Birth Rights:

Birth registration, health, and human rights in Tanzania

by

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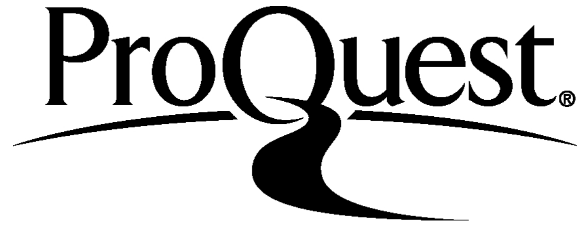

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Chapter 1: Introduction

The first right: Conceptualizing birth registration

> "In the scheme of things, the need for a birth certificate may not seem profound, especially when compared with the hurdles children routinely have to scale in developing countries.
>
> But in reality, that piece of paper is crucial. It is the proof that what might be called the 'first' right, the right to an official identity has been fulfilled."
>
> —Unity Dow, Botswana High Court Justice (retired)[1]

In September of 2012, the UN Economic Commission for Africa held a meeting in Durban, South Africa, for African ministers who were responsible for civil registration in their countries, including registration of births, marriages and deaths (referred to collectively as "civil registration") and vital statistics, which are basic population statistics derived from data collected through these forms of civil registration. Along with various official proposals and statistical reports circulated at the meeting was a small booklet with hand-drawn illustrations, called "Civil Registration: The Moving Elephant in Africa" (UNECA 2012). The booklet uses a well-known fable about an encounter between six blindfolded men and an elephant to describe the key problems with civil registration systems in Africa. Although the fable originates from the Indian

[1] (Dow 1998: 1)

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subcontinent and can be found in Buddhist, Jain, Hindu and Sufi texts (Thompson 1955), it translates quite well to the African context:

> Here goes the famous story of the Elephant and the six blindfolded men...
>
> Each man felt a different part and so described the elephant based on the body part of the elephant he touched.
>
> The first man who touched the elephant's leg said, "This is very thick and strong, it must be a tree." "Oh, no it's not a tree! It's a rope," said the second man who touched the tail.
>
> "No! A rope can't be this thick and it also feels alive so this must be a snake" said the third man who touched the trunk of the Elephant.
>
> "It is a big hand fan," said the fourth man who touched the elephant's ear.
>
> "I don't know how you say all those things while it obviously is a wall," said the fifth man who touched the belly of the elephant.
>
> "You are all wrong! This without a doubt is a spear," said the sixth man touching the tusk of the Elephant.
>
> They began to argue about the Elephant and each one of them insisted that he was right.
>
> Of course there was no conclusion for not one had thoroughly examined the whole elephant. How can anyone describe the whole until he has learned about all the parts?
>
> The history of CRVS [Civil Registration &Vital Statistics] in Africa resembles this story.

While this booklet is perhaps one of the more whimsical documents in the history of the UN, it quite effectively illustrates one of the reasons why many African countries have had such a difficult time instituting robust and efficient systems to register births and other important life events, and to generate reliable statistics based on registrations. As the booklet explains:

> The elephant here represents the enormity of the operation and the blindfolded men characterize the various stakeholders, who in past tried to approach the CRVS from their own perspective. However, the story of CRVS could not have ended with mere recognition of the fact that was an elephant but also demanded effort on the part of the

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> stakeholders to make this huge animal move. Different stakeholders in the past were anxious and made efforts to move the Elephant (CRVS) forward but could not succeed due, among others, to limited coordinated and harmonized efforts.
>
> In 2009…stakeholders recognized the fact that CRVS is multi-sectoral and multi-disciplinary in nature and that there was a need to adopt an integrated and holistic approach in improving the situation. The First Conference of Ministers responsible for Civil Registration was one big effort to not only move this huge animal but also provide a clear direction for it to tramp (UNECA 2012:2).

The booklet goes on to provide a short history of previous attempts to "move the elephant" of civil registration. It characterizes the colonial period as "the sleeping elephant", and describes that colonial registration systems were "discriminative, limited to registration of vital events occurring to specified groups mainly the foreigners," and were also used in some cases to "control movements of the people and…for managing the people under colonial rule." The elephant of the post-colonial era is described as "partially awake and confused." Although post-independence countries knew they needed better civil registration systems, they lacked the necessary capacity: "The limited understanding, systematic and holistic approach on how to drive successful systems was a great impediment. With all stakeholders pulling from different directions the elephant was awake but quite confused. This was a phase of stagnation, with no real progress realized."

The elephant finally awakened early in the 21st century, when the global emphasis on quantification and indicators drew attention to the issue of civil registration and vital statistics in developing countries. In 2009, at a meeting in Dar es Salaam, Tanzania, African experts in statistics and civil registration resolved to join forces to address the problem themselves, rather than relying on previous donor-led "isolated, project-based and individual institution-led ad-hoc exercises and initiatives" (UNECA 2012: 5). "The need for joint engagement of national civil

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registration and vital statistics institutions and a holistic approach in addressing the various outputs of CRVS systems such as statistics, health, governance, issuance of national identity cards, passports, electoral lists, and in the measurement of progress in development indicators was at the peak of discussions. However, "among the major challenges identified was the lack of political support towards the systems." The booklet concludes that despite ongoing challenges of political will and resources, "Today the elephant is surely moving if not running!"

I describe this booklet and the story it tells about civil registration in some detail for several reasons, and not only because it is rather charming to imagine ministers, statisticians, and UN bureaucrats sitting in a conference room reading an elephant fable. First, this story provides insights into the epistemological questions at the heart of birth registration, questions which these ministers and statisticians surely confront during such meetings, and which I have confronted during the past five years of my research in Tanzania: What kind of problem is birth registration? How can it be understood? Whose problem is it? Why is it so difficult to accomplish? How can it be improved? The elephant fable highlights the multiple and shifting meanings of birth registration. One's understanding of the nature of the problem, and thus its possible solutions, is dependent on which part of the elephant one is touching. Is it a human rights problem? A health system problem? A kinship problem? A governance problem? A development problem? A data problem? Birth registration is all of the above, which demonstrates its relevance to so many aspects of life. But as I argue throughout this dissertation, its multi-faceted significance across sectors and scales, from the local world of the family to the global world of human rights law

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and development indicators, makes it very difficult to assign accountability for improving the problem.

Second, the choice of an elephant as a metaphor is particularly apt. Like an elephant, a birth registration system is a large and somewhat unwieldy entity. It is difficult to view the whole system at once, except from a distance. It is powerful, but hard to control. Third, rather like elephants, birth registration is seen by the international community as an urgent problem that Africa should address, but few resources are given to support sustainable local systems and capacities. Unlike elephants, birth registration is not indigenous to the African continent, but rather was imported by colonial administrators and missionaries in the 19th and early 20th centuries. Many African countries have had birth registration laws of some kind in place for more than a century, and today rates of birth registration vary drastically within sub-Saharan Africa, from a low of 3 percent in Somalia, to a high of 95 percent in South Africa (UNICEF 2013). Across sub-Saharan Africa, more than 40 percent of births each year are not registered, and 55 percent of children under 5 do not have a birth certificate. Tanzania ranks in the bottom 20 countries in the world for birth registration, with just 16 percent of children's birth registered, and only 8 percent of children under five actually possessing a paper birth certificate (UNICEF 2013, National Bureau of Statistics and ICF Macro 2011). As I describe in more detail below, birth registration has long been a somewhat obscure issue. But as the elephant fable notes, in the past decade the issue of birth registration has been "woken up" by a diverse group of stakeholders, including child rights advocates, public health experts, and African government officials. The current interest in birth registration has been driven by several factors: the need for high-quality statistical data for health and development planning; the proliferation of indicators

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that use birth registration as a measure of various phenomena relating to human rights, health, and governance; and the increasing demand for official forms of identification as African countries rapidly develop and introduce new regimes of documentation to many aspects of life.

I did not set out to study birth registration in Tanzania for this dissertation. Rather, the issue of birth registration found me while I was working on another project: a case study of a child rights indicator that was being pilot tested in Tanzania. I went to Tanzania in 2009 and 2010 to observe this pilot as a part of Sally Merry's multi-sited study of human rights indicators (Merry and Wood 2015). While I had been involved in various research projects related to health in Tanzania for almost 5 years at that point, I had not heard any health workers in Tanzania discuss birth registration. Nor had it been raised in my public health training in epidemiology, demography, and maternal and child health. I first really learned about birth registration at a training workshop for this child rights indicators project in 2009, which involved sequestering about 30 Tanzanian government and NGO representatives and a team of trainers (5 foreign and 1 Tanzanian) in a rather decrepit hotel in the small town of Morogoro in central Tanzania for several days. While the minister who came to open the meeting and various UNICEF staffers all arrived in their own individually chauffeured SUVs, for the rest of us it was a very hot and bumpy six hour bus ride from Dar es Salaam.

On the first day of the meeting, the foreign team who had created the indicators were explaining to the Tanzanian participants which types of data would be used to measure the state of child rights in Tanzania. One of the indicators involved birth registration, and as it was discussed, a spirited discussion broke out. When Tanzania's low rates of birth registration were

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mentioned, several people called out the representative from the Registration, Insolvency, and Trusteeship Agency (RITA), who was responsible for birth registration services. Her interlocutors, a pediatrician from the Ministry of Health, and a woman from an early child development NGO, asked why Tanzania was not doing better on birth registration. The representative from RITA, who later proved herself to be one of the strongest contributors to the project, answered her colleagues: “You all know there is so little funding for us in the budget. We are doing what we can with what we have, but it is very difficult.” Although this was a predictable answer, it was nonetheless accepted by the group. Most people from smaller ministries could sympathize with her. A few more philosophical questions about birth registration arose, such as whether stillborn babies could get birth certificates, and if so what age could be written down for the fetus or baby. One woman mentioned that perhaps mothers of deceased babies would like to have an official record of them to remember them by, once they had gone to heaven and become angels. The foreign staff sidestepped this difficult bioethical and philosophical issue by stating that for the purposes of the indicator, they defined the beginning of life at age 0, and that people could interpret the meaning of that 0 according to their own beliefs. In exchange for observing, I had volunteered to take minutes of the meeting. Going over the transcript the next day, I was struck by how the seemingly bureaucratic topic of birth registration had given rise to so many issues: national budgets, indicators, infant mortality, angels, and personhood in the space of a few minutes. Here was something interesting.

Over the next few years, I planned and carried out the research in this dissertation, examining birth registration in urban Tanzania from a variety of perspectives: cultural, historical, legal, medical, political. At times, I have found the process of studying birth registration

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ethnographically it to be a bit like that elephant—my perception shifts based on where I stand in relation to the whole. Another challenge is that birth registration is not a static system. Rather, its meanings have changed over time in significant ways. Additionally, with the increased international attention to the issue of birth registration in recent years, its practice in countries like Tanzania, which has mostly been unchanged for nearly a century, is now also beginning to change rapidly with the introduction of new technologies such as mobile phone-based registration. In the rest of this introduction, I provide a short history of birth registration, with particular attention to its shifts in meaning over time. I then describe the key arguments I will make about birth registration in Tanzania, and briefly outline the material discussed in each chapter.

Shifting histories of birth registration

The meaning of birth registration has undergone several significant shifts in the last century, while the paper-based practice of birth registration has remained remarkably unchanged until recently. Histories of registration can be organized along three distinct themes: surveillance, rights, and governance. Although these themes correspond to specific historical eras, there are also significant overlaps in these themes across time in particular contexts.

Birth registration has been most often studied as a form of population surveillance. Forms of birth registration for the purpose of population surveillance have been documented in ancient societies including China, Greece, Rome, Egypt, Peru, and many Muslim societies (Szreter and Breckenridge 2012). The oldest known systems of individual and household registration date back over 2,000 years in China (Von Glahn 2012). Japan has had a complex system of household

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and land registration system known as *koseki* which dates back to the Meiji era (Saito and Sato 2012). These examples of non-Western systems of registration put to rest the "Foucaultian canard that the registering, planning and controlling state is a product of European modernity somewhere around the sixteenth and eighteenth centuries" (Szreter and Breckenridge 2012: 24). The Catholic and later Protestant churches of Europe introduced practices of registration to Italy and France in the 14th century, Spain in the 15th century, and then to England in 1538, during the reign of Henry VIII (Szreter 2006). Thomas Cromwell, chief advisor to Henry VIII at that time made an argument for introducing birth registration as a secular practice, with the purpose of "avoiding of sundry strifes and processes and contentions arising from age, lineal descent, title of inheritance, legitimation of bastardy, and for knowledge, whether any person is our subject or no" (Cromwell quoted in Szreter 2006: 73).

In the 19th century, new developments in mathematical statistics coincided with the expanding power of European states, giving rise to statistics as a "science of the state" (Porter 1986, Schweber 2006). Systems for collecting vital statistics on births and deaths were a political priority during this era, as rulers were concerned with population size and health as a form of state power (Foucault 2007). However, registration as a form of surveillance did not necessarily have the negative connotations associated with Foucault's reading. For example, Victorian public health researchers such as the early epidemiologists William Farr and John Snow advocated birth registration as a means of identifying and acting on high rates of infant and child mortality (Eyler 1979, Susser and Bresnahan 2001). British abolitionists also used birth and death registers of enslaved people as part of their successful campaign to pass an act which emancipated enslaved people in Britain and the Caribbean in 1807 (Engerman 2012). However,

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at the same time, birth registration was also being introduced as a negative form of population surveillance and control in European colonies, particularly in Africa and Asia. The extent and effects of these laws varied widely in different colonial contexts, leading to some colonized populations that were heavily surveilled, and others that mostly evaded the gaze of the state (Ittmann, Cordell and Maddox 2010). In most colonial states, population registration was linked to taxation, giving it a very negative connotation among colonized peoples (Iliffe 1979, Burton 2008). The colonial expansion of the early 20th century also gave rise to the field of tropical medicine, and British epidemiologists at the London School of Hygiene and Tropical Medicine strongly advocated for the expansion of birth and death registration in colonies as a means of monitoring the fertility and health of local populations. This was referred to as a system of "book-keeping wherein the items of account are expressed in terms of human beings" (Edge 1931: 1269). While colonial administrators were reluctant to use scarce personnel and funding to set up comprehensive systems of registration, tropical medicine experts continued to argue that "Reliable birth and death records are urgently needed, since, without them it becomes impossible to estimate the effects of civilizing influences upon native health" (Edge 1931: 1275). With the advent of World War II, attention turned away from such schemes.

The second era of registration began after World War II, during the era of major human rights treaties. In this period, birth registration was re-framed in the international community, going from a method of population surveillance, to a source of individual human rights. While some parties argued for the inclusion of a right to birth registration in the Universal Declaration of Human Rights in 1948, this issue was considered too controversial at the time (Marshall 2012), and was postponed until the International Covenant on Civil and Political Rights in 1966,

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Article 24 of which states that “Every child shall be registered immediately after birth and shall have a name” (UN General Assembly 1966). The status of birth registration as a basic human right was further elaborated by the Article 7 of the Convention on the Rights of the Child in 1989: “The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents” (UN General Assembly 1989). The African Charter on the Rights and Welfare of the Child (1990) also affirmed the right to birth registration in its Article 6: “Every child shall have the right from his birth to a name. Every child shall be registered immediately after birth” (OAU 1990). In the 1990s, Botswanan High Court Justice Unity Dow played a key role in theorizing birth registration as an aspect of legal personhood, and a “gateway right” that is both a right in itself, and a necessary precursor to the fulfillment of other rights, including civil and political rights such as voting and obtaining a passport, as well as social and economic rights including access to education, and protection from rights violations as a legal minor (Dow 1998: 1).

After the passage of the Convention on the Rights of the Child, UNICEF and the child welfare NGO Plan International began advocacy campaigns to promote birth registration in developing countries. These campaigns have framed birth registration as specifically an issue of children’s human rights, although as I will argue below, people do not experience many of the consequences of being unregistered until they are teenagers or adults. Despite this advocacy, birth registration remained a relatively obscure issue into the 21st century. Unlike many other issues facing children in Africa, it is interesting to note that birth registration has never attracted the types of celebrity spokespeople that flock to issues such as malaria, HIV/AIDS, clean water,

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or women's empowerment. The only celebrities to promote birth registration have been Harry Belafonte, during his time as a UNICEF envoy in the early 2000s, and Archbishop Desmond Tutu. Archbishop Tutu said in 2005: "it's a small paper but it actually establishes who you are and gives access to the rights and the privileges, and the obligations, of citizenship" (Plan 2005). Plan International partnered with developing country governments, including Tanzania, to sponsor special "registration drives" which temporarily expanded access to birth registration services and promoted it as a child right, but did not impact the underlying structures that make registration difficult in poor countries. Viewing birth registration as a human right raises interesting questions for this study about how human rights are translated and vernacularized into local cultural contexts (Merry 2006). In particular, how does both the meaning and practice of birth registration differ in low-income countries like Tanzania, which provide few entitlements and also have technical difficulties issuing identity documents? In the conclusion, I consider how the right to birth registration is viewed in Tanzania, not as a universal human right but as a specific citizenship right.

The increased attention to birth registration brought by human rights activists also resulted in renewed interest from other fields, including public health and statistics. This has served to shift the meaning of birth registration yet again, away from rights and towards more technical issues of administration and governance. In 2007, *The Lancet* medical journal published a landmark series of papers called simply "Who Counts?" which played a major role in shifting the discourse on birth registration, framing it as a governance problem amenable to technical solutions (Setel et al 2007, AbouZahr et al 2007). The research team behind these papers is notable in that it prominently featured anthropologist Philip Setel and historian Simon

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Szreter, in addition leading epidemiologists and statisticians. While these papers affirm that birth registration is a basic human right, they focus instead on governance issues, both in terms of how better vital statistical systems can improve governance, and how specific administrative and technical interventions can raise rates of registration. The papers strongly condemned the lack of attention to civil registration systems in the developing world, and declared it an "orphan issue: everyone's concern but no one's responsibility" (AbouZahr et al 2007: 8). The authors concluded: "Individual proof of birth and death is possibly the clearest indicator of that much-hyped concept of 'good governance.' Its absence surely ranks as the single most critical failure of development over the past 30 years" (AbouZahr et al 2007: 8). As I discuss in chapter 7, governance is a difficult concept to measure, and some of the arguments about birth registration and good governance are tautological. However, it is clear that many problems of birth registration are ultimately tied to systemic governance issues.

The history of birth registration in Tanzania is relatively consistent with the eras of surveillance, rights, and governance that characterize the global history of birth registration. The first birth registration law was passed in 1917 (Proclamation No. 15 of 1917), when Tanzania was part of German East Africa. Given that the law was passed towards the end of Germany's rule, and mandated birth registration only for children with at least one white parent, it is thought that the law did not have much impact (RITA 2015). In her history of the German colonial empire, Wildenthal (2001) notes that most German colonies had birth registration laws of this type, which were concerned with monitoring *rassenmischung* or "race mixing" between German

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men and local women (2001: 80). When the British took over administration of Tanganyika in 1919, they kept a similar version of the German birth registration law in the legal code, as the Births and Death Registration Ordinance of 1920 (Cap.108). Again, this law mandated registration only for children with at least one white parent. My archival research in the British National Archives suggests that British colonial administrators placed a very low priority on birth registration during the interwar period. They were much more concerned with death registration, in particular collecting data on deaths of colonial staff in various regions of the country, so that they could arrange for replacement staff to be sent as needed.

For most Africans in rural areas, interaction with the British authorities during this time was largely limited to tax collection. As I discuss in chapter 7, under indirect rule, British governance relied on Native Authorities comprised of hand-selected local leaders. These local leaders were charged with both collecting taxes and keeping records of births and deaths in villages, creating a strong disincentive to inform the authorities about any new additions to the household (Burton 2008). World War II brought many Africans closer to British forms of governance and bureaucracy, either through African men who fought with the British army in campaigns in Somalia, Abyssinia, Madagascar, and Burma, or through women and children living in towns who received ration books during the war (Iliffe 1979). In the 1950s, the British attempted to introduce a scheme of selective registration of men from certain ethnic groups in northern Tanganyika suspected of being sympathizers with the Mau Mau uprising in Kenya. However, this plan proved so unpopular that it was never implemented (Elkins 2005).

In the post-independence era, the births and deaths registration law from 1920 remained unchanged in the Tanzanian legal code, and is unchanged to this day. In 1961, a Registrar

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General Department was established as part of the Ministry of Justice and Legal Affairs (RITA 2015). It is difficult to know why birth registration was not of interest to the Nyerere government, even as neighboring countries such as Kenya were taking steps to expand access to birth registration for Africans. Certainly the newly independent country had many competing priorities and ideas of how they wanted to govern themselves. Considering the ideas of governance outlined in Nyerere's *Ujamaa* philosophy, it seems that the focus on families and villages as the principal units of society would discourage the need for formal identity documentation (Nyerere 1968). Ten-cell leaders were supposed to keep lists of births and deaths in the community, although it is not clear whether this data was regularly reported to the central government (Hyden 1980). Another barrier to registration cited by the elders I interviewed was that during the *Ujamaa* era the vast majority of people were born at home, and for many people the closest government office would have been several days' walk away.

The Registrar General Department also underwent a series of re-organizations from the 1960s to the 2000s, being shuffled around to different ministries and undergoing several major changes in its responsibilities and scope. From the 1970s through the 1990s, the Registrar General Department in its various guises would have been impacted by Tanzania's financial crisis and the ensuing austerity measures imposed by structural adjustment policies, as I discuss in chapters 3 and 7. These measures included cuts to staff, salaries, equipment, and budgets, which made it increasingly difficult for government departments to fulfill their duties. The Registrar General Department would have been especially hard hit by these cuts, because whereas other government entities, like the Ministry of Health, could relieve some of this financial pressure with funding from donors, the activities of the Registrar General Department

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were not donor priorities at this time. The Registrar General Department became the Registration, Insolvency and Trusteeship Agency in 2005, and is today part of the *Ministry of Justice* and Constitutional Affairs. Known by its English acronym RITA, the Agency is now responsible for a wide array of services: registering not only births, adoptions, marriages, divorces and deaths, but also the registration of businesses and trustees, and matters relating to bankruptcy. Currently RITA has 132 employees to provide all of these services for a population of more than 45 million people. They have a fairly modest national headquarters in Dar, which I describe further in chapter 8. But they have no employees at the district or regional level, and must rely on staff from other departments in those offices to provide registration services (RITA 2015).

One constant over the history of this agency is that its scope of work has been large and unwieldy, and it is expected to provide a wide array of services with insufficient resources. In 2009, Tanzania passed the Law of the Child Act, which finally superseded the colonial-era law to make birth registration compulsory for all Tanzanians. Article 6 stipulates that:

1. A child shall have a right to a name, nationality and to know his biological parents and extended family.
2. A person shall not deprive a child of the right to a name, nationality and to know his biological parents and members of extended family.
3. Each parent or guardian shall be responsible for the registration of the birth of his child to the Registrar-General.

The growing interest in birth registration in the international community has led to increased pressure on RITA to improve services, but as the staff told me, this pressure is not accompanied by political will or additional resources. In 2012 RITA's budget for birth registration activities

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was $300,000, and they were also receiving funds from UNICEF for a pilot project to improve birth registration in one region out of 30. The staff I spoke with told me that the funds from UNICEF for one region were equivalent to their total national budget for the year. The disparity between the vast number of unregistered people, and the modest resources allocated for registration work points to the structural difficulties faced by staff and parents alike, leaving both sides frustrated by the lack of progress on birth registration.

RITA is under pressure to improve both registration services and the vital statistical data that are derived from registrations. Different stakeholders all want to make their issue the top priority: child rights groups like UNICEF want to prioritize access to paper birth certificates; epidemiologists like *The Lancet* research group want improved death registration data so that they can use it to calculate mortality rates more accurately. As difficult as birth registration is, it is actually easier to promote than death registration, which many people still find very disturbing. At least with birth registration, RITA can run a campaign with UNICEF featuring cute babies and smiling mothers. That is uncontroversial, but promoting death registration is another matter entirely. Although death registration is a fascinating and very important topic, it is mostly outside the scope of this study. Even through RITA is responsible for both birth and death registration, most people do not seek a death certificate unless there is an urgent legal matter, such as a dispute over inheritance.

While the overall rate of birth registration in Tanzania remains low at 16 percent, there are significant disparities within Tanzania. The island of Zanzibar has the highest rates of birth registration (87.9 percent), and the rural region of Manyara in north-central Tanzania has the lowest rate (4.1 percent). Unfortunately Zanzibar is outside the scope of my study, although a

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comparison between registration on Zanzibar and the mainland would have been fascinating. In general the greatest disparity in registration rates on the mainland is between urban (44 percent) and rural areas (10 percent), for several reasons I discuss in greater detail in chapter 3 and 7, including high rates of home birth in rural areas, and long distances to government offices in rural areas. One heartening sign is that there is no disparity in rates of registration for male and female children (all statistics from National Bureau of Statistics and ICF Macro 2011). Tanzania does not collect any administrative data disaggregated by religion, but within my sample I did not find any significant differences in rates of registration among Muslim and Christian families. However, Christian families do sometimes have the option of using a baptism certificate as a proxy form of identification for children, while Muslim families do not have this option. But as I discuss in chapter 5, class was by far the most significant factor impacting rates of registration.

Studying an "orphan issue"

In the rest of this introduction, I will consider some key problems and conceptual issues associated with studying birth registration ethnographically, before describing my research methods, and the contents and arguments outlined in the following chapters. Birth registration encompasses many issues of core interest to the field of anthropology, including personhood, childbirth, kinship, social reproduction, family life, gender and class, law and governance, human rights, citizenship and belonging, technology, and the production of knowledge. A number of ethnographies contain interesting mentions or side notes about birth registration. These ethnographies are typically related to childbirth, including Nancy Scheper-Hughes' study of infant mortality in Brazil (1992), Alma Gottlieb's study of childhood in the Beng community

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of Côte d'Ivoire (2004), and Elisha Renne's study of reproduction among the Yoruba of Nigeria (2003). Each contains a few pages or a few references to birth registration, both as a bureaucratic struggle for poor families, and as a site of the bureaucratic production of personhood. These ethnographies all provided valuable starting points for me to think about birth registration ethnographically, especially in contexts of developing countries with relatively high infant mortality rates. However, as far as I know, no full-length ethnographies of birth registration have been published to date in either English or French, although there may very well be such ethnographies published in languages that I do not read. In order to conceptualize a full-length study of birth registration, it became necessary to expand the scope of previous studies, by looking at how the practice of birth registration occurs across different domains, including the hospital, the family, the community, and the local and national government. In a sense, I used a method of reverse engineering, starting by looking at how birth registration was used by global child rights indicators, and then tracing those statistics back to their origins to understand not only why birth registration rates are so low in Tanzania, but getting to know the people behind the statistics.

Studying birth registration ethnographically has posed several interesting challenges. First, since rates of birth registration are so low, how could I study something that is not happening? My approach to this problem was to talk to people who had tried to register unsuccessfully about the problems they encountered, and to identify patterns of similar experiences. I began from the standpoint that the experiences of people who failed to register were as meaningful as the experiences of those who succeeded. The second problem was that for those who are successful in registering, it is often a slow process that takes months or sometimes

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years of persistent visits to different government offices to actually walk away with a birth certificate. I interviewed many people who were at different stages of what some people referred to as a "long journey" to registration. Ultimately, I found that the same factors that make birth registration difficult but important to accomplish also make it difficult but important to study. Birth registration touches on many different and often sensitive aspects of life: birth, health, family, money, class, citizenship and marginalization. A birth certificate is a simple piece of paper, but it carries the weight of competing meanings and expectations.

I sought to explore two main research questions: 1) what is the cultural, social, and historical significance of birth registration in Tanzania? and 2) what factors contribute to the low rates of birth registration in Tanzania? Over the course of about 14 months of fieldwork, I explored these questions through a variety of research methods. Most of my time in Tanzania was spent engaged in household surveys and ethnographic observations in three neighborhoods of Dar es Salaam, Tanzania's largest city. I complemented this community-based research with observations of registration activities at local government offices, and interviews with Tanzanian government officials and experts in the fields of law and public health. I also spent time studying documents and reports related to birth registration and vital statistics in various archives in Tanzania and England, including the Tanzania National Archives, the British National Archives, and archives and libraries at the Wellcome Library, the British Library, the London School of Hygiene and Tropical Medicine, and the School of Oriental and African Studies.

Before arriving in Tanzania, I spent several months designing a household survey which combined basic demographic data on family members, income, education, and health status, and number of people in the family with birth certificates, before moving on to open-ended questions

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about peoples' experiences in trying to register, their feelings and frustrations about their interactions with the government, their views on public services for children and the performance of the government in general, and their own ideas for improving birth registration. After completing a draft of the survey, I translated it into Swahili. Once I arrived in Tanzania, I worked with two of my research assistants, Flora and Agatha, to correct and improve the translation, and to refine the questions as needed to make sure they were clear. We then pilot-tested the survey for two weeks, and made additional refinements to the survey based on those initial interviews. A third research assistant, Winston, suggested several important changes that really improved the accuracy of the survey and the flow of data collection, leaving more time for unstructured conversation and observation during the home visits.

I cannot overstate how important Flora, Agatha, and Winston were to the success of this research. They were all in the mid-twenties, and referred to me by my friend and informal research mentor, a Tanzanian professor of medicine. Agatha and Winston had been his students at Muhimbili University, where they were both finishing their medical degrees at the top of their class. Flora was a family friend of my professor, and had recently graduated from university with a degree in public administration.

All three worked with me part time, depending on their school schedules and other obligations. In the community, we typically worked in a team of three, and although this posed some problems when trying to crowd into tiny one-room dwellings, it worked very well in general. Typically one of us would ask the survey questions, a second person would write down the answers in Swahili, and I would also make fieldnotes in a mixture of Swahili and English at the same time. We did not use any recording devices, which would have made people nervous,

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especially since being unregistered is technically illegal. Before each interview, we went through an informed consent form in Swahili, and if the interviewee did not read and write Swahili, we would find a neighbor or adult family member who could independently confirm the contents of the form for them. Interviews lasted anywhere from 45 minutes to several hours, depending on how busy the person was, and how much they said to say about birth registration in particular, or the health system and the government in general. Many women talked with us while continuing their household chores or income generating activities, such as cooking soup or chapatis, making charcoal, doing laundry, or braiding hair. Others heard we were coming, and put on their Friday or Sunday best outfits to receive us.

Some people clearly found it a bit nerve-wracking to receive a random American visitor in their home, but they seemed to enjoy interacting with Agatha, Flora, and Winston, who were always smartly dressed and very respectful to all the participants. Elders in particular enjoyed seeing highly educated young Tanzanian professionals at work in their neighborhoods. By the end of the interview, most people seemed to get used to me as well. I should mention that at the end of each interview, I offered a small “thank you” gift of Tsh 5,000 in cash, equivalent at that time to about US$3. There is a great deal of debate about whether or not researchers in low-income countries should give cash gifts in exchange for participation in research. After discussing this with Tanzanian academic researchers, I decided to go ahead and give cash, rather than typical gifts such as tea, soap or phone cards. Not only is cash the standard among Tanzanian researchers in their own studies, but I felt that it was appropriate given that many interviewees would be taking time away from other work to talk with me, and I wanted to recognize this and not assume that because people were poor, their time was somehow less

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valuable. In general, I tried to work in the neighborhoods in a gentle, low-key way, in part because we were asking questions on some sensitive topics. According to one ward political leader who I had to approach for a stamp for my research permit, birth registration was “only a small issue for small people, just women’s business,” and this actually worked in my favor. While we did have an obligatory local government representative assigned to us in each neighborhood, they did not hinder the research in any way, and some, like Yusef in the neighborhood of Magomeni, actively assisted us.

Dar es Salaam is a fascinating and sometimes chaotic place to live and do research. Founded in the 1860s by the Sultan of Zanzibar primarily as a trade center and port, today it is the third fastest growing city in Africa, with a population of 4 million expected to grow to 7 million by 2025, which will earn Dar the status of a “mega-city” (UNFPA 2013). While the inland city of Dodoma is Tanzania’s official administrative capital, Dar es Salaam remains its largest and most powerful city, in terms of population as well as politics, economic activity, and culture. Dar es Salaam has been a cultural and religious melting pot for more than a century, although the city’s deep divisions between the minority of middle-class and wealthy residents, and the majority of impoverished people living in informal settlements still follow the divisions of the *cordon sanitaire* which divided Dar es Salaam into European, Indian, and African neighborhoods during British colonialism (Brennan, Burton and Lawi 2007, Brennan 2012). Approximately 70 percent of Dar es Salaam residents live in informal settlements without proper access to basic infrastructure services including sanitation and water (UNICEF 2012, African Development Bank 2012). In 2012, 71 percent of people in Tanzania were living on less than $2

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a day (World Bank 2015), and this included about 80 percent of my study participants, while the remaining 20 percent were lower middle class or middle class.

Dar is currently in the midst of a rapid but very uneven economic transition (Brennan 2013, Coulson 2013). Discoveries of natural gas reserves, along with a robust rate of economic growth ranging from 5 to 8 percent a year (World Bank 2014) are evinced by a rapidly changing Dar es Salaam skyline where old colonial-era buildings are replaced by Western-style glass office buildings and hotels. Although the government is heavily promoting an economic development plan called "Big Results Now" which envisions that Tanzania will become a middle-income country by 2025 (PMORALG 2013, World Bank 2014), many of the benefits of economic growth have yet to reach the neighborhoods where I worked, which in 2012 still largely lacked reliable electricity, water, and sanitation. In the rainy season, dirt paths became impassable muddy pits, filled with fetid, stagnant water that provided ideal breeding grounds for malaria-carrying mosquitos. Along with neighborhood residents, we crossed these pits everyday using a makeshift system of wobbly planks. Given that such conditions persist in most African neighborhoods in Dar, many people I spoke with felt left out of the government's narrative about economic progress and development. This sense of marginalization contributed to fears about citizenship and belonging which I discuss in the conclusion. Despite the hardships of life in Dar faced by ordinary people, many were also proud of their status as city-dwellers. Younger Dar residents refer to their city by the slang term *bongo*—literally meaning "brain"—suggesting that life in Dar requires intelligence and creativity (Perullo 2011). This was certainly true for people in my study who exercised many forms of agency to provide for their families and track down birth certificates for their children.

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Initially, I had thought that this study would include a comparison of birth registration in Dar es Salaam and a rural area in northern Tanzania, but this proved not feasible for several reasons. I was advised that in rural areas, most peoples' reasons for not registering would be primarily geographical: in many rural areas, the nearest government office can be several days' journey away, making it prohibitively expensive to travel in search of a birth certificate, especially, as I describe in chapter 7, as the process of registration typically takes a minimum of three visits. Although the traffic in Dar es Salaam is legendarily bad, most Dar residents are within a same-day trip to a government office where they can register. Although rates of birth registration in Dar are higher than the national average, at 44 percent, this is still low for an urban area. So I shifted my framing of the issue to focus on the other barriers besides physical distance that prevent people from registering, and that proved to be a fruitful approach.

Several factors determined the selection of the three neighborhoods where I carried out this research. One factor was advice from my Tanzanian research mentor, and also from my research assistants, all of whom were long-term residents of Dar, about which neighborhoods were likely to have a significant number of unregistered residents, but also be welcoming and safe to work in. One neighborhood, Manzese, thought to have some of the lowest rates of registration due to extreme poverty, was deemed by my research assistant to be an unsafe place to work, even for Tanzanians. My research assistants also felt that individual households would be difficult to identity, as many residents of Manzese lived in very basic improvised lean-to structures, rather than discrete dwellings. Another factor was my need to have a sample of neighborhoods that roughly reflected the demographics of Dar overall, meaning a relatively equal distribution of Muslim and Christian households. A third factor was gaining permission for

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the research from ward leaders in each neighborhood. Although I had already obtained all necessary research clearances at the national and municipal level, in practice I also had to obtain permission from local leaders in each neighborhood. One local leader we approached denied permission for the study to proceed in his neighborhood, and referred us to a leader in an adjacent neighborhood. Through this process, three neighborhoods were chosen: Kimara, a majority Christian neighborhood on the far outskirts of Dar; Mwenge, a hectic and somewhat insalubrious neighborhood near a major bus station; and Magomeni, a majority Muslim neighborhood near to both a large mosque and a municipal government office. I will now briefly describe each neighborhood (please see the neighborhood map below).

Kimara

Kimara is a peri-urban neighborhood on the outmost edge of Dar es Salaam. Thirty years ago it was still largely undeveloped, but by 2012 it was developing rapidly and households and small agricultural plots extend from the main road far up into the hills. My friend the professor had the foresight to purchase land there in the 1980s, and had built up a large compound over the years. My research assistant Flora had grown up in Kimara, and her mother, a retired home economics teacher, had many small businesses in her compound, including milking cows, chickens, and stands of banana plants. Getting to Kimara took up to two hours from downtown Dar depending on the traffic and road conditions, but once I had arrived and hiked up into the hills, it felt like being in a village. People with even small plots of land took every opportunity to grow food or keep chickens and goats. Many Kimara residents preferred this quasi-rural way of living, and they saw their neighborhood as healthier and safer (both physically and morally) due

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to its distance from Dar es Salaam proper. Certainly the air seemed a lot cleaner up in the hills, although people reported that they had difficulty getting water because the *maji safi* (clean water) tanker trucks that deliver water to most Dar neighborhoods could not make it up the steep hillside tracks in Kimara.

One tradition of rural life that was preserved in Kimara was that when we took off our shoes in order to enter someone's home, when we emerged after the interview we would often find our shoes neatly lined up, having been cleaned by some invisible female hands while we were inside. I found this quite moving, and Flora and Agatha, who loved nice shoes but were on student budgets, also appreciated the effort to keep their shoes tidy. While most American male researchers would have worn sneakers or hiking boots for trudging up and down the hills of Kimara every day, Winston always wore neatly shined dress shoes. Kimara was the only neighborhood of the three where this shoe-cleaning practice was observed. This is not to say that Kimara was without its problems. The local leader who was assigned to us in Kimara, Nickson, was a middle-aged father with a clear problem with alcohol. Some days he would take us energetically around the neighborhood, and other days he would show up smelling strongly of local alcohol, or fail to appear at all. At first we had a problem with him hanging around outside interviews and clearly making younger women a bit nervous about speaking openly to us. After Winston had a diplomatic but stern chat with him about this, he kept a respectful distance from all future interviews.

Kimara had a large number of churches of various denominations, and several private Christian schools, as well as a private non-religious kindergarten and primary school called Brookside, which appealed to many parents, including Muslims who also lived in the

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neighborhood. Culturally, Christianity was a major part of life in Kimara, and people often offered to pray with us or for us, during or after interviews. One lay minister offered an extended blessing on our research, which was unexpected but really quite heartening. I should note that everyone on the research team was a practicing Christian, and this may have had some imperceptible effects on the research. However, I made a strong effort to seek out a representative number of Muslim households to interview, and was able to use my training in anthropology of the Muslim world from scholars like Marcia Inhorn and Elisha Renne to work well in Muslim households, for example, offering appropriate greetings during Ramadan.

