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Medicalisation and the Practice of Labour Augmentation in Mwanza, Tanzania

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Abstract

Since the late 1900s, maternal health has increasingly been medicalised as a result of growing global concerns about poor maternal outcomes. An example of this medicalisation process is the use of oxytocin for labour augmentation. This practice of administering oxytocin to shorten the duration of labour is increasingly questioned. Feminist scholars have often questioned the routine use of oxytocin, depicting it as unnecessary and as an inappropriate use of the drug that undermines women's autonomy and contributes to negative birth experiences. However, these feminist arguments overlook individual agency and the complex ways in which actors encounter and interact with oxytocin as a part of medicalised maternal care. Using the intersubjectivity framework, the study examines how oxytocin use is negotiated by women and healthcare providers in Tanzania. This study is based on eight months of ethnographic fieldwork that involved participant observation, a series of semi-structured in-depth interviews with women, and informal conversations with women and health providers who had experience with oxytocin during childbirth. The study shows that the use of oxytocin for labour augmentation is coproduced through intersubjective negotiations between women and health providers. Although it partially contradicts official guidelines, both groups view it as beneficial, thereby normalising its use and weakening the existing debate that portrays women primarily as subjects of medicalised care.

Keywords: *Medicalisation, Intersubjectivity, Labour augmentation, Oxytocin, Tanzania*

Introduction

Medicalisation remains a debated concept, with multiple definitions and implications across scholarly discussions and literature, including anthropology and sociology. Medicalisation is broadly defined as the process by which natural life events, such as childbirth, are redefined as medical problems requiring medical intervention (Conrad & Bergey, 2015; Van Dijk et al.,

2020). Medicalisation has been heavily critiqued as a form of social control that disempowers women by privileging medical authority over embodied knowledge and cultural understanding (Harlow, 2025; Mauadie et al., 2022; Wechuli, 2023). Historically, pregnancy was not considered a domain warranting formal healthcare interventions, however, the growing evidence of high maternal mortality and morbidity, together with advances in obstetric knowledge and practice, increasingly positioned pregnancy as a condition requiring medical attention in the 20th century (Rosenfield & Maine, 1985). Consequently, biomedicine reframed pregnancy as potentially pathological, unpredictable, and risky, therefore requiring expert monitoring of pregnancy and labour. A vast array of medical interventions was introduced to improve birth outcomes, thereby positioning medical authority at the core of maternal care. However, evidence also suggests that the routine use of technologies, surgical procedures, and pharmaceuticals during pregnancy and childbirth reflects a broader process of medicalisation, in which childbirth is increasingly constructed as a clinical event and pregnant women are positioned as patients subject to ongoing medical surveillance and interventions (Halliday et al., 2022; Mobarakabadi et al., 2015; Zeynep et al., 2020). This biomedical dominance in pregnancy and childbirth has been documented and scrutinised in sociology and anthropology (Martin, 2001a; Zola, 1972). Some scholars argue that medicalisation not only defines biological processes clinically but also exerts regulatory power over bodies and behaviours (Foucault, 1978; Thompson, 2003). Moreover, some scholars have highlighted how medicalisation has disproportionately disempowered women by subsuming their reproductive autonomy beneath male-dominated medical expertise (Van Dijk et al., 2020). We argue that these debates on the medicalisation of childbirth have often overlooked women's agency and the complex ways they negotiate different aspects of medicalised maternal care.

A central example of medicalisation in childbirth is the growing use of the synthetic hormone oxytocin (Pitocin) to shorten the duration of labour (Born Ontario, 2025; Ejekam et al., 2024). Oxytocin was introduced in the 1950s and aimed to reduce maternal mortality through prevention of postpartum haemorrhage and support of vaginal delivery through the induction and augmentation of labour (World Health Organisation, 2012). Existing guidelines suggest that the use of oxytocin for labour augmentation should be performed when there are clear medical indications for its need, such as evidence of prolonged labour, and when a physical examination has been performed to ensure that there is no abnormal foetal presentation or scarring of the uterus and that the benefits of using oxytocin outweigh all potential harms (United Republic of Tanzania, 2019; World Health Organization, 2014). The use of oxytocin carries significant risks, including foetal distress, uterine hyperstimulation, and, in severe cases, death resulting from uterine rupture and intrauterine asphyxia (Oláh & Steer, 2015; Payrastre et al., 2025). It is therefore highly recommended that oxytocin be administered in facilities with emergency obstetric capacity and that women are consistently monitored to prevent adverse outcomes (United Republic of Tanzania, 2019; World Health Organization, 2014).

