]), and madness (*wazimu*). There is a strong concern about blood, which reflects broader cultural and religiously influenced ideas about the creative and destructive qualities of women's blood. Especially during the postpartum period, the mother's loss of blood is closely monitored by questions and inspection of her underwear and sanitary pads. The frequency of changing sanitary pads is used by health care staff, too, in order to assess the severity of bleeding after delivery.

Mamu: managing the dangers of childbirth

A number of practices in response to birth-related crises are widely shared, both among the urban and the rural population, as the following case shows. Mamu, a 32-year old woman of third generation Hadhrami origin, gives birth to her fourth child in 2011, a year after an abortion due to an abdominal pregnancy. When her waters break, she goes home to her mother's house, following Zanzibari tradition, and I watch over her throughout her labour. Walking relentlessly in a circle in the upstairs sleeping quarters, she calls Dr Aisha[6], a midwife and nurse in the government hospital who she had been consulting for her previous pregnancies, too. Dr Aisha tells her to come to the hospital straight away, but Mamu declines: 'I'm not coming yet, there's still time.' Over the next hour, her labour progresses quickly, aided by drinking hot tea and honey, both to increase the heat in her body, and castor oil ('to soften the stool,' she says). She manages the pain by constant walking and hitting herself on the thigh, as recommended by her mother, who periodically comes to check on her. In between contractions, which now come every one to two minutes, she prays silently, sometimes bending over with pain. She still refuses to go to the hospital. After about two hours, she finally asks me to call her husband to get the car and we drive to the maternity ward, where Dr Aisha receives her. We have to buy a file and bring all the childbirth supplies: a syringe and a dose of oxytocin, a plastic sheet (to avoid soiling the hospital bed), four pairs of rubber gloves, sanitary pads, and *kanga* cloths for the baby. A relative slips the ward staff some money. About half an hour after arriving at the hospital, Mamu gives birth to a healthy daughter.

We bring Mamu some *uji* (porridge) and water, but she is eager to go home. The hospital policy dictates that mothers should stay in the hospital for 24 hours after giving birth, which had been reduced to six hours, due to the shortage of beds. Nevertheless, Mamu pleads with Dr Aisha to let her go, and after an oxytocin injection to stop the bleeding we are on our way back home, one hour after she gave birth. While her husband recites the *shahada,* the Islamic creed, into the baby's ears, and her mother feeds the baby honey and bitter aloe – to show her that 'life is both sweet and bitter' – Mamu rests on the bed and chats with the family members who came to congratulate her. After a couple of hours, her sister

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[5] According to an epidemiological study in Zanzibar's referral hospital Mnazi Mmoja in 2007, of a sample of 100 women, 9 had pre-eclampsia (4 mild–moderate, 5 severe), and 2 had eclampsia. The prevalence of eclampsia and severe pre-eclampsia in Zanzibar was thus 40 and 10 times higher, respectively, than in the UK, pointing to the comparatively low quality of antenatal care in Zanzibar (Tufton and Patel 2011: 69).

[6] Not her real name. Dr Aisha is also not a medical doctor, but rather a nurse and midwife in the maternity ward.

and I take her to the bathroom to shower. Suddenly, her face loses all colour and blood gushes from between her legs and I can just about catch her when she collapses in the shower. We drag her onto a bench in the hall and she seems better. But suddenly her face turns ash grey and her eyes roll back. She chokes and starts shaking as if in a fit. Everybody is wailing and praying at the same time. 'My child is dying! This is exactly how her aunt died, I was there, I saw her, she's dying!' her mother screams. Someone calls Dr Aisha, who cannot come, but orders Mamu back to the hospital immediately. In the meantime, Mamu's mother prays the death prayer and spits *maji ya zamzam*, holy water from the Zamzam well in Mecca, which her father had brought home from his last Hajj, at her face. She later recounts again and again how this was the decisive action that helped Mamu back to life. An aunt, who is a nurse, advises to put Mamu's feet up, but offers no further first aid. Milk, strong coffee and *maji ya zamzam* is given to Mamu to drink, and her feet and head are rubbed with *habasoda* oil (oil of black caraway seeds, an important, powerful substance in Islamic medicine), while a friend lays her hand on Mamu's head and prays fervently. Slowly, Mamu regains consciousness and silently joins in the prayer. A neighbour advises rubbing the feet with lime juice, to keep the feared *maradhi ya baridi* (lit. 'cold diseases', denotes a number of illnesses including anaemia, intermittent fevers, paralysis, and vegetative states) at bay. 'What kind of blood did she lose?' her mother asks me. 'Bright red blood,' I respond. 'That's *damu ya mwili*,' (literally 'blood of the body'),' she wails in horror. This kind of blood is different from the dark, almost black and often thick 'dirty' blood that comes from the uterus and must leave the body. *Damu ya mwili* is thin and bright red. It is the blood that carries life force. Loosing even small quantities of this blood is considered life-threateningly dangerous.

Finally the men bring a chair to carry her to the car and we drive back to the hospital, where she is immediately put on a drip and given a curettage. She is hospitalised for a night and slowly gets better over the following week, although she remains weak and dizzy from the blood loss. During this time she is closely observed by her family members, and her strength is built up through the traditional blood-increasing foods provided during the postpartum period.