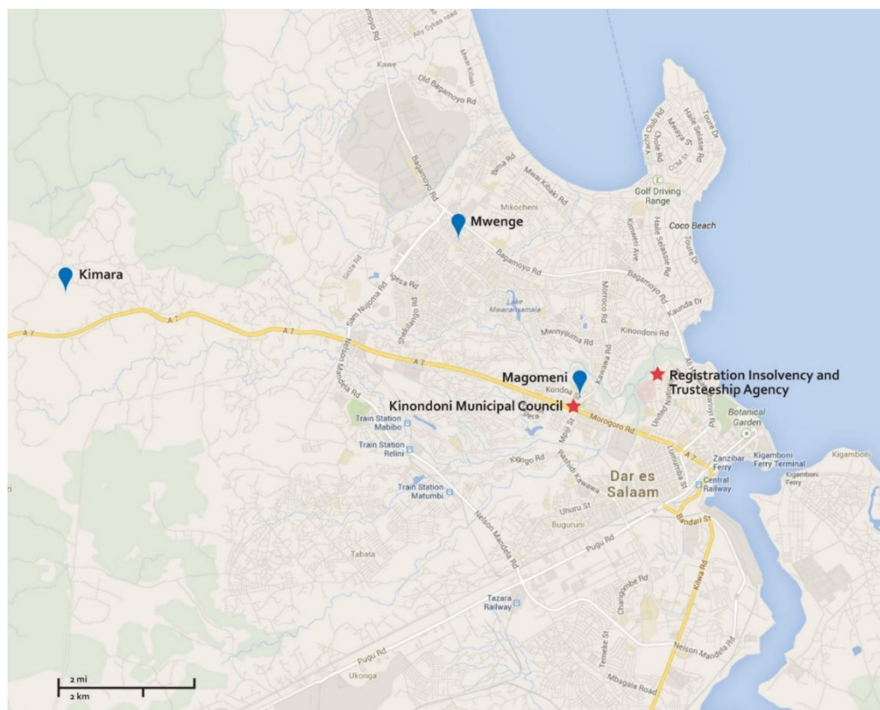

Figure 1: Map of research neighborhoods (blue dots) relative to birth registration offices (red stars) in Dar es Salaam

Mwenge

Mwenge is a neighborhood in northwest Dar es Salaam, and at the time of this research, its name was synonymous with a major public bus station and market at the intersection of two

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of Dar's main roads. Mwenge was known at that time for being a busy, chaotic, and somewhat insalubrious place. Buses from all over the city and surrounding countryside delivered people, goods, and baskets of chickens, and the bus station was tightly packed with stalls, bus hawkers, and travelers, and a number of elderly polio sufferers who sat on the ground to receive alms. During the course of our research all three of the women on our team (myself included) were mugged or pickpocketed near to the bus station. Over the years this has happened to me several times, and I am no longer surprised when it does, but I was quite surprised to learn that Flora and Agatha, both very savvy urban residents, had also fallen victim to robberies during our research, and I felt terrible about it. Suffice to say, they did not like working in Mwenge. A number of women in the neighborhood confided to us that drug addiction was a big problem in the neighborhood, and that the bus station was a transit point for moving illegal drugs from the coast. Drug addiction is a growing problem in Dar es Salaam, in particular heroin use and its links to HIV infection, and there are very few resources available for treatment (McCurdy et al 2010). Several women in Mwenge admonished me that drug addiction was a much bigger problem than birth registration, and if I wanted to do useful research I should come back and do a study on that instead.

Mwenge was a religiously mixed neighborhood, but seemed to be lacking in strong local intuitions, either churches or mosques. The primary school was in poor condition, and although there was a government health clinic in the neighborhood, it was rarely open. Many people sent their children to schools and clinics in other neighborhoods. Our local leader in Mwenge was Bibi Salima, a stern grandmother who was also a local leader of the ruling CCM political party. She was a respected presence in the neighborhood, and had a good knowledge of most of the

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local households. Although Mwenge was at times a difficult place to work, I also had many interesting conversations there, including the single mothers and grandmothers who spoke out about corruption, as I describe in chapter 6, the resourceful family of charcoal-making women from chapter 5, and the many women who operated small roadside food stalls catering to the bus station.

I have been told by other anthropologists that the neighborhood of Mwenge has changed dramatically since 2012, due to the closing of the Mwenge bus station last year as a result of a new World Bank project to upgrade public bus service in Dar. Local news reports suggested that the closing of the bus station was swift, and put most of the small vendors out of business. On hearing that, I wondered what would happen to the families I interviewed in Mwenge, especially the women who supported their families by selling food to passersby for a few dollars a day.

Magomeni

The third neighborhood was Magomeni, a largely Muslim neighborhood located off a main road, less than a kilometer from the Kinondoni Municipal government office, which is one of few places in Dar where birth registration takes place, aside from the RITA headquarters. One reason for the selection of Magomeni was that it was so close to the government office, and I wondered if this would improve rates of registration. However, I found that Magomeni's rates of registration were not statistically different than the other neighborhoods, and local leaders and families in Magomeni confirmed for me that just being geographically closer to the office didn't make it much easier for them to access registration services. However, the public health clinic at Kinondoni was well-used, and we would see mothers heading out early in the morning on clinic days, dressed in their nicest outfits, walking their babies over to the clinic to receive vaccinations

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and basic health checks. I had never been into Magomeni before, and at first glance it looked a bit foreboding. Several buildings bore faded posters of Muammar el-Qaddafi which had been put up after his death the previous year and never taken down, as well as old campaign posters for the opposition CUF political party. But Magomeni turned out to be a relatively calm and welcoming place to work. Our local leaders in Magomeni were Mzee Hamisi, who we will meet in chapter 7, and his assistant Yusef, a quiet and earnest man who politely accompanied us around the neighborhood, and even brought a second-hand golf umbrella during the rainy season. Although as I mentioned above, some leaders saw birth registration as "women's work," Yusef was especially supportive of the project and took the research seriously, owing to his own problems registering his children.

I should briefly mention some of the demographic characteristics of the households in the study, as well as the methods I used to identify households for participation in the study. Sampling of households is a common problem in household survey research in developing countries (Bernard 2011). Methods of identifying a random sample based on such factors as zip code or address are not feasible in a developing country context where many dwellings are informal and most do not have an address. I was not aiming for a purely random sample in this study, but rather a collection of households that would together be representative of larger demographic trends in Dar, and which would provide a diverse starting point for further ethnographic observations. In order to find appropriate households to interview, I relied to some extent on the knowledge of local leaders. I explained to them that I wanted to find families who had at least one child or grandchild under 18, mostly ordinary (meaning low-income people), and

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a few families who were more well-off. Knowing that Kimara and Magomeni were majority Christian and Muslim respectively, in Mwenge I asked to visit roughly equal numbers of Christian and Muslim families. In the areas were houses were organized along streets, I requested that we visit every 3 houses until finding one that met the criteria, but in areas like Kimara were dwellings were more spread out, I relied to some extent on local leaders to suggest homes where they knew children were present. I analyzed the demographic data on a weekly basis during the study, making adjustments as needed to keep the various factors in balance, and of the 154 households that participated in the study, I ended up with 79 Christian households and 75 Muslim households, and as I mentioned above 80 percent were low-income and 20 percent were lower-middle or middle-income families. The majority of parents had a primary school-level education and worked in the informal sector, but I also interviewed 9 people who had university degrees and held professional jobs such as teaching or working in a bank. As I discuss in chapter 5, class was a major factor influence birth registration, but not always in predictable ways.

"Everyone's concern, but no one's responsibility"

I will conclude this introduction by outlining the five key arguments I will make throughout this dissertation. First, I argue that birth registration has been largely misunderstood by international policymakers and some social scientists. My research shows that birth registration is a problem of governance, but not governmentality. Registration is not typically imposed by developing countries like Tanzania as a form of surveillance; rather, because systems of governance are weak in many respects, people must actively seek registration. In effect,

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people want to be seen by the state, and they view birth certificates as a positive form of recognition by the state.

Second, the lack of universal access to birth registration in Tanzania means that it is increasingly becoming a site for the reproduction of social inequalities. This is a particular concern now that the Tanzanian government is moving towards requiring official identity documents for many purposes. While many previous studies of birth registration argue that low income people may not register due to ignorance of the importance of birth registration (Plan 2005, Setel et al 2007, UNICEF 2013), I found that even people who cannot read and write, and who exist on the margins of Tanzanian society, understand and value birth registration and aspire to register their children. They are not prevented from registering by their lack of education or personal agency, but rather by a host of structural factors (time, money, information, access to government offices, and geographical and social distance). Paradoxically, lack of a birth certificate also constrains future opportunities for economic and social mobility for children from low-income families, through creating barriers to post-secondary education, formal sector employment, and inheritance of property.

Thus, I argue that disparities in access to birth registration can be seen as a form of structural violence. This is particularly true in light of the Tanzanian's government's recent moves to require birth certificates to access various services, without expanding access to registration for all citizens (Tanzania Daily News 2014). This argument builds on Gupta's recent work on bureaucracy as a conduit for structural violence, in which he defines structural violence simply as "social inequalities that foreshorten the life chances of the poor" (2012: 21). Structural violence can be found in "any situation in which some people are unable to achieve their

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capacities or capabilities to their full potential, and almost certainly if they are unable to do so to the same extent as others. The reasons such violence is considered to be structural is that it is impossible to identify a single actor who commits the violence. Instead, the violence is impersonal, built into the structure of power" (Gupta 2012: 20). This is an apt description of the scope and impact of lack of access to birth registration. As the authors of *The* Lancet series argue, birth registration is "no one's responsibility" (AbouZarh et al 2007:8). In Tanzania, no one person was preventing people from registering out of malice, and there was no policy specifically discriminating against certain groups. The system was just too difficult for many people to navigate. As Farmer argues, systematic problems are often symptoms of structural violence: "Structural violence is violence exerted systematically—that is, indirectly—by everyone who belongs to a certain social order: hence the discomfort these ideas provoke in a moral economy still geared to pinning praise or blame on individual actors. In short, the concept of structural violence is intended to inform the study of the social machinery of oppression" (Farmer 2001: 307).

I argue that ongoing disparities in access to birth registration are resulting in the emergence of a kind of stratified citizenship in which there are two classes of people: the registered, and the unregistered. People largely framed birth registration as an issue of citizenship rights, and were concerned about having official proof of their Tanzanian citizenship. Unregistered people are effectively undocumented in their own country, and this has two serious effects: a rights effect of making people feel marginalized and disenfranchised, and a governance effect in that having a largely undocumented population poses major problems for both development and democracy.

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Finally, I consider recent efforts to improve rates of birth registration in Tanzania. A UNICEF pilot project to use mobile phones to aid registration has shown promising results. Any increase in birth registration is welcome, but I argue that the focus on mobile technologies, while important and innovative, also runs the risk of becoming what Ferguson refers to as an "anti-politics machine" which distracts from the more systemic and inherently political problems of governance which must also be addressed in order to provide sustainable and equitable access to birth registration (1994).

These arguments are explored throughout the following chapters, which are organized in a way that follows the path that most people take in their search for birth certificates. Because problems with birth registration occur across multiple sectors of society, I have focused on a series of "zones of awkward engagement" (Tsing 2005: xi) where these conflicts are likely to occur. I have grouped the chapters into five sections. Part 1 includes this introduction, which provides historical and methodological background to the study, and chapter 2, which explores the materiality and "social lives of birth certificates" drawing on theories from the anthropology of science and technology. Part 2 explores how problems with birth registration begin in the health system, as soon as the baby is born. Chapter 3 describes the history of the Tanzanian health system to show how its current problems with fragmented and under-resourced maternity services contribute to low rates of birth registration. Chapter 4 explores the role of fees in the health system, and argues that even basic health services that should be free are unofficially privatized due to official and unofficial fees. Part 3 is comprised of chapter 5, which explores various dynamics in the family that affect birth registration once the baby is brought home,

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including issues of kinship and personhood, gender, and class. Part 4 explores what happens when parents try to interact with the government in order to register children, including problems with corruption (chapter 6), and bureaucracy and governance (chapter 7). Chapter 8 considers the perspectives of staff at the Registration, Insolvency and Trusteeship Agency, as well as parents' ideas for how the government should improve birth registration. In Part 5, I conclude the study by exploring several issues related to the future of birth registration in Tanzania, including discourses of citizenship and rights, and the future of birth registration in Tanzania, including the role of new technologies of identity being used in the upcoming 2015 presidential election. Finally, I consider the contributions and potential future directions of this research.

It's true that birth registration is a small problem in relation to the daily needs and concerns of most Tanzanian families. My research reveals that it's a small problem, until one day when it might become a big problem, and suddenly that piece of paper can have a powerful impact on a person's life, for better or worse. It's a small problem, but nonetheless an important one. Ultimately, I argue that studying birth registration ethnographically provides insights into larger issues of health, governance and rights in a rapidly but unevenly developing country. Improving access to birth registration is becoming a status symbol and sign of modernity for both individual families and the nation as a whole. But for families and the Tanzanian government it is one need among many, and must be managed in the context of scarce resources and competing priorities.

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Chapter 2

The Social Lives of Birth Certificates in Tanzania

Introduction: an old technology made new again

Birth registration is currently being promoted as a "new" way of improving health and development outcomes for children in low-income countries (UNICEF 2013, 2014). Although in countries like Tanzania the practice of birth registration has not changed much at all in the past century, international organizations such as UNICEF are promoting the use of new technologies, such as SMS text messaging, to improve rates of birth registration and accurate reporting of data to national registration authorities in real-time. Although such efforts, typically conducted as pilot studies, can be effective in improving rates of birth registration in the short term, I argue that this focus on new technologies overshadows the key structural problems in the birth registration system, which cannot be solved by technological "silver bullets" alone (Packard 1997).

Identity documents, including birth certificates, are increasingly necessary for economic survival and advancement in urban African contexts, and birth certificates are typically required in order to access other forms of official identity documents such as passports, drivers' licenses, and the modern biometric national ID cards now being introduced in many African countries, including Tanzania. While most people remain unregistered, birth certificates are increasingly

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becoming a status symbol, signifying parents' aspirations for their children's futures. However, most parents still face many economic and social barriers when they try to register their children. For the Tanzanian government, which has announced its aspirations to become a middle-income country by 2025, its ranking as one of the worst countries in the world for birth registration is seen as something of a national embarrassment (United Republic of Tanzania Office of the Prime Minister 2013). Tanzania's recent focus on technology and data-driven development includes a plan to improve birth registration using mobile technologies, which have successfully expanded access to other basic services, such as banking and health information. Failure to raise rates of birth registration will lower Tanzania's rankings in the Sustainable Development Goals proposed to replace the Millennium Development Goals later this year (UN Department of Economic and Social Affairs 2015, Merry and Wood 2015).

In this chapter, I consider the problem of birth registration through analytical frameworks drawn from ethnographic studies of materiality and technology. A birth certificate is simply a piece of paper containing a few pieces of demographic data, but it is also a powerful and valuable technology of signification and identification. In Tanzania, birth certificates are difficult to obtain, closely guarded, and imbued with powerful meanings related to kinship, identity, and opportunity. The process of obtaining a birth certificate has changed little since the British colonial era. Women who give birth in a hospital or clinic are supposed to receive a *tangazo* or birth announcement, handwritten by a nurse, which they must then bring to a local government office within 90 days to receive an (ostensibly) free birth certificate, known in Swahili as the *cheti cha kuzaliwa*. However, since nearly half of all women give birth at home (Tanzania National Bureau of Statistics 2011), they are already disadvantaged in the registration process

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since they must make an addition trip to try to get the *tangazo*, in order to apply for the birth certificate. Given that in rural areas, the nearest government office may be several days' travel away, and that even local travel within urban areas is challenging with a newborn baby, and it is easy to understand why birth certificates are so difficult to obtain. The system is complicated in theory, but as I describe below, it can become even more challenging in practice.

The social lives of birth certificates

An analysis of the difficulties of birth registration begins with a consideration of the materiality of birth certificates, and their "social lives" or patterns of circulation within and between public and private spaces. As Whyte, Van Der Geest, and Hardon note in their study of the social lives of medicines in Africa, "it is analytically useful to trace the careers of material things as they move through different settings and are attributed value" (Whyte, Van Der Geest and Hardon 2002: 13; see also Martin 2006 on the materiality of pharmaceuticals). The materiality of birth certificates is fragile at best: a piece of paper can easily be misplaced, or destroyed when a thatched or rusted metal roof inevitably leaks during the rainy season. The people I spoke with who had birth certificates typically kept them hidden, or tucked into the family Bible on a high shelf. One man tracked me down in the middle of the street in his neighborhood to very proudly show me how he had laminated his son's birth certificate. His household wasn't part of my sample, but he heard from a neighbor that I was asking questions about birth certificates, and just wanted to demonstrate his creative solution to the material frailties of birth certificates.

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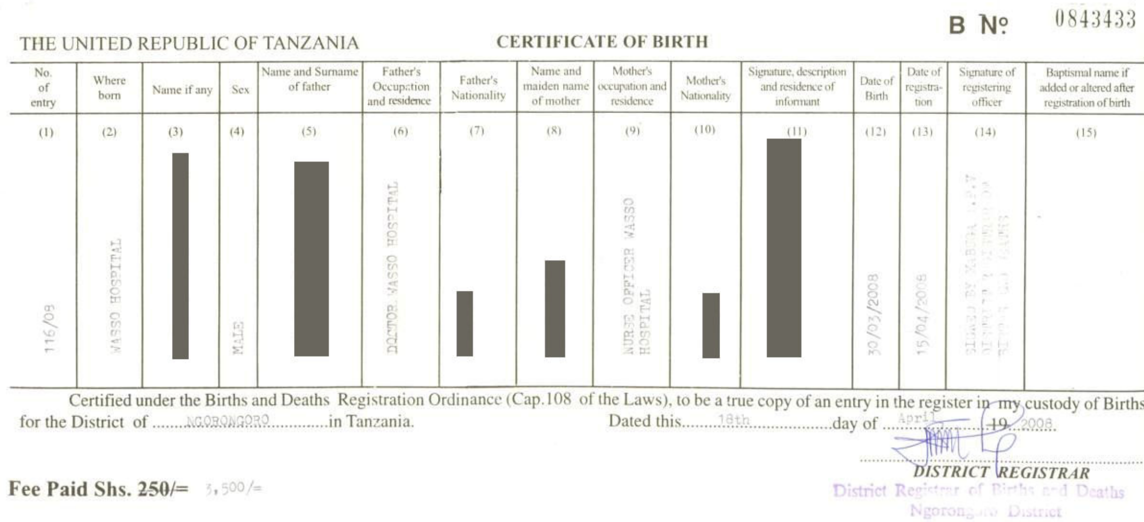
In his ethnography of bureaucracy and poverty in India, Gupta (2012) identifies similar problems with the materiality and fragility of official documents:

> I found that a villager, particularly an illiterate one, would carefully keep every written communication from a bureaucratic office as if it were a sacred object. It would be wrapped in paper, then perhaps in cloth, and the cloth would then be carefully placed in a metal trunk, along with other precious commodities, and kept inside the sole room in the village house that was protected from the elements.
>
> Dust was the greatest enemy. Dust would get inside every little nook and cranny in the house, and paper, particularly if it was not of high quality (and usually it was not), disintegrated quickly once it was exposed to dust… documents were usually stashed away, like so many hidden treasures, protected from the depredations of dust… At first, this attitude toward documents might appear to stress the unusual importance given to state writing by people at the margins of literacy. But how different is it from our own practices of putting presumed valuable documents in safe deposit boxes in banks? (212-213).


THE UNITED REPUBLIC OF TANZANIA CERTIFICATE OF BIRTH B Nº 0843433

No. of entry	Where born	Name if any	Sex	Name and Surname of father	Father's Occupation and residence	Father's Nationality	Name and maiden name of mother	Mother's occupation and residence	Mother's Nationality	Signature, description and residence of informant	Date of Birth	Date of registration	Signature of registering officer	Baptismal name if added or altered after registration of birth
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
116/08	WASSO HOSPITAL		MALE		DOCTOR WASSO HOSPITAL			NURSE OFFICER WASSO HOSPITAL			30/03/2008	15/04/2008	[illegible]	

Certified under the Births and Deaths Registration Ordinance (Cap.108 of the Laws), to be a true copy of an entry in the register in my custody of Births for the District of NGORONGORO in Tanzania. Dated this 18th day of April 19 2008.

DISTRICT REGISTRAR
District Registrar of Births and Deaths
Ngorongoro District

Fee Paid Shs. 250/= 3,500/=

Figure 2: Tanzanian birth certificates are simple in format, and thus potentially open to forgery.

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Birth certificates are fragile, which means they are also quite easily falsifiable. Neighborhood fixers known as *vishoka* run a lucrative trade in counterfeit birth certificates and other identity documents.[2] The problem of false birth certificates is difficult to quantify, but is enough of a concern that the Tanzanian government launched a campaign against fakes in 2013, enlisting the help of popular local newspaper editorial cartoonist Simon Regis.

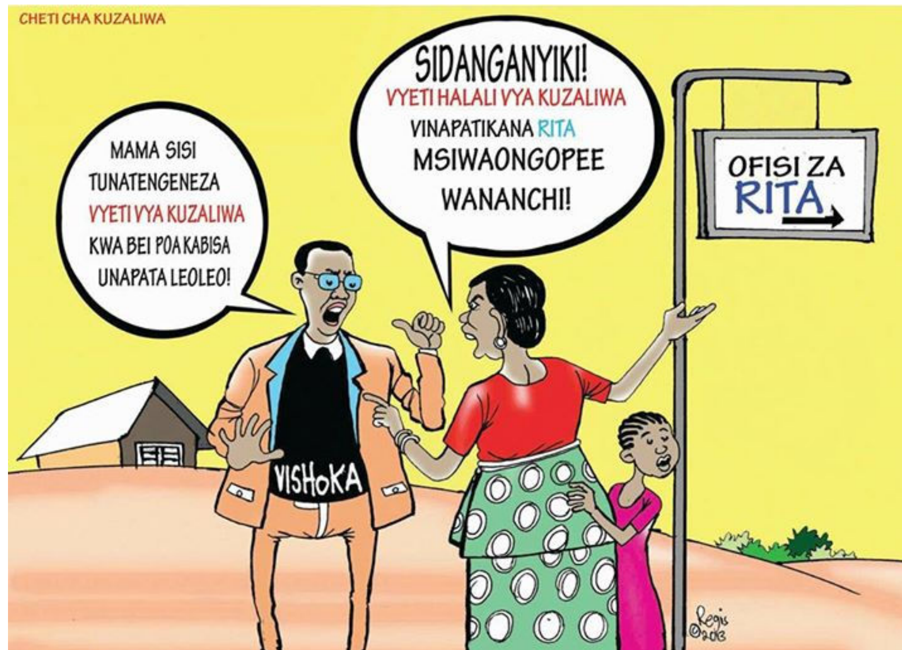

Figure 3: Swahili language cartoon about counterfeit birth certificates.

Translation:

Vishoka (counterfeiter): “Mama, we are providing birth certificates at a very good price, you can get it TODAY!”

Mother: “I will not be deceived! Legal birth certificates are only available at RITA [the Registration, Insolvency and Trusteeship Agency]. Do not lie to the people!”[3]

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[2] *Vishoka* means literally “little axe” in Swahili, and is used to refer to informal/illegal service providers in many trades.

[3] Source: https://www.facebook.com/ritatanzania, cartoon by Simon Regis.

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Parents who do not have the time, education, or social connections to obtain a birth certificate through official channels must sometimes make the difficult choice of paying for a counterfeit birth certificate, or paying bribes to government workers in order to obtain a "legal" one illegally. Either option could cost significantly more than a week's wages. Materially, there is often no difference between a real birth certificate and a counterfeit one; they circulate in the same ways as well. As Das (2004) argues, falsified official documents do not corrode state power; rather, they enhance it. A counterfeit document thus "becomes not a sign of vulnerability but a mode of circulation through which power is produced" (245). That forged documents are in such demand shows the power of the state; the authenticity of the documents is less important than the need to possess them.

Recent ethnographies of bureaucracy in post-colonial states offer another way to trace the social lives of birth certificates. As Hull (2012a, 2012b) notes, bureaucratic documents have until recently not received much attention from anthropologists. Latour has noted that documents are "the most despised of ethnographic objects" (1990: 54). Building on works such as Harper (1998) and Riles (2000, 2006), several major ethnographies in recent years (Rottenburg 2009, Hull 2012b, Gupta 2012, Bierschenk and Olivier de Sardan 2014, Merry 2015) have explored the relationships between documents, bureaucracy, and governance in developing country contexts. These ethnographies explore the proliferation of endless varieties of documents, from World Bank reports, to land registry certificates.

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Hull notes that identity documents are of particular analytical interest for the ways that they construct, coordinate, and control relations between the person, the family, and the state (2012a). Because identity documents circulate widely, they allow the state to literally and figuratively "enter the life of the community" (Das 2004: 245). This relationship between persons, documents, and the state, is mutually constituted. Identity documents render the individual visible to the state (Scott 1998, Scott et al 2002, Das 2004, Cody 2009), and the recording of names is fundamental to "the ability of the state to make its subjects legible to its gaze (Scott et al 2002: 12). The Swahili verb used to describe registration directly invokes legibility: *kuandikwa* (to be written, a passive verb construction). Identity documents are also a primary site for the constitution of biological citizenship, which enables individuals to claim certain rights and services from the state, and provides evidence of belonging to a particular family, community, or nation (Petryna 2002, Fassin and d'Halluin 2005). At the national and international level, demographic data extracted from birth registries is essential to many forms of governance (Greenhalgh 1995, Kertzer and Fricke 1997, Szreter and Breckenridge 2012). These valuable data, referred to as "vital statistics" are transmitted from local government offices, through a series of national and global "centres of calculation" (Latour 1987: 232), including the Tanzania National Bureau of Statistics, RITA, UNICEF, and entities such as the World Bank and ICF Macro, where they are further refined into indicators, including those designed to measure child rights and governance (Merry and Wood 2015).

However, bureaucracies are far from all-powerful or all-seeing. Since the vast majority of people in Tanzania are unregistered, it could be argued that they are illegible to the state. While they are not invisible to the state when the state wishes to exact a tax or fine of some kind,

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unregistered people lack the documentation to make similar claims of the state on their own behalf. Certain kinds of people, such as orphans, pastoralists, informal refugees from conflicts in neighboring countries, children born outside of marriage, and the poorest of the rural and urban poor, have particular trouble in accessing identity documents. As Hull notes, "poor and uneducated people unable to master the conventions of bureaucratic documentation or recruit for themselves a capable agent remain excluded even from programs aimed to help them" (Hull 2012a: 259; see also Cody 2009, Gupta 2012). Attention to the places in the birth registration system where the bureaucracy fails, and birth certificates do not circulate freely, is key to understanding the problem. In the next section, I describe four key barriers to birth registration.

Barriers to birth registration

My research reveals four key barriers to birth registration: time, money, structural barriers, and social and cultural barriers. I will discuss each one briefly here, and then in more detail in subsequent chapters. The amount of time it takes to seek out a birth certificate is the main barrier, and it influences all the other barriers as well. Obtaining a birth certificate can take months or even years and numerous visits to various government offices and law courts, with entire days spent traveling to offices and queueing all day, only to receive the dreaded and familiar command "*njoo kesho*" or "come back tomorrow." Sometimes they find that the office is un-staffed, or there is no electricity, or they have run out of the special paper used for birth certificates, or the typewriter ribbon has run out of ink; any of these occurrences can mean that registration services will not be offered that day. For the majority of people who are employed in

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the informal sector, especially women who support their families by doing "small small business" such as cooking, doing laundry, or selling in a market stall, a day away from work could mean the family doesn't eat that night. Parents must weigh the economic survival of the family in the short term, with the hopes that a birth certificate could lead to a better future.

Money is another key barrier. Although birth certificates are supposed to be free if obtained within 90 days of the child's birth, very few families are able to accomplish that task within such a short time period, especially with a new baby at home. Between 90 days and ten years, the registration fee is supposed to be Tsh3,500, or about US$2. Although that sounds low, factoring in the travel costs and missed days of work, the true fee for registration is often ten times higher. For children above 10, the government starts charging late fees, which go as high as US$15. In a family with multiple children, this starts to add up quickly. And of course, these are only the official fees. Many people feel they have no choice but to pay a bribe in order to secure a birth certificate. More than forty percent of the people I interviewed reported paying some kind of "extra fee" or in order to secure a birth certificate, although only a few people were willing to discuss corruption openly. The unofficial but widely known bribe or "extra fee" for same-day service for a birth certificate is seven times the official registration fee. Many families save up for months or years to pay this "extra fee" up front, knowing that their chance of securing the birth certificate is greater, although still not guaranteed. As Blundo and Olivier de Sardan (2006) have documented in their ethnographic studies of "everyday corruption" within African bureaucracies, many basic public services are "unofficially privatized" because the payment of bribes for services has become so routinized. The unofficial but widely known bribe/"extra fee" for same-day service for a birth certificate is 7 times the official registration fee.

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Many parents spoke of their frustration that basic services for children were, in their words "free, but not really free." One mother, Fatuma, describes the problem: "The government says that services for children, like education and health, and even birth certificates for babies, should be free. But in truth, nothing is really given for free. You are always expected to give *chai,* to make some extra contribution, for services that are supposed to be free." Subira, a mother and grandmother, was one of the few people willing to openly speak about corruption: "The expense of birth registration is high in part because of corruption. Nowadays you will find that even if you do everything correctly, you will not receive a birth certificate unless you pay bribes."

Parents face many structural and bureaucratic barriers in the health system and at local government offices. Because nearly half of children in Tanzania are born at home, particularly in rural areas, parents don't receive the birth announcement needed to apply for the birth certificate. Because nurses in hospitals and clinics are so overworked, often attending to numerous women in labor simultaneously, parents report that some nurses won't stop to fill out the birth announcement without receiving an extra payment or bribe (Spangler 2011, Makoye 2012). Additionally, RITA, the government department responsible for registration has only one dedicated office nationwide, which is located in Dar. This means they rely on civil servants in local government offices around the country to process registrations in addition to their other duties.

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The national budget for birth registration activities is just US$300,000 annually for the entire country of more than 45 million people. I interviewed several mid-level government employees at RITA who expressed frustration that despite rhetoric to the contrary, there is a lack of political will to fix the birth registration system. When I asked one of the employees whether birth registration was a priority for the government, he pointed to RITA's small, rusted signpost, outside the agency's modest headquarters, on a dusty back street a few blocks away from Muhimbili National Hospital and said wryly, "just look at our sign. Do we look like a priority to you?" I discuss the financial and political constraints faced by RITA in detail in chapter 8.

Figure 4: Outside the national headquarters of RITA, the Registration, Insolvency and Trusteeship Agency.

There are also numerous social barriers to birth registration, especially among the poorest families. Many people reported feeling intimidated when they visit government offices,

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especially if they lack the literacy skills necessary to fill out forms. Single mothers said they felt ashamed or embarrassed if they didn't have a father's name to put on the certificate, and many delayed registering as a result. The roles of class and social capital are key when interacting with the bureaucracy, and many people relied on a senior family member or friend to advocate for them at the government office. People without the social capital to cut through bureaucracy, or the economic capital to pay bribes, are sometimes shut out of the system. As a result of the class dimensions of birth registration, a birth certificate has become something of a status symbol in Tanzania. Borrowing a phrase from Kenyan medical anthropologist Benson Mulemi (2013: 162), I argue in chapter 5 that birth certificates are a "technology of hope", symbolizing parents' plans and aspirations for their children's futures, balanced against the harsh realities of daily life for low-income families in Dar es Salaam.

Parents attribute many powers to birth certificates. In popular discourses about the benefits of birth certificates, they seem to circulate around the community helping children with many things: get into a private school, take a university entrance exam, get a student loan, find a job in the formal sector, open a bank account, register a business, buy land, get a passport and travel overseas, get married, inherit property. While in the past, parents would often wait until children were teenagers to register them, if it looked as though they had the academic potential to take the university entrance exam, children increasingly need their birth certificates at earlier ages. Some private pre-kindergartens in Dar, referred to (always in English) as "baby class", require birth certificates to enroll children at age 2 or 3. Nur, one of the only college-educated parents in my study, was a middle class mother whose son attended a private kindergarten. Nur explained the significance of birth certificates among Dar's well-off families: "Children are

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angels…You have to make the best life you can for children, and a birth certificate is a must. You have to plan everything for your babies, you have to make sure they will have the documents they will need to be successful in life." Due to her high level of education, confidence in interacting with government officials, and middle-class economic status, Nur encountered no difficulties in registering her son, but her experience was very unusual among the parents I interviewed.

However, birth certificates and the benefits they are supposed to provide remain largely aspirational, as is seen in a television commercial produced by UNICEF and RITA, encouraging parents to register their children. The theme of the campaign was "*ndoto*" meaning "dreams." For the majority of people, registering their children remains largely a dream, or at least a future aspiration. While parents see birth certificates as "technologies of hope", government employees at RITA responsible for improving birth registration services have placed their hopes in technology. In chapter 8, I discuss RITA's successful pilot program to use mobile technologies to modernize birth registration. However, the costs of the pilot in one district exceed their annual budget for the entire country. The problem of birth registration in Tanzania is one that resists straightforward technological solutions or "silver bullets." It is partly a technical problem, and one which creative use of mobile technologies will help to address. But birth registration is embedded within a much more complex set of issues including governance, economic development, social marginalization, and citizenship rights. Despite the promising results of the mobile registration pilot, birth certificates themselves look much the same as they did nearly a century ago. They are an old technology, and a fragile one that can easily be damaged by a rainy season flood. But birth certificates and other identity documents are taking on new social lives,

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with serious social and political consequences for undocumented Tanzanians, as I discuss in the conclusion. But first, I follow the social lives of birth certificates from the moment of a baby's birth in the health system, from the hospital or clinic back into the baby's family and community, and then again back into the wider world of government offices, political debates, centers of calculation, and perhaps all the way to the UN General Assembly.

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Chapter 3

Medicalizing mothers:
Histories of childbearing in colonial and post-colonial health systems

> "Medicine—whether Western or African—has always been an instrument of social and cultural power through its capacity to define, act upon (and in), and claim authority over bodies, and thus over persons residing therein."[4]

For many Tanzanian women, giving birth is a time of significant physical and social risks. The Swahili verb for childbirth is "*kujifungua"* meaning literally to open oneself up, which conveys some of the intimacy and vulnerability of the experience of childbirth (Spangler 2011). For low-income women in Tanzania, opening oneself up to give birth is a mundane event, but also one that carries the possibility of illness, injury, or even death if a medical emergency arises and skilled medical assistance is not available, or not affordable. Tanzania has one of the highest rates of maternal mortality in the world, and women have a 1 in 23 lifetime chance of dying as a result of childbirth. The average Tanzanian woman gives birth 5.4 times, and almost half of all births still occur at home, without help from a skilled birth attendant (WHO 2010, DHS 2010). Medical anthropologists have long argued that reproduction is a powerful site for the production of biological, socio-economic, and gendered forms of inequality (Martin 1987, Ginsburg and Rapp 1995, Lock and Kaufert 1998, Rapp 1999, Bledsoe 2002, Inhorn 2003). Anthropologist and

[4] (Setel 1999: 187).

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midwife Sydney Spangler, who has delivered babies and conducted ethnographic research at a clinic in rural central Tanzania, describes how many lower-income Tanzanian women view childbirth as a life event that is mundane, but also potentially dangerous:

> Unlike food production or malaria prevention, childbirth was not an everyday concern. But given the frequency of this occurrence and its associated risks and significance, it occupied a prominent place in the life course of many. Childbirth posed an extraordinary predicament for women who were socially or economically disadvantaged (2011: 484).

The predicaments facing pregnant women can range from how to remain healthy during pregnancy despite a heavy workload of manual labor and household responsibilities, to finding transportation from a remote area to a clinic, to how to save or borrow enough money to afford all the costs—both official and unofficial—associated with childbirth. Inability to pay the costs associated with giving birth in a health facility is a key reason why many low-income rural Tanzanian women still give birth at home. For many women, whether they deliver at home or in a health facility, childbirth can become a site for the reproduction of "embodied inequalities" (Spangler 2011: 481). Such inequalities are reflected and amplified by the conditions in which women give birth, which can impact both their lives and those of their children for years to come.

Tanzania has made impressive progress over the past two decades in reducing infant, child, and maternal mortality rates, and has been widely celebrated by the international community for its success in achieving Millennium Development Goal 4, the reduction of under-5 child mortality by two-thirds by 2015 (Afnan-Holmes et al 2015, Kruk and Mbaruku 2015). Tanzania actually met this milestone ahead of schedule, reducing deaths of children under 5 from 166 deaths per 1,000 children in 1990, to 54 deaths per 1,000 children in 2012 (UNICEF 2013). Tanzania has also made progress in reducing the number of women who die during or soon after

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childbirth, although progress on this goal has been slower, going from a rate of 910 maternal deaths per 100,000 births in 1990, to 410 deaths per 100,000 births in 2013 (Tanzanian Ministry of Health 2014). Although this reduction in maternal deaths is substantial, it falls short of the target for Millennium Development Goal 5A, which calls for a target of fewer than 220 maternal deaths per 100,000 births by 2015 (WHO 2015). While 98 percent of Tanzanian women now have at least one prenatal checkup, only 43 percent of women receive the recommended minimum of at least four prenatal visits (DHS 2010). Women give birth an average of 5.4 times, down only slightly from 5.6 times in in 1999 (ibid). Tanzanian President Jakaya Kikwete has gained international recognition for Tanzania's achievements in improving women's and children's health, and was asked to co-chair a prominent WHO taskforce called the "Commission on Information and Accountability for Women's and Children's Health" (WHO 2011).

Despite the substantial progress Tanzania has made in improving health outcomes for mothers and young children, childbirth and infancy remain times of uncertainty and anxiety, especially for low-income women and those living in rural areas—the majority of Tanzanian women are in one or both of these higher-risk categories (DHS 2010, Spangler 2011, Lawn et al 2014, Allen 2004). Birth registration is often used as an indicator of whether countries like Tanzania are improving access to maternal and child health services (UNICEF 2014), and the real-time data generated by the registrations of births, stillbirths, and infant deaths is an essential tool for tracking and further improving health outcomes for mothers and babies in developing countries (Mason et al 2014, Phillips et al 2015). However, most of the epidemiological and policy research on birth registration frames birth registration as an outcome, rather than a process. Good health systems register children, while struggling ones do not.

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However, very little research has focused on exploring the reasons why some developing country health systems have adopted processes that facilitate the registration of births, while neighboring countries struggle to do so, despite post-colonial health systems that have been shaped by similar colonial histories, economic forces, and present-day constraints (Turshen 1999, Dilger 2012, Prince and Marsland 2013). For example, when I began this research five years ago, I was initially struck by the question of why the rate of birth registration in Tanzania is 16 percent, compared with 30 percent in Uganda, and 60 percent in Kenya (DHS 2010, UNICEF 2010). A robust comparison of the situation of birth registration in Tanzania and its East African neighbors is unfortunately outside the scope of this study. But in interviewing parents, studying laws and policy documents, and comparing the processes of birth registration in Tanzania and Kenya with the help of one of my interviewees, it became clear that the problem starts in the health system, before the baby who needs to be registered is even born.

How does the Tanzanian health system contribute to low rates of birth registration? Studying birth registration as a health system problem is far from straightforward. Birth registration is fundamentally different from most other problems occurring in the health system: it is not a specific disease or health condition, and it has no self-identified group of people who suffer from the condition of being unregistered. It is not a fatal condition, and it is not emergency—until one day far in the future when it might become an emergency if an unregistered person suddenly needs proof or their identity or age, or has an inheritance or custody dispute, or a promising young student is unable to take the university entrance exam because their family can't find the extra Tsh 20,000 (about $12 US) required to get a birth certificate for a teenager. These are all slow-burning, mostly invisible problems whose uncertain

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consequences, years or decades later, seemingly have little to do with the health system. However, looking at the situation through an ethnographic lens reveals that many of the forms of socio-economic exclusion that lead to lack of registration are reflected in the conditions into which babies are born.

Chapters 3 and 4 are companion chapters that together explore the medical, historical, structural, and social ways that the health system impacts birth registration rates in Tanzania. In this chapter, I offer a historical overview of the development of the health system in Tanzania from the colonial eras to the present, with a particular focus on medical care for pregnant women and children, and the ideological and practical considerations that have driven interest in maternal and child health in Africa. I also include a brief discussion of how birth registration was addressed—or not—in each era, establishing that the lack of attention to birth registration has been remarkably consistent over time. In chapter 4, I describe the Tanzanian health system's current shift towards the official and unofficial privatization of health services, in particular the heavy burden of fees. Drawing on the experiences of my interviewees, I show how poor people use discourses about fees to protest the stratification of health access and outcomes, and consider their views as expressions of biological citizenship (Petryna 2002).

In this chapter, I identify three interrelated trends that have characterized the history of the Tanzanian health system: medicalization, projectification, and quantification. I discuss each trend in detail below, but will briefly summarize them here. Medicalization refers to the expansion of medicine as a form of knowledge and authority into various other realms of society (Clarke et al 2003, Conrad 2005). Medicalization in developing country contexts tends to be a very uneven process, concerned primarily with particular bodies or specific conditions that are

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thought to pose a threat to economic development. In the African context, selective medicalization was an important aspect of colonial power although its reach was limited. Childbirth was a particular target of medicalization by both missionaries and colonial governments, and remains so in the era of the Millennium Development Goals. Projectification refers to the fractured system in which most health services in Africa are provided by a patchwork system of public, private, non-governmental and faith-based entities, each with their own agendas and stakeholders (Whyte et al 2013). Although projectification is typically associated with post-independence African health systems, it has clear roots in colonial medicine. Quantification is an important aspect of both medicalization (recording and tracking the numerical details of individual bodies or disease epidemics) and projectification (in which individual projects all have their own demands for various types of data, which may or may not be relevant to the host country's own priorities).