The practice of labour augmentation is not new, and evidence from various communities suggests the use of a variety of herbal remedies to stimulate uterine contractions. However, this practice has been strongly discouraged in modern health care (Dika et al., 2017; Fukunaga et al., 2020). In contrast, the use of oxytocin for labour augmentation has expanded globally, often without adherence to recommended guidelines and often framed as "misuse" of oxytocin (Oliver et al., 2018; Reproductive Health Supplies Coalition, 2022; World Health Organization, 2014). In low- and middle-income countries (LMICs), including Tanzania, this

"misuse" of oxytocin beyond the recommended guidelines has been linked to the need to shorten the duration of labour and birth in the context of systemic health system constraints, such as understaffing and overcrowding maternity wards (Ejekam et al., 2024; Osaki et al., 2024). While guidelines exist on when and how oxytocin should be used for labour augmentation (United Republic of Tanzania, 2019; World Health Organization, 2014), gaps in monitoring, supervision, and documentation often undermine adherence to these standards, resulting in routine deviations from recommended practices (Ejekam et al., 2024). Within this existing scholarship, oxytocin "misuse" is therefore largely framed as a technical problem of inadequate monitoring and weak guideline implementation. From this perspective, strengthening monitoring systems and translating global guidelines into more context-specific protocols are commonly presented as key solutions to correct this "misuse" (Ejekam et al., 2024; Osaki et al., 2024). However, this guideline-centred logic risks overlooking broader structural and contextual factors that shape how oxytocin guidelines are interpreted and enacted in practice.

This debate on "misuse" supports the argument presented by some feminist scholars that women are positioned as disempowered subjects in medicalised childbirth (Khalil et al., 2023; Kidanto et al., 2007; Kujabi et al., 2024). Traditional feminist scholars, including Martin (2001), have significantly advanced the understanding of how medicalisation can reinforce structural inequalities and disempower women, especially in resource-poor settings. However, these feminist frameworks often emphasise oppression and structural violence while underexploring the lived, negotiated experiences of women, who may accept, prefer, or even embrace medical interventions as forms of care and protection. Applying Jackson's (1998) intersubjectivity framework, this paper focuses on the relational, embodied, and contextual nature of experience. It highlights how women actively engage with and reinterpret biomedical practices within their social and cultural worlds. By using the administration of oxytocin as an example, this approach allows us to move beyond the binary framing of medicalisation as simply oppressive or liberatory, revealing a more nuanced interplay between women's and health providers' intersubjective engagement with oxytocin use and its perception as a beneficial practice. Furthermore, the study aims to contribute to the ongoing anthropological debates that nuance medicalisation. Using the intersubjectivity perspective (Jackson, 1988), the study explores how women and health providers in Tanzania grapple with the use of oxytocin for childbirth, highlighting the complex relationships between biomedical authority, individual agency, and broader intersubjectivities. Specifically, it seeks to advance the debate by demonstrating how women's and health providers' experiences are intricately shaped by both subjective and intersubjective dimensions, in which the meanings constructed through biomedical knowledge and medicalised care are juxtaposed with, and sometimes challenged by, women's own intersubjective understandings. By using the negotiation of oxytocin use as a case, we argue that experiences of medicalisation are not monolithic but are characterised by a nuanced interplay of subjective and intersubjective factors.

Theorising the medicalisation of childbirth

The application of anthropological and social science theories to questions of health and illness can be traced back to Rivers's 1920s work, which pioneered the understanding of health and illness as integrated into social and cultural systems, a view later elaborated by other scholars (Bhasin, 2007). Another body of scholarship has focused on political economy perspectives on

health (*ibid*). Some of the most recent theorisations have been conducted by feminist scholars, who have focused particularly on how biomedical interventions render women passive subjects within patriarchal systems (Davis-Floyd, 2003; Ehrenreich & English, 2011; Martin, 2001b). Feminist critiques emphasise how obstetric authority often overrides women's embodied knowledge and reframes childbirth as a clinical procedure rather than a lived, relational experience. Such analyses have been foundational in revealing structural power and technocratic control in obstetric care. However, as Haaker (2024) noted, this critique often relies on binary models of dominance and resistance, ignoring the nuanced, relational dynamics through which medical technologies are interpreted and reinterpreted in practice. In these feminist accounts, agency tends to be understood as oppositional rather than as relational, pragmatic or situational.