While postpartum haemorrhage is feared as one of the most common causes of childbirth-related deaths, blood that flows from the uterus is considered dirty at the same time, and controlled bleeding is therefore necessary for a healthy recovery. Menstruation is widely regarded as an opportunity for women to regularly rid their bodies of dirt (*uchafu*) and a number of practices and medicines are dedicated to cleaning the vagina, which is seen as a place where dirt accumulates easily (and thus a seat of infection and disease). Both menstruation and sexual intercourse confer on the woman's body a polluted state (*janaba*) in which she is prohibited from praying or touching the Qur'an. From menarche on, girls are taught to perform the ritual ablutions necessary to cleanse the body after menstruation. New brides are reminded to wash their vaginas with hot salt water after having sex, and never to have sex during their menstruation, due to the dangerous polluting character of menstrual blood. Traditional midwives (*wakunga,* Pl. Singular*: mkunga*) sell herbs that are placed inside the vagina to cleanse it of polluting remnants after menstruation.

Because of the harmful potential of blood that originates in the womb, sexual intercourse is strictly prohibited for the seven days of menstruation and during the first 40 days after childbirth (*arobaini*), although the last rule is often not adhered to and the period of abstinence is sometimes limited to the phase in which the woman is still bleeding. If conception takes place from sexual intercourse during menstruation, the child is believed to contract epilepsy (*kifafa*), be disabled (*mlemavu*) (for example through trisomy 21 (*kichwa kubwa*)), or can develop outside of the woman's uterus, causing prolonged labour, severe pain, and even death of the mother at the time of birth. An old traditional midwife explained this as follows: 'Every month the dirty blood from the uterus gathers in one of the ovaries, one month on the right side, the other on the left. During menstruation the bladder bursts and the blood flows out of the body. If you have sexual intercourse, then the man's semen will block the way, the blood cannot leave, and a child can start to grow outside the uterus. Often these children are very big, because they are not constrained by the uterus, and have to be born by caesarean section, or it might be born 'feet first' (*miguu mbele,* i.e. in breech position), causing great problems for the mother and the child.'

During pregnancy the menstrual blood stops flowing and contributes to 'feeding' the foetus: '*mtoto anakula damu*, the child eats blood', women often complain when they feel weak and tired during pregnancy. *Upungufu wa damu* (anaemia, also called *ukosefu wa damu*, 'lack of blood', or *safura*) is considered one of the most common and serious pregnancy problems, and pregnant women's blood levels are constantly monitored by their relatives who look out for paleness, weakness, dizziness, feeling cold, and shortness of breath. This concern is underlined by blood tests performed in antenatal care facilities, which measure the woman's haemoglobin levels. Anaemia is very widespread among women in Zanzibar and increases the risk of postpartum haemorrhage (Kavle et al. 2008). Therefore, iron and vitamin supplements like Hemovit are routinely prescribed by health care providers, and families try to provide blood-increasing foods (*chakula cha kuongeza damu*) such as milk and dates, green vegetables, and Lucozade for pregnant women.[7]

Because the menstrual blood is not shed for nine months, the woman's body is considered full of dirt at the end of the pregnancy. This dirt must be expelled through controlled bleeding, which is induced by a range of techniques that create heat in the mother's body: she is placed inside a hot room, wrapped in warm clothes, and is only given 'hot' food and drinks to consume. She is served special food, such as spicy porridge (*uji mtamu*), chicken soup, and octopus soup, that must be light and fluid (*vyakula vyepesi*), because her stomach is still said to be soft (*laini*), but at the same time should be hot and spicy (e.g. strong ginger tea, and large amounts of black pepper as a seasoning[8]) to make the blood flow. She is also washed with hot water and placed on a traditional Swahili bed, or

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[7] For a more detailed discussion of traditional treatments for anaemia, see Young and Ali 2005.

[8] Black pepper causes heat, but not of a blood producing kind; its heat can be dangerous as it makes the blood leave the body. In women this can result in stronger menstrual bleeding which is dangerous for the uterus (*ni hatari kwa mfuko wa uzazi*), and can make the woman feel dizzy (*kuona kizunguzungu*). Because of this blood-expelling effect of black pepper it is consumed in larges amounts after childbirth in order to purify the womb.

alternatively a chair with a hole in the seat, while burning coals with fumigations (*mafusho*) are placed underneath. This is supposed to 'dry up' (*kukausha*) the uterus through maintaining a steady but slow flow of blood over a longer period, preferably for at least 20 days. Strong and painful massages with *habasoda* oil carried out twice a day by the *mkunga* and firm binding of the stomach with several pieces of *kanga* cloth are said to help with making the still soft body firm again and shrinking the belly. The ultimate goal is for the cleansed body to regain strength and to 'contract' (*kukaza*), reflecting a concern with 'openness': 'The vagina needs to be washed with hot water after sex and after childbirth, so that it contracts and gets tight again, so it doesn't stay open (*ikaze, isikae wazi*),' explained the *mkunga*. 'If it remains open (*wazi*) it invites disease.'