Each of these trends can be seen in the history of the Tanzanian health system, and its approach to maternal health in particular. I argue that women's bodies are selectively medicalized and quantified during pregnancy in limited ways, which relate to the physical survival of the mother and child. Historically, this limited form of medicalization and quantification did not extend to documenting the identities of individual children through birth certificates; in the health system, mothers and babies were made legible as statistics and not individual persons, and this remains true to a large extent today.

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Situating birth registration in the health system

An exploration of the history of the Tanzanian health system serves two key purposes in my overall analysis. First, it highlights the fragmented way that health services have developed, from the colonial eras, through Tanzanian socialism and structural adjustment, to the present, and how certain aspects of each era contribute to the persistent challenges within the current health system. Second, it provides context for the struggles that ordinary Tanzanians have with registering their children, by showing how those difficulties often begin as soon as a baby is born. A full history of medicine in Tanzania is far beyond the scope of this dissertation. I have focused instead on the trends of medicalization, privatization, and quantification as they have shaped health services available to women and children in particular. Of course these same trends also impact the health of all Tanzanians in many similar ways. One theme that has been a constant over more than a century of biomedical services in Tanzania is "the considerable gap between ideals outlined in policy and the realities of daily practice" (Sullivan 2011: 70)." Biomedical professionals, traditional healers, government officials, and patients have had to struggle with competing expectations about what kind of care can and should be provided to the Tanzanian people. As Phillip Setel has observed of Tanzania, "medicine—whether Western or African—has always been an instrument of social and cultural power through its capacity to define, act upon (and in), and claim authority over bodies, and thus over persons residing therein" (1999: 187). However, as the history below makes clear, the power of medicalization in Tanzania has always been incomplete, and often makeshift, whether by design or simply due the extreme difficulties involved in providing medical care to a large and mostly rural population.

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Although my approach to studying birth registration is very much influenced by my training in both public health and anthropology, birth registration does not easily lend itself to the classic clinic or hospital-based approaches often used in medical anthropology. It would not have been feasible for me to spend many hours sitting in a maternity ward, observing women giving birth and then not receiving their *tangazos* or paying extra to get them. Laboring women and midwives alike would have found this a very strange request. Instead, I relied on women's recollections of their experiences of giving birth, as told to me in community-based interviews. Although I was not observing in medical facilities for this study, I have drawn on my past experiences working as a research assistant on various studies based in the Tanzanian public health system, dating back to my first trip to Tanzania in 2005. At that time, I was part of a team of American and Tanzanian public health researchers, conducting studies and providing training as part of the scale-up of the massive USAID-funded PEPFAR initiative (President's Emergency Plan for AIDS Relief). Part of my work involved collecting data on the working conditions of nurses and midwives from around Tanzania, and observing conditions in various hospitals and clinics in Dar es Salaam. I was struck by the fact that although these nurses and midwives were training to deliver complex antiretroviral treatment regimens to their patients across the country, a very exciting prospect, many of them worked in clinics that still lacked basic supplies such as soap, running water, latex gloves, and a dedicated place to safely dispose of dangerous medical waste such as needles and razors. As I discuss below, recent studies show this situation has not improved significantly in the past decade. Understanding the working conditions of staff in maternity wards provides another key insight into why completing birth registration paperwork takes a very low priority.

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Returning for a moment to the problem of studying birth registration through an analysis of the health system, it is important to recall that birth certificates are not available directly through the Tanzanian health system. As I described in chapter 1, two registration-related events are supposed to happen within the health system shortly after a baby is born. First, a nurse or midwife should record the details of the birth in the ward or clinic's registry book, and report this data to the district authorities at some point in the future. Second, either that staff member or another person should write out a small piece of paper called the *tangazo*. The *tangazo* is the birth announcement that must be used to apply for the birth certificate at a local government office, and it is often filled out by a harried nurse who does not have time to issue instructions about when and how to exchange the *tangazo* for a birth certificate, let alone how much it should officially cost. Both the writing of the baby's details in the registry book and the filling out of the *tangazo* should be free, but as I discuss in chapter 4, these actions often attract requests for "extra" fees (Spangler 2011, Makoye 2013). Under the current system, the most that parents can hope to bring home from the hospital or clinic where they give birth is a healthy baby and a *tangazo*. However, many parents do not even receive the *tangazo*, and this becomes the first of many obstacles to birth registration.

Given that birth certificates are not actually available within the health system, how does an analysis of the Tanzanian health system contribute to understanding the problem of birth registration? As I show in this chapter and chapter 4, a number of factors within the health system contribute to the many barriers to birth registration, barriers that begin in the health facility and follow the baby home into the community. These factors include: the health system's long history of fragmentation and lack of coordinated services and policies between public,

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private, and mission facilities; the selective medicalization of pregnancy; the high rate of home births due to geographical and financial exclusion from services; the lack of adequate staff and supplies in health clinics; the many expenses and fees associated with childbirth; and the lack of attention from government officials and donors focused on disease-specific projects and MDG priorities. The antecedents of many of these problems can be found in Tanzania's colonial-era experiences with biomedicine.

Missions and medicine

Colonial medicine, whether secular or mission-based, was only one aspect of larger systems of colonial governance throughout Africa. Whereas certain philosophies and methods of governance varied substantially, in particular between French and British colonial styles (Cooper and Stoler 1997, Hunt 1999), they shared many key elements. Missionization, education, medicine, wage labor, and law were deeply intertwined systems for colonial knowledge production and social reorganization (Beidelman 1982, Hunt 1999, Setel 1999). Churches, schools and clinics became the key spaces for disseminating new ideas of personhood and the body, and many of these ideas were centered on reproduction. Making colonies economically productive required a healthy male workforce for work in various industries including mining, cash crop agriculture, and infrastructure development plantations and in mines (Vaughan 1991, Packard 1989, Turshen 2010). Three aspects of colonial medicine are of special interest in framing my study of birth registration: the focus on producing a healthy workforce of wage laborers; the particular concern with women's reproductive capabilities and child-rearing skills; and the efforts to document and enumerate native populations in various ways.

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Women's reproductive labor was seen as the key to ensuring a healthy population of workers, and thus "the problem of women" (Vaughan 1991) became a key preoccupation of colonial governance worldwide (Summers 1991, Allman 1994, Thomas 2003, Renne 2003, Boddy 2007, Boddy 2011). This "problem of women" had several key dimensions, including attempts to regulate sexual conduct outside of marriage, establishing laws to encourage marriage and discourage prostitution, and the promotion of European-style modes of dress, hygiene and homemaking (Allman 1994, Stoler 1996 and 2002, Merry 2000, Hunt 1999, White 1990, Comaroff 1993, Burke 1996, Boddy 2007). This focus on the "responsibilization" of women continues implicitly in many contemporary health programs across Africa that target women as the key agents of change for almost every health issue, from child nutrition to AIDS prevention (Foley 2010). Although these practices, and their acceptance by local populations, varied greatly within and between colonial states, one key outcome was that they served as an alibi for colonial and mission authorities enter the private space of home and family (Boddy 2011). Such projects can be seen as constituting "a hygenic form of indirect rule" (Hunt 1999: 6). Setel (1999) argues that the end effect of colonial health interventions centered on the domestic space and family was to medicalize parenthood itself, superseding traditional forms of kinship and family dynamics, and ideas of parenting and personhood.

The lines between mission and secular colonial authority were often blurred, particularly in rural areas where missions provided the only available health and education services. Although men were the primary targets of evangelism, women often converted to Christianity at higher rates than men (Hodgson 2005), and thus may often have had more interaction with mission-provided health care. While some colonial powers such as Belgium adopted

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Catholicism-influenced “pro-natalist” policies such as paying state benefits to parents with large families (Hunt 1999), the British relied heavily on missionaries to provide health and education services, but maintained an officially secular policy (Jennings 2006).

Both government and mission health facilities were fairly narrowly focused in terms of the services they provided: treatment of certain tropical diseases such as yaws and trypanosomiasis; basic first aid; pregnancy care and vaccination of children; treatment of sexually transmitted diseases; training of low-level African health workers; and recording of basic health statistics. Treatment of STDs was a particularly high priority, due to the negative impact of syphilis on fertility rates. By some estimates, syphilis was responsible for 70% of miscarriages and stillbirths in Tanzania in the 1920s (Turshen 2010). Similar levels of infection in other colonies contributed heavily to concerns about declining populations in Africa in the 1920s and 1930s due to disease, famine, and low fertility rates (White 1990, Turshen 2010, McCurdy 2010).

The capacity of most colonial states to provide health services to local populations remained quite limited, due to factors including lack of political will, and lack of sufficient numbers of medical personnel (Sullivan 2011). Training of African health workers was seen as a partial solution, and was often directed by missions, especially the training of young African women as European-style midwives (Boddy 2011, Hunt 1999). Older, experienced traditional birth attendants were excluded from these efforts because it was thought that young women with little experience would be easier to train in biomedical techniques and ideologies of childbirth and hygiene (Hunt 1999). Young African men were trained as “tribal dressers” who provided basic first aid and treatment of tropical diseases (Iliffe 2002). Despite these efforts to expand

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care, most health facilities for Africans remained very meager. One African ward at a hospital in northern Tanzania in the late 1930s was described as a collection of mud huts with “red hot tin roofs” which were “infested with body vermin” (Setel 1999: 272).

The role of health services in the proliferation of colonial bureaucracies is another important aspect of the history of African health systems. Although the capacities and practices of medical bureaucracies varied greatly in different colonial contexts (Ittmann et al 2010), as I discuss in chapter 1, the keeping of basic medical records and statistics—however incomplete—was a key aspect of colonial governance. Hunt (1999) argues that childbirth was a key event for the convergence of documentation and medicalization:

> The medicalization of childbirth was tied to the increasing bureaucratization of colonial life…medicalizing birth was not only about giving birth in the Congo, but about counting—privileging and enumerating birth. The bureaucratic imperatives of *colonial inscription*, the demographic arm of the sanitary modality of colonial rule, effected this intense pressure on getting numbers (Hunt 1999: 263).

Although the Congo’s passion (some might say obsession) for bureaucracy far outstripped that of most other colonial states, this nexus of medicalization, documentation and quantification of childbirth can be seen in most colonial and post-colonial contexts in similar ways, for example through the common practice of weighing and measuring babies (Allen 2004). Reporting positive outcomes of medical services, such as number of children delivered or patients treated for various diseases, was also an important tool for both mission and government medical services to make the case for additional resources for their work, and thus their relative importance among other colonial government or church priorities. Administrators also relied on the annual reporting of health statistics for timely—if incomplete—data on population trends in

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rural and remote areas, rather than having to wait for the results of decennial censuses (Ittmann et al 2010). Overall, the history of colonial medicine, especially as it concerns maternal and child health, reflects "a dual concern with altruistic health interventions and with the political control of bodies" (Renne 2003: 137). This dual concern is certainly reflected in the history of Tanzania's health system.

A brief history of the Tanzanian health system

Various traditional medical modalities existed in pre-colonial Tanzania, including healers who provided treatments including herbal remedies, sacred waters, and spiritual treatment for afflictions understood to be caused by witchcraft (Feierman and Janzen 1992, Langwick 2011). Indigenous theories of disease, including the link between mosquitos and malaria, influenced peoples' choices of where to live, keep livestock, and cultivate crops (Iliffe 1979). Traditional healers were perceived as a threat by German colonial authorities after a healer played a key role in a major anti-German uprising in southern Tanzania, known as the Maji Maji Rebellion (Iliffe 1969, Koponen 1995). The healer, Bokero, distributed a war medicine to his followers that he promised would turn the Germans' bullets into water, or *maji*, hence the name of the rebellion. The uprising lasted almost two years, from 1905 to 1907, and caused the German authorities to regard traditional healers as a threat to governance, although they had little control over what types of traditional medicine were practiced in the privacy of rural homes and villages (Iliffe 1979, Feierman and Janzen 1992, Langwick 2011).

German physicians first arrived in German East Africa in 1888, traveling with the German army. Their role was primarily to provide medical treatment to Germans, as well as

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Asian and African laborers employed by the German government (Clyde 1962, Koponen 1995). In the 1890s, several mission doctors arrived and began treating a limited number of African patients, ushering in an era of "therapeutic pluralism" in Tanzania that continues to this day (Ranger 1992). Medical missionaries attempted to use health and education services to attract converts, who were often lower-status or marginalized people in their communities (Iliffe 1979). By the 1890s, the healthcare landscape was gradually expanding with the building of Tanzania's first two hospitals in Dar es Salaam. One, Ocean Road, was built by the Germans to treat white patients, and the other, Sewa Haji, was funded by a wealthy Ismaili Muslim businessman, and provided medical services to patients of various races (Kaiser 1996, Sullivan 2011). After independence, Sewa Haji became Muhimbili National Hospital, Tanzania's top public medical facility, where my research assistants Agatha and Winston were completing their medical training.

In the 1910s, the government and missions began to train African young men as "tribal dressers" or medical assistants, who could provide basic first aid and other health services to African populations, particularly in rural areas. The German government also instituted a number of government schools offering a secular curriculum for African boys during this time (Wright 1968). However, most Africans had little or no experience with Western-style education or biomedical health care unless they lived near to a mission. The advent of World War I brought the majority of medical services to a halt, as both German and African health workers were recruited for military service (Iliffe 2002). During the war, the Germans enacted Tanzania's first law regarding registration of births and deaths (Proclamation No. 15 of 1917), but it required registration of births of children with at least one white parent, and it is unclear how many

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children's births, if any, would have been registered during the last year of the war, or during the relative chaos of the transition from German to British colonial rule (RITA 2015). Remaining medical staff were very overwhelmed, for example there was one British nurse caring for 65 patients by herself at Ocean Road hospital in 1919 (Clyde 1962).

The British takeover of Tanganyika Territory (beginning in 1918 and officially formalized in 1923), included plans to expand the health system along the lines of older, more established British colonies in Africa (Iliffe 2002). However, this effort was slow and plagued by a lack of personnel and resources. In 1920, the British passed the Births and Deaths Registration Ordinance, which retained all the main provisions of the previous German law, including the non-compulsory nature of birth and death registration for Africans. As I mentioned in chapter one, archival sources indicate that birth registration was not a pressing interest for British officials, who were trying to figure out how to govern a new and very large territory that was not a political or economic priority for the British government. Administrators were primarily interested in registering deaths of government personnel so they could dispatch replacements to rural areas with few staff members, whose numbers could be swiftly reduced by a disease outbreak or other causes of death (Iliffe 1979).

In 1921, the Tanganyika Territory health system consisted of 26 British medical officers, 17 nurses, 19 Indian "sub-assistant surgeons," and an uncertain number of "tribal dressers" who had been trained by the Germans before the war (Nsekela and Nhonoli 1976). After World War I, demand among Africans for access to biomedical health services seemed to increase: "Previously, the government had tried to make the African seek treatment; after the war it was the African who requested medical services. He demanded more than the government could give

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him" (Beck 1970: 131). The British resolved to train more young men as tribal dressers, for political and economic reasons as well as medical ones. After a three month training in first aid and the diagnosis of common diseases, tribal dressers would become the main providers of medical care for the majority of Africans until after World War II. A second level of African medical staff known as dispensers received 18 months of training, after which they were qualified to run rural outpatient clinics and dispense basic medicines, as well as diagnosing and treating malaria. The only medical school in East Africa which provided training to African doctors was Makerere University in Uganda, which graduated its first Tanzanian physician in 1940 (Iliffe 2002).

Despite these modest improvements in medical services, Tanganyika remained a somewhat neglected part of British colonial administration in Africa, especially compared with Kenya and Uganda, which had longer histories of British involvement and greater investment of health services funding and medical personnel (Beck 1970). As a result, the British authorities continued to rely heavily on missions to provide the majority of health services in rural areas of Tanganyika, owing to "the desire of the colonial medical department to minimize the costs of its own services while relying on the voluntary sector wherever possible" (Jennings 2006). Unlike in the Congo, where the explicitly Christian and pro-natalist aspects of mission health care and its focus on childbirth were an integral part of colonial governance, British authorities in Tanganyika were less ideological. Their interest seems to have been more focused on outsourcing the difficult problem of African health services to missions, which often had a greater knowledge of the Territory and its medical problems than they did. In Tanganyika, "the

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evolution of maternal child welfare emerged from this blend of Christian rhetoric, colonial state pragmatism, and international trends in public health" (Jennings 2006: 230).

World War II was a key period of transformation for many African colonies, including Tanganyika (Cooper 2002). It was a time of increased migration from rural to urban areas, where many migrants had their first experience of British colonial bureaucracy and individual documentation through the issuing of ration cards (Iliffe 1979). After a series of strikes and labor unrest across Africa in the late 1930s, including at the port of Dar es Salaam, Britain passed the Colonial Development and Welfare Act in 1940. The Act represented a major investment in economic development, infrastructure, and social welfare services aimed at improving the standard of living of colonized peoples. The Act was based on the theory that "better services would produce a healthier and more efficient workforce, and above all a more predictable and less combative one" (Cooper 2002: 31). However, plans to expand health and welfare services were largely postponed until after the end of the war, when Britain and other colonial powers entered a period of "developmental colonialism" which included an expanded emphasis on science and technology as solutions for development problems in Africa and elsewhere (Cooper 2002:37, Packard 1997).

Within the British colonial service, there was a shift towards viewing health as essential part of overall economic development: "it was the theory that overall development could be promoted through better health, and better health, in turn, depended on development" (Beck 1970: 158). Actual changes in health services and outcomes were slow to occur. Although Tanganyika's medical budget doubled after the end of World War II, the country's medical director in the late 1940s considered the budget "absurdly small" and sufficient to fund "merely a

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token service" (Beck 1970: 161). Infant mortality, parasitic diseases and malnutrition were still widespread problems in the post-war period. Medical administrators complained of delays in accessing Colonial Development and Welfare Act funds, and still relied heavily on missions to provide health services.

Independence and *Ujamaa*

When Tanganyika gained independence from Britain in 1961, there were only 20 rural health centers to serve a majority rural population of some ten million people (Sullivan 2011), and shortages of medical staff and basic medicines were common. A review of the health system commissioned by the Nyerere government concluded that "progress, where it has been achieved, has quickly been caught up by population growth and rising demands" (Titmuss 1964: 31, quoted in Sullivan 2011: 90). The health system was decentralized, with responsibility for rural health services left to local and district-level authorities to manage. Lacking in administrative capacity, communications infrastructure, and adequate funding, rural authorities continued the colonial-era dependence on missions to provide health services in the post-independence period. For example, there were twice as many mission-run maternal and child health clinics as government-run ones at independence (Jennings 2006). In coastal areas, the Aga Khan foundation also expanded its network of dispensaries and health clinics (Kaiser 1996). As I discuss further below, the continued reliance on a decentralized patchwork of healthcare services in the post-independence era, each with its own internal bureaucracy and system of record-keeping, may be one reason that Tanzania has struggled to establish a standardized procedure for birth registration based in the health system.

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The post-independence Tanzanian government inherited a health system with many problems. One early priority was expanding hospital services outside of Dar es Salaam, and two major new hospitals were built in Tanzania's second and third largest population centers, Bugando Hospital in Mwanza and Kilimanjaro Christian Medical Centre in Moshi. Muhimbili National Hospital in Dar es Salaam began training Tanzanian physicians in 1963 (Iliffe 2002). These efforts were partly funded by European donors, including Britain. The U.S. became a significant force in foreign aid to Africa, investing in programs to address particular conditions such as malaria or malnutrition through the application of new "silver bullet" technologies as part of its overall Cold War strategy to exert geopolitical influence through development (Packard 1997). At the same time that new hospitals were opening and new technologies for malaria prevention were being deployed, health centers in rural areas continued to lack basic medical supplies, including life-saving essential drugs like penicillin and chloroquine. Health workers in remote areas described agonizing decisions about rationing drugs and withholding medicine from patients with lower chances of survival (Sullivan 2011). Although medical care was supposed to be free of charge during this time, scarcity of medicines and medical staff meant that care was difficult to access.

In 1967, Tanzania officially adopted an African-influenced form of socialism known as *Ujamaa* (meaning family in Swahili) as its official mode of governance. Improving health services was not a main policy priority under *Ujamaa*, which focused instead on education, agriculture and industrial development (Coulson 1982). However, the adoption of *Ujamaa* had a range of effects on health care in Tanzania (Sullivan 2011). Drawing on models from other socialist or Communist developing countries such as China and Cuba, *Ujamaa* health policies

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focused on expanding access to basic rural health services, with the eventual goal that everyone should live within 10 kilometers (considered a reasonable walking distance) from a health facility (Iliffe 2002). In the late 1960s and early 1970s, basic health interventions such as immunization campaigns and village sanitation projects began to show positive outcomes. More than 70 percent of Tanzania's health budget was provided by foreign donors, mostly Scandinavian countries. Much of this funding was still channeled towards what are referred to as "vertical projects" which focus on a particular disease, intervention and/or region, and are often managed by foreign staff, so that they do not contribute to building local technical knowledge or capacity to continue the project independently of the donor, and thus have a negative impact on health governance. Malaria projects are a classic example of vertical interventions that may involve pharmaceutical treatment, or prevention through bed nets, insecticide spraying, or environmental clean-up, but rarely are these approaches integrated in a comprehensive approach. Such projects were a common aspect of colonial medicine, and continued relatively unchanged in the post-independence era (Packard 1997 and 2010; for critical analysis of more recent malaria projects see Gerrets 2012, Kelly 2012, Cueto 2013).

Economic crises and neoliberal reforms

In the late 1970s, Tanzania experienced a major economic crisis as a result of three factors: the 1979 global oil crisis, falling export prices for Tanzania's main commodities such as coffee, and its war with Uganda (Coulson 1982, Tripp 1997). The economic crisis had both immediate and longer-term devastating impacts on health in Tanzania. Unchecked inflation led to rapid rises in food prices, and shortages of many staples including cooking oil. Many health

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professionals left Tanzania to seek work elsewhere, and those who remained tried to augment their incomes (as public sector salaries were often not paid on time) by illegally practicing medicine privately from their homes, or engaging in informal income-generating projects referred to as *miradi* (Tripp 1997, Lugalla 1995, Obrist 2006).

After a number of failed attempts to negotiate a loan package from the International Monetary Fund, an agreement was reached with the World Bank and IMF in 1986 after President Nyerere stepped down from power the previous year. Tanzania's main foreign aid donors in the US and Europe had made their continued assistance to Tanzania contingent on reaching a loan agreement and implementing a package of economic austerity measures known as a structural adjustment program (Tripp 1997). Under these terms, Tanzania was obliged to make several major changes to its health system: to institute user fees for most services, to allow for-profit private medical facilities, and to freeze the salaries of health workers (Lugalla 1995, Tripp 1997, Benson 2001). Although people who had come of age in the *Ujamaa* era deeply resented the introduction of user fees and privatized health care (Kamat 2008), Ellison (2014) notes that "although people vigorously opposed paying for a previously assumed right…they did not discuss biomedical care under *Ujamaa* as uncomplicated or idyllic" by comparison (2014: 3).

As has been well-documented, structural adjustment policies have had many negative impacts on health systems and health outcomes throughout the developing world (Turshen 1999, Farmer 2003, Stein 2003, Benson 2001, Pfeiffer and Chapman 2010, Kentikelenis et al 2015). Tanzanian anthropologist Joe Lugalla was among the first researchers to document the disproportionate impact of structural adjustment on poor women and children in Tanzania. These negative impacts took several forms: cuts in government health spending; 300 to 400 percent

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increases in drug prices as a result of currency devaluation; lack of access to health services due to understaffed facilities; and user fees that could amount to half a month's wages to treat a common malaria infection (Lugalla 1995). The introduction of user fees also opened the door to corruption within the health system, as patients did not know what the official fees were supposed to be, and unscrupulous health workers sometimes took advantage of this by adding a bit extra for themselves (Tripp 1997, Green 2000). As I discuss further in chapter 7, such "everyday corruption" may be viewed from several competing moral viewpoints.

Growing frustration with the cost and quality of health services led many people to avoid seeking care until conditions became very serious and thus often more difficult and expensive to treat (Green 2000, Tibandebage and Mackintosh 2005). Although vulnerable groups including pregnant women, children under age six, the elderly, and people with disabilities were supposed to be exempt from paying user fees for healthcare, this was often not the case (Sullivan 2011). Negative consequences for health were not confined to the health system itself. At the community level, growing public health crises during this period included chronic malnutrition among low-income women and children; poor sanitation in overcrowded housing contributing to many preventable deaths from diarrhea and cholera; and increasing vulnerability among women and girls to HIV infection through transactional sex (see also Susser 2009 on the gendered dimensions of the AIDS epidemic). As a result of both the economic crisis and the austerity measures intended to address the crisis, overall health outcomes in Tanzania deteriorated during this period (Lugalla 1995, Vavrus 2005, Obrist 2006, Sullivan 2011).

The very serious financial constraints Tanzania faced during the 1980s and 1990s impacted the government's capacity to devote time or resources to non-urgent issues. This lack

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of administrative capacity surely would have hindered the development of a robust birth registration system during this period. Improving statistical capacity in developing counties was certainly not a key issue for donor countries during this period, but in the late 1980s, the UN Statistical Commission began outreach efforts to developing country governments, offering assistance in modernizing vital registration systems (UN Statistical Commission 1991). In the Tanzania National Archives, I found a series of letters sent by the Statistical Commission to the Tanzanian National Bureau of Statistics beginning in 1987, inquiring whether Tanzania would like to participate in this technical assistance project. After a few letters back and forth between the Bureau of Statistics and the Statistical Commission, the project seems to have stalled. This is perhaps not at all surprising, as Jerven's history of post-independence statistical capacity in Africa shows that government statistical bureaus were hard hit by austerity measures, and severely under-resourced (Jerven 2013). The focus of government statisticians in Tanzania and elsewhere during this period was in generating economic data required for IMF and World Bank reporting, not on issues such as birth registration data, which were seen as non-essential to economic recovery.

"The debris of past systems"

When Tanzania began to emerge from its economic crisis in the 1990s, it was immediately confronted with an equally severe crisis: the HIV/AIDS epidemic. Tanzania's health system, still in disarray from the many changes imposed during economic restructuring, was ill-equipped to respond to the AIDS crisis. Historian John Iliffe described the fractured state of Tanzania's health system in the 1990s: "the country was littered with the debris of past

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systems, with the remains of socialism lying thick and the surface patches of private practice still spreading" (Iliffe 2002: 219). The system was comprised of a patchwork of government, NGO, faith-based and private health facilities, with myriad domestic and international funding sources. Public health services had been de-centralized down to the district level, with well over 100 districts nationwide. This hybrid and ever-changing mix of services and projects made it very difficult for the Ministry of Health to implement system-wide policies or maintain control of national priorities.

In the late 1990s and early 2000s, as the HIV prevalence rate rose to a high of 9 percent, one of the highest rates in the world at that time (UNAIDS 2015), the Tanzanian Ministry of Health spent a great deal of its capacity dealing with the epidemic, which included responding to the priorities and requirements of the many donors who offered assistance with various aspects of the AIDS epidemic. Sullivan (2011) argues that the Tanzanian Ministry of Health became very externally focused during this time, both in terms of attracting donors, and performing discourses and practices that were appealing to donors, in order to demonstrate that Tanzania was a worthy aid recipient capable of "accountability" and "good governance." However, much of the AIDS-related foreign aid during this time went directly to national and international NGOs. By 2005 nearly half of all donor health funding to Tanzania was for programs administered outside the government, with activities and goals often not in coordination with the Ministry of Health's official national 5 year plans for health services (Sullivan 2011). It is not difficult to extrapolate that birth registration was once again sidelined by the response to the AIDS crisis, when the government's energies were going primarily towards trying to prevent

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people from becoming infected, treating those who had already become infected, and dealing with the social consequences of hundreds of thousands of AIDS-related deaths.

Paradoxes of PEPFAR

Two major events significantly impacted the Tanzanian health system in the early 21st century: the advent of the Millennium Development Goals (MDGs) in 2000, and the US government's *President's Emergency Plan for AIDS Relief* (*PEPFAR*) in 2005. Three of the eight MDGs had an explicit focus on health: Goal 4: Reduce Child Mortality, Goal 5: Improve Maternal Health, and Goal 6: Combat HIV/AIDS, Malaria, and Other Diseases. Tanzania ranked poorly on all three of these MDGs, and President Jakaya Kikwete's administration made improving on the MDGs an explicit goal, in particular reducing child mortality rates (UNGASS 2007). The MDGs were instrumental in ushering in a new era of quantification in the areas of global governance and international development (Merry 2011, Fukuda-Parr and Yamin 2013). While proponents of the MDGs argued that a data-driven approach to development was necessary to target resources and make significant gains, critics of the MDGs argued that onerous measurement and reporting requirements detracted from developing countries' efforts to independently establish and measure their own development priorities (Easterly 2006, Hulme 2009, Jerven 2013, Storeng and Behague 2014). It is interesting to note that birth registration was not included as an indicator for MDG 4 on child survival, although it is arguably very relevant to both maternal and child health. However, many of the countries with the highest rates of infant mortality have correspondingly low rates of birth registration, so data for assessing MDG 4 was drawn from other sources in most low-income countries (UNICEF 2015). As Sally Engle Merry

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and I have argued (Merry and Wood 2015), indicators such as the MDGs entail a "paradox of quantification": those phenomena that are more easily quantifiable are those that are more likely to be measured and tracked by indicators. Birth registration in Tanzania is difficult to measure because the data are incomplete and the majority of children are unregistered, so it remains relatively unmeasured and there is little incentive for the data quality or the outcome to improve. I will return to this problem of paradoxical measurement in chapters 6 and 9.

The PEPFAR initiative has arguably been one of the greatest influences on the Tanzanian health system in the post-independence era, other than structural adjustment (Dilger 2013). Beginning in 2005, PEPFAR entailed an unprecedented influx of new medicines, technologies, personnel, and ideologies into the Tanzanian health system. In the decade since its inception, the Tanzanian government's partnership with PEPFAR has yielded some major positive outcomes, including slowing the rate of HIV infection to five percent, and dramatically reducing the risk of HIV transmission during childbirth (United Republic of Tanzania 2014). People receiving antiretroviral therapy have referred to its "Lazarus effect" for the seemingly miraculous way it can bring dying people back to life (Robins 2005). Hundreds of thousands of people who would have died if not for AIDS treatment continue to live their lives, working and taking care of their families, which brings many positive social and economic benefits. Hospitals and health centers have built new, dedicated HIV testing and treatment facilities with PEPFAR funds. Sullivan (2011) describes one such hospital-based clinic in a hospital in northern Tanzania, which contained new equipment and supplies not found in any other part of the hospital: an abundant supply of gloves, needles, and other basic medical supplies, plus computers and internet access, machines for testing patients' blood, refrigerators in which to store medications, generators to

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provide consistent electricity, and even a comfortable waiting room for patients. Doctors and nurses noted what a difference it made for them to have the necessary time and tools to do their work and help their patients (Sullivan 2011).

Pregnant women have been a particular priority for PEPFAR, as preventing mother-to-child transmission of HIV (referred to as PMTCT) is one of the most effective ways of slowing the overall rate of infection. A relatively simple regimen of medications given before, during and after birth, along with formula feeding only if safe water is available, can reduce the risk of HIV transmission during pregnancy, labor, or breastfeeding to 5 percent or less (UNAIDS 2013). In order to receive this treatment, women must be screened for HIV during their pregnancy and given the necessary counseling and follow-up care. This has meant that pregnant women's bodies are now subject to additional surveillance in the form of HIV tests and special clinic cards if they test positive so that they can be referred for needed treatment.

By 2012, 77 percent of Tanzanian women who were HIV-positive and attending prenatal clinics were receiving the necessary medications to prevent transmission (UNAIDS 2013). While the outcome of PMTCT is usually good, the process of undergoing testing and surveillance can be difficult for many women. Anita Hardon and colleagues found that some women found the process of testing coercive, and that only 37 percent of women who tested HIV-positive has disclosed their status to their husband or partner (Hardon et al 2012).

PEPFAR has achieved a number of major outcomes in its first decade, including supporting antiretroviral treatment for 7.7 million people as of 2014 (PEPFAR 2015). However, critics argue that PEPFAR has also had a number of negative consequences for African health systems, as Crane (2013) details in her ethnography of PEPFAR in Uganda (see also Pfeiffer

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2012 and 2013). Crane argues that PEPFAR and similar global health aid programs take on a neo-colonial role in poor countries whose health systems have been decimated, in part, by legacies of colonialism such as political instability and economic exploitation. Such programs can be seen as part of a new "scramble for Africa" in which researchers and clinicians from wealthy countries come to Africa looking to extract valuable data, in addition to providing necessary services to local patients:

> [N]orthern nongovernmental organizations, foundations and governmental aid agencies provide substantial funding and services to countries where state power has been hollowed out by structural adjustment, political unrest and corruption. Although these providers of funding and aid can enable projects that might otherwise not be possible, they bring with them sets of expectations and priorities determined elsewhere, in much wealthier settings, which may or may not meet local scientific priorities and protocols. The result is a postcolonial science characterized by an "uneasy symbiosis" of collaboration and discontent (Crane 2013: 11).

In her study of medical students in Malawi, Wendland has characterized a similar feeling of ambivalence or "desire and distaste" about participating in externally funded and directed global health projects (2010: 167). Critics of PEPFAR argue that it has actually weakened developing country health systems overall, by recruiting the most highly trained medical staff to work for donor programs rather than in the public health system (Pfeiffer 2013). It is possible to both celebrate the successes of PEPFAR, and question its larger impact on African health systems: "current attempts to expand access to [HIV/AIDS] treatment are long overdue, but concern has been expressed that this risks overwhelming what little health care infrastructure is left in Africa and undermining fledgling attempts to reinforce primary health care" (Sama and Nguyen 2008: 9).

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Large foreign-financed projects such as PEPFAR typically disburse funding among different public and private sector grantees, rather than through a lump sum to the host country government. Neoliberal theories of “good governance” argue that this approach of spreading resources among various grantees prevents government corruption and misappropriation of funds (Anders 2010). However, this also has the effect of creating additional chaos in already fragmented health systems. In her long-running series of ethnographic studies of HIV/AIDS in Uganda, Susan Reynolds Whyte has termed this effect of PEPFAR “projectification.” Projectification occurs when a veritable alphabet soup of donor-funded programs provide an array of various medical and social services, which AIDS patients must learn to actively negotiate as “clients,” circulating among different programs to seek HIV medication, food, and social services (Whyte et al 2013, also Pfeiffer 2013). Although this means that AIDS patients with the physical energy and social capital to navigate this complex system can receive good medical care, “projectification” also results in so many different funding sources, supply lines, and models of treatment that government ministries of health find it difficult to effectively monitor and manage what is happening within their own borders. Vinh-Kim Nguyen calls attention to this paradox of global health:

> If African health systems are ungovernable, it may be in large part because powerful international donors work at cross-purposes, setting competing agendas, cycling policies at a rate that defies bureaucratic assimilation, fragmenting efforts, and undermining local systems of accountability (Sama and Nguyen 2008: 9).

PEPFAR and other major global health programs also entail new regimes of quantification through the collection of large amounts of data on participants. The data requirements and priorities of global donors and country health ministries are often very

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different, and foreign researchers and donors often expect that their data needs will take precedence. This often entails introducing complicated new data collection procedures or computerized databases customized to the data needs of the donor or the research project. These data demands place an extra burden on already overtaxed health workers, who are expected to enter and manage new forms of data, often without additional compensation. These data are often not considered the property of local health authorities, but in a troubling neo-colonial parallel, are exported as “raw” data to be “refined” into scientific papers in donor countries (Crane 2013; see Wood and Merry 2015 for an example of similar data demands in indicators projects).[5]

However, this demand for all kinds of health system data has not so far had a positive impact on birth registration data in Tanzanian hospitals. This is part of the paradox of quantification: because birth registration rates are low, researchers are not interested in using the data, or they get it from another source, in this case the Demographic and Health Surveys conducted every five years (DHS 2010). Some researchers have also tried establishing their own birth registries within particular hospitals (Bergsjo et al 2007). While this approach, essentially involving a second set of registry books customized to the researchers’ data collection needs, may collect valuable information, it can also be seen as an example of projectification. Although

[5] I am aware that a similar dynamic exists in ethnographic studies like this one. Although I tried to be very conscious of the burdens that my data collection placed on my research participants and research assistants, and to make sure that everyone involved was compensated appropriately for their time and effort, I am also responsible for processing of “raw” data harvested in Tanzania into “refined” products that will provide professional benefits primarily to me. I am currently thinking of ways to share the results of this research with Tanzanian audiences, as well as how to secure funding for future research projects that would provide more equal professional benefits to myself and my Tanzanian colleagues. However, my research assistants also thought that birth registration was a slightly boring topic, and suggested that in future, we should work on a more interesting and complex research topic like cancer or diabetes!

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the new system may be useful, it will probably end when the foreign research project is finished. Thus, if birth registration data within the health system is not seen as reliable or valuable, resources are not invested to support and improve it in a consistent and coordinated way throughout the country, and so it remains devalued. Additionally, improving data collection is only one half of the birth registration problem: the other even more intractable half of the problem, as I show in chapters 5, 6 and 7, is how to actually get birth certificates into peoples' hands.

Tanzania's health system today bears the cumulative effects of more than a century of interaction with western biomedical, political, and economic ideologies and practices. As in many African countries, the result can be described as follows, in a recent critical analysis by Joao Biehl and Adriana Petryna:

> A fractured and uneven health system in which state of the art facilities for HIV/AIDS testing and treatment coexist with all-but-dilapidated state hospitals, where wealthy donors create showcase clinics in one region while clinics in a neighboring region atrophy and their long-term sustainability is always in question.
>
> In this makeshift system, the focus is squarely at the level of the clinic, where interventions can be followed and their results measured. Attempts to make assessments at the national level are left by the wayside and the myriad social factors that can contribute to positive health outcomes are by and large ignored (or, if acknowledged, not acted on) (2013: 135).

Conclusion

Tanzanian children today are born into a health system where babies and mothers stand a better chance of healthy survival than at any time in the past. The Tanzanian government is justifiably proud of this achievement. And yet, where babies are born still matters a great deal. A

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minority of lucky children benefit from the trends of medicalization, projectification, and quantification that may result in a higher quality of care for those who can afford to access it. But most are still born at home, perhaps with the help of a grandmother or traditional birth attendant, or in an overcrowded clinic or hospital ward where the lone midwife on duty may or may not have her hands free to guide the delivery. Even in a health facility, it is not uncommon for women to deliver by themselves, or with the help of a family member instead of a medical professional. Unlike in wealthy countries, where many women are opting for a less medicalized birth where possible, many Tanzanian women are eager for a *more* medicalized birth.

In this chapter, I have shown how the trends of selective medicalization, quantification, and projectification have contributed to the development of the current health system, and the place of childbirth and birth registration within it. In chapter 4, I outline how challenges in the current system contribute to low rates of birth registration. I describe Tanzanian peoples' experiences in the health system, in particular their frustrations with health care that is increasingly privatized, and highly variable in both quality and cost. Parents express deep frustrations with public health services for women and children, in particular the endless demands for fees for services that are "free but not really free." I share their opinions and critiques of health services, as well as their innovative ideas for improving birth registration through the health system. I then analyze their discourses in the context of theories of biological citizenship. While most people are not thinking much about a piece of paper when a baby is born, they are conscious that disparities in access to a birth certificate start at the moment of birth.

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Chapter 4

"Free, but not really free": Fees and frustrations in Tanzania's neoliberal healthcare landscape

> *"Dawa haitolewi bure."* (Medicine is never given for free).
>
> —Swahili proverb

> "Health services in this country are very bad. When you go to the hospital, they will not help you unless you have your clinic card. They will send you home to go and get it, even if your child is very ill. They have no IVs or medicines at public hospitals, you have to go to the *duka la dawa* [pharmacy] to buy them before anyone will even treat your child. It's a big problem.
>
> When you go to give birth, if you do not bring all the *vifaa* [birth supplies] that are required, the nurse might shout at you and you may feel very embarassed. But I cannot afford to go to a private hospital. I can barely afford those services that are supposed to be free. Free? In terms of health, nothing is really free."
>
> —Latifa, mother of 1, Mwenge

In today's Tanzanian health system, even services that are supposed to be free rarely are, including birth registration for babies three months old or younger, and health care for children age five and under. As the quote above from Latifa demonstrates, parents often experience a great deal of frustration when they interact with the health system. In particular, fees are a major source of anxiety. Even when seeking services that should be free, such as routine care for children under age five, parents know that there will be hidden or unexpected expenses. I found that asking parents and grandparents about fees for birth registration and other services was a

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great way to get people talking animatedly. These conversations about fees, in particular complaints about services that are "*bure, lakini sio bure*" or "free but not really free," provide a concrete way for people to voice larger socio-political critiques about governance and rights.