Scholars have approached medicalisation as a social process (see, for example, (Whyte et al., 2002)). To further these scholarly debates, this study adopts the concept of intersubjectivity, as developed by Jackson (1998), to enhance understanding of women's subjectivity, embodiment, and agency during childbirth. Rather than viewing meaning as formed within isolated individuals, intersubjectivity emphasises how identities and experiences are co-constructed through embodied, relational engagement in specific social and cultural contexts (Jackson, 1988; Sambaiga, 2014). Jackson (1998) frames intersubjectivity as emerging from enduring modalities of embodied social interaction and dialogue, in which individuals are simultaneously subjects for themselves and objects for others. Similarly, Sambaiga (2014) demonstrated how individuals negotiate meaning through dialogical, embodied, and morally situated interactions, emphasising how intersubjectivity is felt and lived in shared bodily worlds.

Drawing on these insights, this study seeks to understand oxytocin use for labour augmentation as an intersubjective experience for both women and health providers. Women's experiences of oxytocin use, for example, are not reducible to biomedical authority or individual preferences. Rather, these meanings are co-constructed in everyday interactions with healthcare workers, other mothers, and within their communities. Furthermore, Jackson's (2007) notion of "thoughtless" intersubjectivity, in which shared understanding often arises from mundane interactions, helps account for how meaning emerges around childbirth practices. In this view, meaning is not always reflective or oppositional but unfolds experientially, socially, and bodily. This perspective enables a re-reading of women's engagement with oxytocin use as negotiated, relational actions woven into social worlds. For example, the communal valuation of oxytocin in Sengerema may arise not from deliberate ideological stances but from a tacit, embodied consensus built through shared narratives, labour experiences, and mutual witnessing in the clinical space (Jackson, 2007; Sambaiga, 2014).

Methods

This study draws on data collected by the first author (LM) between July 2024 and February 2025. The study was conducted in Sengerema District, Mwanza Region, northwestern Tanzania, where LM spent eight months conducting exploratory ethnographic fieldwork. Rooted in the anthropological tradition, the study employed ethnography to explore women's lived experiences with maternal healthcare (Madden, 2022). Participant observation, central to ethnographic research (Bernard, 1994), was the primary method of data generation. It was complemented by informal conversations and a series of in-depth interviews, as is commonly

employed in ethnographic work (Read, 2018). Throughout fieldwork, LM participated in women's daily activities in homes, community spaces and a dispensary and health centre where women sought antenatal, delivery and postnatal care. Participant observation focused on women´s pregnancy journeys, including care-seeking practices, interactions with health care providers, and decision-making around maternal care, labour and delivery practices. Observations also included one direct observation of oxytocin administration during childbirth, complemented by interviews, informal conversations, and observations of interactions and decision-making surrounding its use. The core category of study participants was pregnant women, and women who had experienced pregnancy and childbirth in the past year, as well as health providers from various health facilities that women visited. Ten women were purposively selected and followed throughout their pregnancy journeys, each of whom also had experience with oxytocin during childbirth. The initial recruitment involved five pregnant women identified by a local community health worker, subsequent participants were recruited via snowball sampling. The study participants recruited provided a grounded, experiential lens through which to explore perceptions of, practices of, and experiences with labour augmentation.

Guided by Read's (2018) approach to in-depth interviews, a series of semi-structured interviews with the same 10 women were conducted to capture women's perceptions, decisions, and experiences related to childbirth and medical interventions over time. All interviews were conducted in Kiswahili and recorded with participants' informed consent. The recorded interviews were transcribed verbatim to preserve the integrity of meaning. English translations were produced only for quoted excerpts. Furthermore, informal conversations noted down in a digital field diary were integral to the data, contributing rich contextual details. These notes were used to complement and deepen the interpretation of the interview narratives. Interpretation of the data began during fieldwork through daily reflections on observation conversations and interviews. Data analysis was conducted after the fieldwork concluded. This phase involved coding, during which codes and themes were identified and refined iteratively. Furthermore, detailed case narratives were constructed for each woman, providing insights that complemented and enriched the thematic analysis. Field notes based on observational data and informal conversations were used to provide additional case details and emerging themes. The data were managed in NVivo 12 and analysed thematically using Braun and Clarke's (2023) reflexive thematic analysis, which highlights the researcher's interpretive role and the contextual nature of meaning making (Braun & Clarke, 2023).