In addition to the physical dangers of excessive bleeding, fever, and infection, the postpartum period is also spiritually dangerous, because in an impure state the woman cannot pray and thus cannot protect herself (*kujikinga*) from malevolent attacks, while the smell of the blood is said to attract the spirits (*masheitani*), whose food is human blood. Therefore, women who had suffered from spirit possession episodes commonly do not want to visit a woman in the first days after giving birth, because they 'cannot stand the smell of the postpartum blood' (*Ile harufu ya mzazi, damu inanuka, hii siwezi*). Fumigations (*mafusho*) with strongly smelling substances, such as dried leaves, onion or garlic peel, *habasoda*, *mvuje* (asafoetida, an important and powerful local medicine), and *ubani* (frankincense) are used to cover the smell of childbirth blood and thus deter spirits.[9] 'Every occasion has its smell', Bi Fatuma, an old *mkunga* explained, 'the smell of weddings is *udi*, a scented incense (from the Arabian *oud*); for funerals, you use *ubani*, frankincense. And for birth you use *mafusho* and *mvuje*, a herb that is *dawa kubwa*, strong medicine. So when you pass by a house, people can tell by the smell what is going on: "*nasikia harufo ya mtoto*, I'm smelling the scent of a baby".' Some women also use protective amulets *(hirizi)* and black bracelets, which contain a small pouch filled with *mvuje* for protection against spirit attacks, both on themselves and on their children. This practice is not shared by everybody, however; some consider it superstitious (*shirk*) or a matter of custom (*mila*) and thus un-Islamic.

A Leap of Faith

Mamu's example demonstrates both the dangers of childbirth, and the many beliefs and practices used to manage their uncertainty about a positive outcome. It shows how in the absence of reliable emergency and postnatal medical care, women draw upon a number of longstanding practices throughout pregnancy, birth and the postpartum period in an effort to reduce the dangers of childbirth and strive for safe delivery. These practices are rooted in local understandings of the body, the agency of spirit and divine forces, and the knowledge of other women experienced in childbirth matters.

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[9] The baby and the baby's clothes are also fumigated thoroughly, and most babies have their forehead painted with *wanja* (kohl), an additional deterrent for spirits and witchcraft attacks.

These beliefs are widely shared in Zanzibar, and discussions among those involved in Mamu's care reflect this sense of common understanding. They represent what Parkin has termed 'trust talk': talk about (and response to) an illness by the patient, healer(s), and members of the wider community, each 'speaking from established roles and cooperating in a common search for repatriation or remedy' (Parkin 2011: 12).

Especially the use of Islamic remedies and a strong belief in the effectiveness of prayer are shared and practised by all of my informants, rural and urban, poor and wealthy. Trust is first and foremost placed in the hands of God and in long-standing practices. In this sense, trust is a form of faith – or rather derives from faith, as the shared linguistic root of the Kiswahili terms for trust, faith, hope, and security suggests. Trust, as a leap of faith, requires a lack of transparency, of full information; rather than being based on complete knowledge off all relevant factors, trust relies on a basic confidence in the reliability of tried and tested practices and the divine power that underlies every action. Thus, "paradoxically trust rests on, but also tries to surmount uncertainty" (Parkin 2011: 9).

While trust and confidence refer to expectations that can be frustrated, faith also implies an element of pragmatism, based on the notion that one has to try to make the right choices and find the person or practice that is most trustworthy and thus likely to lead to a positive outcome. Zanzibari women, and their wider social network, try to establish a sense of security in the face of deep uncertainty by taking an active, but pragmatic approach in pregnancy, according to their means. They try to eat a number of foods that are believed to increase the amount and quality of blood in the body;[10] pray and follow Islamic rules more closely; avoid provoking envy or anger; engage in exercise, which maintains the baby's health during pregnancy by circulating the blood, and after childbirth helps contract and tighten the body softened from pregnancy; and 'open the way' for the baby's birth through sexual intercourse close to the due date.[11] At the same time, they acknowledge that certainty and full control over their pregnancy cannot be achieved.

Additionally, those who can afford it consult specialists. These are not easily trusted, however. Rapidly increasing privatisation and marketization of health services has exacerbated existing uncertainties about the quality of care and the ulterior motives of health care professionals, both in the private and public sectors, and including non-biomedical healers and carers. Moreover, biomedical authorities, who are often socially distant from the patient, alienate the patient's experience and codify it into judgements of cause and effect (Parkin 2011: 13). 'Trust talk' here turns into 'alienable talk', where different viewpoints create contradictory suggestions and claims, and may lead to accusations and counter-accusations (ibid: 12). Experts are thus carefully tested through hiding previous diagnoses in consultations, as the following case demonstrates.

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[10] Pregnancy is a time of heat (*joto*) and therefore all heat-inducing substances must be avoided until the time of childbirth, when heat helps with the progression of labour. Therefore, care is taken to avoid 'hot' foods such as pepper, honey, ginger, etc. during pregnancy.

[11] During the earlier stages of pregnancy, sex is mainly regarded as important to keep the husband content and 'at home'.