As I outlined in chapter 3, several current problems with birth registration are rooted in the history of the health system. First, Tanzania's public health system has a long history of being fragmented and severely under-resourced, leaving scarce personnel to focus on the basic issues of trying to keep patients alive. In this context of chronic everyday emergencies, filling out paperwork for birth announcements becomes a low priority. Donor funding has contributed to this trend by focusing on "vertical" projects that do not increase the government's capacity to manage its own public health system. Second, the neoliberal trend towards privatization of medical services and the introduction of user fees for even basic public services has led to a stratified system of childbirth, in which families who are able to pay more receive greater attention from medical staff and are more likely to go home with the correct birth documents (and are also more likely pay a bit extra to ensure this). A birth certificate is, as UNICEF puts it, a "right from the start" (UNICEF 2002). But disparities in accessing this right also begin right from the start of life, whether a baby is born at home, or in a health facility.

This chapter draws on parents' experiences with the health system to show that birth registration rates are influenced by disparities in how and where women give birth, and what types of care they are able to access for their young children. First, I offer an analysis of structural problems within the health system, and the specific factors that impede access to the first step of birth registration, receiving the *tangazo* or birth announcement after a baby is born. I then relate these problems to the privatization and increasing stratification of the health system,

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and outline some anthropological analyses of this trend. Second, I discuss parents' opinions of the current system, in particular their views on fees. I relate their critiques of services that are "free, but not really free" to theories of biological citizenship, and consider whether birth registration can be viewed in this light. I begin with a story from the neighborhood of Magomeni that illustrates several key points about experiences of exclusion in the health system.

This story concerns a woman named Rose, who had two 1 year-old twin girls. She was from Tanga on the northern coast of Tanzania, and shared a small room in a dilapidated house with her husband and the twins. Rose had finished primary school, but that was all. Now she looked after her family and did various small income-generating projects when she could. Her older daughter, a 15 year-old, worked for another family as a "house girl" or domestic worker. The room had only a tiny window with no screen, and they had no electricity, so it was very dark. The room was stifling and humid in the mid-day heat, and sweat dripped down all of our faces as we talked. Flora, Agatha and I all perched on the edge of the bed, the lone piece of furniture, next to Rose and her twins. I was glad it was dark in the room, because I felt quite sad about what I saw and it was easier to regain my composure in the dim lighting.

Rose was a slight, shy woman, and she looked exhausted. One of the twins, Sarah, was quietly napping, tied securely to Rose's back with a faded *kanga* cloth. The other twin, Ruth was clearly in distress and very unwell. Rose held Ruth on her lap as she cried, her little body was stiff with pain, and her arms jutted out at unusual angles. She was visibly smaller than her twin sister, and Rose said it was difficult to get her to nurse properly. Rose tried to swaddle Ruth in a blanket despite the heat, and she gently patted her and soothed her attentively throughout our conversation. Agatha, ever the keen medical student, asked a few questions about the baby's

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symptoms. Rose said she had fallen sick during the last dry season with a high fever. The first few times she took Ruth to the local health clinic, they had said it was just malaria and given her an infant dose of malaria medication for a few thousand shillings. But when Ruth started having seizures, she was referred to the pediatric ward of the nearest hospital, where the doctor said it was probably meningitis, although they lacked the diagnostic equipment to confirm it. They gave her a dose of phenobarbital for the seizures, and some antibiotics, but said there was little else they could do for Ruth. Meningitis, an infection of the membranes surrounding the brain and spinal cord, is endemic across west, central and east Africa, especially among infants. About 10 percent of infected people die, and another 10 to 20 percent suffer permanent neurological damage or hearing loss (WHO 2015). Since 2004, cases of meningitis in African countries have declined significantly as a result of vaccination campaigns (WHO ibid), but there are periodic meningitis vaccine shortages. In general, Tanzania has been very successful at immunizing more than 90 percent of infants and young children against major vaccine-preventable diseases (UNICEF 2013), but for some reason the twins had not yet received the meningitis vaccine when Ruth got sick.

The trips to the health clinic and hospital had bankrupted the already poor family, and they had no money left to buy more doses of phenobarbital to ease Ruth's seizures. If Ruth didn't start to gain weight, she probably would not survive, and if she did survive, the chances were that she would have serious cognitive or physical impairments. In light of the seriousness of the situation, I felt a bit foolish asking about birth registration. Who would care about a piece of paper with a child who was so ill? I thought that, given all she was coping with just trying to keep Ruth alive, it might not even be a concern for her. But it was part of the household survey,

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so I asked. Neither Rose nor any of her children had birth certificates. Her older daughter was born at home when Rose was still a teenager, so she never had a chance to get a *tangazo* for her. Although she gave birth to the twins at a health center in Dar, she was so overwhelmed at the time with trying to care for two newborns, she forgot to ask for their *tangazo* before she left. Rose said she wasn't sure how she could get birth certificates for her children now, but she knew that birth certificates were important, and she hoped that maybe, *Mungu aikpenda* (God willing), one day all of her children would be registered, including Ruth. Although Rose lived within a few kilometers of the Kinondoni municipal government office, it still seemed very far away to her: "The government should help us to register by bringing services here to the neighborhood. True, the office is not too far away, but it would still be very difficult to go over there with my twins, especially this little one who is not well. She cries so much, and we could not queue up all day to wait." Rose concluded, "I hope the government could reduce the difficulty somehow; those people who are in charge of registrations should give we parents their time and help. Then maybe all my children could be registered." It was time for Rose to try to feed the twins again, and we said our goodbyes. When we stepped outside, I asked Agatha what she thought of Ruth's chances. She lowered her eyes and shook her head. It was better left unsaid. We walked along in silence for a few minutes.

Staff, stuff, space, and systems

The story of Rose and Ruth is very sad, and similar stories are all too common among low-income families in Tanzania. Rose might have hidden her away, but clearly she wanted us to see what had happened to Ruth, and to witness her suffering. Rose's story casts a harsh light on

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simple failings of the health system that can have disastrous consequences. Her experience raises several issues about how people interact with the health system, and how these interactions shape opportunities to access basic services, including birth registration. First, Rose's older daughter never got a *tangazo* because she gave birth at home, when she was still a teenager. Second, even though Rose's twins were born in a health clinic in Dar, which should theoretically have improved her access to the *tangazo*, the birth of twins creates an extra burden, both for short-staffed delivery wards, and for parents who are faced with the expenses and time pressures of caring for two newborns at once. It is easy to understand why, with new twins at home, Rose could not face the time or extra expense to seek out two birth certificates. Third, Ruth's infection with meningitis, which could have been prevented if she received her vaccine on time, entailed both a life-threatening health crisis and a financial crisis that seemed to push her family, already living in poverty, into dire circumstances.

Although Rose's situation was an especially difficult one, many families face at least some of the same barriers to medical care and birth registration. There are three common reasons that newborn babies do not get their *tangazo*, the first step of the birth registration process. Half of all babies are still born at home, like Rose's older daughter (DHS 2010).[6] For babies born at home, getting the *tangazo* entails a special trip to a local government office, one that few people in rural areas with a new baby at home would be able to make. The *tangazo* cannot currently be obtained through the infant and child health clinics that provide immunizations and routine

[6] The rate of hospital births was higher among my interviewees given that Dar is an urban area. Seventy-three percent of women in my study had given birth to at least some of their children in a medical facility. Typically, those who began having children at a younger age had their older children at home, and their younger children in a hospital or clinic after they moved to Dar. About 10 percent of women had moved to Dar after they became pregnant, partly in hopes of accessing better medical care.

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health care, including health checks for babies born at home, although those clinics issue all babies and young children a *kadi ya kliniki* (clinic card) that contains very similar information. For those babies who are born at a health facility, getting a *tangazo* is far from certain. As I detail below, maternity wards are often overcrowded, under-staffed and lacking even basic supplies, not to mention a steady supply of *tangazo* forms. Finally, childbirth is expensive, even if everything goes well. Parents already subject to so many official and unofficial fees for childbirth and other health services, they cannot afford to pay extra to ensure they receive the *tangazo*.

Parents and grandparents I spoke with were quite eager to share their experiences and frustrations with the accessibility, quality and expense of the health services available to them. A nationally representative survey of Tanzanian households conducted around the time I was doing my fieldwork found that three out of five respondents were dissatisfied with the current state of the Tanzanian health system (Twaweza 2013), and this was also borne out in my sample. Although a number of people I spoke with mentioned positive improvements in the health system, such as routine immunizations for children, and coupons for discounted bed nets to prevent malaria, most people also had many complaints, as well as thoughtful suggestions for improvement. Following a brief overview of the current challenges of the health system, I will share peoples' concerns in their own words. I will then situate the problems faced by Tanzania's health system within the larger context of privatization and stratification of health services, and anthropological critiques of this trend. Before beginning my analysis of the key problems of the health system, it is important to pause for a moment and reiterate that Tanzania has also achieved some major health successes in recent years, including slowing the rate of HIV transmission,

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vaccinating a higher percentage of children than some wealthy communities in the US, and significantly improving child survival rates (Afnan-Holmes et al 2015). That much of this work has been accomplished by public sector health workers operating within the many constraints I now describe makes these positive outcomes even more impressive.

Staff, stuff, space, and systems

Paul Farmer (2014) offers a simple but effective shorthand for thinking about the issues facing health systems in developing countries: staff, stuff, space, and systems. Although he was referring specifically to analysis of health systems in West Africa in the context of the Ebola epidemic, this same framework is also useful for thinking through health system problems more broadly. The Ebola emergency caused the international community to finally pay more attention to systemic problems like shortages of basic medical supplies, but people on the ground know very well that these problems are chronic, not acute.

Staff

At the heart of the health system's problems is the issue of medical staff. Here I do not refer to the people themselves, as the doctors, nurses and midwives I have met over the years have been dedicated professionals who do their best despite difficult conditions (see also Wendland 2010 and Livingston 2012 for positive ethnographic representations of African health workers). Rather, I refer to the fact that Tanzania's public health facilities are continually under-staffed. Currently in Tanzania there are 0.1 physicians per 10,000 people, while next door in Kenya there are 1.8 physicians per 10,000 people. Although this is the average country-wide, the majority of Tanzanian doctors practice in urban areas, which offer better facilities,

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opportunities, and schools for their children. Many health facilities, especially in rural areas, are staffed primarily or entirely by nurses and midwives. There are 2.4 nurses and 4 midwives per 10,000 people, compared with 7.9 nurses per 10,000 people in Kenya. Even adjusting for Kenya's higher GDP, the disparity remains (WHO 2014). Many public health facilities have difficulty ensuring that their staff work during their scheduled hours. A 2012 World Bank study of public health facilities in urban areas of Tanzania found that as many 33 percent of staff who were scheduled to be on duty were absent at the time of unannounced visits by researchers (World Bank 2012).

Given the shortage of medical staff, anyone who is an inpatient at a health facility is expected to have a female relative or friend come to the hospital to help take care of the patient by bringing food and drink, helping with bathing, and even giving blood if a transfusion is required (Allen 2004, Spangler 2011). Public buses to and from Muhimbili Hospital in Dar are usually full of women traveling to the hospital from all over the city and beyond, bringing baskets of food and thermoses of tea and soup to sick relatives, and coming home exhausted in the early morning after seeing their relatives through another night or staying with them until the end if they can. Without these legions of volunteer female caretakers, the public hospital system would likely cease to function.

Chronic under-staffing at health facilities impacts child birth and birth registration in two ways. First, delivery wards almost never have enough nurses or midwives on duty to care for all the laboring women. Since labor is unpredictable in its onset and duration, midwives are constantly triaging and having to decide which women urgently need help, and who can wait or labor on her own for a while longer. Sullivan (2011) gives a vivid account of a night she spent

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observing and assisting a lone midwife on a maternity ward in a hospital in Arusha. She describes a series of births that happen during the night. The first delivery is uncomplicated, and the baby is healthy, so the first mother is handed a pad of cotton wool and told to tidy herself and walk herself and her baby over to a shared bed in another ward within a few minutes of giving birth. The second baby is a long and difficult delivery, and he is born blue and not breathing. Although his mother has a badly torn perineum and is still bleeding, the midwife has to rush the blue baby over to an old foot-operated suction pump to see if she can get him to breathe. The only oxygen mask on the ward is too large to fit over the newborn's face property. The baby struggles to breathe, but there is nothing more she can do for him. The midwife puts the baby under a high-wattage light bulb to try to keep him warm, while she sews up his mother's torn perineum. Finally the baby cries, and is handed over to his mother and discharged from the hospital the next day. There is no incubator for babies born in distress, so his mother tries to warm him up by placing him in between herself and the other new mother sharing the narrow bed in the recovery room. Happily, that distressed baby did survive the night.

Sullivan goes on to describe how the midwife must then try to attend to record-keeping at the end of her shift: "The midwife tries to fill out the partograms and forms in her registers and on the women's clinic cards. But then yet another woman delivered. So late at night and having stood for hours tending to laboring and birthing women, the details of back-to-back births were starting to blur together" (Sullivan 2011: 324). Given the difficult circumstances under which midwives and nurses work, it is certainly understandable that filling out registry books and *tangazo* forms takes a back seat to keeping mothers and babies alive with little or no help and few supplies.

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Stuff

The problem of stuff, i.e. medical supplies, is also a key contributor to the high costs of child birth, costs which in turn impact birth registration. When women come to a health facility to give birth, they are supposed to bring their *vifaa* ("things"), which refers to the basic medical supplies needed to give birth. The first thing a midwife might ask a woman in labor as she enters a public facility is not "How close are your contractions?" but instead "*Habari za vifaa?"* meaning "What about your supplies?" The required *vifaa* can vary by facility, but at a public health clinic or hospital, women are expected to bring an extensive—and expensive—collection of supplies. Spangler (2011) provides a list of the currently expected *vifaa* in one rural area: at least 2 pairs of latex gloves, soap, a plastic basin, a razor, cotton wool, a needle, a syringe, a plastic sheet, some kerosene, some disinfectant, and 3 to 4 new *kanga* (large fabric wrappers worn by women to use as sheets and blankets). These supplies are for an uncomplicated delivery. If a woman needs an IV, blood transfusion, or a c-section, the costs increase further. The cost of even the standard *vifaa* is beyond the means of many poor families, and could be as high as Tsh16,000-20,000 which could represent several weeks' wages. As Latifa describes in her quote at the beginning of this chapter, women who arrive at a clinic without sufficient *vifaa* may be sternly admonished by the staff and feel ashamed. Spangler (2011) also observed some women in labor being turned away from a clinic and told to come back when they have their *vifaa*; she describes one woman's husband frantically cycling around the village to borrow bits and pieces of *vifaa* from other family and friends while his wife's contractions grew closer together. It is an open secret that the private pharmacies known as *duka la dawa* (medicine shops) where patients are sent to buy *vifaa* supplies and medicines are often owned by higher-level hospital staff, and

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ordinary people often resent that they seem to profit from the suffering of their own patients (Foley 2010, Spangler 2011, Twaweza 2013).

Vifaa are a source of stress for all concerned. On one hand, it is unsafe for midwives to have to deliver babies without the bare minimum of clean gloves for each patient. Basic hygienic supplies such as gloves, clean razors, and soap and running water help to protect the health of both staff and patients. A study of Tanzanian health facilities found that 83% of hospitals surveyed reported that gloves were out of stock at some point in the previous year, and two-thirds of those facilities lacked gloves for more than 4 weeks at a time. Supply chains are a particular problem for facilities in rural areas (Sikika 2013). Another study found that 97% of health workers in Tanzania say they do not have enough supplies to do their work properly (Mbaruku et al 2014). On the other hand, some people consider the extensive list of *vifaa* to be excessive, and argue that it prevents poor women from giving birth in health facilities. One senior Tanzanian nurse describes the marginalization of women who cannot afford *vifaa*: "Many are ashamed if they can't get the *vifaa* or new kanga. They stay at home [to give birth] because they don't want others to know of their hardships" (Spangler 2011: 485). Medical debts are a growing problem for poor families, and one study found that nearly half of women in one rural Tanzanian district had to cut down on spending, sell household assets, or borrow money to pay for a hospital delivery (Kruk et al 2008). Another reason that poor women give birth at home is that traditional birth attendants will accept a small non-cash payment such as some eggs or grain from a future harvest, and do not make women feel ashamed for not having *vifaa* (Allen 2004, Spangler 2011). While private and mission facilities seem more expensive than public facilities,

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their fees for childbirth typically include most supplies, and they may actually be less expensive in the end than paying for the *vifaa* required at a public facility (Spangler 2011).

The lack of supplies in public facilities has two possible effects on birth registration. First, facilities often run out of the special paper used for the *tangazo* form, so the staff cannot write the *tangazo* even if they have the time and inclination. Keeping *tangazo* paper in stock seems to be a particular issue in rural areas (Strong 2014). Second, buying the *vifaa* (in addition to paying all the other expenses associated with childbirth) completely exhausts the financial resources of poor families. In many cases, the *tangazo* is seen as an extra or optional expense, and since the opportunity to get a *tangazo* occurs at the end of the hospital or clinic stay, the family's money may have already run out.

Access to medicines is another important dimension of the problem of stuff. In 2013, 46 percent of patients at government health facilities found that medicines that should have been available had to be purchased at private pharmacies, usually at greater cost (Twaweza 2013). Another advantage of mission and private health facilities is that they are more likely to stock medicines in their own in-house pharmacies. Eighty-five percent of patients at mission facilities and 69 percent of patients at private clinics were able to purchase their medicines at the clinic. Fatuma was disturbed by the inflated cost of her daughter's malaria treatment: "At the hospital services are supposed to be free but the medicine is never there. My daughter was supposed to get medicine for 1500, but it was not in stock and they told us to go to the *duka* to buy it, where it cost 15000."

Access to more specialized medicines is even more difficult. Mary Stella's husband, a welder, had been diagnosed with tuberculosis in 2011 after being ill for some time. Although the

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standard treatment for active TB is a carefully managed six to nine month drug regimen (Farmer 2003, WHO 2010), they had been having a very difficult time getting his medications. She describes: “when you go to the hospital, the only medicine they have is Panadol [asprin]. Anything else, you have to go and buy yourself from a *duka*. Everyone knows they are owned by those same doctors who work at the hospital. It is very difficult looking for all those medicines, it takes me a long time to find them all.” Given that TB can become resistant to treatment if medicines are not taken every day, this is very worrisome for Mary Stella, her husband, and their two young sons. Specialty medicines for children are even more difficult to find. Selina’s daughter had asthma, and Selina saved up extra money from her teacher’s salary to buy and stockpile extra inhalers whenever she found some available at a pharmacy.

Space and systems

The remaining two problems are space and systems. Space is a constant problem. Public maternity wards in Tanzania are notoriously overcrowded, with many operating at over 100 percent capacity (Sikika 2013). While the government’s efforts to reduce maternal mortality by increasing the number of hospital births is essential, the capacity of maternity wards has not been increased accordingly. It is quite common for two laboring or recovering mothers to share a single narrow cot, with each baby tucked in beside them as well. Those sharing beds may be lucky to get even that small space—other women may have to sleep on the floor. Due to this overcrowding, mothers and babies without apparent complications are typically discharged as soon as possible to make room for new patients, and it is difficult for women to demand that their paperwork is in order when they are being rushed out of the ward. Finally, in terms of systems, one frustration that parents expressed is that it is difficult to know exactly who is in

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charge of writing the *tangazo*—there is no standardized system of when, where, or from whom to get the *tangazo*. Are you supposed to get it from the midwife who delivered the baby, who is now finished with her shift or on a tea break? From the midwife who just replaced her, who doesn't know who you are or any of your details? From another department entirely? This ad hoc system is very confusing to parents, and unless the mother is very insistent about getting the *tangazo*, or has a family member to advocate on her behalf, she may just take the baby and go home to try to get some rest. As I mentioned in chapter 3, because childbirth is a time of risk and anxiety for many families, most are unlikely to be thinking about paperwork during this time.

Privatization and stratification

The issues with staff, stuff, space, and systems I describe above are common features in many health systems throughout sub-Saharan Africa. Critics have argued that many of these shortcomings are a direct result of the privatization of public sector services that was a key feature of the structural adjustment programs of the 1980s. In 1987, the World Bank issued the blueprint for the privatization of health services that was widely adopted across the developing world, including in Tanzania. The World Bank approach was centered on four principles: institute user fees in government health facilities; introduce private insurance schemes; encourage nongovernmental organizations to provide health services (both non-profit and for-profit); and decentralize government services (World Bank 1987, Pfeiffer and Chapman 2010). This policy was premised on the neoliberal notion that cost savings would result from transforming patients into economically rational "consumers" of health care, which was a radical proposition in post-socialist Tanzania (Ellison 2014).

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Privatization has taken two main forms within the Tanzanian health system. The first is the proliferation of non-governmental health providers which began in the colonial era, but which has expanded at a much more rapid pace during the past two decades, once the ban on for-profit private practice was lifted in the early 1990s (Tripp 1997). The second is the *de facto* privatization of public services through the introduction of user fees and other financial barriers to accessing care, including most recently the advent of health insurance schemes and even "first class" wards in public hospitals in Tanzania (Ellison 2014). Both types of privatization have resulted in a neoliberalized health system in which both access to care and health outcomes are increasingly stratified by income.

Anthropologists have played a key role in documenting the effects of neoliberal economic policies and philosophies of governance in Africa (Comaroff and Comaroff 2001, Ferguson 2006, Rottenburg 2009, Bierschenk and Olivier de Sardan 2014), with a particular focus on the impact of these policies on health services (Lugalla 1995, Green 2000, Fassin 2007, Kamat 2008, Susser 2009, Nguyen 2010, Pfeiffer and Chapman 2010, Foley 2010, Pfeiffer 2013, Sullivan 2011, Geissler and Rottenburg 2012, Biehl and Petryna 2013, Whyte et al 2013, Marsland and Prince 2014).

Turshen (1999) predicted many of the negative effects of the privatization of health services in Africa that can be observed today. However, economic rationing of health care is not a new practice. Rather, it is now justified by a new neoliberal rationale:

> Health care has long been rationed in Africa—by scarcity, by excessive travel time to services, and now by cost recovery measures and user fees. In promoting health sector privatization, monetarists relegate equity to second place in favor of efficiency. The private sector is not innately more efficient than the public sector: it may be used

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> effectively to disenfranchise certain groups, creating the illusion of efficiency by attracting healthier and wealthier patients from the state sector" (Tushen 1999: 59).

Tushen goes on to argue that the collection of user fees is actually an economically inefficient practice. The time spent collecting money, haggling with patients, keeping payment ledgers, and writing out receipts places a heavy administrative burden on public sector staff who already have too many tasks to do in too little time. The fact that user fees generate only about 5 percent of the overall public health budget in many developing counties calls into question whether collection of fees for basic public services from patients who can least afford to pay is a legitimate or effective policy in poor countries (Turshen 1999, Mamdani and Bankster 2004, Farmer 2004, Sama and Nguyen 2008).

Birth registration is considered to be a basic public sector service, and perhaps therefore it would be exempt from privatization. Official birth certificates cannot be obtained through private channels, except perhaps illegally via counterfeiters. However, because of the unofficial fees that most people must pay to obtain a birth certificate, birth registration can be viewed as a victim of the "de facto informal privatization" common to many if not most public services in Africa (Blundo and Olivier de Sardan 2006: 101).

For ordinary Tanzanians, the effects of neoliberalism and privatization are most acutely experienced in the form of fees, and the heavy burdens they impose on almost every aspect of life. As I describe below, people are acutely aware of the hierarchical nature of the health system, and frustrated that payment of fees is no guarantee they will receive good care. Although the majority of Tanzanians still rely on public health facilities (77 percent of patients), those

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Ewho can gather the financial resources to do so increasingly seek care at private or mission-run health facilities (16 percent and 7 percent respectively) (Twaweza 2013). Whether at public or private facilities, paying fees is now the norm, often from the moment a person steps inside.

Medical anthropologists working in Tanzania have documented many different types of fees encountered by patients, encompassing both official and unofficial fees. Payment is often required for everything from registering as a patient and opening a file, to obtaining a referral letter for further treatment at a hospital, to having a prescription written up at the end of the visit. Some of these fees are standard and relatively consistent between facilities, for example registration as a patient typically costs between Tsh1,000-2,000, about US$0.50-1.00 (Sullivan 2011, Ellison 2014). This type of fee, although perhaps annoying, is relatively affordable and predictable for patients.

Unofficial or extra fees tend to be at the discretion of staff, and are thus very unpredictable (Maestad and Mwisongo 2011). Green (2000) describes a number of extra or unofficial fees. For example, a medicine that appeared to be out of stock might suddenly become available, for a person who knows to discretely offer an extra fee. As I discuss in chapter 7, knowledge of appropriate ways to offer an extra fee or bribe, and the going rates for various extra fees, constitute a form of social capital that many poor patients lack (see also Gupta 1995 for a discussing of bribe-paying and social capital in India). Unofficial fees may also be solicited as "contributions" to the basic running of a health facility. Green (2000) documents cases of parents bringing their children for vaccinations being asked to contribute towards the fuel costs for the generator which ran the fridge where vaccines were stored. Effectively, patients are made responsible for paying for not only for services they receive, but for the operational costs of the

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facility itself. At least in the case of paying extra for vaccine refrigeration, parents can hope the vaccines will be effective as a result of being properly stored. However, the payment of extra fees does not always translate into better care: "accessing medical treatment in the public sector inevitably entails the payment of a whole gamut of additional unofficial costs while very little is guaranteed in return for payment" (Green 2000: 416). While paying fees may not guarantee good care, people often feel they have little choice but to pay, either because the clinic is the only one in their area, or because they do not want to risk getting on the bad side of the person who they rely on for medical care (Spangler 2011). Makoye (2013) makes the point that middle class and well-educated Tanzanians are in a stronger position to refuse to pay extra fees and bribes. They know the rules, and feel confident in advocating for themselves, while poor people lack access to information and may not know what their rights are. The poor, paradoxically, can end up paying more.

I have paid unofficial fees myself while seeking medical care in Tanzania. In 2007, I contracted a fairly serious and painful parasitic infection, and was faced with the difficult decision of whether to return to the US early and waste an entire summer's worth of Swahili language funding, or try to find treatment locally. Fortunately, my friend, a professor of medicine, knew a Tanzanian specialist who could effectively treat this condition, and he kindly used his extensive social capital to get me an emergency appointment with this eminent Tanzanian doctor. The specialist was a senior physician at the national hospital, but also had a private clinic around the corner from the hospital, and this is where I saw him, in his very modest and simple office. The doctor calmly examined me, explaining that he had seen this condition many times before, and prescribed a series of medications. I paid a fee of about US$50 for this

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appointment, and an additional US$15 for the prescriptions purchased from his in-house pharmacy. My friend the professor explained beforehand that this unofficial fee was several times higher than a middle-class Tanzanian person would have been expected to pay, and asked me if that was okay. Given the amount of pain I was in at the time, it seemed quite reasonable to me. The professor framed this unofficial fee not as a form of corruption, but rather as an expression of my respect for the specialist's knowledge and time, as well as a guarantee that I would receive high-quality medications from his personal pharmacy. I asked the professor if I should feel guilty for taking an appointment slot away from a Tanzanian patient, but I was told not to worry about this since he was at his private clinic that afternoon anyway, not at the hospital where he saw his public sector patients at much lower fees. In retrospect, I still feel somewhat conflicted about this experience, but also grateful that I was able to receive good medical care. Of course most Tanzanian people do not have the luxury of making this choice, but my friend assured me he would have done the same for his own family.

A neoliberal economist might take my experience as proof that private health care can work well in Africa, while the average medical anthropologist might view it as evidence of how deeply broken and inequitable the system is. For me, a much more interesting question is why do ordinary Tanzanians seek out private health care? The people I spoke with often had a complicated view of private services, including health care and education. On one hand, they deeply resented having to pay for services that had previously been free. Older people who came of age during the socialist era seemed to find this particularly troubling, and a failure of the social contract between citizens and the state (see also Kamat 2008 and Ellison 2014). But on the other hand, if they were going to pay official and unofficial fees in the public sector anyway,

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they might as well seek the best services they could. I noticed that when people talked about using private services, they would usually say the word "private" in English, even if the person spoke little or no English otherwise. It was often said with a slight emphasis and hint of pride that they had been able to have a baby in a private hospital, or send their children to a private school.

Theresia from Kimara expressed this pervasive disillusionment with public health services: "The government? They have not yet done their job. There are major problems with health services, especially for women and children. Those government health clinics are rotten, useless. If I am going to pay anyway, why can I not look for something better for my child?" She had recently taken her four year old daughter to a private clinic. The little girl had been listless for months, and the public clinic had given her a dose of malaria medication without testing her blood, and sent her away. When the girl did not recover after completing the malaria treatment, Theresia took her to a private clinic where her blood was finally tested, and she was diagnosed with anemia, or "small blood" as it is known in Swahili. On the proper treatment, she was finally starting to get better. For Theresia, a seamstress, it was a real point of pride that she could afford private treatment for her daughter. She had been taking on extra sewing work to make up for the expense of the treatment.

Should parents like Theresia stick with the public system and demand improvements? Do they suffer from false consciousness about the negative impacts privatization is having on the health system as a whole? Several studies of women's health care decision-making in Tanzania have found that ordinary women make strategic and rational choices about what kind of care to seek, and where to spend their limited resources. One study (Kruk et al 2009) found that even in

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rural areas of Tanzania, more than 40 percent of women chose not to deliver at their nearest health facility, preferring to travel further from home to seek what they perceived as better quality medical care at a district hospital or mission health facility. Several studies have found that Tanzanian people tend to prefer the types of fees charged by private or mission facilities: these fees are typically higher, but they are official fees and often all-inclusive. Official fees are more predictable, and also leave less room for solicitation of bribes (Green 2000, Spangler and Bloom 2010). Given the high costs of birth supplies or *vifaa* that I mentioned earlier, women find that paying flat fees to deliver at a mission hospital (which in 2010 cost Tsh 10,000 for a vaginal delivery, and Tsh 38,000 for a caesarian section), could actually be less expensive than paying for *vifaa* to bring to a public facility, which at that time cost at least Tsh 16,000, not including an *asante* gift for the midwife (Spangler 2011). Ellison (2014) also notes that people perceive medicines that are purchased at private facilities to be "stronger" and more effective than medicines available at public facilities. Another key factor in favor of private or mission facilities, especially for women giving birth, is that they tend to have more staff and less overcrowding than public wards, and women hope this will translate into receiving more medical attention. Spangler (2011) describes the phenomenon of women delivering by themselves in public wards due to a lack of midwives and too many births occurring simultaneously.

In Tanzania's de facto privatized health system, where almost everything attracts a fee, families must strategize about where and how to spend what money they have, deciding which symptoms or conditions are emergencies and which must be suffered through for a while longer. One perspective would view such care-seeking as a form of agency: "as individual agents differentially positioned by multiple markers of power, women pragmatically negotiate amidst a

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wide array of deterrents to secure the best care they can" (Spangler and Bloom 2010: 760). For both patients and health care providers, this continual circulation between public, private and NGO realms in search of opportunities for employment and health care is a normal part of life in African countries with neoliberalized health systems (Geissler 2015). However, it is important to note that this search for affordable and effective health care takes place within larger structures that may offer new opportunities for some through private and non-governmental options, but this fragmented system reproduces existing inequalities for the majority of people.

"The government has made many mistakes"

The issues of staff, stuff, space, and systems are all in evidence in the critiques of the health system raised by families I spoke with. In addition, their critiques raised two additional, interrelated problems: access and cost. Access problems can include distance, time, and access to information. In rural areas, 37 percent of people are still at least an hour away from the closest health center, and emergency transport is often difficult to arrange and still more difficult to afford (Twaweza 2013). Distance can be a problem even within Dar es Salaam. Even though many residents are technically within 30 minutes of a health facility, Dar's gridlocked traffic during much of the day means that in reality it can take hours to get to a hospital. As I mentioned in chapter 2, Dar is Africa's third fastest growing city, and the city's rapid population growth is far outpacing the building of new health facilities, especially in outlying neighborhoods and informal settlements.

People I spoke with in the neighborhood of Kimara cited distance as a major barrier to accessing health services, or going to the central office of RITA to register. Depending on the

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time of day and the direction of traffic, it can take more than two hours to travel from Kimara, on the outskirts of the city, to central Dar, where Muhimbili Hospital and the headquarters of RITA are located. Many Kimara families live high up on steep hills, adding up to an extra hour of walking just to get to the main road. Factor in carrying one or more small children, and it starts to look like a long journey indeed. As Happy, a mother of two explained, "I have not yet registered my children because I was told to go to an office near to that big hospital [the RITA central office] to follow up. I gave up hope and decided not to go, it is too far away. I don't really know that place, it takes the whole day just to travel there and back." Ingrid, one of only two women in the study with an advanced degree, noted that the RITA central office is difficult to find, in its location tucked away on a side street behind Muhimbili. Many middle class people are familiar with the surrounding neighborhood and probably know someone who works or lives in the area, but it can be quite unfamiliar and confusing to navigate for people from lower income neighborhoods. Unlike other neighborhoods in Dar, there are no large markets or other public spaces, other than the hospital bus stop, where people from different neighborhoods and income levels would naturally congregate and feel comfortable. Social distance is a barrier to visiting the RITA office, in addition to physical distance, as I explore further in chapter 6.

Another distance-related problem is the common confusion about whether people are required to return to the health facility where their child was born in order to register them, whether it is on the other side of Dar, or even if it is in another region of the country up to a week's travel away. Donatus of Kimara mistakenly paid more than Tsh150,000 (about US$90) to travel from Dar back to his home village in western Tanzania to register his four year old son because he had been incorrectly told that he could not register the boy in Dar. Nixon, the local

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leader we were assigned to work with in Kimara, paid about Tsh100,000 to return to his home village in central Tanzania to register his own six year old son, based on the same misinformation.

Even when people are able to travel the distance to a health center, access to services is also impeded by long waiting times. *Foleni* (queue) was one of the first Swahili words I learned in relation to the health system. It is common for people to arrive at or even before dawn to begin queueing, in the hopes that they may be seen sometime by the end of the day. In 2012, public sector doctors were on strike, which made the queues even worse than usual. However, most people blamed the government, not the doctors themselves. Upendo explained: “The government has made many mistakes. They do not pay the doctors enough, so they have gone on strike. Even when they are not on strike, there are long queues at health services. It is very hard for pregnant women and the elderly to stand all day and wait.” Shorter waiting times were a major selling point of private clinics, especially if people perceived the situation was an emergency. On average, people seeking care at private or mission clinics reported waiting less than half an hour to be seen (Twaweza 2013).

These various problems of access to healthcare have a common but costly solution: the payment of fees. However, the proliferation of fees, even for services that should be free, is parents’ single largest complaint about the health system. Fees are both widely resented and begrudgingly accepted. Asking people about fees for birth registration and other services for children proved to be the best way to get even the most reserved women to open up and share their opinions. Impassioned discourses about fees and non-existent free services provide a concrete way for people to articulate larger critiques of the health system.

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“Free, but not really free”

The neoliberalization of the Tanzanian health system can be observed through changes in the language of healthcare itself. Sullivan (2011) cites a key shift in the subjectification of health system users. The patient, long referred to as *mgonjwa* (an ill person), is now referred to as *mshitiri* (a client) or *mteja* (a customer) (Sullivan 2011: 320; see also Whyte et al 2013 for similar examples from Uganda). This shift is even more apparent in the many different Swahili words used to describe different types of fees. I regularly heard all of the following terms about fees and other costs in conversations about the health system in general and birth registration specifically:

ada (general term for fees)

asante (an expected “thank you” gift, often for an act within a person’s normal job duties)

bei kawaida (a normal or everyday price or fee, denoting the official price of a service)

bei kubwa (a large fee or price)

bei ghali sana (a fee or price that is suspiciously high, seen as exploitative)

bei haraka (a rush fee for “same day” service; unofficial and many times the official fee)

bei nzuri (a good price, but may also be offered by a counterfeiter)

bure, lakini sio bure (describing a service that should be free, but that must be paid for)

chango (a contribution, often in addition to the actual fee)

chai (“tea”, denoting a bribe or gift; staff can also be accused of taking too many tea breaks, implying that they are corrupt, not working hard enough, or perhaps both)

fedha (money, often used in the negative: *sina fedha*, I don’t have money for this)

gharama (expense or cost)

kiingilio (entry fee, paid to register as a patient)

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rushwa (corruption; rarely said aloud, but often implied through other language; see chapter 6)

zawadi (a gift, but also a common euphemism for bribe)

The single most common phrase I heard in relation to the health system was "*bure, lakini sio bure,"* meaning "free, but not really free." This refers to the fact that although the government has an official policy that health services in public facilities should be free for children under five and elders over sixty, and birth certificates should be free for children under 90 days old, these services are rarely actually received for free. In a recent study, only one in five Tanzanian children who were eligible for free treatment actually received it (Twaweza 2013). Free services are not actually free either because people are charged unofficial fees, or because medicines that are supposed to be free, including vaccines and malaria medicine, are out of stock. People said "free, but not really free" with special emphasis, conveying their strong disapproval. What they seemed to resent most was that the government would make a promise to provide free care to those most vulnerable members of society, and then break that promise. Whether the lack of free services was intentional, or the result of incompetence, seemed to matter less than the principle.

Quite a few people used this phrase to criticize the government directly. Zarihina said "There is nothing done by the government for children, we still have to pay a lot of money for school and hospital fees. It is supposed to be free but it's not." Winifrida added, "The government says that children under five should receive free medical care, but it is never really free. Also school is supposed to be free but there are still a lot of expenses." Justina felt that ordinary people had been abandoned by the government: "The government does not do much,

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we help ourselves. They say health services for children are free, but when you go to the hospital there is no free medicine, we have to buy it ourselves at a *duka*.*"* Justina's use of the phrase "we help ourselves" was another common refrain, echoing both Tanzanian socialist ideals of self-reliance, and neoliberal notions of responsibilization. I will return to this interesting confluence of competing ideas in chapter 6.

People did not generally see receiving free basic services for children and the elderly as some kind of charity or hand-out from the government. Most people were fiercely proud that they worked hard to provide for their families, and seemed to receive little direct aid either from the government or private entities like NGOs, with the exception of HIV positive people who were receiving free treatment. When people complained about services that were "free, but not really free," I understood them to mean that caring for the very young and very old was a moral obligation and a valued aspect of Tanzanian culture. If the government had promised to help children and elders, and then it did not follow through, this was a serious breach of the social contract. One father, Jackson, took this idea a step further when he spoke about birth certificates as a universal right for all Tanzanians. By his reasoning, basic rights should be beyond price: "Yes, the birth certificate is necessary for everyone. It's a right, but it's not free. If it's a right, it should be free."

How can this discourse of "free, but not really free" be interpreted? Can Jackson's call for free birth registration be seen as a claim to biological citizenship? At first glance, birth certificates seem like a natural site for the constitution of biological citizenship: here is a document, given at birth in a health facility, which inscribes the personhood and nationality of the individual, and at least theoretically enables them to claim rights based on their citizenship.

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However, a closer reading of the concept of biological citizenship as defined by Petryna (2002) and Rose (2007) highlights several limitations of the applicability of this theory in the Tanzanian context. First, its basis in illness identities; second, its focus on claims to state-based entitlements.

Petryna's formulation concerns the relationship between individuals and the state: people who have a shared illness identity as sufferers of Chernobyl-related health conditions, and bureaucrats who evaluate and process their claims for treatment and entitlements from the state. This negotiation of rights claims through examinations, medical records and treatments, legal testimony, and regimes of documentation is what produces biological, rights-bearing citizens. In post-socialist Ukraine, this relation between the individual and the state is mediated by the state-run health system. Conversely, in post-socialist Tanzania, the public health system lacks the basic resources needed to mediate relations between the individual and the state, let alone provide many entitlements. A patchwork of public, private, and NGO providers offer basic care, but there are very few entitlements available to anyone, other than for HIV-positive people who have been identified through HIV testing and selected to receive ARV treatment. People sometimes step forward to be tested of their own accord, but often they find out their status as a result of seeking medical care for other issues, for example the screening of pregnant women I mentioned in chapter 3.