Ethical approval for this study was first obtained from the National Institute of Medical Research (NIMR), permit no: NIMR/HQ/R.8a/Vol. 1X/4176 and the Tanzanian Commission for Science and Technology (COSTECH), permit no: 2023-36-NA-2022-469. Furthermore, letters of introduction from regional and district authorities were obtained to facilitate access to health facilities and communities. A two-stage consent process was adopted, acknowledging ongoing debates around consent in ethnographic research. Initially, oral consent was obtained for participation in the women's daily activities, including permission from the household heads of the women's residences. Furthermore, written informed consent was obtained for all interviews, and they were audio-recorded. In instances in which some health providers declined to be recorded or formally interviewed, but agreed to participate informally, informal conversations were conducted, and detailed notes were taken after the discussions.

Confidentiality was maintained through the use of pseudonyms to deidentify participants. For additional privacy, the genders of some health providers have been altered.

Findings

In Sengerema District, Mwanza Region, Tanzania, where this study was conducted, oxytocin was colloquially referred to as *maji ya uchungu* (water of pain). The term derives from both the drug's mode of administration and its effects on the body. Oxytocin is administered intravenously through an IV drip containing normal saline (*maji*) and is widely associated with intense and painful uterine contractions (*uchungu*) that are induced during labour. In everyday Kiswahili usage, *kuumwa uchungu* refers to labour pain, whereas in Kisukuma cultural idioms, a mother is sometimes described as "one who has been through pain" (*aliyeumwa uchungu*), emphasising childbirth as an embodied and morally significant passage. While oxytocin is biomedically classified as a uterotonic drug used for labour augmentation, in Sengerema, it is interpreted as a socially meaningful substance whose significance extends beyond its clinical uses. For both women and health providers, *maji ya uchungu* is understood beyond its capacity to intensify pain and accelerate uterine contractions, and it is interpreted as a beneficial and standard of care that women receive. These meanings are negotiated between health providers and women.

The findings from this study show that the use of oxytocin for labour augmentation in Sengerema is shaped by a complex interplay between health providers' judgment, women's agency, and the intersubjective meanings produced through everyday interactions during childbirth. Although public health debates largely frame oxytocin in terms of safety and appropriate monitoring of women during labour and childbirth in Sengerema, oxytocin is used within their own experiential and social worlds, attributing to it meanings pertaining to the effectiveness and care expected in health facilities. As elaborated below, health providers participate in these meaning-making processes related to oxytocin use, drawing on both biomedical knowledge and an intersubjective understanding of childbirth. Taken together, these findings suggest that oxytocin use in Sengerema cannot be understood solely from a technical perspective; it is enacted through subjective and intersubjective practices in which biomedical guidelines, cultural ideologies of childbirth, and the relational dynamics between women and health providers converge during childbirth.

Oxytocin as a Means of Negotiating Risk, Resources, and Responsibility

Beyond the debate on the "misuse" of oxytocin, three major issues have emerged regarding the use of oxytocin from the health providers' perspective in Sengerema. First, it outlines the rationale for the use of oxytocin in Sengerema. Here, the study revealed that healthcare providers make decisions based on time and workload. Some health providers use oxytocin to avoid adverse pregnancy outcomes, whereas others use it simply to help women in situations where they think that oxytocin use would help them. Helena, a 19-year-old girl living with her parents, was in labour during the first author's household visit. LM escorted Helena and her mother to the health facility, where she was given oxytocin. The vignette below illustrates how Helena's labour was augmented.

Helena, her mother , and I arrived at the dispensary approximately 4 pm, as the health providers were finishing for the day and preparing to close. At the entrance, after a health worker named Salome asked why we were there, she instructed us to go to the next building,

which served as a labour room. There, she instructed Helena to climb onto a bed and explained that she would perform a physical examination. While Salome did this, she asked Helena a few questions, including when she had started experiencing labour pain (uchungu) and whether she had eaten any food that day. Helena reported that she had begun feeling uchungu that same morning. After the physical examination, a bag of normal saline IV fluid was collected, hung, and connected to Helena's arm. She then took a small vial, which she identified as oxytocin, and injected it into the IV, which was slowly dripping. Once she was done, Salome turned to me and explained that although Helena was in active labour, she had given her a bit of oxytocin to "speed things up". Shortly after, Helena's pain (contractions) began to intensify, growing stronger every minute, and by approximately 6 pm, less than two hours after arriving at the dispensary, Helena had delivered a healthy baby boy.