Establishing Trust through Secrecy: Nassra

Mamu's younger sister Nassra was in her late 20s and newly-wed when she fell pregnant. Like her sister, she does not belong to the rural poor; her family are urban traders and have worked their way up to a comfortable middle-class status. While financial resources were not unlimited, she could afford good quality food, as well as locally available private health care and medicines. But even under these nearly ideal circumstances, she was extremely anxious from the beginning of her pregnancy, a feeling that was exacerbated by her experience of Mamu's postpartum complications. Throughout her pregnancy her comments conveyed her heightened anxiety and uncertainty. Whenever asked how she felt about the baby, or whether she was looking forward to being a mother, she claimed: 'I don't care about the baby right now, only about my health. You never know if you are going to survive…' She avoided all information about the baby's development; she neither wanted to know about the foetus' size, nor hear its heartbeat. Instead, her focus was entirely on the changes her body went through and all the aches and pains she experienced. In order to alleviate some of her uncertainty and anxiety, Nassra took an active approach and, in addition to the widely shared and trusted practices, frequently consulted a number of different experts on pregnancy and childbirth.

Not surprising considering the high frequency of sexual intercourse especially in the first weeks of marriage, Nassra fell pregnant one month after her wedding. One day, she felt dizzy and went to a large private hospital, Al Rahma, to get checked for malaria. No malaria was found, but instead the doctor told her she was pregnant. 'I was shocked,' she says, 'I didn't even cry, I was so afraid.' On the next day, she told her sister Mamu, who advised her not to tell anybody else, but took her to another private hospital, a mother-and-child clinic specialised in pregnancy care (the Mama na Mwana clinic), where she had an ultrasound, which cost TSH 20.000. The pregnancy was normal, but she was diagnosed with cystitis and prescribed antibiotics. Before taking them, she went to a private pharmacy and pretended to buy the same antibiotics for a pregnant friend, to test if they were safe. The pharmacist informed her that the antibiotics she had received from the mother-and-child clinic were not safe during pregnancy, so she did not take them. Instead, she went to another doctor and asked about antibiotics during pregnancy. Here, she was prescribed a different antibiotic (amoxillin), which, the doctor reassured her, was especially for pregnant women. He also gave her some general advice on personal hygiene (always wash from the front to the back when going to the toilet), diet (eat fruit and vegetables to increase your blood), and exercise (don't sit much and don't bend your stomach). Several doctors, including one in Mnazi Mmoja, added the benefits of prayer to this general advice – the physical movements of standing up, bending over, and getting down on the knees would work to turn the baby around – which resonated well with a strong local belief in Islamic prayer as treatment for illness.

These were only the first of frequent and numerous visits to different health care providers. On average, Nassra sought expert advice about two to three times per week, most of the time for a fee, for issues including headaches, constipation,

nausea, backaches, worry about the baby kicking/not kicking, dizziness, fatigue, fast heartbeat, shortness of breath, heartburn, and general reassurance that everything was well. She consulted at least four different private clinics, besides registering with the government hospital ANC.

While the majority of women have to make do with whatever services they can access, those who can afford private health care tend to prefer this arrangement, especially when the pregnancy does not fulfil societal expectations. Women who get pregnant while their last child is younger than two years, for example, often complained of being scolded in the public ANC for not spacing their childbirths correctly. I have also witnessed moralising questioning in the public hospital about the marital status of the mother and open contempt if she was unmarried, and a doctor voiced suspicions of adultery in the case of a woman who claimed she had only fallen pregnant seven years after getting married (which was a lie). Women therefore tend to keep secret any information they think may invite judgement, and often recount their pregnancy history along socially acceptable lines. Many of my informants also used false names when registering with the hospital, not trusting hospital staff to treat their information confidentially and reflecting a general concern about keeping private information secret. This means that doctors often have a very limited understanding of the patient's medical and social history, as details that may be important for diagnosis are left out, including the use of other biomedical or traditional medicines, pre-existing conditions, or undesirable behaviours such as earth-eating.[12] Yet, despite the moralising and harsh treatment women often experience in the government health sector, it is considered important to register with the ANC, in order to get a 'clean' maternity card, so that delivery can take place in the hospital without problems.

Making connections

The most important strategy in securing good quality care within the public health system is to connect with somebody who works in the hospital. In discussions about their interactions with the health care system, women – and men – constantly emphasised how vital it is to have a relative or friend among the staff: 'You need to know somebody in the hospital, and also pay them a bit, then they look after you really well, *wanakushughulikia vizuri*, and they will let a family member visit you.' The need to know someone in the hospital to get good care is even more pronounced in the sister island Pemba, a stronghold of the political opposition, which has frequently been punished by the government for its oppositional politics through inducing shortages of medicines, water, electricity, and qualified personnel. In general, party politics play an important role in people's perceptions of hospital care in both islands: poor quality of care, lack of drugs, and harsh treatment by health care providers are closely associated with the hospital as an extension of the ruling party. The mistrust of government health facilities goes as far as accusing health staff of deliberately mistreating patients and killing infants during birth, through poor treatment or medical neglect. Many patients, especially those affiliated with the opposition party, thus consider it vital

[12] Eating soil is described as a common craving amongst pregnant women, and also regarded a treatment for anaemia.

to have a relative or close friend among the health staff to look out for them while in the hospital.