HIV-positive people (those who are receiving treatment, at least) are perhaps the only clearly biological citizens in most African countries. Several recent studies of other conditions such as malaria and sleeping sickness have found that the biological citizenship concept is not equally applicable even to other illnesses in Africa (Gerrets 2012, Redfield 2012). The successes

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of African AIDS activists such as the Treatment Action Campaign in South Africa in advocating for their rights to treatment are based in part, like the Chernobyl sufferers in Ukraine, around a specific medical condition and its treatment through technologies such as chemotherapy or antiretroviral medicines (Fassin 2007, Comaroff 2007, Hardon 2012). While South African AIDS activists and human rights scholars have developed a powerful and effective discourse around the right to health (Achmat 2004, Cameron 2000), it is less common in many other African countries. Ellison (2014) notes that the idea of the "right to health" is seen as somewhat anachronistic by most Tanzanians, at best a nostalgic relic of the *Ujamaa* era: "Many people recall when biomedical care was a right of citizenship, but most do not see that as a realistic possibility today" (Ellison 2014: 11).

The problem of birth registration in Tanzania differs from either the situation of Chernobyl sufferers or HIV-positive people in two key ways. First, people without birth certificates have no shared illness identity. When the majority of people are unregistered there is no common identity to rally around. Being unregistered, and the consequences that come with it, is just a normal part of life as a poor person in a poor country. Being unregistered is a symptom not of any specific condition, but rather a symptom of a pervasive marginalization that starts at birth and may continue throughout life. This marginalization begins in the health system, through lack of access to a *tangazo* at birth. After birth, the marginalization continues, and sometimes compounds with other axes of marginalization such as gender and class, as I show in chapter 5. Some people might live their entire life without a birth certificate and suffer few negative consequences. For these people, being unregistered is a benign condition. For others, the condition of being unregistered can suddenly become acute, and may cause great suffering.

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Second, birth registration does not fit the typical biological citizenship formulation in that even people who do have a birth certificate do not automatically gain access to any entitlements, in the health system or otherwise. As my interviewees note, almost nothing in life is free, not even those few services that *are* supposed to be free entitlements, such as vaccinations. When people complain about vaccines or birth certificates being "free, but not really free," they are critiquing specific shortcomings of the health system. But these everyday complaints about fees and health services also provide a way for people to voice much broader dissatisfactions about their relationship with the state.

To conclude, this chapter illustrates the ways in which the privatization and stratification of the Tanzanian health system contribute to problems with birth registration. Whether they are born at home or in a public health facility, babies who don't get a *tangazo* soon after birth face an additional barrier to getting their birth certificate in the future. Even for those lucky and persistent parents who do get a *tangazo* through the health system, the search for an actual birth certificate must move out of the health system and into the wider world, and this search can take years or even decades. In the coming chapters, I explore various factors that impact access to birth registration at the local, national, and global levels. First, in chapter 5, I look at aspects of family life and kinship, with particular attention to issues of gender and class. Then, in chapters 6 and 7, I focus on peoples' interactions with government bureaucracy as they attempt to register children. Chapter 8 considers the right to birth registration, and how it exemplifies contemporary struggles over governance, citizenship, and belonging in a rapidly changing Tanzania.

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Chapter 5

"The hard work is in bringing up the child": Personhood, kinship, gender and class in Tanzanian families

> *"Kuzaa sio kazi, kazi ni kulea."*
> (The hard work is not in giving birth, but in bringing up the child).
>
> —*Swahili proverb*

> "Because I don't have a birth certificate myself, that's why I decided to get them for my children, so that it will help them for their future life and development."
>
> —*Paulina, mother of 2, Kimara*

> "From what I know now, when you have a baby you have to get a birth certificate. But when I was married I was very young (14), I didn't know about it. I didn't understand about birth certificates then… I understand the registration issue is very important now, and when a mother delivers she has to register her baby to avoid problems in the future."
>
> —*Mbone, mother of 2, Kimara*

Since Tanzanian babies do not receive birth certificates right after they are born, factors in the home, family, and community can have a significant impact on the baby's chances of being registered in the future. In my conversations with families, I identified several socio-economic and cultural barriers to birth registration, which I discuss in this chapter. The factors include: cultural ideas of personhood in the context of infant mortality, issues of family and kinship, and forms of exclusion that intersected along the lines of gender and class. It is not

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surprising that low-income families and single mothers faced particular challenges in registering their children. What was surprising was the remarkable agency some disadvantaged parents showed in pursuing birth certificates for their children against many odds.

Throughout this study, I have referred to three additional types of barriers to birth registration, which bear repeating here as many are relevant to this chapter. The first barrier is time, owing to the fact that obtaining a birth certificate without paying bribes takes at least three visits to government offices over a period of weeks or months. This poses particular challenges for subsistence-level workers who must forfeit a day's wages, and also for mothers who must arrange child care for other small children, and risk bringing a newborn onto crowded public transport. As a result of time pressures, few parents succeed in obtaining a birth certificate during the 90 day time period after birth, when certificates are supposed to be free of charge. The second barrier is financial, including the costs of both official and unofficial fees, as well as transport in rural areas. The third barrier includes problems related to access: both access to accurate information about registration costs and procedures, and access to government offices, either due to distance, long queues, or feelings of marginalization among low-income people.

These barriers are formidable, but throughout this research I was fortunate to meet parents who were doing their best to overcome such obstacles. One of my favorite examples was a mother and daughter who had a small charcoal-making business in Mwenge. Magdalena, mother of 4 and grandmother of 5, was hard at work with her daughter Jesca, mother of 3, when I met them. There were hard at work tending large piles of wood that they were slowly cooking down into charcoal, and though it was still early in the day, they were already covered in a film of soot and sweat. This was very hot, hard, dangerous work. Rates of severe respiratory disease

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are high among African women who make charcoal or cook with it on a daily basis, as most low-income women in Tanzania still do (Lugalla 1997, Kouassi et al 2012). But this was how the women supported their family. They had a small, simple house with a proper roof, and a goat munching away in the yard who provided milk for the grandchildren. Magdalena offered her elbow in greeting, in lieu of her soot-stained hands, and I arranged to interview her, and then Jesca, so that one could watch the fire at all times.

Magdalena was born before independence, and didn't have a birth certificate herself. She had attended primary school, but that was all. Now working full-time into her sixties, she suffered from diabetes (locally called *sukari,* or sugar), but couldn't afford to buy insulin, or a fridge in which to store it. She regretted that she had not been able to register any of her 4 children, but charcoal-making was a subsistence business—she had to work every day but Sunday to provide for her family, and could never find the time to go looking for birth certificates. But Magdalena believed that birth certificates were important, and she said she hoped that perhaps her grandchildren would stay in school, and not become charcoal-makers. At this point, a girl of about 12 came to buy a large bag of charcoal. Magdalena went to serve her, and helped her hoist the bag onto her back to carry home.

Jesca switched places with her mother. She had enjoyed attending secondary school, but had been compelled to drop out when she got pregnant at 17. She really regretted not being able to graduate. However, although she did not have a birth certificate herself, she had made a great effort to register all three of her children. She had saved up for months to pay Tsh20,000 for her oldest daughter's birth certificate. Jesca was committed to her daughter's education, and wanted to make sure she finished secondary school. "Parents should try their level best to get their

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children registered because birth certificates are really necessary these days, especially if the child gets a chance to continue with education," Jesca concluded, before joining her mother back at the charcoal-making fire. The story of Magdalena and Jesca exemplifies the key arguments in this chapter, showing some of the many barriers to birth registration, and also the agency that ordinary people often exercise in trying to improve their children's life chances.

Socio-economic and cultural barriers to birth registration

Cultural ideas of personhood and infant mortality

When I began this research, I wondered whether parental fears about infant and child mortality would impact decisions about when to register children. The few ethnographic studies that mentioned birth registration in developing countries linked it with rates of infant mortality and ideas about personhood (Scheper-Hughes 1992, Jewkes and Wood 1998, Renne 2003, Gottlieb 2004). Scheper-Hughes described the normalization of infant mortality amidst "an average expectable environment of child death" in poor neighborhoods of Brazil (1992: 273). In her study of childhood among the Beng people in Côte d'Ivoire, Gottlieb (2004) draws attention to the invisibility of births and infant deaths in rural areas, where even the death of the grandson of a village's registrar remained unrecorded because he died within two weeks of being born.

Clearly infant mortality remains a concern for many parents in the developing world (Lawn et al 2014). I wondered what role it might play in birth registration decisions in Tanzania, where rates of death among children under 5 have been steadily declining, from 166 deaths per 1,000 children in 1990, to 54 deaths per 1,000 children in 2012 (UNICEF 2013). However, despite this positive development, which has received a lot of local media attention in Tanzania,

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demographers note that parents' attitudes towards infant and child mortality may take time to adjust accordingly. In such demographic transitions, there is usually a time lag between decreases in infant and child mortality, and corresponding decreases in fertility rates (Afnan-Holmes et al 2015). The specter of child death is still present in Dar; every day on my way to the bus stop at Muhimbili Hospital I passed the shop of a coffin-maker who had a small, white child-sized casket on display.

I did not ask women directly about their miscarriages, stillbirths, or infant and child deaths in my interviews. To do so as a new visitor to the household would have been very disturbing, as many Tanzanian women consider that "these are not good things for other people to know" and may not even tell their own partners about a miscarriage (Haws et al 2010: 1764). However, quite a few women chose to tell me about such reproductive misfortunes themselves.

I wondered how ideas about personhood might impact parents' views of when to register children. In their study of birth registration in rural South Africa, Jewkes and Wood (1998) note that personhood is a socio-cultural process, not a hard biological or legal fact. After children are born, they become alive in stages, as they become more known to family members and the community. This seems to be true for many Tanzanians. Some religious or ethnic groups have specific practices around naming of children, while others do not. Muslim families may observe the practice of *saba*, waiting for seven days after the child's birth to name them (Inhorn 1996, Kanaaneh 2002). Christian families may do a baptism and receive a baptism certificate which may be used in lieu of a birth certificate for certain purposes, like registering for primary school. There also seem to be some more general Tanzanian cultural understandings of personhood that are not specific to religious beliefs. Ideas of fetal personhood in Tanzania are relatively fixed

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from the time that the mother can feel the fetus moving. At prenatal checkups, the midwife will ask "*mtoto anacheza?*" (is the baby playing?) to assess the health of the fetus (see also Rapp 1999 on similar language used by sonographers in biomedical settings). The exact same language would be used to ask if a small boy was playing soccer in a yard.

In many cultures, the period directly before, during, and after birth is considered a dangerous space of liminality for both mother and baby, a time when personhood is unstable (Kaufman and Morgan 2005). In Tanzania, the postpartum period is considered a time of danger for mothers and new babies, and women who can afford to do so are supposed to stay close to home with the new baby after giving birth (Allen 2004, Haws et al 2010). This period of staying home with a new baby unfortunately coincides with the only window of time during which the government offers free birth certificates (within 90 days of birth). Selina, a Catholic school teacher and new mother described the many problems with this policy:

> It is very difficult to register babies by three months, because many mothers have to rest after giving birth. They cannot go out and go all over the city seeking a birth certificate. This is not proper. Also what do you do with your new small baby? Who is going to feed it while you are away? It is very unhealthy to take a new baby on a crowded *dala dala*, or to queue up all day at a government office. It is not good for the new baby's health. These are the reasons why so few people can register for free during this time.

Family and kinship

Ideas about family and kinship also shape the social meanings of birth registration. Kinship features prominently in the language of Tanzania's birth registration law, part of the 2009 Law of the Child Act:

> A child shall have a right to a name, nationality and to know his biological parents and extended family.

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> A person shall not deprive a child of the right to a name, nationality and to know his biological parents and members of extended family
>
> Each parent or guardian shall be responsible for the registration of the birth of his child to the Registrar-General.

Although most international human rights conventions that mention birth registration frame it as a right to a legal identity as an individual, and a form of legal personhood, in Tanzania the emphasis is on the right to be recognized as part of a family, and to know one's parents and kin. Birth certificates are about showing belonging, and this is an appealing idea to many families. One day, I asked Flora how most people could prove their identity if they did not have birth certificates. She smiled kindly at the naiveté of my question. We were queuing outside a local government office in her neighborhood of Kimara, where her family had lived for more than 20 years. She gestured around: "everyone here knows who I am. They know that I am the child of my mother, Mama Flora. I am a member of this community, so I am known." We would often run into relatives of hers while we were hiking around Kimara visiting households, and I began to understand that although her family lived a modest lifestyle, her large kin network was a source of great wealth.

However, proving or documenting kinship can be a struggle for many people without robust kin networks. Single mothers and people adopting orphans face particular difficulties in this area. There were an estimated 3,100,000 orphaned children in Tanzania in 2012, including 1,200,000 AIDS orphans (UNICEF 2013). However, the actual number of orphans may be higher, given that many families informally foster or adopt children from their extended kin networks (Yamin et al 2013). A number of families I spoke with had adopted children for

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various reasons, including the death of a close relative. Mwanakhamis was a hairdresser in Kimara, and she had adopted her niece and nephew after her sister passed away. Mwanakhamis told me that she had wanted children of her own, but was infertile ("not blessed"). Although she did not have a birth certificate herself, she made sure to register the children when she adopted them. Since she did not have their *tangazo*, she had gone to court to swear to their identities, and for Mwanakhamis it had been worth the trouble, as she liked having official proof that they were related.

Mr. and Mrs. Mahulu, retirees in Mwenge, had adopted two of their grandchildren after the girls' mother died. Born during the colonial era, Mr. and Mrs. Mahulu had obtained birth certificates as adults, which were required for their jobs at the Dar es Salaam airport. We sat on the Mahulu's tidy veranda, and the two little girls brought us glasses of mango juice. Mr. Mahulu explained that they had obtained birth certificates for the girls soon after they began looking after them, and he carefully brought out the birth certificates from a drawer in his desk to show me. Mrs. Mahulu explained the importance of birth certificates: "It identifies the child and gives information which they will need in the future. Those people who are registered have an advantage in life, when it comes to education, work, and property rights." However, they felt that the quality of government services had really declined, and were disappointed that the birth registration system was so difficult. Several other people in Mwenge also mentioned that birth certificates were a good idea in case the child's parents died. Sauda from Zanzibar was also looking after several children in addition to her own, and she said "if the child's parents die, they will need to know the details of their birth, and where they came from." Mariam, a mother of two young boys in Magomeni, said that birth certificates were important in case of family disputes

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over custody, “because it proves who the child legally belongs to.” Rebecca, a grandmother in Kimara, felt this was a particular concern for Muslim women: “if a man has multiple wives, the children must be registered as proof that he is their father.

Inheritance was another important kinship-related issue raised by a number of people. Women in particular were concerned about their inheritance rights, and Latifa from Mwenge had a sad but common story that illustrates the long-term consequences of not having a birth certificate. Latifa was a *mama lisha* and worked at a small roadside food stall near the bus station, with several other women. She had one son, 8 years old. Latifa’s mother had passed away the year before, and she was supposed to inherit her mother's house and land when she died. Officials at RITA told her she had to show her birth certificate and her mother's death certificate in order to have the title to her mother’s house and land changed into her name. She didn't have a birth certificate, and her mother died at home and had no death certificate. Very few Tanzanians receive death certificates unless they die in a hospital, and the rates of death registration are so low that the statistics are considered unreliable (National Bureau of Statistics and ICF Macro 2011). For Latifa, it was very upsetting to her to have to "prove" that her mother was dead. So the inheritance, which could have been life-changing, was now in limbo. She had only a primary school education, and found it very difficult to navigate the legal system on her own. She said sadly, “Now some of the men in my family are trying to take my mother’s land for themselves. I don’t know what to do. It has all been very upsetting.”

Finally, family members also seemed to exert a positive influence by encouraging other relatives to register their children. Mary, a mother of two small boys in Kimara, had no birth certificate of her own. But she described how her sister, a teacher, encouraged her to register her

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sons soon after birth. Her husband had also needed his birth certificate to get a good job as a driver for one of the foreign mining companies, and she hoped her boys would have similar job opportunities themselves one day. Registered family members can also be an important source of social capital, in that they can give current information about how the system works, and what the correct fees are, or accompany relatives to registration offices.

Gender and marriage

Gender inequalities also exert powerful effects on birth registration. Although rates of birth registration do not differ significantly by sex in Tanzania (UNICEF 2013), the effects of not having a birth certificate can be gendered. Gender has a particular impact in terms of early marriage and childbearing. Tanzania has high rates of early marriage: 37 percent of girls are married before their eighteenth birthday (Human Rights Watch 2014), and the issue of early marriage is controversial in Tanzania. Girls who marry early are less likely to attend secondary school, and at higher risk of complications associated with early pregnancies such as obstetric fistula (Human Rights Watch 2014). A recent study of early childbearing in African countries found that those with consistent laws prohibiting marriage of girls under 18 had 25% fewer teen pregnancies (Maswikwa et al 2015). Although Tanzania is a signatory to the Convention on the Elimination of All Forms of Discrimination against Women, which prohibits marriage of children (defined as all persons under age 18), Tanzanian law allows girls to marry at age 15 with parental consent, while boys must be 18. There has been debate about raising the age of marriage for girls to 18 in the new Tanzanian constitution, but given the low rates of birth

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registration it is difficult to establish girls' legal age, and families who are determined to marry their daughters early may often do so without legally registering the marriage.

Single mothers also experienced marginalization when they tried to register their children. Emmy was a single mother of two teenagers, and she braided hair out of a small plywood storefront on a dusty sidestreet of Mwenge. She felt it was important to register her children, which she did when they were 13 and 17. She had paid a non-standard price of Tsh16,000 each and was told she had to get passport photos of the children, an extra expense that was not required. The experience had been very trying for her: "it's very disturbing when you have to go back again and again to the government office to follow up. It's especially hard for us single mothers, sometimes you are made to feel very bad if you do not have the father there."

A second gender issue is that teenage mothers are among the least likely to register their children. About 1 in 5 mothers I interviewed had their first child before age 18, and many said they did not know about birth registration until they were older, and then registered their subsequent children. Teen mothers are often not allowed to finish secondary school, which may further compound their socio-economic marginalization (Human Rights Watch 2014). Reine, from Magomeni, had her oldest daughter when she was 15. She explained: "I had my first child when I was 15; I didn't know anything about birth registration then, I was just in my village in Tanga, and few people were registered there. But now I know that it's very important and very useful in life, therefore you have to get it for every child. If you don't have it, you can get a lot of problems later on." She was very proud of having registered her youngest child for free, within the 90 day window. Mbone, a mother of two also from rural Tanga, had a similar story. She had

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her first daughter when she was 14, and gave birth at home in her village. No one in her family was registered, so she had no one to tell her about birth registration.

> From what I know now, when you have a baby you have to get a birth certificate. But when I was married I was very young, I didn't know about it. I didn't understand about birth certificates then… I understand the registration issue is very important now, and when a mother delivers she has to register her baby to avoid problems in the future.

Class

Class often intersects with gender to fuel disparities in birth registration. Tanzanian children living in urban households with at least one registered parent are the most likely to be registered (National Bureau of Statistics and ICF Macro 2011). This is also the case elsewhere in Africa, as shown in recent studies of birth registration from Ghana and Nigeria (Amo-Adjei and Annim 2015, Adi et al 2015). For many children, even in urban areas, birth registration is not a universal right, but a rare privilege conditional on the socio-economic status of the child's parents.

The impact of class and gender disparities is often felt most keenly by women who work as subsistence laborers. The opportunity costs of taking a day away from work to seek birth certificates are highest for those women who are the sole provider for their families. Women like the charcoal-making ladies, Magdalena and Jesca, must carefully weigh the short-term economic risks of stepping away from their work, with the long-term possible benefits of registering their children. However, those benefits are uncertain and distant, whereas the loss of income is an immediate problem. Amina, one of the women who worked at a food stall in Mwenge, told me she had just given birth to her third child a month earlier, and was already back at work. None of her children were registered, in large part because she could not afford to take a day off of work.

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She would very much have liked to get birth certificates for everyone in her family: "It makes many things in life easier if you have a birth certificate, it helps with many things." She had a practical suggestion to help mothers in her situation: "The government should set up special centers in neighborhoods where people can go and register. People like us, we are working everyday just to feed our children, we cannot go and queue all day at a government office."

Faced with scarce resources of time and money, and many competing needs, women like Amina have to make pragmatic decisions to delay birth registration until the need becomes more concrete. Although many parents know that registration fees get higher as the child gets older, they just have to hope that somehow their situation will have improved by then. As Scheper-Hughes observes, "most poor families delay registration until the child has to confront the 'state' for the first time—usually on registering for primary school" (Scheper-Hughes 1992: 292). This was often true for the families I interviewed as well. However, as lack of financial and social capital limits access to birth registration for many poor families, it can lead to the social reproduction of poverty. If people do not have birth certificates, it is increasingly difficult for them to enroll in secondary school, join the military, register a small business, or find a job in the formal sector.

For low-income families, birth registration is typically not urgent (until it is), and can thus be delayed. For families with lower incomes but big dreams for the future, birth certificates are aspirational. For many middle-class families, birth certificates have become something of a status symbol. Younger mothers with formal sector jobs, in particular teachers, place a heavy emphasis on registering children as early as possible, so that they can enroll them in private pre-k "baby classes" (always said in English) and kindergartens. Selina was one such mother. A

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teacher at a Catholic secondary school, she was married to an IT consultant. The walls of her home were decorated with photos of Pope John Paul II, and also photos of her university graduation. She explained the importance of birth registration for future economic mobility:

> I registered my daughter within one month, because it will help her when she goes to school. It is not needed for public school, but you have to have it for private schools, and that is important if you want your child to get a good education. As a parent, it should be your "first priority" [in English] to register your child.

Most of the middle-class women I interviewed agreed that although birth registration was not difficult for them personally, due to their level of income or education, it was a big problem for most Tanzanian families. Zafra, a well-to-do *mama mkubwa* ("big lady") and mother of two teenagers in Kimara, was a business woman who juggled a handful of mobile phones and was decked out in gold jewelry and a tailored *kitenge* dress. "Birth registration is not a big problem for me. You go to the municipal office, you pay, you get it. No problem. It is very important to get it." She continued, "it is mainly a problem for those people who are not educated, for them registration is very difficult. The government must work to educate those other people."

As Zafra pointed out, education, and specifically literacy, is another major class barrier to birth registration. Tanzania's adult literacy rate in TZ is 67.5% (World Bank 2014), meaning that at least a third of adults have difficulty with basic tasks such as reading and filling out forms, which of course is central to birth registration. Many people I interviewed who did not read and write spoke of feeling ashamed by their lack of education when trying to access government services. As Gupta has observed, bureaucracies are structured in ways that perpetuate the relationship between literacy and power, through "the emphasis placed on writing and written

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materials. The insistence on writing in a context in which the overwhelming majority of poor people are illiterate has enormous political consequences" (2012: 35). For example, Asha worked as a *mama lisha* and hadn't registered her daughters because couldn't read or write and so could not fill out birth registration forms. She had no one to help her with this. Her 14 year-old daughter needed a birth certificate to continue school, but she had no way of getting the money for late fees. But despite her lack of formal education, she understood very well why birth registration was important for her daughter: "There is no secondary school, and no good job, without a birth certificate. It's very necessary." She felt frustrated and ignored by her government: "This government is only interested in the rich, it ignores we people who are living in poverty. We will die poor."

"Technologies of hope"

However, despite the many socio-economic and cultural barriers facing low-income people who want to register their children, sometimes the most marginalized people had the greatest drive to register, and exercised remarkable agency in this pursuit. I noticed that in particular, mothers who were unregistered often had a particular strong desire to register their children. I will end this chapter with a few such success stories.

Mwanahamisi lived in Magomeni, with her husband, a fish seller, and her five year-old twin daughters. She was seriously hearing impaired after a case of meningitis as a child. She did not know Tanzanian sign language, but she had taught herself to read lips, and with the help of her friend and neighbor Mariam, who sat close to her and passed on our questions, we communicated well. She was especially proud of having registered her daughters, as she had no

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birth certificate and no formal education herself. Her husband or Mariam had gone with her to the Kinondoni municipal office each time, and although it had taken three follow-up visits, she had registered the girls without paying any extra fees.

Prisca was a shy, mother of three from Mwanza in northwest Tanzania. She had her first child at 14, and had three children by age 24. She had never gone to school, couldn't write her name, and worked braiding hair. She gave birth to her first two children at home. Despite her circumstances (which statistically would make her much less likely to register), she had registered her older girls when they were less than three months old, while they were living in Mwanza. Although the birth certificates should have been free, she was charged Tsh10,000 each, and she thought this was the normal price. It was a lot of money for her, it took a lot of braids to earn that much. She said that she knew that birth certificates were important: "I know it helps children later in life, for example with finding work, or if they want to study further. If you don't have it, you get a lot of problems." She advised, "other parents should also make an effort to understand the importance of birth registration."

Upendo had no biological children of her own, but had adopted three orphans who ranged in age from seven to fourteen. She had no birth certificate herself, but she had saved up to register all three of her adopted children. Although their certificates should have been free because they were orphans, she paid Tsh20,000 each. Upendo described the challenges she faced:

> In truth, birth registration is very difficult. I had to go to RITA, it was very far away and I didn't know where their office was. They need to be closer to the people.
>
> I had 3 children to register, and it cost Tsh60,000. I had to work a very long time to save that much money. And then I had to keep going back and following up, again and again, I almost lost hope.

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However, Upendo managed to maintain her hope, based on her belief that "a birth certificate helps with many things in life." However, she cautioned, "It is a right, but it's not a right if you can't get it." For parents like Upendo, Prisca, Mwanahamisi, and Jesca, birth certificates can be seen as a "technology of hope" (Mulemi 2013). For lower-income families, they symbolize future opportunities, or at least the vague possibility of opportunities. But as I discuss in chapters 6 and 7, many parents' hopes are dashed when they try to register their children, and encounter corruption and marginalization at government offices.

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Chapter 6

Drinking chai: Corruption in the birth registration system

> "The system now has too much corruption. The mother should be given the child's birth certificate when the child is born, that way she can avoid having to pay bribes later on."
>
> —Lidia, mother of 1, Mwenge

> "The expense of birth registration is high in part because of corruption. Nowadays you will find that even if you do everything correctly, you will not receive that [birth certificate] from the government unless you pay bribes."
>
> —Subira, mother of 4 and grandmother of 3, Mwenge

> "I tried so hard to register my children. Some people came through the neighborhood a while ago, saying they were there to do birth registration. So they took some money and said they would bring back the birth certificates, but until now I have never seen them again. I have almost given up hope."
>
> —Salma, mother of 6, Mwenge

"You are entering a corruption free zone"

Patients, staff, and visitors to Muhimbili National Hospital are greeted with by an imposing 4-sided billboard. Two sides say "welcome to Muhimbili National Hospital" in Swahili, and the remaining two sides bear a much more stern message in English: "YOU ARE ENTERING A CORRUPTION FREE ZONE—DO NOT GIVE BRIBE FOR SERVICES."

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Since I first came to Muhimbili in 2004, I have wondered why the anti-corruption warning was in English, and what audience the sign was intended to reach. Agatha, Flora and Winston were all staunchly anti-corruption, and clearly it was a concern for the many people I interviewed who had paid irregular or unofficial fees for birth registration or other services for their children. Some people paid extra fees on purpose, try to try speed up the process, while others were effectively tricked into paying bribes because they had no way to find out the correct fees.

Figure 5: Anti-corruption sign outside Muhimbili National Hospital, Dar es Salaam

In this chapter, I attempt to explore the extent of public sector corruption as it relates to birth registration. I analyze various aspects of corruption, drawing on ethnographic theories of

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"everyday corruption" which re-frame low-level corruption not as a moral failing, but as survival strategy commonly used by low-income people who lack the social capital to avoid paying bribes, and also a means of financial stability for low-level government workers who are often not paid on time. I argue that corruption in the birth registration system can be viewed as evidence of systemic governance problems which impact both bribe-seekers and bribe-payers, as I describe further in chapter 7. While corruption was clearly a concern for many of the families I interviewed, it is interesting to note that corruption is rarely cited as a key barrier to birth registration in most of the technical and policy literature on birth registration.

Several of the most influential ethnographic studies on corruption in recent years have emerged from sub-Saharan Africa (Blundo and Olivier de Sardan 2007, Smith 2007, Bierschenk 2008). Blundo and Olivier de Sardan have observed that corruption "is ultimately part of the profound process of transformation under way in the African state" in the post-colonial era of neoliberal governance (2007: 101). Corruption can be seen as both a symptom and a consequence of the weakening of public services and state capacity under economic austerity measures mandated by structural adjustment programs, as I discuss in relation to African health systems in chapter 4. This lack of state capacity results in a proliferation of low-level corruption or "everyday corruption," which Blundo and Olivier de Sardan argue is more accurately understood as a form of "informal privatization" (ibid).

In African states with weak structures of governance, Blundo and Olivier de Sardan observe that people sometimes use bribes as a way of managing uncertainty in interactions with the government. For example, a middle-class parent who can afford to pay Tsh10,000-20,000 extra as an unofficial rush fee to get a birth certificate quickly may choose to do so, because

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paying extra fees up front is less costly than making subsequent “follow-up” trips to the office again and again to try to collect the certificate. However, Blundo and Olivier de Sardan argue that routine payment of unofficial extra fees to manage uncertainty can be seen as creating a “vicious cycle” of corruption: as more people pay extra fees under the table, public services become “unofficially privatized” and thus even more unpredictable for those users who cannot or will not pay bribes (Blundo and Olivier de Sardan 2006: 105).

Because the process of obtaining a birth certificate involves numerous steps and bureaucratic hurdles both in the health system and at local government offices, the complexity of the process unfortunately creates many opportunities for low-level corruption or solicitation of extra fees. As I describe in chapter 4, childbirth attracts many requests for both official and unofficial fees, and this can include an extra payment to a nurse or midwife to ensure that the *tangazo* is filled out on time. When people try to exchange the *tangazo* for a birth certificate at local government offices, they face a confusing and inconsistent system of official and unofficial fees. The many barriers to obtaining a legal birth certificate have created opportunities for document forgers or *vishoka* as I describe in chapter 2. Another realm for corruption seems to be birth certificate scams which prey on the poor, and I will describe a sad example of this later in this chapter. Most people I interviewed who admitted to paying unofficial fees did not use the term *rushwa* meaning corruption, but rather spoke in various euphemisms for the practice. However, a few bold women were not afraid to make direct accusations of corruption in the birth registration system. I relate some of their stories below.

Forty percent of the parents and grandparents I interviewed had paid some kind of “extra fees” to obtain birth certificates, in amounts ranging from a few thousand shillings to more than

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Tsh 20,000 (US$13) extra in emergency situations where the birth certificate was needed immediately. One man mistakenly paid more than Tsh150,000 (US$97) for a birth certificate for his son, because he was given misinformation that he and his son had to travel from Dar to his home village in western Tanzania. When he arrived after several days of travel, the local government office charged him Tsh10,000 for a birth certificate for his four year-old, which should have cost only Tsh3,500. But having traveled so far, he had no choice but to pay the extra fees. Even when people have only traveled a few hours with the Dar es Salaam city limits to a government office, if they have spent an entire day queueing, many people feel they have no choice but to pay whatever fee they are quoted. I should be very clear that I did not personally witness any birth registration workers soliciting extra fees or bribes, rather I rely on the first-person accounts of my interviewees.

Given the time and effort people must exert in order to register their children, many are troubled by the solicitation of bribes. When they make plans to register their children, they have to save up enough money to pay both the official registration fees, and potentially an unknown additional amount to cover "extra" fees they are likely to encounter along the way. The 2010 East African Bribery Index, which asked Tanzanians to rank various government offices by their perceived level of corruption, found that 66 percent of Tanzanians perceived corruption to be a problem within RITA (Transparency International Kenya 2010). However, it is important to note that this study relies on perceptions of corruption, rather than documenting actual instances. Perceptions of widespread corruption may however help to reinforce the "vicious cycle" of low-level corruption. For many ordinary Tanzanians, low-level corruption is a normalized if resented part of daily life. Although paying the equivalent of a few dollars extra here and there may seem

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like a small amount, the constant solicitation of extra fees has a significant economic impact on the poorest Tanzanians, and may be a major deterrent in seeking birth certificates, especially as children get older and registration fees increase.

Baby's first bribe?

Birth registration is often described as a child's "first right," and the first official recognition of their existence by the government of the country where they are born (Dow 1998). However, for some Tanzanians, attempting to register a child's birth also represents the first of many times they may be asked to pay a bribe in order to secure basic government services for their child. In 2012, while I was conducting my fieldwork, Tanzanian investigative journalist Kizito Makoye published an article in which he detailed his own experience of corruption within the Tanzanian birth registration system. He writes:

> I will never forget the hide-and-seek game that I played as I was celebrating the birth of my daughter on 28th March... The officer in charge of registering particulars of new born babies at Mission Mikocheni Hospital in Dar es Salaam repeatedly asked me to give him *Chai*—euphemism for a bribe. He insisted that I pay him something so that he could write down the details of my daughter in a hand-written ledger, from which data is taken to the district registrar to process the birth certificate (Makoye 2012).

Makoye describes the deliberations that followed. He needed his daughter's birth certificate and recognized its importance to her future, and as a middle-class professional he could afford to pay a few thousand shillings (the equivalent of a few US dollars) to speed up the process. But as a journalist known for covering corruption issues, Makoye writes that he felt it would be morally wrong to pay even a small bribe. Unlike many average Tanzanians, Makoye's class status,

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education, and knowledge of anti-corruption laws put him in a unique position to confront the corrupt hospital official and obtain the necessary paperwork.

> I used the only weapon I had, the power of a journalist who is bound to tell the truth without fear or favour. I was forced to threaten that I was going to report him to the higher authority, possibly the Prevention and Combating of Corruption Bureau (PCCB). He reluctantly signed the document bearing the names of my daughter (Makoye ibid).

Makoye lists the various points in the complicated process of obtaining a birth certificate where bribes are often sought: by the nurse or doctor delivering the baby in the hospital; by the hospital clerk to write the baby's name in the register and issue the *tangazo* or birth announcement; by the registration clerk at the local government office to look up the baby's birth record; and even by the person who types up the birth certificate. This is how the official fee for a birth certificate of Tsh3,500 (about $2.20) can easily inflate to an actual cost of Tsh10,000 or more (about $6.27, close to a week's salary for a low-income Dar es Salaam household).

Due to his knowledge of the system and the correct fees he should pay, Makoye paid only the official fee to register his daughter, but it still took him numerous trips to the local government office. Despite his knowledge and persistence, even he was told "*Njoo kesho"* ("come back tomorrow") several times before he succeeded in taking home the birth certificate. Many middle class or wealthy Tanzanians pay "extra" fees as a matter of course, to avoid the dreaded command of "*Njoo kesho"* in favor of unofficial "same day service." "Extra fees" or "same day service" are a polite way of indicating the option to pay a bribe. Other middle class Tanzanians, including several people I interviewed, refuse to pay bribes of any amount as a matter of national pride or religious convictions. Even though the poorest Tanzanians are least able to afford even small bribes, my interviews suggest that the poor are especially vulnerable to

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paying bribes, either due to lack of information about the correct fees and procedures, or due to fear of—and sometimes intimidation by—government officials. The disproportionate impact of corruption on low-income Tanzanians is evident in Aili Tripp's study of everyday life in Dar es Salaam in the years following the economic liberalization of the 1980s and 1990s. Tripp writes that "the poor not only suffer tangible monetary losses as a result of bribes and extortion, they also experienced these practices as a personal affront. Bribery [violates] societal norms of economic justice in which the poor ought to pay the least for whatever good or service is being sought" (1997: 182).

Makoye concludes his article by pondering how much more difficult the process of registering his daughter would have been for an average Tanzanian without his advantages.

> What if I was not a journalist? Could I ever secure this important document without risking paying bribes? How many Tanzanians are skilled enough to avoid corruption traps to obtain their rights? Maybe that explains why Tanzania is still poor, despite all the resources we have at our disposal (Makoye ibid).

Makoye frames the problems of the Tanzanian birth registration system primarily in terms of corruption. But many of the issues related to birth registration that he describes (an understaffed hospital, government clerks who haven't been paid on time, long lines at government offices, and lack of public information on correct fees for birth registration) are actually governance problems that create opportunities for corrupt practices to flourish. Corruption is a symptom of systemic governance problems that go far beyond a low-level clerk trying to earn a bit of extra money on the side because he's the only person in his family with a job in the formal sector.

This chapter explores the ways that birth registration brings to light larger issues of corruption and governance. Following a discussion of research on corruption in Tanzania, and ethnographic perspectives on corruption and governance, I present several stories about

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corruption from women in the Mwenge neighborhood. How do Tanzanians experience birth registration as a site of everyday corruption, and how does this influence their understandings of their government works, and how it *should* work? I argue that people use discourses of corruption in the birth registration system as a concrete way to articulate their general dissatisfaction with how their country is governed. Framing the debate in terms of children's needs gave allegations of corruption an additional level of moral authority. Discourses of corruption were often subtle, either out of Tanzanian politeness, or out of concerns about possible repercussions for reporting corruption. However, even subtle or indirect references to corruption provided a way for people to air their general grievances about governance in Tanzania.

Counting corruption

Corruption in Africa has received a great deal of attention (some would argue, disproportionate attention) from donors, development organizations, and academics. World Bank president Jim Yong Kim has called corruption "public enemy number one" in the developing world (World Bank 2013), and corruption has been blamed for many of Africa's development problems. Stereotypical images of African "cultures of corruption" range from email scams involving fake Nigerian princes, to plutocratic leaders who live lavishly off the proceeds from corrupt mining contracts (Smith 2007). Global indicators and rankings of corruption and governance have proliferated rapidly in the past two decades, the most well-known and controversial of which is Transparency International's Corruption Perceptions Index (Wang and Rosenau 2001, Andersson and Heywood 2009, Akech 2015). Most African countries, including

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Tanzania, do not fare well in these rankings. Most recently, Tanzania was ranked 119th out of 175 countries (Transparency International 2014). However, critics of corruption indicators argue that they often fail to adequately measure the ways that corruption and poor governance affect the lives and livelihoods of everyday people in developing countries (Andersson and Heywood 2009, Akech 2015).

Kenyan legal scholar Migai Akech identifies several key problems with existing corruption indicators as they relate to Africa. First and foremost, corruption is difficult to define, and many ideas about what is corrupt are culturally specific: "There is no international consensus on the meaning of corruption, and people do not agree on what is the uncorrupt state of affairs" (Akech 2015: 7). Definitions of corruption sometimes rely on normative and moralistic ideas about corruption. For example, Transparency International's Corruption Perceptions Index refers to the least corrupt countries as being "very clean" (Transparency International 2013). Second, corruption is difficult to observe and measure accurately because corrupt acts are usually carried out in secrecy. Third, many indicators of corruption rely heavily on surveys about perceptions of corruption, and Transparency International has been criticized for focusing on perceptions of elites and foreign business people, rather than everyday people who are often most affected by corruption (see also Andersson and Heywood 2009).

Akech describes how the Kenyan office of Transparency International has attempted to address some of these critiques through the creation of the East African Bribery Index, which surveys a random sample of people in Kenya, Tanzania, Uganda, Rwanda, and Burundi. The Bribery Index asks people to anonymously report on their experiences with everyday corruption. The East African Bribery Index ranks institutions in each country, such as police, tax authority,

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judiciary, and various ministries, according to the proportion of people who report being asked for bribes by these entities. The survey also asks people to report how many bribes they paid in the past year, how much money they spent on bribes, and their reasons for agreeing to pay bribes. However, some people may be less forthcoming about reporting their involvement in paying bribes. Although corruption is fairly common, it still carries a social stigma. The most recent results of the East African Bribery Index for Tanzania will be further discussed below. The 2013 Index ranked Burundi as the most corrupt country in East Africa, followed by Uganda, Kenya, Tanzania and Rwanda (Transparency International Kenya 2013). The release of such rankings typically inspires some spirited media coverage in Tanzania, poking fun at their more corrupt neighbors.

Indicators such as the Bribery Index may have a limited power to influence reforms. "For organizations that are sufficiently embarrassed by appearing in the Bribery Index, this tool may therefore precipitate internal institutional reforms," Akech observes. However, Transparency International's name-and-shame approach "makes the assumption that organizations are capable of reforming themselves" (Akech 2015: 27). This may result in a few firings of officials in those ministries ranked as most corrupt, but Akech argues this is not sufficient to bring about system-wide governance reforms. Critics of corruption indicators argue that their focus on measurement and technical solutions fails to address the deeper political roots of corruption and governance problems (Andersson and Heywood 2009, Wang and Rosenau 2001). Despite the shortcomings of corruption indicators, Transparency International's corruption measures are often included in governance indicators, including the Ibrahim Index of

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African Governance. The methodological and cultural limitations of these indicators will be discussed further in Chapter 10.