From the vignette above, Salome decided to administer oxytocin without explaining or consulting Helena. Later, Salome offered several justifications for why she had given Helena oxytocin when she was already in active labour. She explained that it was a matter of her own logistical considerations regarding her time: "*She is already in an active labour stage, but I will give her a bit of oxytocin so we do not spend the night here*". Salome remarked that her decision to use oxytocin was based on the fact that Helena had come to the facility past working hours, and the dispensary was open from 8 am to 3 pm only. Hence, she was already providing services beyond working hours and would not be compensated for the extra time. As the statement above shows, Salome was also concerned about spending the night at the dispensary. The other health providers left under the excuse that they were hungry, so if Helena's child's birth was delayed, she would have to help Helena deliver the child alone, and she was already tired and hungry.

However, Salome's decision to administer oxytocin to Helena was not solely based on concerns about time. A recurring narrative among health providers was concern for newborn safety and the perception that women were not fully honest about when they began feeling pain versus when they decided to seek facility care, often noting that labour pain began earlier than reported. Thus, the administration of oxytocin occurred in a context in which health providers made decisions on the basis of their experience with women and their culture, having lived with and continuously interacted with women over an extended period. For example, when commenting on the course of action that she took during Helena's labour and birth, Salome said the following:

Do you think they tell the truth when they come here? No, they do not. For example, that day, Helena did not tell the truth. It was not true that she started feeling pain at the time you were rushing her to the facility. Did you not see how little time it took before she pushed the baby? It was less than an hour. Now, in a situation such as that, if I had waited for labour to progress naturally, she might have ended up pushing the baby at 10 pm with an asphyxiated infant. Many women here have already been in labour for a long time (when they arrive at the dispensary), but they do not always tell the truth. That is why I told you I was giving her oxytocin, but I set it to go slowly. She comes here and is not honest about her situation. Just give her oxytocin; the most important thing is that both the mother and baby stay safe.

Salome trusted oxytocin to secure a safe birth for a mother and child in a situation where she lacked confidence in women's reports about the onset of labour. The uncertainty about the onset of labour, combined with her understanding of how labour should progress, spurred her

decision to administer oxytocin for labour augmentation. She explained that, in the dispensary, health *providers* administer oxytocin to prevent birth asphyxia, which can lead to bad pregnancy outcomes. On recounting how she once administered oxytocin on the basis of how she understood that labour progression should take place, she described the following:

A 16 year old girl arrived here a few weeks ago. After examining her, I had to give her oxytocin. She was too young and had been in labour for a long time already. They first arrived at approximately 11 am or 12 noon, but she was only 3 cm dilated. Since it was too early, I told them to come back later when she was in more pain, assuming she would be fully dilated. However, when they brought her back at 2 am, she was only 7 cm, which meant that her labour was not progressing well. Now, what would I have done in such a scenario? I decided to give her oxytocin so she would dilate faster and could push the baby.

Health providers were seen to face significant work-related dilemmas in Sengerema. They work in limited-resource settings where referrals are not always feasible and transportation to higher facilities is constrained. In such situations, oxytocin is perceived to serve as a tool to prevent risk. As one health provider recounted about one of the times they had to administer oxytocin:

That girl was very young, which means that her pelvic bones were not expanded enough; on top of that, she had already been in labour for a very long time. In addition, her mother said that she would rather have her daughter deliver at home because she could not afford to take her to the hospital (located in Sengerema town). Therefore, we had to step in to help her since she was already in labour. Fortunately, no complications arose.

The perceived need for action is intensified by the strong institutional and governmental pressure to reduce maternal mortality. As a result, health providers appear to negotiate the risks of using oxytocin against the recommended guidelines and the risk of birth asphyxia or stillbirth. This is illustrated by Salome's reflection on the case of a perinatal death that had recently occurred in the community. She explained how she thought administering oxytocin could have prevented the death:

That girl may have gone to the facility late (after being in labour for a long time) and did not get help on time; however, had she come here (to the dispensary) and I was around, I would have given her oxytocin and delivered her quickly.

On the other hand, the study presents observations that align with the argument that women are often disempowered in birthing situations and are often subjected to health providers' decisions about what is best for them and their pregnancy outcomes. What is shown below complicates this narrative by illustrating how women would expect to receive oxytocin even in circumstances when health providers consider it inappropriate, as a health provider named Katarina explains below.

Do you think it is simple to administer oxytocin? The problem is that women believe that when you give them a drip, it is oxytocin, but sometimes it's just other fluids to give them energy, since when they come here, they may have not eaten, and childbirth requires a lot of energy. However, when they return home, women narrate their experiences to others. So everyone leaves here and reports that they received maji ya uchungu and gave birth quickly... Their minds work in magical ways, as a result of this circulating narrative; when women come for

delivery, they request maji ya uchungu, and question why we have given it to other women. They even mention the names of women who recently gave birth, insisting that those women received oxytocin.