Therefore, when it was time for Nassra's first ANC visit, Mamu took her on a visit to Dr Aisha's home, her own trusted maternity ward nurse. Mamu had known Dr Aisha through connections via her extended family, and had delivered her last children in her care. Mamu describes her as very capable (*hodari*), warm and friendly. Mamu bases her judgement on her previous positive experiences with Dr Aisha, but also on the fact that she is an older woman who has been working at the hospital for many years, and – crucially – that she never asked for payment. Together with Dr Aisha's pious demeanour, this makes her a person of high morality, and thus particularly trustworthy. While Dr Aisha indeed seems to be a caring and professional nurse, she also knows that Mamu's family will not be stingy; for her last delivery, Mamu gave her an envelope with TSH 20.000. Dr Aisha refused, which increased Mamu's trust in her, and she insisted that she accept the present. So we pay her a visit in her home, at first politely enquiring over her health, her little niece's progress, and about her other relatives, just like in a normal visit among friends. Only towards the end of our stay, Mamu mentions that Nassra is pregnant, too, and would like to come to the ANC. Dr Aisha sends us home with her private mobile phone number and instructions to arrive at the hospital early the next morning. When we get to the antenatal clinic on the following day, Nassra calls her on her mobile phone and Dr Aisha meets us outside, channelling us through the crowded waiting room, bypassing the long queue, and makes sure Nassra is treated well and without delay. On every further visit with the ANC, Nassra follows this routine.

Secrecy: Testing and Trying

Despite all the different options for treatment, it is often difficult to get the care needed. For example, one night in her sixth month of pregnancy, Nassra was very sick, so her husband took her to the government referral hospital Mnazi Mmoja at 3am. In Mnazi Mmoja they were told there were no doctors, because it was a Sunday. So they went to the private Al Rahma hospital, where they found a doctor, of course for a fee. There she was told to have a blood test, but there were no needles. After a long odyssey, they managed to buy a needle and take some blood. She was diagnosed with mild malaria and prescribed an injection, the painkiller panadol, omeprazil, and a blood-building tonic. But Nassra did not trust the doctor's expertise enough to take the medicines. Instead, she called Dr Aisha, who advised her not to get the injection, but to use Fansidar, a different anti-malarial instead. Her husband tried everywhere, but this drug is only given out in the government hospital Mnazi Mmoja, where it has to be prescribed by a doctor. When she went to Mnazi Mmoja the next morning, there were still no doctors available because of a bank holiday, so instead she went to see Bi Nafisa, an old midwife who claims to be biomedically trained, but also performs spirit rituals. She is widely known in Zanzibar as an experienced midwife and 'doctor', and impresses her patients by writing English words in their patient booklet and performing physical examinations, which combine biomedical procedures, such as measuring blood pressure and taking blood, and inspections of the eyes and tongue. A woman in the waiting area told me how she had tried to trick Bi Nafisa

by simulating pain, but one glance at her face and tongue sufficed for her to uncover her fib. Nassra was ambivalent about Bi Nafisa, as her expert reputation is tainted by her involvement with spirit healing, which many consider an un-Islamic cultural practice, thus making her morally ambiguous in Nassra's eyes. As with all consultations, Nassra did not tell Bi Nafisa of the test results from the hospital, but pretended to have come straight to Bi Nafisa, and only described her symptoms. Bi Nafisa measured her blood pressure and palpitated her abdomen, diagnosing that the baby was already in birth position. She prescribed multivitamin tablets, folic acid, vitamin B1, and buscopan.

In addition to these formal and semi-formal biomedical facilities, Nassra also consulted a number of 'traditional' and alternative pregnancy experts, despite the fact that she and her family tend to subscribe to a more essentialist version of Islam, where most traditional forms of diagnosis and treatment are regarded as un-Islamic, and she herself considers traditional healing largely as an expression of backward, superstitious rural belief. However, in her opinion, these practitioners are not necessarily less trustworthy than medical doctors – in her experience, the latter often also have questionable qualifications and hidden motivations. Thus, in her quest for some sense of security, she spread the net wider and tried out different routes.

In addition to herbalist treatments and a traditional midwife who took on her postpartum care, Nassra also decided to test a famous 'miracle healer' who is frequented by some of her relatives, particularly her brother's wife. He is known for his success in treating reproduction-related issues, such as infertility and childbirth problems, and his patients claim that he is a trained medical doctor who became proficient in herbal and spiritual treatment. Indeed, he uses biomedical terminology and drawings that resemble anatomical renderings of body parts in his diagnoses and prescriptions, although these do not hold up to medical scrutiny. Nassra was suspicious of 'miracle healers', whom she regards as quacks of questionable moral disposition, but nevertheless decided to test his skills, because she trusts her relatives who swear by the effectiveness of his treatments. As a first trial, she therefore asked him about the position of her baby (which had presented in breech position on the ultrasound a couple of days earlier) and about the due date. 'That way I will know if he has any knowledge,' she explained. We arrived at his practice late in the evening. A large billboard on the gate reads 'Dr Haji Ali Haji, miracle doctor and herbalist, cures every disease'. His large, tiled, up-market house and the number of patients waiting outside the treatment room speak of his commercial success.