Anthropologies of everyday corruption

Anthropologists have argued that corruption is more accurately understood not as a moral failing of individuals or institutions, but rather as a cultural practice that is central to the constitution of the state (Gupta 1995, Roitman 2004, Blundo and Olivier de Sardan 2006, Arifari 2006, Smith 2007, Bierschenk 2008, Anders 2010, Gupta 2012, Goldstein 2012, Bierschenk and Olivier de Sardan 2014). Ethnographic studies of corruption have tended to focus on the forms of everyday corruption or "petty" corruption that make ordinary peoples' lives more difficult, more uncertain, and more expensive, rather than on the kinds of mass corruption scandals that make headlines. The act of paying a bribe equivalent to a few US dollars in order to get a birth certificate is not particularly dramatic or remarkable. Paying small bribes here and there is an accepted part of life in Tanzania and many other developing countries. But as Ferguson and Gupta have argued, "it may be more important to look at the less dramatic, multiple, mundane domains of bureaucratic practice" (2002: 984). Everyday corruption becomes a lens through which anthropologists can observe relationships between states and their citizens, and power relations between individuals.

In their study of corruption in West Africa, Blundo and Olivier de Sardan describe everyday corruption as "processes involving the informal redistribution of public resources and of forms of power and authority" (2006: 6). Observing everyday corruption thus provides insights into how governments and structures of power operate in reality. Everyday corruption

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blurs lines between the legal and the illegal. Roitman, in her study of economic practices, violence, and governance in the Chad Basin of central Africa, argues that for both state and non-state actors engaged in corruption, there is no normative separation between the legal and illegal. Many accepted forms of everyday corruption are "on the margins, but in the norm" (Roitman 2004: 24).

Everyday corruption is fundamentally a process of social exchange, and "the corrupt exchange is not separable from other similar or closely related forms of exchange involving social capital as opposed to economic capital" (Blundo and Olivier de Sardan 2006: 12). Using the example of a failed attempt to bribe a land registrar in a small village in northern India, Gupta (1995) illustrates the ways in which paying a bribe is a cultural practice that requires cultural and social capital to skillfully negotiate the bribe, along with the economic capital to pay the bribe. In many situations, a bribe is never directly demanded, it is up to the person seeking the service to know whether a bribe is necessary, and if so, the appropriate amount and method of delivery. As Blundo and Olivier de Sardan describe, an entire industry of brokers, fixers, and middlemen exist in many developing countries to facilitate such deals on behalf of the uninitiated, for an extra fee.

Everyday corruption takes many forms. If a service exists, there is most likely some avenue for bending the rules in order to obtain that service. Blundo and Olivier de Sardan have identified at least six categories of everyday corruption prevalent in Africa: payment of gratuities for services received; payment for illicit services; nepotism and influence-peddling; payment of unwarranted fees for public services; charging of fake levies or tolls; and misappropriation of public goods (2006: 81). In the case of birth registration, corruption usually takes the form of

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payment of unwarranted fees for public services. By taking a bribe to process a birth certificate, a government employee effectively "sells" a public service he or she is supposed to carry out for free as part of their job duties. The only fees that should be paid are the official fees for the birth certificate. Blundo and Olivier de Sardan found that corruption was common in birth registration systems in Benin, Niger and Senegal. They conclude that everyday corruption has become a normalized part of the process of obtaining official identity documents, including birth certificates.

> The everyday activity of issuing these documents is almost never an automatic one. The procedure is always deferred and liable to postponement and therefore engenders a sense of uncertainty among users…even when the user carries out all the required formalities, the only way of obtaining certificates in a reasonable time frame is to pay…such practices are carried out quite openly and are now considered normal (Blundo and Olivier de Sardan 2006: 149).

A 2013 Afrobarometer survey of people in 34 African countries found that trying to gain access to official documents was the most common reason to pay a bribe. Sixteen percent of people surveyed reported paying a bribe in order to get a document in the past year. In Tanzania, seventeen percent of people said they paid a bribe to get a document (Richmond and Alpin 2013).

Blundo and Olivier de Sardan argue that payment of bribes for public services that are supposed to be freely available constitutes a form of "internal privatization." Although the services are ostensibly public, only those who can afford to pay extra will actually be served. This kind of "internal privatization" is often justified on the grounds that lower-level government workers are often not paid on time, or are not paid very well, especially under the austerity measures and cuts to public services mandated by structural adjustment programs in the 1980s

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and 1990s. Aili Tripp's study of the informal economy in Dar es Salaam observes that the Tanzanian financial crisis of the late 1970s and 1980s, and the ensuing program of structural adjustment corresponded with a rapid rise in many forms of everyday corruption in Tanzania (Tripp 1997).

I have had a few brushes with everyday corruption during my years doing fieldwork in Tanzania. In order to officially begin my dissertation research, I had to acquire various permits, stamps, and letters of permission from different national, municipal, and local government entities. As anyone who has done research in Tanzania can attest to, this can be very a drawn out and convoluted process, especially for an independent researcher. One day, I visited a municipal office in Dar es Salaam in order to show them my research permit and visa, and receive a letter giving me permission to conduct research in specific neighborhoods within that municipality. I would then have to take that letter and show it to local leaders to gain formal permission to enter their neighborhoods. It was mid-afternoon by the time my research assistants, Agatha and Flora, and I arrived at the municipal office, after a long hot public bus ride through heavy traffic. After a few tries, we located the office of the person who would issue the letter from the municipality, who of course was gone for the day. Her assistant clerk, a young man, told me to come back again the following day. Mildly annoyed at having made the long trip for nothing, we started to leave. But before we were halfway down the hallway, the clerk quietly called after us. He beckoned Agatha over, and her usual smile vanished as he whispered something to her. She took down his mobile number, and said something I couldn't hear in reply. She then gave him a stern look and said "we will be back tomorrow."

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When I asked Agatha what had happened, she said the young clerk had suggested that if I gave him Tsh 5,000 (about US$2), I could be assured of "rush service" for my letter. She had replied that we were not the kind of people who pay bribes, and that he should just do his job. The next day we returned to the office, ready for a long wait. But in about an hour, the clerk rather sheepishly handed over my letter. Later that day, I stopped by the office of a friend who is a professor of medicine. When the professor asked how my research was progressing, I told him the story of how I was asked for a bribe. He leaned back in his chair and laughed, "oh, you must not worry about that! Those small guys asking for a few shillings, that is only petty corruption. Who knows, maybe that guy hasn't been paid this month, and he probably has a lot of people at home to support." He continued, "what I really worry about is those big guys at the top, who are using their positions to siphon off money and hide it in their accounts in Switzerland. That is what really hurts this country."

I was able to avoid paying a bribe at the municipal office in large part because I was working with Agatha and Flora, who are both very knowledgeable about the workings of the government, and politely assertive about getting things done. If I had been on my own, or in a rush to secure a necessary document, who knows what might have happened? When I have navigated other Tanzanian bureaucracies by myself, such as the immigration system, I have avoided paying bribes only through many days of sitting on hard benches in sweltering offices, asking again and again if my papers were ready yet. It is perhaps telling that the only foreigners I saw doing their own queuing at the immigration office (rather than employing a local fixer), were a handful of other graduate students, and some elderly Italian nuns.

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In his ethnography of corruption in Nigeria, Daniel Smith (2007) relates his encounters with a corrupt bureaucracy while trying to register a car to use during his fieldwork. Smith is very open about the fact that he paid some "extra fees" in order to secure a Nigerian driver's license and license plates for his car. While his experience was frustrating and time-consuming, Smith takes a larger view of the circumstances. He argues that "it is just as crucial to understand the perspectives of civil servants who sit behind those desks and expect to receive something on top. Typically, Nigerian civil servants are poorly paid, and salaries are often not remitted on time. At the time I applied for my license, civil servants in Imo State had not been paid for four months" (2007: 60).

Blundo and Oliver de Sardan call this kind of everyday corruption practiced by low-level employees trying to supplement their meager or unpaid salaries "corruption that acts as a means of survival" (2006: 149). However, most people in my study found this excuse illegitimate. The majority of people I interviewed were employed in the informal sector, and living in poverty or not far from it. They considered a person with a job in the public sector, even as a low-level clerk typing up birth certificates, to be very lucky indeed. People thought that civil servants should do their jobs properly, without asking for extra fees. However, they also recognized that one employed person may be obligated to provide financial support for a large extended family. Given these pressures, it is possible to understand why some civil servants might give into the temptation to seek extra fees. When Tripp asked Tanzanian public servants why they accepted bribes, "people invariably answered that their wages were low and they had to make up the different somehow. In many peoples' minds, the 'hustle' was a way of claiming what they believed was owed them" (1997: 181).

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Class and corruption

Kizito Makoye's story above highlights the ways in which the effects of corruption are mediated by class. He avoided paying bribes because he had more authority in the situation as an educated and middle class person who knew the law in question. Conversely, other middle class or wealthy people might choose to pay bribes as a matter of convenience. Several middle class people in my study admitted to paying informal "same day" fees for birth certificates for this reason. Tripp's account of corruption in Dar es Salaam highlights the differential effects of corruption on the poor: "the poorest members of society were most victimized by [corruption] and had the least opportunity to engage in it [themselves]" (1997: 182). Gupta (1995) notes that even the ability to successfully pay bribes is often dependent on class. The poor are even at a disadvantage when they try to pay bribes, because they often lack the social and cultural capital necessary to negotiate bribes effectively. In his study of a land registry office in rural India, Gupta found that "the 'practice of giving a bribe was not…simply an economic transaction but a cultural practice that required a great deal of performative competence" (1995: 381). Someone who is new to a neighborhood and doesn't have family or friends to advise them on whom to approach and what the current "going rate" is for a service are open to even greater exploitation.

A second class dimension is that the poor are disproportionately affected in declines in quality of basic public services that may occur, either because workers are tending to those clients who are willing to pay extra, or because government workers are off tending to their other income-generating projects. For example, nurses not at health clinics because they are running their *duka la dawa* (private pharmacy), or teachers not in class because they are running their

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shop or mobile phone kiosk, or at their farm in the countryside. In 1987, Tanzanian President Mwinyi actually encouraged workers to start second businesses because it would support the economic recovery. He encouraged doctors and university professors to supplement their incomes by farming and raising livestock for profit (Tripp 1997). Tripp notes that this widely accepted practice of public sector workers engaging in income-generating side projects is a source of resentment among many poor people: "low-income citizens generally experienced more intensely the hypocrisy, double-standards, and injustice of a system in which they were told to abide by the rules that were not followed by those who made the rules" (Tripp 1997: 185).

I would argue that the differential access to public services based on class, and willingness to pay bribes, is also a barrier to improving the birth registration system. As I mentioned in chapter 5, most middle class people I interviewed said that birth registration was not a problem for them personally, although the recognized it was difficult for poor people. The middle class and elite people who run the Tanzanian government are able to use their class privilege and social capital to either avoid bribes, or willingly choose to pay "rush fees" to expedite the process. Perhaps one reason why birth registration has yet to be reformed is that those who hold the power to initiate reforms have not suffered under the current system in the same ways that ordinary people do. Ironically, those in positions of power are more likely to pay the official and relatively affordable price of Tsh3,500 to register their children, while the poor are more like to pay much more.

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Corruption in Tanzania: drinking *chai*

What is the scale of everyday corruption in Tanzania, and how do Tanzanians view corruption in their country? A recent national opinion poll found that a majority of Tanzanians viewed most public and government services as somewhat or very corrupt, including police (89 percent viewed police as corrupt), health services (62 percent viewed public health services as corrupt), and local government (41 percent viewed local governments as corrupt) (Twaweza 2014). Forty-three percent of Tanzanians reported paying a bribe to avoid trouble with the police (Twaweza 2014), while in another survey conducted by Afrobarometer, seventeen percent of Tanzanians reported paying a bribe to obtain a government document (including birth certificates) within the preceding twelve months (Richmond and Alpin 2013). One in five Dar es Salaam residents reported paying a bribe to access public health services in 2012 (Twaweza 2012). Clearly, corruption is a part of everyday life for many Tanzanians, including those I interviewed.

Tanzanians have developed a lexicon of terms for talking about different types of corruption. The official term is *rushwa*, from the Arabic *rashawa* (Blundo and Olivier de Sardan 2006: 121). However, few people openly talk about *rushwa*, preferring other more polite euphemisms. Tripp (1997) documents a host of new Swahili words that emerged in the 1980s and 1990s to describe the different types of informal and illegal economic activities many people engaged in during the economic crisis, either because they were unemployed, or employed but with salaries that could not keep up with rapid inflation (or were not paid). A distinction is commonly made between two types of corrupt acts: those which are technically illegal but small

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and thus seen as acceptable means of survival, especially for the poor, and those that are larger, done by people in power, and seen as corrupt and greedy.

Terms describing acceptable small but technically illegal acts:

miradi (small projects)

biashara ndogo ndogo ("small small business" or informal business, typically unreported and untaxed, though often requiring the payment of bribes to police)

dagaa ("small fish," children who illegally sell small items on the street)

Terms denoting greed or unacceptable levels of corruption:

mipango ("plans," making extra money illicitly through one's formal job)

mchuzi ("gravy," an extra payment on top)

chai ("tea", denoting a bribe or gift)

chakula cha daktari ("food for the doctor"; traditionally this meant giving actual food as a genuine thank you gift, now refers to a bribe for anyone working in a hospital in order to obtain or speed up services[7])

People also came up with wry new ways to allude to corruption in the ruling political party, CCM. While CCM stands for *Chama Cha Mapinduzi (*Party of the Revolution), people in the 1990s half-joked that CCM actually stood for *Chukua Chako Mapema* ("take yours as fast as you can") or *Chama Cha Majangili* ("the party of crooks") (Tripp 1997: 180). The anti-corruption squad established by the government in the late 1980s was referred to on the streets as the "corruption squad", as they could reportedly be bribed to *not* report allegations of corruption (Tripp 1997).

[7] See also see also Hasty (2005) and Blundo and Oliver de Sardan (2006) on the prevalence of food-related metaphors for corruption in African cultures.

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The colorful, varied, and usually oblique Swahili vocabulary used to discuss corruption gives a good sense of the omnipresence of corruption in daily life. Corruption is a fact of life, but only sometimes openly discussed. Although at least forty percent of the people I interviewed had paid some kind of bribe in the form of an "extra fee" to secure a birth certificate, many people were afraid to explicit accuse the government of corruption. However, they were unafraid to report paying non-standard fees, with the clear implication that the amount they reported to me included payment of bribes. As I show in the vignettes below, discourses about corruption in the birth registration system form part of a larger critique of governance. Birth registration provides a concrete example of the problems that people face in gaining basic services. Corruption is a symptom of systemic governance problems: people have to pay bribes to get birth certificates because of fundamental problems in the relationship between the government and the people. As Gupta (1995) suggests, discourses of corruption provide a way for average people to articulate larger, more diffuse critiques of governance.

"We do not accept the current system, it is corrupt": voices from Mwenge

Miriam and Lidia were sisters and single mothers living in a small walled compound on a dusty side street in Mwenge, away from the bustle of the bus station. The compound had a tattered green flag from the ruling CCM party flying from a tree branch. Miriam had two girls, ages 4 and 1, and Lidia had one son, age 3. Miriam and Lidia both lived with their mother, a friend of the local leader Bibi Salma who escorted us around Mwenge. Bibi Salma and the mother of Miriam and Lidia sat outside and talked, while I interviewed Miriam and Lidia inside.

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Miriam worked in a small shop nearby, but had to drop out of secondary school when she was pregnant with her first child. Lidia finished secondary school, but was unemployed. The fathers of their children are not involved in their lives, it's just women and children in their household. Miriam was quite shy, but her older sister Lidia was more outspoken. She wore a t-shirt with an American flag on it, along with a *kanga* cloth skirt, and her hair was styled in a short, modern pixie cut. Both sisters had their own birth certificates, and had made multiple attempts to register their own children, but all three children were unregistered.

Miriam explained the shame she was made to feel in trying to register her children without a father's name on the birth certificate. "I was very upset when I tried to register my children. I really got the run around. They sent me to RITA and then to Magomeni [municipal office], and told me I had to get letters from different government offices. Finally I gave up because it was too difficult. I really did try, though." She says she did not feel welcome in the government offices, even though she was trying to follow the government's rules by registering her children. Miriam wanted her older son's birth certificate so that she could enroll him in kindergarten, but the school had accepted his baptism certificate instead.

Lidia faced similar problems: "I tried to get [the birth certificate], but they kept telling me to come back. And come back again. It was just too hard." Lidia is one of the few people I spoke with who was willing to directly accuse the government of corruption, using the word *rushwa* rather than a euphemism such as *chai* (tea) or "extra fees." Lidia explained: "I could not get my daughter's birth certificate because I was not willing to pay bribes. If you don't pay, they tell you to come back later. The system now is full of *rushwa* (corruption). The mother should be given

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the child's birth certificate right when the child is born, that way she can avoid having to pay bribes later on."

Both Miriam and Lidia recognized the importance of birth registration, but they also faced more immediate problems in trying to provide for their children as single mothers. They were concerned about health services and education for their children, but expected to receive little help from the government. Miriam observed, "when you go to the hospital, there is no pediatrician to see the children. They give the wrong medicines because they do not know the right way to treat children." Lidia was also one of the only people I interviewed who spoke openly about issues of unplanned pregnancies and family planning: "There are many orphans here. Parents give birth to too many children that they cannot afford to take care of. We need family planning here but it is not available."

Although they do not articulate it directly, both Miriam and Lidia were talking about governance: they wanted to feel more welcome when they went to government offices, they wanted to claim their right to register their children without paying bribes, and they wanted access to better quality public services such as health care and family planning. They expressed disappointment in the government, despite the CCM flag flying on their compound, but what they wanted was more and better involvement from the government in their lives. Despite all their troubles with birth registration, they both hoped to try again in the future. "I would be very happy to see more people getting birth certificates," said Lidia. "The government should motivate us to do so, and make it easier." Like many Tanzanian parents, Lidia believed that the government had a moral obligation to help children: "Children do not have good lives here. They

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are innocent creatures who have committed no sins on earth, and they deserve to have a better life."

Lidia and Miriam's elderly neighbor, Bibi Osmunda, was from a different generation, but she shared many of the sisters' views about corruption. Osmunda was a very devout evangelical Christian, born in a village in rural Iringa in 1954. She had no birth certificate because they were not commonly available to African Tanzanians born during the colonial era. She gave birth to several of her three children at home, and did not register them, as it was still an uncommon practice in the 1970s. Although she did not have a birth certificate, Osmunda was very proud of her baptism certificate, which she kept tucked safely inside her Bible, placed on a high shelf in her living room. The walls of her small, tidy home were covered with religious posters. Although her husband had passed away and her children were grown up, she was looking after her 14 year old grandson, and worked every day except Sunday, cooking and selling food as a *mama lisha* (feeding lady). I talked to her as she worked on cooking a large pot of fish stew over a charcoal fire, in time for the lunchtime rush. She said life in urban Dar was much harder than the simple life she had growing up in her village. Osmunda worried about her grandson and considered Mwenge a dangerous environment for children. "Children are not living in good conditions here. Many are using drugs and getting infected [with HIV]," she warned.

Although she did not register her own children, she had strong views about the importance of birth registration in the modern era. Like many older Tanzanians I spoke with, Osmunda was drawn to the idea that a birth certificate provides proof of Tanzanian citizenship. She explained: "If you are a real Tanzanian, and not a refugee, the birth certificate is necessary to show you are Tanzanian. It proves your true identity." Bibi Osmunda said she had heard many

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complaints from younger mothers at her church about their difficulties with registering their children, and as she stirred her pot of stew, she described the problems with the current system:

> For one thing, there is too much corruption in the birth registration system. Birth certificates should be given on time, right after the baby is born. The way it is now, you only get a *tangazo* [birth announcement] and then they tell you to come back tomorrow, and tomorrow, and tomorrow…unless you pay bribes, and that is sinful.
>
> Another problem is the cost. Many Tanzanians cannot afford to get birth certificates. Including bribes, the cost can be up to Tsh 20,000. Only the rich can afford that. No, we do not accept the current system, it is corrupt. Birth registration should be a right for everyone.

On another day in Mwenge, I met another *mama lisha* whose living situation was much worse than either Bibi Osmunda, or the sisters Lidia and Miriam. She too had experienced corruption in the birth registration system. Salma was a slim woman who looked much younger than her 35 years, and had three children of her own. Salma had a small charcoal fire set up by the side of a street behind the bus station, where she was making and selling chapattis. She left the chapatti stand under the care of her eldest daughter, a 13 year-old who was not attending school, and brought us back to her living space to talk. Her living situation was one of the saddest I saw during my fieldwork. Her family was squatting in an abandoned building that was half falling down. Most of the living area was under a corrugated metal lean-to out front; but beyond that we could see into a sleeping room with crumbling plaster walls and a few bare foam mattresses spread out. Dank pools of water gathered on the floor of the sleeping room, and outside. It was no wonder Salma and her children had all had malaria recently. Flies swarmed everywhere. Salma was the second wife of an elderly man who sat on the only proper chair, eating a bowl of fish soup and some of Salma's chapattis. He had taken Salma on as his second wife, but then he had some health problems and was unable to walk and could no longer work, so

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Salma found herself providing for a household of 3 adults and 7 children. She described the difficult circumstances of her life to us, out of her husband's earshot.

When I met someone like Salma living in abject poverty, I typically felt conflicted about asking them about pieces of paper, when they clearly had so many much more urgent struggles to attend to. But Salma knew exactly what birth registration was, and it was something she wanted for her children. She described an unusual occurrence that had taken place earlier that year: some people had come to her neighborhood, saying that they were from RITA and could get birth certificates for her children. Salma had been excited about this, and had given the people her children's information and some money. Sadly, she described what had happened next: "So they took my money and said they would bring back the birth certificates in a few weeks, but until now we have never seen them again." Since RITA does not provide house-to-house registration services, the clear implication was that Salma had been the victim of a scam. Unfortunately, this kind of scam is made easier by the "projectification" or fragmentation of many services for children. People from the government or NGOs had come through the neighborhood giving vaccinations or health checks for children in the past, so why would Salma have had any reason to doubt the legitimacy of these con artists posing as registrars? An older woman like Bibi Osmunda might have thought to ask for official ID before handing over money, but low-income women like Salma are not used to making demands of people they think represent the government.

Salma looked so disheartened as she remembered what had happened, and ashamed that she had been taken advantage of. "I tried so hard to do the right thing for my children," Salma

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said. “But this really made me feel like maybe I will give up hope." Even though Salma had such a negative experience, she still wanted to register her children for real one day: “Truly, the birth certificate is needed for everything in life. It identifies the child as a citizen of Tanzania. Also when they go to school and work it is very important to have. But we are tired of waiting for help to register our children.” A look of weariness passed over Salma’s face, and then she stood up, wrapped her kanga tight around her waist, and walked back to work at her chapatti stand.

Conclusion: the limits of self-reliance

As these stories and discourses about corruption show, Tanzanian families experience corruption both directly and indirectly in their daily lives, and worries about having to pay bribes help to shape peoples’ perceptions of birth registration and their decisions about whether or not to register. However, this did not mean that people rejected birth registration as being associated with a corrupt government. Rather, they wanted the government to improve the system so that they could register their children without being subject to extra fees or bribes. When I asked Bibi Osmunda what the government should do to improve people’s lives, she replied using rhetoric common to older people raised during Tanzania’s post-independence era, which draws on Tanzanian socialist values of *kujitegemea* or self-reliance. “We cannot only blame the government for not fulfilling all our needs,” cautioned Osmunda. “I ask citizens to take the initiative to help ourselves, without waiting for the government.” Osmunda concluded that it was up to “parents and religious leaders to take action and help children stay on the right path.” Bibi Osmunda’s advice for Tanzanians to be more self-reliant and proactive is in line with the World Bank’s prescription for “good governance” through increased involvement from citizens and

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civil society organizations. Bibi Osmunda's socialist-era rhetoric of self-reliance and neoliberal discourses of responsibilization make for strange bedfellows. I explore this interesting intersection of socialist and neoliberal ideas about governance and personal responsibility in chapter 7.

In my conversations with families, it became clear that many Tanzanian people are ready to demand more and better governance, in the form of improved public services, and more accountable and accessible government offices. They strongly resent how commonplace corruption is, but are often compelled to pay bribes to achieve a greater good, like getting a teenager's birth certificate so that they can register to take the university entrance exam, and maybe become the first in the family to attend university. Self-reliance is a major part of that kind of success story, in terms of scraping money together to pay school fees and buy books for a promising student, often with contributions from many family members.

But the problem with birth registration is that people cannot rely solely on themselves to register their children. As many people told me, the government must meet them halfway. Tanzanian families rely on themselves to do all they can to register their children. They do their part by setting aside a little bit of money when they can, to pay registration fees, late fees, "extra fees" and travel costs. They stand patiently in long lines waiting for the registration office to open. They may eventually get to the front of the registration queue, if they are persistent and lucky. But that is as far as self-reliance can take them. Self-reliance is cannot ensure that government offices are open, or well-staffed, with the right forms in stock, and clerks who are well-paid enough so that they have no incentive to ask for a little something "extra" to type up a

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birth certificate. These are systemic governance problems that Tanzanian people, for all their hard work and self-reliance, cannot solve themselves.

Although Tanzanians who can afford to do so have turned to the private sector to provide many essential services, including education, health care, security and electricity, birth registration is an essential state function and cannot be privatized. Only the government can reform the birth registration system, and although the employees at RITA I interviewed admit that the birth registration system is in need of major changes, they argue that they lack the financial commitment and political will necessary to repair the system. I explore perspectives of RITA staff in chapter 8. First, in chapter 7, I discuss the complex relationship between birth registration and governance. Birth registration is currently being promoted as an indicator of good governance, but birth registration is itself reliant on the same governance structures which it is now supposed to measure. This raises the question: which will come first, better governance or better birth registration?

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Chapter 7

Being seen by the state: Birth registration, governance and governmentality

"The government must let everyone know the importance of the birth certificate, and they should also make it easier to get. The follow-up needed now is very difficult, especially if you are working. The lines at the government offices are so long, and they just tell you to come back tomorrow, come back tomorrow, again and again. It can really make you start to lose hope."

—Caroline, mother of 1, Mwenge

"The birth certificate confirms your nationality, therefore it's the right of every child to have it. Without doubt it is a right. But in order to get this right, you have to follow up. It will not just be given to you—you have to go and take it!"

—Hamisi, father of 2, Magomeni

Many of the problems with birth registration I have so far described—fragmented and privatized health services, lack of medicines and staff in the public health system, confusing laws and fees, an intimidating bureaucracy, instances of petty corruption—are on a fundamental level problems of governance. In recent years, the Swahili phrase *utawala bora* (literally "improved administration") has gained popularity in the NGO sector to describe "good governance" initiatives, but it is not a concept often used by ordinary Tanzanians. However, when people spoke to me about their experiences with birth registration, many of their key frustrations can clearly be seen as governance problems: the physical and social distance between citizens and their government; the way that people are treated when they try to interact with the state; the

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systemic problems that plague the bureaucracy; and perhaps most of all the disenfranchisement and disrespect people feel as a result of these interactions. Birth registration is a basic function of the state, both in the Foucaultian sense that the exercise of state power requires a population that is enumerated and documented (Foucault 2007), and also in the sense that it is an obligation under the various human rights treaties to which most states, including Tanzania, are signatories.

During the colonial era, birth registration was not considered a matter of individual rights, but rather as a "method of human accounting" to be used by colonial administrators (Edge 1947: 4). The shift to birth registration as a right for individuals occurred with the passage of the Universal Declaration of Human Rights, and *the* International Covenant on Civil and Political Rights, and remained framed as a human right and specifically a human right for children for the rest of the 20th century. However, in recent years, the idea that birth registration is a valuable tool for governance is again gaining popularity (Setel et al 2007, Center for Global Development 2014). Increasingly, birth registration is seen as being good for governments, as well as for individuals. Individuals need access to birth certificates for many purposes, but a robust system of birth registration is also beneficial to governments, as it generates real-time population data that can be used for development planning, allocation of resources, and many other purposes. Birth registration is gaining popularity as an indicator used to measure the performance of governments in developing countries across various domains, including children's rights and human rights, the rule of law, and good governance (Merry and Wood 2015). For example, the Sustainable Development Goals which have been proposed to succeed the Millennium Development Goals include birth registration as one of twelve measures of Goal 16, which encompasses rights including access to justice, provision of official identity documents, and

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good governance (United Nations 2015). I will consider the rising prominence of birth registration as a governance indicator further in the conclusion.

In this chapter, my concern is to show how birth registration sheds light on systemic governance problems that negatively impact peoples' lives. In particular, I am interested in showing how ordinary people experience interactions with the government when they attempt to register births, and what can be learned from their views. In this chapter, I consider these encounters along ethnographic studies and theories of governance, bureaucracy, surveillance, and governmentality. In contrast to previous studies that have emphasized the potentially oppressive dimensions of governance in Africa (Scott 1998), and the role of identity documents in surveillance and control of populations (Breckenridge 2012, Longman 2001, Barnes 1997), my key finding in this chapter is that most ordinary Tanzanians view birth registration not as a form of surveillance but rather as a positive form of recognition by the state. In short, they would like to be seen by the state, but they must work actively to get the state to see them. Presenting oneself and one's children for registration also carries an element of risk, in the form of bribe solicitation, as I discuss in chapter 6. However, corruption is only a symptom of more systemic governance problems. In this chapter, I focus on governance "from below": from the perspectives of people trying to register. Then in chapter 8, I visit the national office of RITA (the Registration, Insolvency and Trusteeship Agency) to gain the perspectives of government staffers who are trying to repair the birth registration system, but find themselves constrained by limited resources and political will.

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"It will not just be given to you—you have to go and take it!"

I was somewhat surprised to find out that even the local government leaders who hosted my research in Kimara, Mwenge, and Magomeni, ran into difficulties registering their own children. These local leaders, referred to by the *Ujamaa*-era term "ten cell leaders," were people affiliated with the ruling CCM political party (*Chama cha Mapinduzi* or "Party of the Revolution"), and who divided their time between general community leadership functions and CCM party business, although they are technically supposed to be non-partisan this is rarely the case (Kelsall 2003, Ewald 2011). The term ten cell leader refers to responsibility for ten households in an *Ujamaa* village, but in Dar most ten cell leaders are responsible for a much larger number of households. These leaders do not necessarily have a high level of education, but have somehow amassed enough social capital to be appointed. My host in the neighborhood of Magomeni, Mzee Hamisi, was in many ways a typical ten cell leader, and I learned quite a bit from him about local governance.

Hamisi was a big man with a wide smile and a joking manner, and he typically wore an embroidered robe and a *kofia* hat slightly tilted to one side of his head. He had a one room office with a rusty corrugated iron ceiling that leaked when it rained. His office had one good chair (for him), and a succession of slightly or mostly broken plastic chairs that would be handed out by his assistant Yusef according to the seniority of guests to his office. The office also had the unruly stacks of yellowed papers that are almost a regulation feature of all government offices in developing countries (and to which I will return below in more detail). However, most of the time Hamisi could be found in the small canteen next to his office, enjoying a bowl of fish soup and soaking up the sauce with a stack of chapatis while chatting with various people from the

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neighborhood. He was in his forties, although having no birth certificate himself, he was not sure of his exact age. He had lived his whole life in Dar, had a primary school education, and engaged in various business transactions in addition to his ten cell leader work. He was married and had two daughters, ages 12 and 4.

After visiting households and conducting interviews in Magomeni for a few weeks, Yusef informed me that it was time for me to have a meeting with Hamisi, the big man himself. On the appointed morning, I reported to Hamisi's office along with Flora and Agatha, and he motioned Yusef to bring me the second best chair. After exchanging a series of greetings and pleasantries, he leaned back and said, "So, you have come to interview me! Please feel free, I will give you all the necessary information!" All of the local leaders I worked with insisted on being part of the research themselves, so I went through the standard survey with him.

Hamisi had registered both of his daughters, but he said the process was difficult, even for him. He paid Tsh 6,000 for each birth certificate, at the Kinondoni Municipal Office about a kilometer's walk from the neighborhood. When I asked him why he had paid Tsh 6,000 each instead of the official Tsh 3,500, he said "oh, that is the way these things are done." In terms of "extra" fees paid by other parents in the study, an extra Tsh 3,000 each was a relative bargain. When I asked Hamisi what he thought about birth registration, he became even more animated than usual: "Is birth registration a big issue here? Yes, in truth, it is a very big problem here! Many people here are not registered. They do not know their birth date, and they do not know how to register. It is very difficult."

Next, I asked Hamisi how he thought the system could be improved, and he had some good ideas: "In my opinion, we need to change the system. Do away with the *tangazo*, and just

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give the birth certificate right when the child is born, instead of *nenda rudi, nenda rudi* [come and go, come and go]. It's too difficult. It will be better to give birth certificates at the hospital, these local government offices are too crowded and the lines are always so long!" He laughed heartily about long lines, and gestured to the shoulder-height stacks of forms from the national ID card registry two months earlier, which were just sitting in his office, starting to get damp now that the rainy season was beginning and his roof was leaking again. I asked what would happen to the forms and passport photos that he and Yusef had collected, and he shrugged good-naturedly and replied: "I don't know. Those higher-ups have not yet informed us what is to happen next. As you can see, we just do not have the capacity to deal with such matters."

Like many other parents, Hamisi felt the government was not doing much for children, and should do more. Curiously, he did not perceive himself as part of "the government" but rather as an average person subject to the machinations of bureaucracy as much as the next person. He concluded: "The birth certificate confirms your nationality, therefore it's the right of every child to have it. Without doubt it is a right. But in order to get this right, you have to follow up. It will not just be given to you—you have to go and take it!" Hamisi's view that rights are something to be actively sought, rather than passively received, was quite common, especially among middle-aged and older Tanzanians I spoke with. This idea of "taking rights" combines echoes of *Ujamaa*-era values of self-reliance (*kujitegemea*) with a kind of weary self-responsibilization that comes from navigating life in a neoliberalized state where nothing is free, and extracting one's rights requires patience and persistence. Even as a low-level political worker, Hamisi didn't expect any special treatment, other than perhaps the fact that the "extra" fees he paid for his daughters' birth certificates were a bargain price.

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Governance, and “good governance”

Many of the difficulties with governance in Tanzania today can be traced back to colonial and post-colonial policies and ideologies of governance. Although a full history of governance in Tanzania is outside the scope of this chapter (see Iliffe 1979, Kelsall 2003, Gould and Ojanen 2003, Gould 2005), looking at a few key moments in the history of governance can inform our understanding of birth registration problems today. Although Tanzania has a reputation for authoritarian post-colonial governance thanks largely to Scott’s portrayal of *Ujamaa*-era villagization policies in *Seeing Like a State*, an ethnographic approach to governance reveals a very different story on the ground. For both ordinary people and bureaucrats alike, many functions of governance are not robustly authoritarian at all, but rather are frustratingly weak. Many of the issues of fragmentation and decentralization that I discussed in relation to the health system in chapter 3 are also present in local government offices. The difference is that, unlike health care services, basic functions of local governance cannot be legitimately privatized (although as I argue in chapter 6, they have been illegitimately privatized through corrupt practices). Local government offices are called upon to provide a wide array of services, but without the necessary staff, basic supplies, and administrative coordination required to provide high quality services. This is especially a problem for birth registration, as I explain further in chapter 8. The staff I spoke with at the national registration office, RITA, identified the decentralization and lack of coordination of governance as one of the main problems they faced in trying to improve birth registration services. The current system of decentralized governance can be traced back to several policy decisions made in the colonial and post-colonial era.

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Although these decisions were based on radically different theories of what constitutes good governance, they have had the consistent effect of decentralizing and hindering governance.

Governance in the pre-colonial period was in some areas dominated by local chiefs and hereditary leadership structures, but some areas had no traditional chiefs and people were largely self-governing within kinship-based forms of social organization (Iliffe 1979). German colonial governance was very uneven, with most colonial officials based in the coastal region, leaving large regions of Tanganyika relatively undisturbed by colonial governance, apart from sporadic attempts to collect taxes and projects of resource extraction in certain areas of the territory (Iliffe 1969, Koponen 1995). After the British took over the administration of Tanganyika, they introduced a policy of indirect rule which had been developed in other British colonies in Africa, in particular Nigeria (Iliffle 1979). Proponents of indirect rule argued that it offered several benefits to colonial powers. First, it would provide a less expensive method of governing colonial territories by relying on pre-colonial or "native" structures of power, via Native Authorities who would be responsible for collecting taxes and keeping order among their own people. However, these "native" power structures were often augmented (or sometimes wholly constructed) by the British, based not on actual lineages of traditional leadership, but on selection of those men the British considered would be most amenable to working with and for them. Second, indirect rule was ostensibly to "protect" indigenous cultures by limiting their exposure to Westernizing influences (Lugard 1922). Iliffe (1979) records that in the 1920s, some remote parts of Tanganyika received a visit from a British colonial official only about once a decade. Central to indirect rule in Tanganyika and elsewhere was a legal system which was a hybrid of colonial and customary law, with separate courts for "natives" and Europeans, also Islamic

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courts which dealt with civil cases relating to property and family law (Nyanduga and Manning 2006). The codes of customary law used in the native courts were themselves a product of colonialism, in which legal traditions were negotiated and codified in response to colonial inquiries, and shaped by local elites to suit their own political purposes (Moore 1986, Merry 1991, Cohn 1996). Indirect rule was thus decentralized and localized by design. However, the introduction of indirect rule was much more straightforward in theory than in practice. In reality, British colonial bureaucracy came to Tanganyika "…in a haphazard way. Newly created posts were held by 'amateurs' in isolated areas. There was no clerical help. Supplies for clerical work did not exist, yet suddenly these 'amateurs' were expected to correspond with their superiors in the proper way of an established office" (Beck 1970: 13).

The British doctrine of indirect rule was in direct contrast to the French theory of colonial governance as direct rule. French colonies in Africa and elsewhere had one legal system based on French law, and French theories of governance centered on the idea that a small, elite class of Africans referred to as "Évolués" could become culturally assimilated and eventually attain French citizenship. However, few non-elite Africans could attain this status (Cooper 2014). In contrast to French theories of governance that were unabashedly racialized, Mamdani has argued that British indirect rule can be seen as "a mediated—decentralized—despotism" in contrast to the more organized and centralized despotism of French colonial rule (1996: 17).

Indirect rule in Tanganyika had two main consequences for post-colonial governance: decentralization, and lack of administrative capacity. By 1951, there were 435 local native administrations throughout Tanganyika. This decentralization was encouraged especially in the post-war era, as a counterweight to the burgeoning nationalist movement (Iliffe 1979). However,

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the independence movement progressed quickly, but at independence in 1961, the new government found itself without enough African staff to take over the running of their new country. For example, only 17 African Tanganyikans graduated from university in 1962. There were only 3 African army officers, and only 2 of 57 district commissioners and 25 percent of mid-level civil servants were African (Iliffe 1979). These numbers are not to suggest of course that only people with a certain level of formal education can lead a country. However, the basic structures of governance that were inherited at Tanganyikan independence did require certain bureaucratic skill sets and practices in order to keep those structures functioning, such as typing reports and compiling statistics. The British largely failed to provide enough opportunities for Africans to prepare for governing their own countries (Iliffe 1979).

In the post-independence era, decentralization continued to be a key feature of governance, although rooted in ideologies of *Ujamaa*-style socialism (*Ujamaa* meaning "familyhood"), which centered on a return to "traditional" rural life and self-reliance through communal agricultural production (Hyden 1980). In practice, *Ujamaa* governance combined elements of decentralization and top-down centralized planning. While *Ujamaa* concentrated on the family and the village as the central building blocks of society, it also entailed a centrally planned socialist economic model. Nyerere argued in favor of "the responsibility of the state to intervene actively in the economic life of the nation so as to ensure the well-being of all citizens, and so as to prevent the exploitation of one person by another or one group by another, and so as to prevent the accumulation of wealth to an extent which is inconsistent with the existence of a classless society" (Nyerere 1968: 14, quoted in Hodgson 2001: 152). Hodgson (2001) observes that *Ujamaa* governance was deeply paradoxical: "Although *Ujamaa* claimed to be in part about

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decentralizing decision-making, control, and funding for economic development to villages, it actually concentrated development interventions in the hands of the state" (Hodgson 2001: 154). While elements of *Ujamaa* such as villagization had long-term negative economic consequences and involved curtailment of many personal and political freedoms, it did also have some positive effects such as the expansion of basic health services in rural areas inspired by the Chinese model of "barefoot doctors," and communal projects to improve sanitation in villages (Hyden 1980, Coulson 1982, Tripp 1997).