Katarina raised concerns about oxytocin and its use. She stated that women are illiterate and thus unaware of what takes place during childbirth. Hence, they may not understand that not every intravenous (IV) drip administered during childbirth is *maji ya uchungu.* Some women will ask for it based on their expectations, and some providers decide to administer plain IV fluids when clinical indications for administering oxytocin are absent:

Sometimes a woman may come and persistently request that they also receive maji ya uchungu, like for "mama xx", who delivered a few days ago, saying I also want maji ya uchungu. Therefore, you hang up any drip and let the placebo effect do the rest.

According to health providers, the women's perception or belief that they received *maji ya uchungu* may actually have expedited labour by reducing anxiety or aligning with their expectations. This observation raises important questions about mutual understanding between providers and patients, but, as we shall see below, women and health providers largely agreed on the usefulness of providing oxytocin and appear to be allies who share an interest in its use during labour.

Oxytocin as a Help and Standard of Care

Women's narratives and experiences further nuance this debate on labour augmentation and the "misuse" of oxytocin. The study revealed that women interpreted, negotiated, and engaged with *maji ya uchungu*, viewing it as a symbol of help, urgency, and quality of maternity care. The administration of oxytocin was often seen as *msaada* (help) and as an expression of *kujali* (care) by health providers. For example, Grace recounted how she received help and emphasised the role oxytocin played in ensuring that she had a live baby after being told "*mtoto alikuwa hashuki*" (the baby was not descending) during her last delivery:

When I got to the facility, the baby was still not coming. The nurses told me that my labour had paused, so they helped me by giving me oxytocin. Just one drip (dose) was enough; my contractions started immediately, and the baby came out. The nurses truly helped me.

The study revealed that, in some instances, depending on the communication that occurred during childbirth, women may view oxytocin as a necessary intervention to save their baby's life. Furthermore, such sentiment resonated in conversations with women about the care and help they perceived they had received during childbirth. Receiving oxytocin during labour was considered the norm and interpreted as a measure of quality of care, whereas women who did not receive oxytocin viewed their experience as not meeting the standard of care. When oxytocin was not administered at all or when referral to a higher health facility occurred without having tried oxytocin, women often felt like they had not received proper care and felt abandoned by health providers. This is illustrated by a remark made by Mama Emma (an older woman whose daughter had experienced perinatal death after prolonged labour): "*They already saw her day to deliver had arrived (past her estimated date of delivery), yet the baby was not coming. Why did they not help her (by administering maji ya uchungu) like they help other women?*"

Mama Emma complained about how her daughter did not receive appropriate help to have a vaginal delivery while she was already in labour, like other women did. After not receiving *msaada* (help), she was eventually subjected to a (late) referral to a higher facility where she underwent an emergency caesarean section and lost her baby three days after delivery. The study findings thus indicate that *maji ya uchungu* symbolises both appropriate action and proper care for the woman in labour. Conversely, women interpreted the absence of oxytocin as neglect, lack of help and care from health providers. Reinforcing the notion that biomedical action, particularly the use of oxytocin, in childbirth is essential for good maternal care. Rather than evaluating oxytocin through biomedical knowledge of its clinical use, women primarily evaluated it through their lived experiences of childbirth and their interactions with healthcare providers. Across narratives, oxytocin was interpreted as timely assistance, provider responsiveness and successful delivery. Consequently, the interventions became a marker of the quality of maternity care. Furthermore, women in Sengerema actively sought oxytocin to hasten the process of childbirth. They explained that it made childbirth more bearable, manageable, and timely. A few days after Helena gave birth, she shared the following thoughts about being administered *maji ya uchungu*:

Maji ya uchungu made the pain even worse, and I could not move because the nurse told me so. Even when I needed to urinate, she said I should do it there (on the bed). However, I believe it helped me deliver the baby faster. Considering that my husband's family was already trying to harm me (through witchcraft), it was good that I was not in labour for a long time.

Helena's reflection on oxytocin was not concerned primarily with reducing pain and limited movement while in labour, but she expressed deep concern over the lingering ill intentions of her husband's family and how she desired a short duration of labour. Other women in Sengerema expressed views on how they thought their child's birth would be incomplete without receiving oxytocin. For example, Tatu described her preference for oxytocin-related births with the following comment:

For me, a child's birth is not complete without receiving oxytocin (….) i would always ask health providers to give me maji ya uchungu; otherwise, I know I will just sit there and suffer, but the baby will not come.