When Nassra and I entered the treatment room she sat down on the floor and asked her questions. He told her to undress her upper body and diagnosed by pressing on her belly. 'The baby is in breech,' he stated, and showed her some exercises to turn the baby around, making her sit on all fours and contract and relax her belly in a cat-like fashion. He also assembled some plant medicines from his shelves with instructions on how to use them, and Nassra left TSH 6000 on a small stool on the way out, as instructed by other patients beforehand. Upon her return home she recounted her experience to her mother and sister, who are themselves doubtful of this 'miracle healer', and decided not to take the medicines,

but to try out the exercise, because his diagnosis did match what she had been told in the hospital. Her subsequent consultations with Dr Haji followed a similar course, him pressing on her belly and feeling the baby, her asking questions. She remained suspicious of his skills because often his answers did not seem to resonate with her own experience, and she never used any of the medicines he gave her.

At home, finally, Nassra sought advice from older women in the family, and relied heavily on praying and adhering to Islamic values. She was told to follow *dawa za kisunna,* (lit. 'sunna medicine'), such as for example eating seven pieces of date at daybreak, following the prophet's example (*sunna*). She was also put on the same treatment regime as her sister: *tende na maziwa* (a thick brownish milkshake with dates which seems to taste terrible) was prepared for her, as well as a brew of *mpambawake*, the powerful blood-increasing tree medicine, and she obediently followed these treatments.

Despite all her efforts in gaining some sense of control, however, Nassra's pregnancy ended in an emergency. About three weeks after my departure, Nassra noticed that her underwear was wet: 'I thought it was urine, I thought my bladder had burst!' She wore a sanitary pad and went to the shop. Out of shame she did not tell anybody at first, but when she went to the bathroom she saw that the pad was soaked, to the extent that water would flow our when wringing it. Scared, she told Mamu, who said: 'that's a sign of labour, you're ready to give birth!' Mamu called Dr Aisha who told her to come to the hospital for a check-up. Since Dr Aisha was away that day, Nassra saw a different doctor, who checked and scolded her for coming in too early. She was sent home with instructions only to come back when she was in pain and bleeding. So Nassra left, and for the next two weeks water kept leaking out. She said 'I drank four bottles of water every day, and rarely went to the loo! But I didn't feel any pain, and there was no bleeding.'

On the 15th day, Dr Aisha passed by the shop by chance, and was shocked to find that she was still leaking water: 'you haven't had the baby yet?!' She prescribed a drug to help induce labour and told Mamu to take her to the hospital the next morning, after making sure she take the two pills.

Despite the medication, Nassra still did not go into labour. Since she had not felt the baby move since the morning, Dr Aisha told her to go to the hospital immediately. Once at the hospital, the gynaecologist shouted at Nassra, because she had not come earlier. The doctor grabbed her belly and squeezed it hard, to check if the baby would move. She then asked Nassra where the heartbeat was, but Nassra was not sure, and pointed first to one side then to another. The doctor shouted at her: 'Are you playing games here?' By now, the baby's heartbeat was very faint, and the doctor told her she needed an emergency caesarean section. Nassra was very scared, and declined at first, pleading with the doctor: 'let me try, I can do it!' She says, 'I was really thinking: should I stay or should I run away? I went to the loo, and was already half-way outside the hospital.' Only Dr Aisha's calm and patient explanation of the process helped convince her: 'First you wear this green gown here. Then you go into the operating theatre, and you sit down on the table. Don't be scared of the machine, they're not going to use it. Now sit

forward, and they will give you an injection in your back, so you won't feel anything.' She finally agreed to have the caesarean section, and both she and the baby were fine. But without Dr Aisha's chance visit, and her patient and friendly care, she would not have gone back to the hospital, and her baby would likely not have survived.

Nassra's story shows women's use of secrecy and 'trying out' in their attempts to gain more confidence and thus security when navigating the terrain of different public and private, formal and informal health facilities and providers. At each visit, she took care to hide diagnoses and treatments she had received from other specialists, reflecting both women's distrust of the various healthcare options, and their active endeavour to gain more confidence and security. At the same time, their deliberate creation of uncertainty through obscuring of certain symptoms, previous diagnoses, and treatments, means that the consulted health providers never gained a full picture of their condition, which in turn could make present diagnoses less informed and diminish the chances for a successful outcome.

Nassra's case also shows the cost of such treatment. Her sister summed up the dilemma that patients face when she discussed their visit at the old private midwife: 'Bi Nafisa is very knowledgeable (*hodari sana*), but now she has started to take money: before you just gave her something small, now she charges 8500 TSH for the first visit, and 7000 for the next ones. The medicine comes on top of that and has to be bought in the pharmacy.' This expense not only raises suspicions about the midwife's intentions, but also adds to the range of treatments Nassra had pursued in the last weeks, which included payments for each consultation, prescriptions, blood tests and ultrasound examinations. This commodification of health care has led to a general loss of trust in the health professions, and patients constantly suspect ulterior motives in their interactions with doctors of any kind. It has also led to a further deterioration of the quality of public health care, since many doctors have started their own practices, where they spend much of their time and energy (Beckmann 2010). As Mamu succinctly states: 'The doctors get such a small salary that they don't spend any energy at the public hospital, they don't "care" (*hawajali*) for the patients. They spend all their time at the private hospital, where they make money – how are they going to have energy for the public hospital? When are they going to rest?'