Tanzania's economic crisis in the late 1970s and early 1980s was in part related to failures of *Ujamaa* governance, but also deeply rooted in worldwide economic trends such as the oil crisis and commodity prices that were far beyond Tanzania's control. In chapter 3 I discussed the economic impacts of the financial crisis and ensuing structural adjustment programs on the public sector in Tanzania in some detail. Here, I will just briefly note the negative impacts of those economic austerity measures as they relate directly to governance. During this period, drastic cuts to public sector budgets severely limited the capacity of government offices at every level to fulfill basic functions of governance. Public sector workers often did not receive their salaries on time or in full, and many government offices went unstaffed as employees pursued informal sector income generating projects in order to make ends meet (Tripp 1997). By 1995, Tanzania spent more than 75 percent of its World Bank loans on servicing the debt and repayment obligations on previous loans, leaving less funding to invest in basic functions of governance such as public services and infrastructure development. During this era, governance became more decentralized as a result of several factors: the power and influence of foreign

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lenders; the lack of state capacity due to austerity measures; and the growing role of private and non-governmental entities.

By the mid-1990s, it became clear that neoliberal economic reforms and austerity measures were not achieving the economic growth predicted by the World Bank and IMF. A new theory was proposed to explain the stagnation of economic growth in poor countries: they were not suffering only from economic mismanagement, but from poor governance and systemic corruption. In a 1992 report, the World Bank made the concept of "good governance" a central aspect of its financial reform packages. The World Bank defined governance as "the manner in which power is exercised in the management of a country's economic and social resources for development" (World Bank 1992: 3). It identified public sector management, the rule of law, public accountability, and information and transparency as the key dimensions of governance. According to this theory, African economies were not growing because of government bureaucracies that were inefficient and "dysfunctional," and a key goal of good governance was therefore to create an "enabling environment" for economic development (Anders 2014). Critics of this theory have noted that the prevailing theory of good governance focuses on the advantages it offers to investors, elites, and the private sector, not necessarily on improving the quality of public services for ordinary people (Abrahamsen 2012). More recent definitions of good governance by the World Bank have added language on "the respect of citizens and the state for the institutions that govern economic and social interactions among them" (Kaufmann et al 2010: 4).

Anthropologists working in Africa and elsewhere in the developing world have amassed a compelling body of ethnographic evidence on the effects of neoliberal theories of development

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and governance on ordinary peoples' lives (Escobar 1995, Ferguson 2006, Gould 2005, Anders 2010, Hodgson 2011, Gupta 2012, Li 2008, Rottenburg 2009). One common finding of these studies is that theories of governance imposed by the West largely fail to account for the historically and locally specific effects of colonial and post-colonial policies imposed by those same actors generations or even only a few years previously. In many ways, policies intended to improve governance have instead had the effect of further eroding the basic governance capacities of many poor countries, as Ferguson argues:

> The reforms demanded by ''structural adjustment'' were— according to their neoliberal proponents— supposed to roll back oppressive and overbearing states and to liberate a newly vital ''civil society.'' The result was to be a new sort of ''governance'' that would be both more democratic and more economically efficient. Formal democratization has indeed swept over much of the continent (though far from all of it)…
> At the same time, swarms of new ''nongovernmental organizations'' (NGOs) have arisen, taking advantage of the shift in donor policies that moved funding for projects away from mistrusted state bureaucracies and into what were understood as more ''direct'' or ''grassroots'' channels of implementation …this ''rolling back'' of the state has provoked or exacerbated a far-reaching political crisis. As more and more of the functions of the state have been effectively ''outsourced'' to NGOs, state capacity has deteriorated rapidly (Ferguson 2006: 38).

A second major problem with good governance is that it is defined according to the priorities of Western donor countries and institutions, rather than taking into account how "good" governance is defined by the citizens of the countries in question, who are the most effected by governance outcomes.

> "Good government," as defined by the lending agencies, may help to legitimate IMF and World Bank policies in the West, but it is not at all clear that it will get to the heart of the crisis in Africa…popular legitimacy in Africa requires a perception not simply of "good government" (efficient and technically functional institutions) but of a government that is "good" (morally benevolent and protective of its people). An efficient and effective government is not necessarily a "good" one in this second sense (Ferguson 2006: 85).

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While most developing countries have incorporated “good governance” into their policies and rhetoric, the lack of local values and priorities reflected in the definitions of good governance imposed from abroad mean that much of the engagement around good governance is performative and superficial. For example, good governance indicators that focus on easily quantifiable measures such as counting the number of government employees attending a good governance workshop, rather than outcomes that are more difficult to quantify, but also more meaningful (Merry 2011). Gould (2005) argues that Tanzania has mastered many of the performative dimensions of good governance, including particular styles of interaction mediated by reports, Powerpoint slides, and face-to-face meetings with international donors (see also Riles 2000 and 2006 on these styles of bureaucratic interaction in development projects). Although the Tanzanian government has a Commission on Human Rights and Good Governance (CHRAGG) that sends representatives to many donor meetings, it is notable that the commission’s name and acronym and name are in English, not Swahili. The Swahili translation of “good governance” as *utawala bora* or “improved rule/administration” indexes a different understanding of governance as administration from above, rather than a participatory process. Before proceeding to the important question of how ordinary Tanzanians experience governance through the birth registration system, I will briefly explore two other relevant bodies of literature on bureaucracy and governmentality, and how each contributes to understandings of birth registration as a technology of governance.

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A “government of paper”

In recent years a number of influential ethnographies have explored various aspects of bureaucracy in developing countries, from the materiality of documents and stamps, to the inscription of persons and properties, to the experiences of civil servants and foreign consultants caught up in ill-conceived development schemes (Rottenburg 2009, Hull 2012, Gupta 2012, Bierschenk and Olivier de Sardan 2014). Gupta’s work on bureaucracy in India has been central to my analysis of birth registration in Tanzania, not only because of certain shared legacies of colonial rule in India and Tanzania, but primarily because of the argument Gupta makes about the interrelatedness of bureaucracy and structural violence in the lives of the poor. “Structural violence is enacted through the everyday practices of bureaucracies, and one therefore needs to look closely at those everyday practices in order to understand why violence coexists with care and why, paradoxically, it is often found in practices of welfare” (Gupta 2012: 33). Gupta argues that these mundane everyday practices are an important site, not only for the constitution of individuals as citizens and targets for development interventions, but also for the constitution of states themselves:

> The study of everyday practices and of the circulation of the representations that constitute particular states might tell us not just what they mean, but how they mean it, to whom, and under what circumstances. The materiality of files, orders, memos, statistics, reports, petitions, inspections, inaugurations, and transfers, the humdrum routines of bureaucracies and bureaucrats’ encounters with citizens: this is the stuff out of which the meanings of states are continually constituted. Such routines are remarkably understudied in contrast to the predominant focus on the machinations of state leaders, shifts in major policies, regime changes, or the class basis of state officials—to name just a few themes that have loomed large in the study of states (Gupta 2012: 70).

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A second key point about bureaucracy is that it is a mundane and yet powerful site for the exercise of governmentality through processes of surveillance and enumeration. Foucault defined governmentality as “the *ensemble* formed by the *institutions, procedures, analyses, reflections, calculations and tactics* that allow the exercise of this very specific albeit complex form of power, which has as its target population” (Foucault 2007: 108). As I outlined in chapter 3, concerns with the management of populations have historically been focused on women and children, particularly in colonial contexts. Gupta argues that governmentality can be seen in ordinary bureaucratic processes as benign as weighing babies, or in the case of my study, registering or not registering their births. The focus on women and children as sites of governmental surveillance, measurement, and documentation is particularly important, as it allows state power to extend into the private domains of home and family (Mitchell 1988, Stoler 2002). Governmental schemes of documentation endeavored to create “discrete biological entities, whose individualized and racialized capacities were the key elements of the colonial state: biological units to be counted, categorized, segregated or combined, assigned to space in precise numbers per square foot or mile, organized, educated and improved” (Boddy 2011: 123).

Mitchell (1988) discusses birth registration as a form of “everyday power” of colonial governance in Egypt, distinct from more coercive forms of power such as military force, but also contributing to the exercise of such power: “The system of surveillance was to start not in the school or the army, but from birth. Following the British military occupation in 1882 a central office was set up to organize the official registration of births in every village…a ‘systematic English inspection’, the everyday method of power that colonialism sought to consolidate” (1988: 95). Birth registration was intended to identify male children for the purposes of future

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recruitment into the army. However, most colonial governments did not seem to be involved in such long-term schemes as registering babies and then waiting 16 years to conscript them into the army. Cooper (2014) describes the typical African colonial government quite differently: "contrary to myths of 'modern' colonial government as bureaucratic and controlling, it was in all but a few areas thinly spread, ad hoc in its daily actions, dependent on African intermediaries" (2014: 154). An authoritative three-volume survey of the demography of the British colonial empire found that the reliability of population data in most colonies before World War II was at best partial and at worst dubious in many colonies (Kuczynski 1948).

In the African context, the apartheid South African government reached an apex of governmentality through its extensive documentation and surveillance of non-white persons, from the oppressive pass laws which restricted the movement of Africans (Barnes 1997), to the compulsory registration of fingerprints of Indians that helped to radicalize a young Gandhi (Breckenridge 2011). In the 1950s, Tanganyika considered a brief experiment in the selective registration of men from certain ethnic groups in northern Tanganyika thought to be sympathetic with the Mau Mau uprising in Kenya, but the scheme was so unpopular that it was never finalized (Elkins 2005). However, the South African apartheid regime's level of documentation and surveillance was the exception rather than the rule of colonial governmentality. Szreter and Breckenridge argue that Foucault's influence "has caused many scholars to overstate the bureaucratic enthusiasm for information gathering and it has discouraged research into the limits of bureaucratic knowledge" (2012: 7). A closer consideration of the historical record reveals that "African colonial governments, and their modern heirs, typically lacked the resources, long-term administrative tenacity and local political agents required to make civil registration work outside

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scattered cities on the continent" (Szreter and Breckenridge 2012: 6). "Far from an oppressive and ubiquitous will to know, African states were built in an informational void" (ibid: 10).

Cooper's body of work on the histories of African colonial and post-colonial states has led this re-consideration of the bureaucratic power of colonial and post-colonial governance, with particular reference to African labor (1996, 2002, 2014). Cooper argues that African colonial and post-colonial governance is largely characterized by weak "gatekeeper" states that sought primarily to control access to and transport of particular natural resources and commodities, and the local labor with which to mine, harvest, and transport commodities to sell on international markets (2002). States were interested in local populations primarily as a source of labor, reproduction, and taxation, but most governments were not interested in investing the administrative resources that would be necessary to extensively document or surveil local populations: "in the African colony the state could not track the individual body or understand the dynamics of the social body" (Cooper 1996: 334-335). As I mentioned briefly above, several French colonies such as Senegal were an exception to this rule, and attempted to provide more extensive documentation of individuals as an aspect of direct rule and French philosophies of cultural "evolution" through colonialism (Cooper 2014).

Offering a sharp critique of Scott's ideas about "high modernist" schemes of development in Tanzania, Cooper argues that Scott has himself engaged in the kind of simplification he decries in order to make Tanzania's villagization experiment more legible. Scott suggests that villagization was able to "transform dispersed, autonomous, and illegible populations" (1998: 246) using an "avalanche of statistics" to do so (Scott 1998: 244). Cooper argues that Scott fails to address the local realities and complexities of rural life during *Ujamaa*.

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Interviews with people who were young adults during *Ujamaa* reveal that in many villages, there was little to no "high modernist" intervention and everyday life continued much as it had before (Lal 2012). Lal found that in some villages, interaction with the Tanzanian state was mostly limited to a few bags of fertilizer which would be dropped off in the village once a year (Lal 2012). If, as Scott argues, the Tanzanian government during this time was focused on rendering rural populations legible, it would be difficult to explain why no efforts were made to expand birth registration during the *Ujamaa* era. On the contrary, the historical evidence suggests that "seeing like a state" means seeing only very selectively, perhaps more like seeing the world through a telescope than a magnifying glass.

Birth registration as a "technology of governance"

So far, we have established that although colonial and post-colonial African states have been quite invested in ideas about the importance of population registration and surveillance for governance, in practice this has rarely translated into robust bureaucracies capable of carrying out these ideals. What questions does this disconnect between ideologies and realities of governance in low-income countries raise about birth registration? If birth registration is an important basic function of governance, what does this mean for countries like Tanzania where rates of registration are so low? In the case of Tanzania, this raises two questions: first, how does birth registration function as a "technology of governance"[8], and second, what can be learned about governance from the experiences of people who try and mostly fail to register? I will

[8] (Rottenburg 2009: 214)

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consider both questions below. My key argument in this section is that looking at how and why birth registration does *not* occur offers insights into anthropological understandings of bureaucracy and governance more broadly. Studying something that is not happening is both conceptually and practically more difficult, but as Gupta argues, it is important to understand governance not as a fixed phenomenon, but rather as "a conjectural and crisis-ridden enterprise" which "engenders its own modes of resistance, and makes, meets, molds, or is contested by new subjects" (2012: 239).

Understanding birth registration as a governance problem involves a certain mode of "chicken or egg" thinking: which comes first, birth registration or good governance? States with good governance are more likely to have robust systems for registering births and providing identity documents. But having reliable identity documents is also an important input for other aspects of good governance, including reliable population statistics, legal rights, property rights, appropriate taxation, voting rights, and protection of certain human rights. Identity documents also contribute to economic development by helping people to attend university, seek formal sector employment, open bank accounts, register small businesses, and inherit land and property. Encouraging people to move from the informal to the formal sector is one of Tanzania's key strategies for future economic growth (PMORALG 2013). However, countries can only develop so far without a robust system of identify documentation. Comparison of a list of those countries with the lowest rates of birth registration, and a second list of countries with the lowest rankings on governance will find quite a few countries in common on both lists (UNICEF 2015). However, without a detailed statistical analysis using linear regression and controlling for a number of potentially confounding factors, the most I can say for now about the relationship

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between birth registration and governance is that it is a relationship of correlation, not causation. What is clear, however, is that in terms of governance, there is a great deal of difference between Tanzania and Somalia or Afghanistan, even though all three appear on the list of least registered countries.

Birth registration has both a "knowledge effect" and a "governance effect" (Merry 2011: S84) and these effects impact both individuals and the state in various ways. Birth registration has a knowledge effect for states in that it provides important real-time data on the growth of the population; this knowledge in turn aids other functions of governance such as budgeting and planning development projects. For individuals, birth registration has a knowledge effect in terms of providing a legal identity document which records important information about the individual. The birth certificate has a governance effect for individuals as helps to establish legal personhood and thus enable individuals to engage with the state as a rights-bearing citizen. These chains of knowledge effects and governance effects can be seen as mutually constituting the individual and the state, and the relationship between the individual and the state. The idea that a birth certificate signifies recognition of the individual by the state is very important to people, as I discuss at the conclusion of this chapter.

Because birth registration is an essential and basic state function, it cannot be officially privatized. However, as I mentioned briefly in chapters 4 and 6, the many problems with the birth registration system mean that it is effectively unofficially privatized for some people. As I argue in chapter 5, those people who lack the social or financial capital to navigate the registration system unofficially are the most affected by this unofficial privatization. In the rest of this chapter, I consider how governance problems contribute to the ongoing difficulties in the

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birth registration system. Disparities in access to birth registration contribute to the social reproduction of inequalities between the registered and the unregistered. Governance problems impact birth registration both in the initial health system phase, and the secondary local government phase of the registration process. These problems include: petty corruption by often underpaid and overworked staff in health facilities and local government offices; outdated colonial-era laws governing birth registration; a bureaucracy that is confusing, fragmented, and perennially under-resourced as a result of cuts to essential public services; and macro-level problems with collecting appropriate taxes from wealthy citizens and large overseas corporations in order to fund basic state operations.

Gaining access to a birth certificate, that simple but increasingly important piece of paper, involves many individual steps, each involving governance problems that have to be solved in order for the birth registration system to function properly. Local government offices must be open during normal working hours and accessible to the public, and employees must be regularly paid and qualified to accurately carry out the various tasks of registration. Public maternity wards should not be so under-staffed that nurses and midwives do not have time to fill out birth announcements because they are tending to multiple women in labor simultaneously. Supplies such as paper forms and typewriter ribbons must be consistently in stock at each office providing the service. Data collected by each local office must be regularly and accurately reported back to the national office. People must have access to correct information about registration procedures and fees, and those rules must be followed uniformly from office to office. Perhaps most importantly, the public should also feel able to assert their rights to receive these basic services, on time and without paying bribes, and should be able to advocate for their

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rights without fear of reprisal. Of course, this is an idealized scenario. What happens in reality when people go to a local government office to try to register their children is rarely so straightforward. Next, I discuss several key governance problems in the birth registration system, as identified by my interviewees. Their main concerns about governance speak to five themes: access to services, fear of interacting with the government, strategies of self-reliance, delayed expectations of the state, and a desire to be seen by the state. Much can be learned from hearing about these everyday experiences interacting with local government, especially from people who tried to register their children but failed to do so.

"Come back tomorrow, and tomorrow, and tomorrow..."

This research was my first time interacting extensively with local government officials and bureaucrats on the neighborhood level, as opposed to my previous experiences in Tanzania, which had mainly involved working with Tanzanian health and development professionals, and interacting with bureaucracies that deal with foreigners, such as the immigration office and the Commission on Science and Technology, which issues research permits. In my time observing in and around local government offices during this research, I learned several new Swahili vocabulary words that are essential to thinking and talking about governance. Besides *utawala bora* (“improved administration” or “good governance”), which ordinary people don’t often use, the important words are:

fuatilia (follow-up; used to describe the process of making multiple visits to a government office to try to collect a birth certificate without paying bribes; this method may take 3-4 or more follow-up visits over the course of many months)

foleni (a queue; used to describe queues at government offices or traffic jams; both a bane of everyday existence in Dar)

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usumbufu	(a nuisance; the most common way to describe government interactions, the syllables can be drawn out to emphasize the speaker's degree of annoyance)
njoo kesho	(a command to "come back tomorrow", in a dismissive tone; people resent being ordered around by local government clerks in this way; also the "tomorrow" in question is almost never actually the next day, but some unspecified point in the future)
-kata tamaa	(to lose hope; many people speak of *almost* losing hope, but then persevering in the end)
bado	(adjective describing something that has not happened yet, and which may or may not happen in the future; often used to describe the government's actions)

This lexicon of governance was used when describing many of the issues below, but all featured heavily in discussions of one of the central problems of governance: lack of access to government offices and services therein. As I mentioned in chapter 5, this lack of access can take the form of geographical distance, or social distance perpetuated by class differences, or arriving and finding the office needed is closed or has a long queue. Because most low-income Tanzanians work in the informal sector making subsistence-level wages, taking an entire day away from work to try to visit a government office is a serious gamble. If they spend the time and money to travel to a government office, only to find that it is closed, or the queue snakes around the building, they risk both losing a day's wages and also not accessing the services they seek. People must weigh this decision very carefully, and access is never certain. As Sabina, a grandmother and street food vendor in Mwenge explained, "Government offices are poorly run. When you go there, you may wait for 4 hours and they say they are taking tea. Or they close early at 2pm while many people are still queueing outside. They go home, and they do not care that they have not served those who are waiting."

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Many access problems are also caused by the need for multiple follow-up visits, known as *fuatilia.* Most people know that when they are told to return “tomorrow” to pick up a birth certificate, it does not typically mean the certificate will actually be ready in one day unless they have an inside connection of some kind. So the question of how, when, and how often to follow-up is very stressful. As Ismail explained, when he tried to register his son and daughter, he felt a lot of distrust in the government. He had already paid more than Tsh10,000, but he had no guarantee of when he would receive his children’s birth certificates:

> I see that it's really difficult the way it is done now, when you have to keep going back to get the birth certificates. They could at least shorten the waiting time to 1 week. You go to the office and they take your money and then say "come back tomorrow, and tomorrow..." you can really lose hope. They already have your money, but how can you trust they will ever give you the birth certificates in return?

The need for repeated follow-up at unclear intervals also greatly reduces peoples’ chances of getting their children registered within the ostensibly free registration period lasting 90 days after the baby’s birth. Rehema was a very determined young single mother, who lived with her parents after having given birth at age 22. She had taken the very unusual step of returning to university to finish her engineering degree. When I met her, she was taking a break from studying her engineering books to feed her 9 month old daughter. Rehema had registered her daughter for free when she was only a month old, which she was able to do in part because of her high level of education. She had been so proactive about registering her daughter early because she had actually had a lot of problems getting her own birth certificate when she was a teenager preparing to enroll at university. She had to get a special letter from the local Magomeni government office, take it to RITA, and put together the Tsh20,000 for an adult birth certificate,

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which was a very drawn out and expensive process. She says she almost gave up hope, but persisted because she wanted to enroll in university. She reflected on the problems in the current system: "the problem is that the process now is very difficult. Whenever you go to the government office they will just tell you to come back tomorrow, and tomorrow, and tomorrow…they keep saying this and it makes you feel like giving up hope. It's very difficult to actually get the BC before 3 months when it is supposed to be free."

The discourse of "giving up hope" used by both Ismail and Rehema is very common, and can be interpreted as a moral rebuke to bureaucrats. Ashura, a mother of four, added that even arriving at a government office intent on registering, and then seeing the queue can dash one's hopes: "Parents are trying to register their children, because we know it is their right. But when we try to register at Kinondoni [municipal office] there are too many queues. There are so many people waiting, you see the queue and already you feel like giving up." Mariam, mother of two small boys added: "The birth certificate is good because it proves the child legally belongs to the parents. But getting the birth certificate is very difficult. At the office they say *njoo kesho* [come back tomorrow]. You feel you will lose hope, you feel so discouraged, it's true. The birth certificate is not a right if you can't get it."

Many people feel frustrated when they have to interact with the government, but for some people frustration turns into fear. This fear can take several forms. People who do not read and write confidently may fear embarrassment when asked to fill out forms. People who have not registered older children fear paying large fines, or being told off by officials for not having registered their children earlier. The greatest source of fear I found was among people who had lost their children's *tangazo* form, and were facing the intimidating prospect of having to go to

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court and swear an oath as to the child's identity in front of a magistrate, and pay extra fees to the court to receive an official letter. For most low-income parents who lose their children's *tangazo*, going to court and having a successful outcome is seen as almost impossible. One single mother from Kimara, Devota, told me about her fears. She had her son when she was 17, and they had recently moved to Dar so he could attend secondary school. Somewhere along the way she had lost his *tangazo*, and was now faced with a difficult decision. Should she try to go to court to get him a birth certificate? She was terrified by this prospect: "like many people, I am afraid of going to the court. I do not know how things work there." Having just recently moved to Dar, she had no family nearby who might help her, and she had no idea how she would save enough money to pay the Tsh20,000 late registration fee, plus whatever the court would charge her for an official letter. But Devota hoped that maybe her son would do well enough in school to take the university entrance exam, and she resolved that if it looked like he could go on with his education, she would do what she could to get him a birth certificate, even if it meant facing her fears and going to court. "I hope maybe he could get a scholarship, get a good job, and go and work overseas," she mused. "He will need his birth certificate for all those good things. It is his right, and it will help him in life."

I asked a young Tanzanian lawyer friend of mine, Steven, why people in Tanzania are so afraid of approaching the court system for something a minor as a lost *tangazo*. Steven explained the key barriers that prevent people from participating the legal system:

> Ordinary people here do not see the courts as a way to receive justice. They do not like our court system. Court is conducted in English, and the majority of people do not understand English at that level. They are not familiar with our laws, and they do not know what their rights are. Also, there is the tendency towards bribes. Our court system

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> is very corrupt. The police are also corrupt. People do not feel welcome to come to the legal system and ask for help.

Steven also noted another governance problem: requiring people with lost *tangazos* go through the court system wastes precious time in an overburdened legal system that should not be dealing with relatively small administrative matters like *tangazos*.

"The government must meet us halfway"

My conversations in different communities left me with a strong sense that people feel distanced from their government. People used several different themes to express their feelings of marginalization. One approach was to adopt traditional discourses of self-reliance, which somehow bore resonances of both Tanzanian socialism and neoliberal responsibilization. Other Tanzania scholars (Kamat 2009, Lal 2012, Ellison 2014) have remarked on the ways that people are adapting ideas about self-reliance to make sense of Tanzania's current neoliberal reality. Lal (2012) historicizes this shift in meanings:

> Over the course of the 1970s, self-reliance as a political maxim became dislodged from a concerted program of national development, and resurfaced as a catchword of international development discourse as well as an emergent set of neo-liberal policies since directed at much of sub-Saharan Africa. The pursuit of individual self-interest for cost-sharing purposes, in other words, displaced the ideal of self-sacrifice for a more ambitious project of nation building as the dominant political ideology in late twentieth-century Tanzania, as across much of sub-Saharan Africa more broadly (Lal 2012: 230).

Some people I spoke with condemned the government soundly, and emphasized the agency and self-reliance of parents. Hellena said, "Parents have to do everything for children themselves, the government does nothing. If you just wait for the government to help you, your children will not be registered. You have to go yourself and make sure it is done properly." This echoes Hamisi's

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advice from the beginning of this chapter, that "in order to get this right, you have to follow up. It will not just be given to you—you have to go and take it!" These ideas of self-reliance can be thought of as a kind of responsibilization or self-management idea in the vein of Rose (1989, 1999). While Rose has argued that his ideas about the neoliberal state and its responsibilization of individuals apply only to "advanced liberal democracies" (1996: 37), others have argued that ideologies of responsibilization and self-management have proliferated in many non-western contexts (Kipnis 2008, Foley 2010). However, there is a clear limitation of self-reliance as it concerns birth registration: people can follow up at government offices as often as they are able, and advocate for themselves as loudly as they can, but ultimately registration can only be done by the government—one cannot register oneself.

Other parents adopted a more measured discourse that placed responsibility for improving registration on both parents and the government. Yusef, Hamisi's second in command in the neighborhood of Magomeni explained it this way: "Many people say they don't have time to register and follow up, but they do not understand the importance of having a birth certificate. The government should reduce the fees and make the registration process easier so that everyone can register, but parents must also make an effort to be more involved in bringing up children well." This philosophy was notably shared by many grandmothers. Sabina argued:

> The government is making an effort, it is true. But sometimes they fail, and we as parents and grandparents must not blame the government, but instead try hard to help our children ourselves. Parents should follow up and get their children's BCs. They should not just keep quiet and wait for the government to do something, they should go out and get their rights.

Vonetta was a university-educated public school teacher whose husband also worked for the government. She critiqued the government strongly: "birth registration is the work of the

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government, it is their responsibility. Parents in our community are trying really hard to help children, but the government must meet us halfway."[9]

These discourses of suggest a deep ambivalence about the role and responsibilities of the government in peoples' lives: on one hand, people are justifiably proud of their strategies for self-reliance, and on the other hand, they are deeply disappointed in a government that they feel does not keep its promises. I discussed one such discourse, about health care that is "free but not really free" in chapter 4. Here, I discuss a second critical discourse that relies on a single word: *bado*. *Bado* describes something that has not happened yet, and which may or may not happen in the future. A kindly older Swahili teacher once explained the uses of *bado* to me this way: "for example, you may use *bado* when people ask you why you have not yet married and started your family." It can refer to something positive that you might hope will happen, but are still somewhat uncertain about if or when it may happen. As such, it is a very useful and flexible concept when applied to experiences of governance in a developing country.

At the end of every interview, I would ask people their views on what the government was doing for children in Tanzania. Were they making progress? Four out of five people responded to this question with the word *bado*. Common variations were *Serikali? Bado!* ("The government? Not yet!") and *Bado, bado kabisa!* ("really not yet!"). Use of *bado* expresses both a critique of the current state of the government, and a guarded hope for better in the future. For example, Fatuma said, "*Bado*. I have not yet seen the government give us much help. On TV

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[9] Notably, Vonetta was one of only three people who declined the small thank you gift I offered for participation in my research. The two other women to decline were also current or former public sector employees: another teacher, and a retired soldier. All three women felt it would be improper for them to receive a gift for participating in research that they saw as being in the public interest.

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they say they are helping, but many children are not receiving help yet." Even Bibi Salima, our somewhat curmudgeonly local leader in Mwenge, and a fairly staunch member of the ruling CCM party was open in her critique of the government:

> The government? *Bado*. There are many children roaming the streets here, they do not go to school. Instead they engage in risky activities such as drug use. There is no employment. People in the government get jobs through knowing the right people, otherwise it is very difficult to get a job.

Bibi Salima, born during colonialism, did not have a birth certificate herself. But even with her connections to CCM and the local government, she had some trouble registering her own children. She concluded, "the government must give the birth certificate at the right time, when the child is born, instead of making it so difficult for us to follow up. It's really a long journey to get a birth certificate."

Being seen by the state

The final governance discourse that people use when talking about birth registration concerns the idea of being seen by and recognized by the state. People seemed to feel that the state could see them when it was convenient for them to do so, for example when a street vendor is asked for a kickback by a policeman in order to occupy a certain space along the road. The census was another major modality for being seen by the state, and as I mention in chapter 2 the 2012 national population census occurred while I was conducting fieldwork in Mwenge, and was at times politically contentious.

Several people mentioned birth registration as being "like the census" in that it provided information to the government about the people. People generally seemed to feel that this was positive. As Monica described: "birth registration is good for children, but also good for the

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government itself. It helps the government to know exactly how many people there are and hence to plan properly for development." Hidaya agreed, and related this idea of being seen by the state directly to Tanzania's plans for children: "It's really true that birth registration is something good for children, and it also helps the government to know how many children there are in a neighborhood so that they can build more schools." Mary added, "birth registration is good, like the census, because it gives information about the people so that the government can make progress on our development."

However, other people made a distinction between the census, which was seen as solely benefitting the state, and birth registration, which was seen primarily as a benefit to individuals, and a recognition of their citixenship. When I resumed my fieldwork after the conclusion of the census, there was a bit of tension in the neighborhood when people saw Agatha, Flora and I walking the streets with our clipboards. We stopped at one house where a number of Muslim families lived one family to a small room. A woman peered out from behind the door and said, "No, we cannot speak to you. We have been told by our imam that the census is not good, and that we should not give information to the government." When Flora politely explained that we were not from the government, but were only doing some "small research" about birth certificates and children's issues, the woman at the door let us in, and I was able to interview five mothers who shared the house. As soon as they felt comfortable we were not from the government, the tension dissipated.

Before I began this fieldwork, I wondered if some people might be reluctant or even scared to register their children and grandchildren with the government. I thought perhaps elders might recall negative experiences of selective registration from the colonial era, and might be

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less interested in registering as a result. However, I could not have been more wrong about this. More than 90 percent of people I spoke with expressed a desire to register their children and even themselves, and viewed birth certificates in a positive light. One of the main disincentives to registering seemed to be that people dreaded the stressful and prolonged interactions with government bureaucracy required to register.

One reason that people wanted to register, and persisted despite the many difficulties it entails, was that they wanted their children to be formally recognized by the government. This was not about the authorities making children legible in a display of governmental power, as Scott and others might suggest, but rather it seemed to be about parents advocating for their children to be written down (*kuandikishwa*) and therefore legible to the government. Several people stated this explicitly. Husna explained why she was trying to register her new baby girl: "it's very important to be written down, and to be known by the government. It will show she is Tanzanian." People closely associated the importance of being seen by the government with a specific idea of citizenship rights. Although many parents had high hopes for the different ways a birth certificate might open doors for their children in the future, the other most common reason for wanting to register (given by 72 percent of people) was that people considered a birth certificate to be a basic right of being Tanzanian, and they wanted an official paper to show that they and their children were *Watanzania kabisa or Watanzania haki*—real or true Tanzanians. As Devota, the mother who was afraid of going to court to get her son's birth certificate said, "It is a question of whether the government will remember us, we the citizens of Tanzania." I explore this idea of birth registration as a citizenship right in the conclusion.

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This chapter demonstrates that viewing birth registration as a governance problem contributes to larger understandings of Tanzanian peoples' experiences of interacting with their government. I have shown that in contrast to previous studies which have theorized registration and documentation of persons as a potentially oppressive exercise of governmentality, many people value birth registration as a positive recognition of individuals as rights-bearing citizens. Even a study of the views of birth registration among black mothers in South Africa, a group that historically was targeted for surveillance and oppression by the *apartheid* state, found that these mothers had positive views of birth registration and aspired to register their children (Jewkes and Wood 1998).

As Szreter and Breckenridge (2012) have argued, birth registration is fundamentally from other forms of state surveillance and documentation in that it involves a reciprocal form of recognition between individuals and the state. However, I find that being seen by the state does not come easily, but rather requires patience and persistence from families. The agency that ordinary people exercise in attempting to register their children directly challenges the way that most NGOs and policy reports frame birth registration, as a problem of "invisible" people. Since the publication of the landmark *Lancet* paper "A Scandal of Invisibility" (Setel et al 2007), the predominant international discourse about birth registration has emphasized the invisibility of poor people (see also Andrews 2014). For example, UNICEF's current birth registration campaign states that "1 in 3 children do not officially exist" (UNICEF 2013). However well-intended, I would argue that this discourse of invisible children who "do not officially exist" is problematic on two levels. First, I would argue that it entails a kind of symbolic violence, in that it conflates being a person who is poor and marginalized, with being passive or not existing.

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These children may not have official identity documents, but they are of course very real to their families and communities, who struggle every single day to ensure their continued existence. I was very attuned throughout this research to whether people might use discourses of invisibility to describe the problem of birth registration, and not a single person described themselves or their children as being invisible. I would argue that wanting to be seen and recognized by the government is not at all the same as viewing oneself as invisible or passive. Second, the problem with this invisibility discourse is that it does not reflect the reality I have described in this chapter, which is that people are actively presenting themselves at government offices in order to try to ensure that their children are formally recognized. As Hamisi, the local Magoneni leader suggested at the beginning of this chapter, they are going and doing what they can to take their rights.

However, it is important to note that this process of recognition through registration is mutually constitutive. People can present their children to be registered, but the government must also do its part to recognize them by issuing birth certificates in a timely fashion. One key frustration I have detailed in this chapter, common to many poor people living under neoliberal systems of governance, is that people are expected to comply with new rules such as mandatory birth registration, without much corresponding increase in help from the government to make it easier to fulfill these obligations. People are willing to register, but they need the government to meet them halfway. Instead, people feel that the government sets them up to fail by making it too difficult to register, but simultaneously responsibilizing them and blaming them when they do not succeed. As Monica, a teenage single mother who had worked her way up to being a hotel

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clerk in Mwenge noted, “The government is now advertising birth registration on TV, they say it is good for children, but they do not give us enough help to actually get it.”

The question of how the government can help people to register successfully sparked many interesting conversations. In chapter 8, I consider the issue of how to improve birth registration from two key perspectives: parents, and employees of RITA themselves. Government employees in developing countries are often vilified, and blamed for many problems of governance. Chapter 8 begins with my visit to the national office of RITA (the Registration, Insolvency and Trusteeship Agency), where I explore the perspectives of government staffers who defy this stereotype. Instead, I find that younger bureaucrats are trying to repair the birth registration system, but find themselves constrained by limited resources and political will. I then share the many thoughtful, practical, and creative suggestions on improving birth registration given by community members, and consider the areas of common ground between ordinary people and government employees. These ideas about the possible futures of birth registration in Tanzania are further explored in the conclusion.

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Chapter 8

"We want to say 'Where were you all this time?' We have been here": RITA responds to its critics

> "You [the international community] should be aware of the challenges we face. Establishing a new system is always a challenge. But we are working hard to go from the bottom of the list to making Tanzania one of the most registered countries."
>
> —Patricia, Registration, Insolvency and Trusteeship Agency (RITA)

> "When every baby is born, it is weighed and the weight is written down. Why can't birth registration be just like that? It should be done automatically, and right away after every baby is born. This would make it much easier for mothers, rather than having to go away and come back again later."
>
> —Nasra, mother of 2, Mwenge

> "Why don't they just send the birth certificate home from the hospital along with the baby? If it's so important to have a birth certificate, why do they make you go around to all these different places to try to get it?"
>
> —Mwamini, mother of 2, Kimara

A visit to RITA

Although I lived less than a ten-minute walk from the national office of RITA, the Registration, Insolvency and Trusteeship Agency, it took months of polite, persistent inquires for me to obtain an official invitation to visit RITA and interview several employees of the birth registration department. Like any interaction with Tanzanian bureaucracy, arranging this meeting required writing a series of official-looking letters to the office of the director of RITA, which Agatha and I would hand-deliver every few weeks, along with copies of my research permits,

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copies of research grant letters from NSF and Wenner-Gren, and my CV and business card. We delivered the same materials to the same impenetrable bank of secretaries multiple times before I was invited to proceed to the next stage of the process, which involved submitting in advance a list of interview questions I proposed to ask the staff. After a few more months of following up on these materials, and a call from Agatha to a friend of hers who worked at RITA in a different department, I finally obtained an official invitation for a meeting at RITA, just a few weeks before my fieldwork was scheduled to end.

The many previous visits I made to RITA to submit and check on my interview request actually provided a wealth of insights into interacting with Tanzanian bureaucracy: submitting the same papers multiple times, interminable waits, unclear policies, annoyed and overworked staff. The key difference was that for me, the stakes were much lower than they were for ordinary Tanzanians. Also, by virtue of the fact that I looked so out of place there, it was never long before someone noticed me and asked why I was there, giving me an opportunity to interact. I also learned a great deal from Flora and Agatha about how women in particular are supposed to interact with government officials. They spoke very politely and deferentially to elders at these offices, and through displaying appropriate *heshima* or respect, they signified that we were serious and respectable people, and thus deserving of respect ourselves. We didn't always succeed with men, but we had very good luck in getting older women who are often gatekeepers in these offices to help us. However, if people do not observe the rules of *heshima* or become annoyed or aggressive, the outcome can be quite different.

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On one occasion when I was waiting at the desk of some of the senior secretaries at RITA for a few hours, I witnessed a telling exchange. An older man in a *kofia* (traditional Muslim embroidered hat) came into the office, where ordinary people were not supposed to go. He began yelling at the senior secretaries about how, yet again, he had waited all day to try to get his son's birth certificate. This was his third visit in a month, and still nothing had happened! "Are you people waiting for me to pay you something else? I have already paid! This is totally unacceptable! What are you people even doing all day?" The secretaries listened impassively to his tirade. Eventually he wore himself out, and seeing that the secretaries would not engage in debate with him, he began made his way back outside. "Sorry for you that this place is so bad!" was his indignant parting line. When he was gone, the secretaries looked at each other and shrugged. "Eh *bwana* [sir], sorry for *you,"* said one lady to her colleague. They shook their heads, and went back to their piles of paperwork. This scene illustrated for me the difficult positions of both bureaucrats and ordinary people. It is difficult to have to wait all day for a birth certificate; it is also difficult to be yelled at by angry clients like this man. The system is not working well, and everyone is sorry about it.

On the morning of my official appointment to meet with RITA officials, I dressed in my nicest fieldwork clothes and walked over to the RITA office. RITA's building is notoriously difficult to find. It is located in the old neighborhood of Upanga, once occupied primarily by Indian families, but now home to a diverse mix of middle-class inhabitants, including Africans, Indians and Middle Easterners, and foreigners. The neighborhood's main landmark is Muhimbili Hospital, but to get to RITA, one must walk past the hustle and bustle of Muhimbili, into the quiet and dusty warren of smaller residential streets that run behind the hospital. The way to

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RITA is marked only by a small, rusted sign bearing RITA's name first in English, and then in smaller letters, in Swahili (see chapter 2 for an image of the RITA sign). A tangle of weeds was growing up around the sign when I was there in 2012. I interpreted the size, language, and physical condition of the sign as a signifier of the lack of the relative lack of importance attributed to RITA. Certainly the signage pales in comparison to the Ministry of Health or the malaria research institute situated on prime real estate to catch the breezes on Ocean Road. As I note below, employees of RITA are acutely aware of their position in the hierarchy of Tanzanian bureaucracy. RITA's lack of clear signage in Swahili is also a problem for many people, as I describe in chapter 7. Many low-income people from outlying neighborhoods do not feel comfortable or especially welcome in the middle-class neighborhood of Upanga. The streets surrounding the RITA office are mostly comprised of private homes surrounded by high fences or walls with barbed wire. Some have guards posted who may tell people to move along. The lack of clear signage for RITA in Swahili creates additional barriers to accessing services, both because it makes the office more difficult to find, and also because it gives a distinct impression that ordinary people and non-English speakers are not especially welcome.