Some women articulated their belief that oxytocin made childbirth possible, elaborating on the specific quantities they believed would be effective for them. For example, Tatu stated that she required two bags (IV drips) of *maji ya uchungu* for delivery. Healthcare providers corroborated this demand, as one healthcare provider noted during a conversation: "*Sometimes women come to the facility and want to give birth quickly, so they ask for maji ya uchungu, and you help them*." This highlights how oxytocin is requested and administered in response to requests from birthing women, demonstrating shared acceptance and strong belief in the effectiveness of oxytocin. These findings suggest that through repeated interactions with maternity services, oxytocin acquires symbolic meaning as evidence of attentive, effective and legitimate care. In this way, biomedical intervention itself became intertwined with women's understanding of what constitutes good-quality maternal care.

Discussion

Existing debates often frame decisions around the use of oxytocin for labour augmentation in the context of both the global north and the global south as predominantly provider-driven and

shaped by converging institutional pressures, infrastructural constraints and clinical judgements aimed at managing time and risk (Doula School, 2022; Ejekam et al., 2021, 2024). Our study findings partially align with this literature, as health providers continue to work within significant limitations while facing pressure to prevent adverse outcomes such as prolonged labour and neonatal deaths. However, this study nuances such accounts by demonstrating that oxytocin use emerges as a negotiated and coproduced practice shaped through interactions between providers' concerns for safety and responsibility and women's interpretations and expectations.

The way in which oxytocin is used in Sengerema reflects complex negotiations between biomedical guidelines, local clinical practices and competing responsibilities for maternal and neonatal outcomes. International and national guidelines stipulate that oxytocin should be administered only in well-equipped facilities with appropriate monitoring and access to emergency obstetric care(United Republic of Tanzania, 2019; World Health Organization, 2014). In practice, health providers in Sengerema operate mainly in primary-level facilities where such conditions are not fully met. Given these constraints, providers appear to administer oxytocin as a means of managing prolonged labour and preventing poor pregnancy outcomes, particularly the risk of birth asphyxia among newborns. Such practices appear to align with findings from other contexts, which portray oxytocin use as driven primarily by provider authority and institutional pressure (Nicol, 2007; Ranjbar et al., 2019). However, findings from Sengerema suggest that the decision-making process is more nuanced, with providers not merely administering oxytocin routinely but rather making decisions based on uncertainty about labour progression, including difficulties in assessing the onset of labour. Providers noted that women's reporting was always inconsistent and unreliable, thus complicating clinical assessments and increasing anxiety around responsibility for adverse pregnancy outcomes. Decisions to administer oxytocin are intersubjectively made within the context of epistemic uncertainty, where providers must balance incomplete information with their moral and professional responsibilities to ensure the safety of both mothers and newborns.

This negotiation became particularly visible in situations where women requested oxytocin despite the absence of clear indications. In such cases, providers did not simply comply with or deny women's requests but instead devised ways of managing women's expectations while avoiding what they perceived as unnecessary interventions by administering intravenous agents, highlighting how providers navigated the competing demands of care, accountability and safety rather than exercising authority on decisions. According to the examples in Sengerema, oxytocin use reflects a form of negotiated responsibility shaped by clinical reasoning and relational engagement with women seeking care.

Importantly, this study nuances the one-sided portrayal of "misuse" as purely provider driven or as justified by infrastructural limitations, as described in studies from Nigeria (Ejekam et al., 2021, 2024). While we do not negate concerns regarding (in)appropriateness of oxytocin use (Reproductive Health Supplies Coalition, 2022), it reveals a more complex reality in which providers' decisions are co-constructed through clinical logics, institutional pressures and women's expressed desires. As a result, oxytocin becomes a tool through which providers attempt to manage risks and responsibility rather than simply assume biomedical control.

The findings also suggest that women in Sengerema who receive oxytocin also interpret the drug as a form of help offered by health providers and an expected component of childbirth

care. This acceptance of oxytocin reflects its incorporation into the local understanding of what constitutes appropriate and effective care during labour. Furthermore, communication from health providers plays a significant role in shaping these interpretations. Women described being told that oxytocin would help save their baby's life, reinforcing the perception that oxytocin is a beneficial intervention. As a result, women came to intersubjectively interpret oxytocin with safety, care and successful childbirth outcomes. This reflects other parts of Tanzania where some emerging evidence suggests that the availability of oxytocin in health facilities is regarded as a way to attract women for facility deliveries (Mayumana et al., 2017).