Secrecy and Morality in Uncertain Times

The introduction of business interests into healthcare, and the close entanglements of biomedical institutions with politics have given rise to rumours about deliberate neglect of patients or even the killing of babies in the hospital. A woman who had a stillbirth and was hospitalised for one week recounted to a scandalised audience of neighbours and relatives: 'Many babies die in the hospital. When I was in Mnazi Mmoja, about twelve babies died. And many babies are killed by the doctors, so that the mother can survive. They get an injection in the head! When the mother is in a bad state, they tell her: "we have to kill your baby so that you survive." The doctors here are negligent (*wazembe*), they don't care.'

These rumours reflect broader concerns about loss of control and a general lack of trust in a world with new and increasingly uncontrollable dangers. When asking about the reasons of a woman's high blood pressure and stillbirth, for example, her relative explains: 'These days the food we eat is bad, it has many chemicals (*vyakula vina chemicals nyingi*). In the old times, plants were grown over many months, but today they are rushed (*kuharakishwa*) with the help of chemicals. This led to many new diseases. Diabetes (*sukari*) for example used to be a rich people's disease (*maradhi ya tajiri*), but today even children and poor people get it; the same with hypertension (*presha*), even young people get it.' These reflections resonate with concerns over extensive social, economic and political transformations over the past decades, which are frequently portrayed in terms of moral and cultural decline. Rapid immigration and expansion of tourism, neoliberal reforms and increasing marketization of basic services, the spread of modern media and communication technologies, and economic decline have led to profound sense of uncertainty both about individuals' and families' prospects, and about the continuity of Zanzibari society as a whole (Beckmann 2009). Life has become harsher, ruled by politics and profits, rather than by moral values of kindness, modesty, and restraint, people often complain.

In such difficult times, trust is hard to establish, and in some respects has become a drawback: where success in life has become connected to savvy and ruthlessness, trusting others has acquired a whiff of gullibility and backwardness. This is especially the case when dealing with the institutions and agents of power, be they connected to the state, or to the powers of the market. People have learned from experience that these socially distant forces are unreliable and largely beyond individuals' control, and have little faith in their workings. Trust is therefore primarily invested in those who are socially close, and the establishment of personal ties with people within institutions of power, such as the hospital, reflects this notion. My informants' encounters with socially more distant health care institutions and practitioners were characterised by scepticism and warranted a careful routine of testing and evaluating, which was achieved through handling the encounters with secrecy.

Parkin (2011) analyses the relationships between patients and healers, which have been captured in medical anthropology in a number of ways, from 'encounter' to 'negotiation'. An encounter usually implies a hierarchical relationship, in which the patient is subordinate and submits to the healer's diagnosis and recommended course for treatment, while negotiation leaves scope for questioning the healer's opinion. 'Negotiation and unquestioned acceptance,' Parkins points out, are 'best seen as points on a possible continuum [...] and as overlapping tendencies [...] rather than as essential and fixed elements.' (2011: 10).

The patients in my paper neither submit nor negotiate – they exercise agency by 'testing' different healers' capacities and intentions and carefully weighing the different diagnoses and treatments in their quest for security and greater sense of control. This sense of control is achieved through establishing a measure of confidence as a basis for who to trust. In a context of heightened uncertainty, such a quest for trust – which is a social project, revolving around social interactions –

is only possible through managing the encounters with secrecy: by approaching care providers with scepticism and testing the trustworthiness of their diagnoses and treatment recommendations through hiding knowledge acquired through previous consultations with other experts, my research participants constantly triangulate in their attempts to determine the most promising treatment course. Women's paths to safe motherhood are therefore shaped by a triangular interconnection: a condition of uncertainty over the best way to manage the dangers of childbirth leads them to search for trust (in the form of trustworthy advice), which they try to establish through secrecy, by testing and trying different professional and lay recommendations. This secrecy in turn deliberately generates more uncertainty.

Issues of secrecy and mistrust characterise life in Zanzibar. Secrecy is a central value in Zanzibari society, and private, domestic matters must always be kept secret (*siri*). This reflects an Islamic concern with concealment of one's inner affairs, including matters concerning family life (and especially intergenerational disagreements or issues between husband and wife), as well as one's innermost feelings, desires and aspirations. Feelings and conduct which violate the practice of social conformity in particular should not be disclosed, but should remain concealed at all times due to the fear of *aibu*, shame (Larsen 2008). Other people's ability to shame and insult a person depends on their knowing about the life and activities of the insulted and his or her family. Thus, to have *siri* (secret) is considered prudent and sensible in order to maintain the family's honour (cf. Swartz 1991, for Mombasa).