My meeting was scheduled for 7:30 am, several hours before the RITA offices would officially open to the public. But nonetheless, as I approached the gates of the building, a queue of people was already forming, some clutching plastic folders of documents, others with babies tied to their backs. A few late-model, slightly battered Toyota Landcruisers assigned to top RITA officials were lined up and ready for their first washing of the day by a few teenage boys with buckets of soapy water. I approached the front gate, which was opened just for me by the lone

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guard. I signed into the guest book (yet another barrier for people with lower levels of literacy), and then proceeded inside.

The RITA compound at this time was divided into two distinct zones. The main office was a modest three-story building, probably built in the 1960s. It had old-fashioned breeze-block stairways and corridors designed to help humid tropical aid circulate, though often with limited success. This relatively small building housed the offices for all of RITA's many functions, including not only registration of births, deaths, and marriages, but also matters regarding the formation, bankruptcy, and dissolution of businesses. I noticed that most people needed to receive permission from a guard to enter the main building. The second zone of the RITA compound was outdoors, and this was where ordinary people mostly conducted their business. There was a an open-air waiting area under a corrugated iron roof, furnished by a few slightly warped wooden tables, where RITA staff would set up their typewriters, papers, and stamps when the office was open. There were also a few old chairs and sagging couches for people to sit and wait, but the number of people queueing nearly always exceeded the number of seats available. A small kiosk in the shape of a Cola-Cola bottle sold drinks and snacks during business hours, to cater to those who would be waiting all day for their turn. There were no restrooms or other basic facilities for the public to use while waiting all day, another factor limiting access to services.

It was a strange feeling to be in the RITA offices before they opened for the day, everything seemed so empty and quiet. A few employees were already in the office, as many travel into work very early to try to beat the notorious Dar morning rush hour traffic. I greeted

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several of the more senior secretaries, to whom I had presented my documents on past occasions. They were having a breakfast of tea and *mandazi* or local donuts. The secretaries motioned for me to sit and wait, and before too long one of my contacts, Elijah, appeared and greeted me. We went up to the top floor, where we met Elijah's colleague Patricia, and sat down in the conference room for our interview. They had turned on the AC unit, one of the few in the building, and the room was icy cold, which in terms of Tanzanian meeting etiquette, was a nice gesture that indicated they took our meeting seriously, and had the seniority to use the AC when they wanted to. Elijah was an energetic young man in his late-twenties, wearing a starched white dress shirt and navy trousers. Patricia was a bit older, around my age, wearing a khaki pencil skirt, red blouse, and dressy four-inch heels. After a round of greetings, we got right into my list of interview questions.

As I discuss below, this interview at RITA was crucial in shaping my understanding of the problems of—and potential solutions to—birth registration in Tanzania. Local and national government officials are most often absent from most of the NGO literature about birth registration. When bureaucrats are discussed, it is often in a tone which implies their incompetence, or at least intransigence. However, I argue that this tendency in the international community to ignore the views and experiences of on-the-ground government workers tends to produce a partial and limited understanding of complex problems like birth registration. If birth registration is a governance problem, then it is important to understand the views from both sides of the bureaucrat's desk. In this chapter, I explore the views of RITA staff, their frustrations with the current system and their visions for how to improve it. I then compare their views with those suggestions for improvement offered by community members, and find that there are several key

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points of agreement between bureaucrats and ordinary people. Finally, I consider the implications of various changes that have been proposed to the system in the past few years.

In recent years, there has been a proliferation of ethnographic studies of bureaucracy and bureaucrats in the developing world, as I discuss further in chapter seven (Rottenburg 2009, Hull 2012, Gupta 2012, Bierschenk and Olivier de Sardan 2014). In certain ways, this approach goes back to Nader's argument in favor of "studying up" as well as down (Nader 1974), and also builds on Merry's work on translation and power in the realms of human rights and governance (Merry 2006 and 2015). Bureaucracy has been a particularly fruitful topic for anthropologists of Africa in the past decade or so, as ethnographers have sought to include the perspectives of government workers in order to better understand the impacts of development schemes and macro-economic policies. As Bierschenk and Olivier de Sardan have argued, the study of bureaucrats and bureaucracies is "a legitimate and productive object of anthropological enquiry" and a central but often neglected aspect of the anthropology of the state (Bierschenk and Olivier de Sardan 2014: 3). "African states, like other states, are made up of bureaucracies and public employees, and … their basic, banal, routinized day-to-day functioning, practices and strategies warrant the interest of anthropologists as much as warlords, smugglers and witchdoctors" (ibid).

When bureaucrats are represented in ethnographic literature, it is often as intermediaries or gatekeepers between the state and its citizens. Bureaucrats are sometimes depicted as being collaborators in or direct perpetrators of social inequalities. Kleinman, Das, and Lock suggest that ''bureaucratic responses to social violence intensify suffering'' (1997: x). Gupta uses the term "bureaucratic indifference" to describe the power relations between ordinary people and the

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state. However, he cautions that the structural effects of bureaucracies are often arbitrary rather than intentional, and that bureaucrats themselves are caught up in these structures. "It would be easy to adopt a cynical perspective on the motivations of state bureaucrats and politicians and blame them for perpetuating structural violence on the poor. Like any other class of people, bureaucrats sometimes fit that image" (Gupta 2012: 23). However, Gupta emphasizes that many bureaucrats who work with poor populations often share the frustrations of their clients about systemic failures: "Many hardworking bureaucrats were often frustrated by their inability to work effectively to bring about real changes in the lives of the poor people who were so often the target of government programs" (ibid). Low- and even mid-level bureaucrats in poor countries often face the pressure to provide many services with constrained resources, as I have discussed in chapters four, six, and seven. Working under difficult circumstances, some bureaucrats, as Gupta argues, may become indifferent to the suffering of their clients. However, what I concluded from my meeting with bureaucrats at RITA, was they were not indifferent to the fundamental problems of the birth registration. Rather, they expressed ambivalence about the immense task of improving the current system. RITA staff felt they were in a difficult position: Tanzania was increasingly being shamed for its low levels of birth registration, and RITA was facing pressure to improve the situation quickly. However, despite the increased pressure, the staff did not sense a corresponding increase in either political will or financial resources.

"Currently birth registration is not a high priority"

I began the interview by asking Elijah and Patricia what they thought ordinary Tanzanian people knew about birth registration. Did they understand why it was important? Both replied

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that they had seen a recent shift in awareness of birth registration. “At first people did not recognize the importance of birth registration. There was an amendment to the Births and Deaths Registration Act in 2009. It took us a very long time to make that change. Changing the law in our country takes some time,” explained Patricia. “Now there is a huge demand for birth registration, because people need birth certificates for university, primary school, employment, passports.” Elijah added an important caveat: although more people are aware of birth registration, the system itself is still difficult to navigate for many people: “Now they do understand why it is important, but the system of registration itself is still very challenging. It is difficult to go from the village to the district office, it may be 200 km away or more, and travel alone could cost Tsh20,000. For a service that costs Tsh3,500, many people say it is not worth the expense.”

Elijah and Patricia identified lack of staff, funding, and local offices as the key barrier preventing them from being able to improve registration services, especially in rural areas. Patricia explained that they had about 50 staff out of 140 working on all registration matters nationwide, not only births but also deaths and marriages. She said that although this was the largest aspect of RITA’s work, they had a disproportionately small staff to cope with all the registration requests. For example, she argued that far more people in Tanzania were having babies than opening registered businesses, but the business registration side of RITA had more resources. Lack of staff was particularly a problem outside of Dar. RITA has no dedicated staff members at the district level, and must rely on other local staff to process registration forms in addition to their other duties. I asked how they could possibly coordinate this work nationwide if they didn’t have any local staff. Patricia raised her eyebrows, signaling that this was a

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contentious issue. “Now and then we remind them, ‘you are supposed to do these registrations,’ but for them, registration is just a supplement to their other work. The district offices are supposed to perform this duty, they are responsible, but they say ‘registration is not our work, it is RITA's work.’”

Elijah explained that they did travel around the country to do field inspections when the roads were good and they could get approval for funds to travel. However, he estimated that “perhaps 50 to 70 districts can be visited in a good year, if we're lucky.” This is out of a total of 169 districts nationwide, many of which are rural districts that are not accessible during the rainy seasons due to road conditions. Elijah added that he would have liked to visit more districts himself, but “recently our government is financially challenged, so we have had to cut the field inspections further.”

Next, I asked whether they felt that the received enough financial support from the government. I wasn’t sure what kind of response to expect, but both Elijah and Patricia shook their heads emphatically. “No, absolutely not.” “We do not get enough support in the budget,” Patricia said matter-of-factly. “The government is not really interested in birth registration. I don't know why. There is a huge demand for birth registration, but the government doesn't see it that way. Our budget is around 500 million Tsh year, of which birth registration alone takes about half that. It is still not enough.” Elijah concurred, and added, “Even though they give us such a small budget, the government knows that RITA will do its work anyway.” I was very interested in the way that Elijah and Patricia spoke about “the government.” Civil service jobs such as theirs are highly coveted and difficult to come by, and they were clearly government

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employees. RITA is part of the Ministry of Justice and Constitutional Affairs. However, working in a small and marginalized government department made them feel outside of "the government" somehow.

Although one of the main complaints about the birth registration system is excessive fees, Elijah and Patricia argued that charging fees was necessary to generate needed revenue to augment their budget. "We may try to lower the late fees in the new system, but we cannot remove them entirely," said Patricia. "We need the fees in order provide funding for birth registration services." However, despite their own relative privilege as government employees, Patricia and Elijah were both very aware of the high financial barriers to registration faced by most Tanzanians. They cited distance and costs as the main barriers. Elijah offered a very insightful analysis of how families weigh these costs:

> In the rural areas, even if they have the *tangazo* already, they simply measure "what is the most I can afford?" Travel expenses to get to the district office are maybe Tsh10,000 one way, it is quite challenging for them.
>
> Even if the fees are low, the travel costs will not change. A parent may be willing to pay the fees for the birth certificate, but if the travel costs are more than Tsh10,000, they may say "should I pay this or spend the money to provide food for my child?" They cannot do both.
>
> Registration is taken as a supplement, something extra. Not a necessity. They simply get demoralized by how hard it is to register.

Patricia nodded in agreement with these examples. They were far from the stereotypical indifferent bureaucrats, and instead displayed a strong understanding of the difficulties faced by low-income and rural people. Certainly many Tanzanians in professional positions like these are responsible for supporting an extended kin network in rural areas. Elijah's analysis demonstrates

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a concept that Metzl and Hansen have termed "structural competency", referring to an understanding among people in positions of power of "the downstream implications of upstream decisions" that disproportionately affect marginalized people (2014: 128). Although Hansen and Metzl refer specifically to medical professionals in their article, I think the concept is quite applicable to bureaucrats in this case. I was particularly struck by Elijah's honest admission that people "simply get demoralized by how hard it is to register," which closely echoes the discourse of "giving up hope" used by many families.

However, Elijah's structural understanding was also tempered by a dose of bureaucratic responsibilization. He appreciated that the system was difficult, but he still wanted to challenge people to make more of an effort to register before the problem became acute. "People have a problem, and *then* they come and they want their birth certificate today. We want to say 'where were you all this time?' We have been here. We have been raising awareness, but it is human nature to wait until the last minute."

When I asked Patricia and Elijah about their ideas for how to improve the birth registration system, they expressed much enthusiasm for two projects they were currently working on. Patricia was part of a team working on lobbying the government to change and update the current birth registration law. Although the Law of the Child Act in 2009 finally made birth registration a requirement for all children, Tanzania's legal and administrative code still needed to be updated with details about the specific procedures to be followed. Patricia was very annoyed that the current law dated back to the colonial era, when so many other laws had already been updated for the post-colonial era. In particular, Patricia wanted two changes to the law: 1)

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to eliminate the *tangazo* and give the birth certificate at birth whenever possible, and 2) to change the law to allow staff in health facilities and local government offices to act as registrars, not only staff at RITA headquarters and district offices. Patricia reported that, "We are now engaging MPs through efforts at awareness and sensitization, so that they understand why the law must be changed. Our Minister is on board, we hope he will ensure we get priority. We hope the law will be changed by 2013." However, as of mid-2015, the law has not yet been changed. It may very well have been pushed aside by other legal and political issues seen as more urgent, including the ratification of a new constitution, and the 2015 elections.

The second major project they were working on, and the source of much hope and excitement, was a pilot project to improve birth registration services using a simple mobile phone-based system. The project was receiving financial support from UNICEF, the Canadian government, and the Tanzanian mobile phone company TIGO. When I met with Patricia and Elijah, they had recently concluded a successful field test of the new, simplified system in the Dar es Salaam neighborhood of Temeke, and were planning to start a full pilot in the rural district of Mbeya in 2013. The pilot involved several changes to the current birth registration system, including the removal of all fees for children under age 5, the simplification of the process from two steps down to one (eliminating the *tangazo*), and the availability of registration services at health clinics and local government offices, instead of only at the district administrative office. These were all much-needed and relatively low-tech interventions. But the aspect of the program that Elijah and Patricia were clearly most excited about was the use of mobile technology. The growing use of mobile technologies in development projects is a source of prestige and optimism, particularly among younger Africans, who are increasingly involved in

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creating their own apps and software for development projects (World Bank 2012). Under the new pilot birth registration system, instead of just writing the details of a birth in a hospital or clinic register, hospital staff would use basic mobile phones to text the data directly to a custom-designed database at RITA headquarters. For the first time in Tanzania's history, RITA would have access to real-time birth data from health facilities. Elijah explained that the improved data would not only benefit the government, but he hoped that by creating a searchable database, people who were registered under the new system who later lost their birth certificates could replace them more easily.

Despite his excitement about the project, Elijah also cited several potential barriers. First, the start of the pilot had been delayed because it was the rainy season, and the roads in Mbeya would be too difficult to travel. Second, and more fundamentally, the long-term sustainability of funding was a major concern. Elijah noted that "Tanzania is a huge country, and it will take a huge amount of money to implement this initiative in even one region. It costs 500 million Tsh [more than US$200,000] to establish the initiative in 1 region. What about the other 25? We have good support from UNICEF for this pilot, but when the pilot is finished, how will we continue? Our donors ask "What is the Tanzanian government contributing?" Elijah and Patricia knew that UNICEF would not fund the program indefinitely, and although the Canadian government has since contributed additional funding, it is still far short of what nationwide reforms would cost. Although this pilot was clearly welcome, and a source of optimism for RITA staff, it could also run the risk of being yet another casualty of the "projectification" of development aid, providing only a temporary solution rather than much-needed structural changes (Whyte et al 2013). Yes, registration rates in Mbeya would rise during the life of the pilot, but as Elijah worried, what

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about the other 25 regions? Elijah was also concerned with what he referred to as the "backlog" of unregistered people in Tanzania, both children and adults: "Every year, about 1.8 million children are born in Tanzania. If we are only registering 200,000 of them now, you have many more who go unregistered, and the backlog will increase each year." Elijah hoped that over several generations, this backlog could be reduced and finally eliminated, but he conceded that they had a very long way to go to reach that goal.

The pilot project placed a greater emphasis on registering children through the public health care system, rather than through local government offices. Given the perennially over-extended state of the Tanzanian public health system, I had some questions for Elijah and Patricia about how changes in birth registration would impact the already overburdened health system. Elijah explained the rationale for the new system's increased linkages with health services for children: "We want to remove barriers to birth registration. So, we realized that although few children have a birth certificate, more than 90 percent of children go to health clinics for immunizations. So we have got to catch them for birth registration while they are at the clinic for immunization, and the birth certificate will be given there for free until age 5. They will not go unnoticed in the new system."

This approach was one that also appealed to many parents. Although as I discuss in chapters three and four, many parents are dissatisfied with the public health care provided for children, the public health system is still the main point of contact between young children and the state. So the approach makes sense on several levels. However, I wondered if RITA had asked nurses how they felt about this new addition to their workloads? Elijah conceded, "It is

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true their jobs are difficult already. But they will only be registering those children who they are already taking care of, either who are being born, or who are brought for immunizations. The nurses are saying they have got a lot of work already, but [registration] work is taken as normal, and they have responded positively so far." I wasn't able to gain permission to interview any nurses involved with the pilot, but it will clearly be important to find out whether this addition to their workloads is sustainable.

In 2012, Tanzania announced an ambitious goal to register 80 percent of new births by 2018, up from a rate of 16 percent in 2010. I asked Patricia and Elijah if they thought this was possible. Patricia paused for a moment, and then responded: "Yes, it is possible if we continue with our new initiative. If we are able to establish the new system it will register children under 5, and then those over 5 also. Somehow, maybe fees can be reduced. In the new system, you will come, you will register, you will not go home without a birth certificate." However, despite the announcement of this optimistic goal, Patricia and Elijah still felt that birth registration was not a priority for the government, especially when compared with other competing initiatives to improve identification documents, such as the new national identity card, and the plans for biometric voter IDs for use in the 2015 election.

The irony, not lost on Elijah and Patricia, was that people needed birth certificates in order to prove their identity for the national ID card. Since the beginning of the national ID registration drive in 2012, RITA had experienced a major increase in adults seeking their birth certificates for this reason. I asked if this was putting more pressure on RITA, and Patricia confirmed that it was indeed the case, "but unfortunately our budget remains the same." Elijah

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argued that the reasons for the sudden focus on the national ID were largely political and external: “the national ID is a higher priority because of political pressure. Tanzania is the only country in the East African Community that does not have a national ID. It is required for regional economic integration efforts, so there is political pressure to get it done quickly.” They were clearly frustrated that this increased political pressure was not accompanied by a corresponding increase in political will.

After a few more minutes, we concluded the interview, and Patricia and Elijah went off to begin their work for the day. I was impressed by their candor and energy during our conversation, and also by their willingness to come to work a few hours early to share their views with me. I was also struck by the complicated discourses of frustration and optimism with which they discussed their work. In fact, it sounded very similar to the ways that community members spoke about birth registration. One of my favorite parts of my community interviews was asking people about what ideas they had for how to improve birth registration. While the majority of my interviewees had a primary school-level education, they offered many practical and creative suggestions, most of which were right in line with RITA and UNICEF’s own policy recommendations. Below, I list some of the most popular suggestions for improving the system.

“The government is too far away from the people”

Parents’ ideas for improvements fell into two broad categories: health system reforms, and governance reforms. The most commonly-requested change to the current birth registration system was to simplify matters by giving birth certificates immediately after babies are born,

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which is one of the key interventions in the RITA/UNICEF pilot project. In Tanzania's neighbors with higher rates of birth registration, such as Kenya and Uganda, this is the standard practice. Nur, a university-educated mother from Nairobi noted playfully that the system in her home country was far superior: "I'm sorry to say, I think you are a bit backwards here in Tanzania when it comes to birth registration. In Kenya they are free, and everyone must have one in order to get healthcare, or to do anything really." After she gave birth to her son in Dar, she said she was astonished not to receive a birth certificate, and she sent her husband, a middle-class businessman, to the RITA office every day for a week until he brought home her son's birth certificate. Being a foreigner herself, she was very anxious to have proper documentation for her son. She suggested that "all hospitals should have an office where you go to get the birth certificate so that it will be easier for parents to get it. They should give it to the mother before she is discharged from the hospital. That is what we do in Kenya. Here, it is much more difficult."

Besides Nur, many women without formal education drew the exact same conclusion. Many women liked the idea of a "special office" at health facilities for just this purpose. Then there would be no confusion about where to go to seek help with birth registration. "There should be a special department in every hospital where you go to get the baby's birth certificate before being discharged," argued Mary. "This would really make it much easier to get, so you don't have to go away and come back again and again." Mwamini agreed: "Send the birth certificate home from the hospital with the baby. If it's so important to have a birth certificate, why do they make you go around to all these different places to try to get it?" This image of bringing the birth certificate home with the baby was a popular one, implying a positive link

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between the baby and the birth certificate. Nasra compared birth registration with other forms of documentation of newborns that are already routine: "When every baby is born, it is weighed and the weight is written down. Why can't birth registration be just like that? It should be done automatically, and right away after every baby is born. This would make it much easier for mothers, rather than having to go away and come back again later."

For those women who give birth at home, offering registration through child health clinics, another part of the RITA/UNICEF pilot, was also popular among parents. Ingrid pointed out that "they ask the exact same questions of parents to get the clinic card, so why not just give the birth certificate at the clinic also?" For her, taking her children to the local health clinic was routine and familiar, if a bit annoying with long queues and lack of free medicines. But at least she knew what to expect at the clinic, whereas the idea of visiting the RITA office was stressful and intimidating because it was unfamiliar and she did not know what to expect. Parents also saw clinic visits as a missed opportunity to educate parents about the importance of birth registration. "There should be education at the prenatal clinic so that parents will know it is important," said Mwanaiddi. "This is a good opportunity: when children come to the health clinic, nurses should ask if they are registered yet."

Apart from expanding access to birth registration through the public health system, many of the suggestions parents made were smaller changes focused on two key aspects of governance: improving access to information, and reducing barriers to interacting with government officials. As I discuss in chapter 7, people often found it difficult to get accurate information about birth registration policies and fees. Rehema, a single mother who was trying to

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complete her engineering degree, was adamant that it was RITA's responsibility to educate the community: "RITA gives conflicting information about how to get birth certificates, it is very confusing. Correct information should be given to everyone. We the people, together with RITA, should make it easier for everyone to get BCs." Monica, a hotel clerk, pointed out that the government could run successful public education campaigns when the wanted to. She cited as an example that mass campaign to promote the census that was underway in her neighborhood of Mwenge when I interviewed her. A massive billboard proclaiming "Census for Development" towered over the Mwenge bus stop, bearing a collage of images of people from different Tanzanian ethnic and religious groups. Every public *dala dala* bus bore several bumper stickers promoting the census, and radio ads blared on every station, every day, for more than a month leading up to the census. Monica had a great suggestion that a similar strategy could be used to promote birth registration: "the government should focus on sensitizing mothers on the importance of birth registration. They should put up posters, and ads on radio and TV. They are doing it now for the census right now, why can't they also do it for birth registration? Very few people are registered. Perhaps more information would help us to improve."

In addition to providing accurate information on when and how to register children, the other key governance reform suggested was in the way that government workers interact with the public. People expressed frustration that they were not made to feel welcome in the offices of their own government. Lower-income people often experienced this as a class issue, and single mothers also felt judged or unwelcome. Caroline, a mother of three, was proudly patriotic, describing herself as "100 percent Tanzanian!" But she felt that her government did not recognize her with equal enthusiasm. She was one of the few parents who had managed to

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register all of her children on time, and for free. This was a point of pride for her. However, it had been a real struggle for her to do so. Caroline felt the government was too removed from the Tanzanian people: “The government? [laughs]. We have lost faith in our government, lost faith that CCM [the ruling party] will do much to help our children. The government is too far away from the people, but it is our government nonetheless.” Similarly, single mothers and sisters Miriam and Lydia said that they felt unwelcome when they tried to register their children. Lydia explained: “If you are not married, they can really make you feel ashamed that you have no name to put for the father. Government offices should be more welcoming when we try to follow up and get the birth certificates. Our children have the same rights as others.” Although, as Patricia and Elijah from RITA explained, they have little control over how government workers at the district level behave towards the public, RITA could consider adopting an official policy of non-discrimination against unmarried mothers.

A number of people mentioned that rather than going to government offices, they would prefer the government to come to them, *nyumba kwa nyumba* or house to house, and register everyone in the household at once. This idea was often raised during and after the census, when many people had the unusual experience of having government representatives come to their homes to collect census data. Those who had a positive experience with the census-takers welcomed the idea of more regular contact with government in this way. However, they imagined that house to house birth registration would be even better than the census, as they would not only provide information to the government, but also get something tangible in return. Donatus, a father of one, had mistakenly spent more than Tsh150,000 to register his four year-old son, having received misinformation that he was required to travel from Dar to his home

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village in Kagera, western Tanzania, in order to register him. When he learned that he could have paid just Tsh3,500 to register him in Dar, he was dismayed. Donatus hoped that in the future the government would register people at home, to save others the immense expense he had incurred.

Sophia, a mother of two, argued that house-to-house birth registration should be open to all family members, including adults: "The government should go house to house and register everyone, not only children. I myself would be very happy to be registered also." Justina pointed out that house to house registration would be a practical way to address the low levels of registration for children born at home. Although her eight year-old son was registered, she was not. She made the effort to register him because she viewed a birth certificate as "both a right and a necessity." Justina continued, "We would be thankful if the government made it faster and easier to get a birth certificate. They should go house to house so that everyone can be registered. Many children are delivered at home, they should be given a birth certificate right there in the community. I would like to get one myself, but it would probably cost Tsh30,000." Emelini, the father of four with the unusual "Lutheran" tattoo, also requested house to house registration for his whole family, himself included. Everyone should be registered "to avoid problems in the future," he explained. "But it should not only be for children, but for all citizens. People from the government and health sector should come to the community to deliver certificates, and they should be on time!"

The popular appeal of house to house registration is another signal that Tanzanian people do not consider registration a form of intrusive surveillance, but a positive form of recognition by the government. It would also be a great way to address Elijah's concerns about the large

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"backlog" of unregistered adults across Tanzania. However, given RITA's perennial budget troubles, this approach seems unlikely in the short term. People saw the census as proof that the government could extend its resources into even remote communities when needed, and this led people to imagine interesting ideas about other ways to use this power to help communities. However, people did not necessarily make a distinction between the census, as a once per decade special event which required extraordinary investments of technical and financial resources, and the everyday workings of government.

"So many things depend on birth registration"

While RITA employees and ordinary people usually saw themselves as being on opposite sides of the birth registration problem, from my vantage point, they had much in common: they were trying to cope with increasing demands for documentation in a changing Tanzania, but without additional financial resources or structural changes to help meet that demand. Clearly, both sides wanted improvements in the system, and were frustrated by the slow pace of change. When the initial results of the RITA/UNICEF mobile birth registration pilot project were released in 2014, they provided some hope. "Mobile phones will finally solve the problem of birth registration," read one local newspaper headline. UNICEF reported that the pilot study successfully registered 36 percent of unregistered children under age 5 in the Mbeya region in less than one year (UNICEF 2014). UNICEF and RITA announced plans to expand the pilot to a second region, Mwanza in north-western Tanzania, in 2015 (ibid). The years of work that Elijah, Patricia, and their colleagues had put into planning this pilot finally seemed to be paying off.

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Although I did not have any funding to allow me to observe the pilot, I tracked its progress closely in local Tanzanian media as well as reports from the project's funders. One Canadian government report quoted a mother in Mbeya who described the new system as "a miracle" (Government of Canada 2014).

It is easy to understand why the idea of mobile phones solving the problem of birth registration seems like a miracle to many Tanzanians, who have within the past decade experienced unprecedented and affordable access to information, communication, and services such as banking, all through mobile phones. Sixty-three percent of Tanzanians currently have access to mobile phones (World Bank 2012), and they are a cherished possession in many households. However, the much-lauded use of mobile phones in this pilot solves only one of two major problems with birth registration: it addresses the government's need for accurate and timely data on births throughout the country, but the use of SMS does not actually help get birth certificates into the hands of parents, a much more difficult problem without a ready technological fix. The certificates given out under the new pilot program are still hand-written or typed on a typewriter, meaning that they still rely on the basic structures of local government working properly: local government offices and health clinics must have staff who are present and trained to do the job of registration without asking for any "extra" incentives; they need electricity to charge phones, and paper forms and typewriter ribbons to fill out the certificates; and enough TIGO phone credit to keep all the mobile phones for the project functioning. None of these are ultimately technological problems, they are governance problems. When I discussed plans for the pilot with Elijah and Patricia, they were keenly aware of these problems. Like parents themselves, they were both excited about the project's potential to improve birth

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registration, and worried about how they would replicate its effects nationwide without additional long-term investments of funding and political capital.

Since I last visited RITA, the agency has come under additional pressure and criticism regarding birth registration services. In 2014, a member of parliament from the leading opposition party CHADEMA accused RITA of corruption, and said that they were illegally charging more than Tsh15,000 for birth certificates in her rural region of Manyara (Tanzania Daily News 2014). The Deputy Minister for Justice and Constitutional Affairs, Angellah Kairuki, promised that anyone caught charging unofficial fees for birth certificates would be prosecuted, and promoted RITA's recent successes in the Mbeya mobile phone pilot. Kairuki said the government's goal would be to increase birth registration of children under five to 20 percent by 2015 (ibid). An increase in registration rates from 16 percent in 2010 to 20 percent in 2015 might just be possible, but there is no data yet to confirm whether registration rates are trending up.

As Elijah and Patricia predicted, RITA also came under additional pressure to provide birth certificates to adults in order to help facilitate the national biometric ID card drive. Six months after I visited RITA, the *Tanzania Daily News* reported that a "scramble for birth certificates" was substantially hindering the national ID registration drive (Athumani 2013). Elijah seems to have been correct in his analysis that the Tanzanian government seemed to be trying to "leapfrog" straight to the newer technology of biometric ID cards, without repairing the older technology of birth registration first, and without considering the distinctly different purposes of birth certificates and national ID cards.

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Although this "leapfrogging" approach worked well with the telecommunications infrastructure in many developing countries including Tanzania (Horst and Miller 2006), the national ID project has encountered a major hurdle: in order to get the new national ID, people first need to prove their identity, which is difficult to do without a birth certificate. Over the past few years, staff at RITA have had to try to clear a decades-long backlog of unregistered adults, in order to facilitate the roll-out of the national ID card in time for the presidential election in October 2015. Despite this new need to register adults in addition to children, Patricia felt that birth registration was losing political ground the newer, flashier technology of the biometric ID:

> Currently birth registration is not a high priority, it is just normal. The national ID effort is given higher priority than birth registration, their budget is quite big compared to ours. But the national ID process depends on birth registration. If you don't have a stable birth registration system, other systems will not be stable either. So many things depend on birth registration. So we are under a lot of political pressure right now.

As Patricia noted, so many other things in life do depend on birth registration, both for families and for the Tanzanian government. However, as RITA employees struggle to improve the system, their parent ministry is considering raising the stakes for registration yet again. In 2013, Deputy Minister Kairuki, announced that Tanzania was considering passing harsh new laws designed to mandate registration by barring unregistered people from receiving some basic rights and services, including opening bank accounts and purchasing land (Simbaya 2013). Kairuki cited a recent official visit she had taken to observe the registration system in Bangladesh, which reports a birth registration rate of 95 percent. Citing Bangladesh's strict legal requirements to show a birth certificate to receive almost any public service, Kairuki argued that

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"our colleagues have succeeded because they have integrated all major services…without having a birth certificate you can't be given any other service" (ibid). Although this south-to-south approach to development policy is intriguing, Kairuki's proposal was missing a key element. As the majority of Tanzanians still face major barriers in getting birth certificates, this approach risks creating a large new under-class of unregistered people, or at least fueling a booming trade for *vishokas* offering forged birth certificates. It is possible that if Tanzania adopted this punitive approach to registration, they could face opposition from local and international human rights observers. However, as I mentioned previously, many changes to legislation in Tanzania seem to have been tabled until after the October 2015 elections, and the constitutional referendum.

In this chapter, I have explored the perspectives of RITA employees who are charged with improving the birth registration system. Elijah and Patricia proved themselves to be thoughtful, creative, and critical thinkers, far from the common stereotype of indifferent or incompetent African bureaucrats. Was it perhaps possible that RITA's directors had purposely had me interview their best staffers? Even if that was the case, the fact that Patricia ad Elijah were trusted to work closely with UNICEF, one of the most coveted international donors, demonstrated that they were valued members of the agency. If they were indeed the best, then I feel fortunate to have gained their perspectives. In line with recent ethnographic studies of bureaucracy, I have argued that understanding the often-overlooked views of civil servants is crucial to ethnographic analysis of governance problems. In comparing RITA's planned policy changes with ideas for improvement generated by community members, I have shown that despite substantial class differences between government employees and ordinary people, they share many of the same concerns, hopes, and frustrations about the birth registration system. In

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particular, both parents and RITA employees are concerned that the government seems to be increasing requirements for registration, without a proportionate increase in either political will or financial resources to make the needed system-wide improvements.

Although the early success of the RITA/UNICEF pilot is a hopeful sign, it risks becoming another example of technology as an "anti-politics machine" (Ferguson 1994), a technological fix that fails to impact larger structural issues, unless RITA can find a way to use mobile technologies to address both the governance problem of data quality, and the also rights problem of getting birth certificates into peoples' hands. In the conclusion, I consider birth registration as a rights problem: what kind of right is birth registration, and how might different understandings of this right impact future efforts to improve access to birth registration? It is fitting to leave the last words of this chapter to the hard-working RITA employees who are helping to drive this change. I asked Patricia what she wanted the world to know about RITA's work, and this was her reply: "You [the international community] should be aware of the challenges we face. Establishing a new system is always a challenge. But we are working hard to go from the bottom of the list to making Tanzania one of the most registered countries." When I left the RITA office, Patricia and Elijah's normal workday was just beginning. As I passed by the open-air waiting area on my way out of the compound, a queue of more than thirty people had already formed, waiting to try their luck with registration of one kind or another.

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Chapter 9: Conclusion

"It is our right as true Tanzanians": Citizenship, rights, and the future of birth registration

> "If you are a real Tanzanian, and not a refugee, the birth certificate is necessary to show you are Tanzanian. It proves your true identity."
>
> —Osmunda, mother of 6 and grandmother of many, Mwenge

> "Getting a birth certificate is a question of whether the government will remember us, we the citizens of Tanzania."
>
> —Devota, mother of 1, Kimara

> "Yes, birth registration is a right, but it's not a right if you can't get it."
>
> —Upendo, mother of 3, Magomeni

> "We must run while others walk."
>
> —Julius Nyerere, first President of Tanzania

In the fall of 2015, two events occurred that have the potential to significantly impact the state of birth registration in Tanzania. First, in September, the United Nations adopted the Sustainable Development Goals, which are intended to set priorities for global development by 2030. The SDGs include 17 goals, 169 targets, and 230 indicators (UN 2016). For the first time, birth registration was officially included in the global development agenda. Birth registration appears as part of Goal 16: "Promote just, peaceful and inclusive societies." Target 9 of Goal 16

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sets a global goal to “provide legal identity for all, including birth registration.” Birth registration is both a goal of SDG 16, and also an indicator or measure of its achievement: “Proportion of children under 5 years of age whose births have been registered with a civil authority” (UN Statistical Commission 2016). There is a persuasive argument to be made that birth registration of children is an inaccurate proxy for access to legal identity documents for people of all ages (Dunning et al 2015, Ladner et al 2014). However, the fact remains that, in less than a decade, birth registration has gone from being an orphan issue that was considered by some to be “the single most critical failure of development over the past 30 years” (AbouZahr et al 2007: 8), to being part of the global development agenda.

The second event that may bring major changes to birth registration in Tanzania was the October 2015 presidential election, considered to be the most competitive election in Tanzanian history. The election was also notable for its mostly successful roll-out of new biometric voter registration technologies, although controversies and allegations of vote-tampering in Zanzibar led to a nullification of the Zanzibar election results and outbreaks of election-related violence (Awami 2015). The ruling CCM party’s candidate, John Pombe Magufuli, was elected with 58 percent of the vote, the smallest margin of victory ever for a country where multi-party democracy is slowly developing. President Magufuli is known by his nickname “the bulldozer”, referring both to his previous government service supervising road construction projects as Minister of Works, as well as his reputation for being a hard-working and straight-talking official (Nesoba 2015). Magufuli was election on a platform emphasizing good governance reforms, fiscal responsibility, and tackling corruption and wasteful spending. After his election, Magufuli cancelled Tanzania’s annual Independence Day celebration, and instead spent the day literally

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and figuratively cleaning up the streets near the State House in Dar es Salaam. He also routinely makes unannounced visits to government offices to see how many civil servants are at their posts. Magufuli's actions sparked the creation of a popular and humorous Twitter hashtag: #WhatWouldMagufuliDo, and a new slang term, "Magulification," referring to efforts to improve public services or other aspects of Tanzanian life (Eyakuze 2016).

It would appear that RITA's birth registration services are another target of this "Magulification" of Tanzanian government services. In April 2016, RITA announced an ambitious new goal to increase rates of birth registration to 50 percent among children under 5 within 5 years, after pilot projects in Mbeya and Mwanza districts demonstrated that rapidly increasing registration rates was possible with the help of a new mobile phone-based reporting system (Rugonzibwa 2016, UNICEF 2014). While the Tanzanian government is especially proud of the use of mobile phone technology in the birth registration pilot, the announcement also stated that low-tech solutions such as supplying enough typewriters, paper forms and registration books to rural districts where electricity is unreliable would also be part of the new program. As he ceremonially handed birth certificates to parents at a government office in Mwanza, the new Minister for Legal and Constitutional Affairs, Harrison Mwakyembe, declared: "Tanzania is a shining example in children's immunization programmes in Africa. Why then can't we do the same in birth registrations? I challenge all the leaders in the region to work as a team and make this endeavor a success" (Rugonzibwa 2016). What will it take to ensure that Tanzania can meet its ambitious new goal of raising birth registration rates to 50 percent within five years? Below, I discuss key findings of my research, demonstrating the contributions that ethnographic and

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historical perspectives can offer to better understanding, and hopefully removing, the barriers to birth registration.

Data, development, and documentation

For the first time in the century since the German colonial government of Tanganyika enacted the country's first birth registration law, it would seem that ordinary Tanzanians, the Tanzanian government, and the international community are all in agreement that making birth registration widely available in Tanzania would be beneficial, both for the Tanzanian government and its people. By tracing the contested history of birth registration from the colonial era to the present day, I have shown that the meanings of birth registration have shifted considerably over time. While birth registration during the German and British colonial eras was viewed largely with suspicion, as a mode of population surveillance (albeit it a largely ineffectual one), the vast majority of parents and grandparents I spoke with viewed birth registration positively, and sought birth certificates for their children, sometimes saving up for months or even years to afford the fees.

However, while Tanzanian people, the Tanzanian government, and the international community agree on the end goal of increasing birth registration, I have found that these various stakeholders have quite different understandings of *why* birth registration should be improved. I describe these differing meanings and motivations as: data, documentation for development, and documentation for recognition.

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Data. The international community, including UN agencies, experts on indicators, child rights monitors, and researchers in fields including public health, child development, and development economics, have advocated for improved birth registration in the developing world because vital registration systems are a very valuable source of data about births, deaths, and health trends (AbouZahr et al 2007, Phillips et al 2015). In 2014, the United Nations established an expert taskforce called the "Data Revolution Group" which recommended the data sources for the list of 230 SDG indicators, including Indicator 16.9.1 which relies on birth registration data. While birth registration is a very popular indicator due to the relative ease of quantifying the act of issuing a birth certificate (Merry and Wood 2015), my research has also drawn attention to the concern that, in its hunger for data, the international community is focusing too heavily on birth registration as a source of data, rather than its equally important—or perhaps more important function, according to most Tanzanian parents—as a basic right for children.

Documentation for Development. With encouragement from the World Bank and other development partners, the Tanzanian government has focused in recent years on improving birth registration and other forms of official identity documentation, including the biometric voter registration used in the 2015 elections, and an ongoing and somewhat troubled effort to create a national ID card, as I describe in chapter 7. The "Identification for Development" movement posits the need for better identity documentation not as a basic political and civil right, as outlined in the ICCPR, but rather as a technocratic tool to promote economic growth and development, for example by increasing tax revenue (World Bank 2016). Tanzania's efforts to modernize its systems of identity documentation are part of its "Tanzania 2025 Plan" the goal of which is to become a middle-income country by 2025. While many of the parents I spoke with

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viewed birth certificates as a possible aid to future economic opportunities, such as university education or a job in the formal sector, economic development was certainly not the key factor motivating parents to try to register their children.

Documentation for Recognition. Rather, parents and grandparents valued birth certificates so highly because they symbolize official recognition of the individual by the state. I found that the most common reason cited for registering a child was that the birth certificate provides proof of Tanzanian citizenship, a deeply appealing idea especially for low-income families who feel forgotten or left out of Tanzania's rapid but very uneven economic transition. For many people I spoke with, a birth certificate is not seen as a human right, but rather as a specific right of Tanzanian citizenship, evidence that one is a "true Tanzanian," and a person worthy of recognition by the state.

While the cultural meanings of birth registration in Tanzania are rich and complex, it may actually be beneficial for birth registration to signify different advantages to the various stakeholders at the local, national, and international level who will all play a role in improving birth registration in Tanzania. The key question is whether the process will be a case of Tanzania "running while others walk", as in the famous words of Tanzania's first president, Julius Nyerere, or of the old Swahili proverb: "*Haba na haba, hujaza kibaba"* or "little by little, the jug is filled."

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