These intersubjective interpretations contributed to the normalisation of oxytocin as part of standard care, leading women to actively seek it when in health facilities for delivery. For many women, oxytocin is considered essential to the delivery process. Women´s expectations became particularly visible when oxytocin was not administered, especially in cases involving adverse outcomes, prompting questions and doubts about the care they received. Our study found that women in Sengerema are actively shaping their expectations around childbirth. This active engagement reflects women's agency in medicalised childbirth practices, challenging the assumption that medical interventions are simply imposed upon unwilling subjects. Similarly, observations in other contexts where women are increasingly expressing a preference for medicalised interventions such as caesarean births in communities that historically value natural childbirth (Johansson et al., 2023; Mobarakabadi et al., 2015). The study shows how women selectively embraced oxytocin on the basis of what they perceived as beneficial; these observed demands and expectations nuance the notion of oxytocin use as being inherently provider driven and uniformly oppressive (Doula School, 2022; Reproductive Health Supplies Coalition, 2022).

Women's acceptance of oxytocin in Sengerema may be influenced by the resemblance between oxytocin and longstanding local practices of using herbs for labour augmentation (Dika et al., 2017; Fukunaga et al., 2020). The use of oxytocin takes this tradition into modern and medicalised spaces. Rather than presenting a departure from traditions, oxytocin emerges as a recontextualised intervention aligned with cultural logics surrounding labour progression and duration. The normalisation of oxytocin use in Sengerema further reflects shifting norms of maternal care, where a shorter duration of labour is not only expected but also often desirable by both women and providers in a context where women are expected to deliver at facilities, while the staff are often overworked and often not paid for extra duty hours. This further blurs the boundary between help and harm and nuances narratives depicting medicalisation as inherently oppressive. The findings also suggest that the cultural significance of labour pain itself remains intact, the local expression *kuumwa uchungu* reflects that childbirth is a socially and morally meaningful experience. Therefore, within this context, receiving *maji ya uchungu* does not replace the cultural significance of labour pain but becomes incorporated into the existing understanding of childbirth, further demonstrating how oxytocin use is negotiated rather than replacing existing cultural meanings surrounding labour and childbirth.

Some feminist scholars have long argued that pregnant bodies are increasingly becoming sites of medical control and resistance (Butler, 1986; Martin, 2001b). Critiques from the Global North often emphasise how medicalisation through interventions such as oxytocin continues to undermine women's autonomy and natural processes (Curran et al., 2017; Doula School, 2022). Findings from Sengerema suggest an intersubjective interpretation, in which oxytocin

is not merely a pharmacological tool but also a culturally meaningful intervention associated with care, trust, and general protection against perceived social dangers. Oxytocin has taken on significance beyond its clinical function, symbolising efficient and attentive care rather than operating as a top-down biomedical imposition. Thus, oxytocin has become integrated into local practices shaped by existing subjectivities. Therefore, the use of oxytocin reflects how sociocultural values and biomedical practices converge, reflecting a deeply ingrained perception of what childbirth should entail. Finally, this study portrays women's trust in oxytocin as sharply contrasting with the emerging global health literature and debates that prioritise natural birth and caution against overmedicalisation (Andal, 2020; Doula School, 2022; Romanzi, 2014). While such debates are often well-intended, there is a risk of overlooking local contexts and individual desires in settings where medicalisation is actively sought.

Conclusion

This study demonstrated that the use of oxytocin for labour augmentation in Sengerema cannot be reduced to a simple case of "misuse". While oxytocin is often administered in ways that diverge from existing guidelines, and can entail harm, the study shows how everyday negotiations between women and health care providers, grounded in intersubjective experiences of care, risk, and responsibility, shape its use. Both groups draw on embodied knowledge and shared expectations about effective childbirth when engaging with oxytocin. Rather than being imposed solely by health providers, oxytocin use is actively interpreted, accepted, and at times expected by women whose *maji ya uchungu* symptoms help, urgency, and quality of care. Health providers, in turn, draw on biomedical knowledge and contextual logic to justify the use of oxytocin in settings marked by uncertainty and limited resources. This study offers a nuanced contribution to debates on medicalisation and oxytocin "misuse" by demonstrating how meanings around the practice of labour augmentation are coproduced by both women and health providers. These negotiations lead to increased use of the drug despite the recommended precautions and its known risks.

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