Secrecy is considered an essential protective feature of good pregnancy care, and women usually try to hide their pregnancies from all but the closest relatives for as long as possible. Wide, loose-fitting garments help in concealing the growing belly, and women take pride in having been able to 'surprise' friends and neighbours with a newborn baby, while nobody had suspected a pregnancy. I have never heard the words 'I am pregnant' spoken by anyone; subtle clues are used to point those who need to know in the right direction. Unusually snappy and sharp behaviour, for example, is a widely used means to convey the message to the husband, and men are instructed in their premarital wedding instructions to look out for this behaviour as a sign of pregnancy.

Even quite mundane everyday or morally not contentious matters are often kept secret, and people make up stories about where they have been, what they have done, who they were with, or what they believe. In fact, skilful story-telling, joking and pulling people's leg are valued and admired, and are an important means to teach others a lesson. As a result, there is a pervasive feeling that nobody can be trusted to tell the truth. Whenever I asked somebody: 'who do you trust?', the answer was always the same: 'nobody, except perhaps my father/mother' (usually not both). A long history of intelligence gathering and reporting on neighbours and family members makes those close to or working for the government particularly suspicious in the islands, which have a long history of oppositional politics. Pervasive corruption both in and outside the health system and experience of bad quality of services have made people wary in their interactions with the health system and constantly doubt the diagnoses they are given. The

truthfulness of a diagnosis is here assessed by judging the morality and intentions of the person, rather than merely their position or qualifications.

Contingency, Social Closeness, and the Creation of Confidence

Trust thus depends on who it is that gives the advice. In addition to consulting and 'testing' maternity care professionals (both for their skills and their moral disposition and intentions), Nassra, for example, used every opportunity to ask those close to her for advice, on how to sleep (on your side), how to get up, what to eat, what to avoid, which movements to do, what exercises are best, which sexual positions to use etc. She consulted Bi Fatuma, the old woman who provides traditional postpartum care, her mother, her sisters, the widely respected, knowledgeable and successful neighbour, and all the relatives who kept coming in. Whether or not she followed their advice largely depended on her assessment of the person's trustworthiness and knowledgeability. Advice coming from her husband, for example, was quickly discarded, since he clearly has no experience with childbirth. Her mother had given birth herself, but is not trusted too much, because she is old and somewhat backward in her belief in a number of un-Islamic traditional practices, while Mamu serves as her main confidant and is highly trusted, due to her position of authority as an older sister who shared experiences of pregnancy, but also because of Mamu's piety and largely essentialist Islamic belief which discards the majority of 'traditional' healing practices as mere custom (*mila*) or even superstition (*shirk*). Dr Aisha shares this strong Islamic belief, which is reflected in her behaviour and reputation as a pious, moral person. Combined with her medical qualification and experience, and her position as a socially close contact within the public hospital, these factors make her the most trusted medical expert involved in Nassra's care.

Ultimately, it is this connection with people, and the ability to weigh different, often contradictory advice from different individuals, institutions and professions, which is the balancing act people in Zanzibar have to strike in navigating the health landscape. This social contingency, the relationships with and dependency on others, is often decisive in directing matters towards a positive outcome, as Nassra's experience of childbirth demonstrates. While contingency in its relational form necessarily implies uncertainty, a lack of control over the person upon whom one depends, Whyte and Siu (this volume) demonstrate its positive potential. The deliberate creation of contingency by forging links with those who may help improve security is an 'attempt to move an uncertain situation towards greater confidence' (Whyte and Siu, this volume).

Zanzibari women's understanding that contingencies can have significant effects on outcomes at the same time increases and decreases their sense of security and confidence in the course of their pregnancies. Connections to strategically important persons within the health system are widely recognised as vital for good care and increases patients' confidence considerably; but those who do not succeed in making these connections know that their care will likely be poor.

At the same time, contingency upon others of course cannot guarantee success – particularly in a context where secrecy is highly valued and trust is elusive – but,

in the face of uncontrollable forces such as powerful state and market institutions, people turn to those who are close to them, whose intentions and motivations appear more easily knowable. Forging relationships with people inside the health system – trying to 'put a face' on abstract forces (Whyte and Siu, this volume) – here is one way to gain greater control over the highly uncertain and unpredictable process of reproduction and highlights an 'ethos of contingency', a 'disposition of hopeful "you-never-know-keep-trying"' (ibid).

Conclusion

Pregnancy and childbirth in Zanzibar is a dangerous endeavour. Strategies to control the risks include an active quest for care that can be trusted. In the private and family realm, trust derives from a firm faith in God and use of long-standing remedies. In the more socially distant, institutional encounter with professional healthcare providers, trust is harder to establish and impeded by an increasing marketization of health and longstanding political interconnections.

While biomedicine's claims to effectiveness rest on the assumption that its remedies work directly on the body, regardless of belief or personal connection, patients know from experience that its practitioners are closely entangled with state and market forces which are widely regarded as untrustworthy. They thus try to establish some sense of trust by building personal relationships and careful testing, drawing on practices of secrecy. Ultimately, personal connections are vital: contingency upon personal connections ensures survival, much more so than money and drugs.

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