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The maternity ward as mirror

Maternal death, biobureaucracy, and institutional care in the Tanzanian health sector

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Preface

After spending nearly an entire month in Dar es Salaam, Tanzania waiting for research and residency permits, I was finally able to set off for Sumbawanga, a two-day bus journey across the country, dragging over 200 pounds of luggage with me. I arrived in the beginning of February 2014, the rainy season well underway, and reported to the Mawingu Regional Hospital the very next morning. I stood up in front of the morning clinical meeting, nearly 100 hospital staff members staring back at me, to (re)introduce myself and explain to them my purpose for being in their midst. I was proposing to research maternal death, a subject often accompanied by resonances of blame and failure on the part of individuals, institutions, and the state. I explained the goals of my research in a way that emphasized the need for the voices and perspectives of healthcare providers, those who were working hard to provide pregnant women with life-saving care during emergencies, despite many challenges.

In less than three weeks after my arrival, we saw five maternal deaths on the maternity ward. I've reconstructed the following from my field notes from March 5th, 2014 in order to give a sense of some of the ways in which bureaucracy and institutional constraints appeared to be influencing the ways in which nurses and doctors were able to engage in care practices on the Mawingu Hospital maternity ward. Over the course of the following 15 months at the hospital, I began to unravel the complex intersections of history, geography, regional identity, state policies, political economics, biomedicine, and institutional and individuals' goals for receiving (and providing) care as these factors all influenced maternal health and death in the Rukwa region.

March 5, 2014 Wednesday

7:30am, Morning Meeting

There were 6 deaths last night: 3 on ped[iatrics], one on maternity, one in the ICU, and one on Ward 3. There was another serious, maternity-related case that came in around 5:30am and she has been admitted on Ward 8. The working diagnosis is severe anemia and heart failure. She was admitted previously on February 17th of this year due to a retained placenta. They performed an evacuation and she got two units of blood via transfusion. Her blood hemoglobin level (Hb) was 4 point something and an x-ray wasn't done (to look at her heart) because of an electricity issue. Dr. Fakhiri is saying that CCF¹ can be life-threatening and Patron says we will continue to review the case.

Patron is making several announcements this morning, including about washing all of the mosquito nets because the hospital has two full sets of good nets so they should be washed once per month or per every two months. He is now talking about the new trolleys in the storeroom and saying they are going to go to ICU, the theatre, ward 9, ward 3, and ward 5. There is going to be a meeting for the In Charges (nurses) with Patron and all the supervisors (everyone who rotates through Supervision), including theatre, tomorrow, Thursday at 10am, in the morning meeting room.

8:30am, Maternity Ward

I got to the ward and started trying to track down files for the women who have died. Today, working the morning shift, we have Kinaya, Martha, Lucy, Rukia, and Linda. I was in Kinaya's office and she had a list of the deaths from February that was sort of only half filled out. I was looking at it and started copying down some information. One woman, P.N., seems to have been

¹ Congestive Cardiac Failure

written down on the list as having died on February 7th from severe pneumonia but I'm wondering if that wasn't the woman who died right after I arrived, on the 17th, who had HIV Stage IV? Who knows if the name is even P.N. because the other woman's file says Jesca but her name was actually Joyce. Documentation is an issue here. Why? That is one thing I want to know. It seems like just a little bit more time and rigor would solve a lot of problems and save a lot of confusion. Is it possible the nurses don't think it matters? Or they don't care? Or there's just not enough time to fill everything out? Everyone deserves to have accurate information in their file and they deserve to be called by their actual name, not to mention it would make it easier to keep people straight. Dates and times are often confused. I've seen more than one place where Dr. Charles has only written "—am—" or "—pm—" without including an actual time, which makes it impossible to reconstruct an accurate timeline, which I think is 100% necessary for their own information and efforts at quality improvement. In the maternal death audit meeting last year that I attended they talked about documentation and staff members not recording times. I need to follow up with all the doctors involved in these cases and I need to figure out which nurses were working each of the shifts involved and try to talk to them.

9:56am

One patient came in with a retained placenta sometime early this morning, or possibly on the night shift, it wasn't clear to me when exactly she arrived, and had to have the placenta manually removed. Now, at 9:56am, Linda is telling Rukia that Rukia needs to help her in the post-natal room because the patient is still bleeding excessively. Linda also wants to take a blood sample to the lab and clean up the patient who didn't bring very many clothes with her. The woman appears to be sleeping, and Linda tells me it's because she's still coming out of general anesthesia. I went to help Linda clean up the patient, mopping up the growing pool of blood with

some of the woman's khangas she had brought with her, and whatever else we could find. The ward doesn't have much in the way of disposable pads or linens that could be used for this purpose so most times we have to use something the woman has brought with her. The woman or her relatives then have to wash these blood-soaked clothes by hand in the communal bathroom in the ward. Not very sanitary, for anyone involved. I worry about, not only the pregnant women, but their relatives getting infected with something. There are women with severe infections in the same room though they're in beds slightly separated from the other women who have already given birth. However, I think they all share the one bathroom off the room.

10:15am

Right after that incident, we got another woman (now 10:10am), Pascalia, who has started hemorrhaging after giving birth. She has a lot of clots still in her uterus and has lost a lot of blood. They are starting an IV and a catheter now, at 10:15am. Rukia was up almost to her elbow in the woman's uterus, trying to do a manual removal of any clots or bits of the placenta that might be preventing the uterus from contracting. And we don't have any gynecology gloves that go up to the elbow so she had blood well up her arm and certainly far beyond the extent of her gloves. She was desperately asking for antiseptic after she finished because of the blood contamination.

Things have calmed down a bit now so I am back in the office and looking around in report books to try to find out who P.N. is and whether and when she died and of what. It appears she was 25 years old, from Village I, and did, in fact, die on February 7th. However, the postnatal report book says that her cause of death was anemia. She had a C-section and had twins who both died. The woman I was remembering is named Rose R. S. She was also 25 and the report book doesn't say where she was from. She was admitted on February 12, 2014 and died on

February 17, 2014 at 9:40pm, so that was the first death after I arrived. It didn't say anything about the status of her pregnancy or even if she was pregnant. Maybe she'd recently had a baby? It's not at all clear from the book's entry. I tried to find her in the admission book on the antenatal part of the ward and I was absolutely unable to find her there. We seem to be having a particularly bad period in terms of death for the last month or so. I'm trying to collect this information about each of the cases so I can start trying to trace them but there are so many conflicting accounts in the report books and case files that it is rapidly becoming overwhelming and confusing.

According to the records in Kinaya's office, it looks like there were 28 deaths in 2013 (at least, but I can't tell if this includes those from ward 5 [gynecology]?) and maybe as few as 18 in 2012. According to the audit forms it seems like there were actually at least 19 deaths reviewed [in 2012] and I don't know if there were any more from ward 5 that should have been included. There were 4153 live births, per this count, for 2012, which makes the maternal mortality ratio (MMR) 457 per 100,000, about the national estimate. Using the same number of live births for 2013 and counting at least 30 deaths from 2013, we come up with an MMR of 722.4 for last year. The average age of those who died in 2013 is 25.4 years old. Just estimates but it gives me an idea of what's been going on. Also, it really makes it clear how questionable some of these data are, because it's unclear how complete the information is. I don't find much mention of any deaths from the gynecology ward but surely there are women admitted there because they are early on in their pregnancies. That ward gets cases of severe anemia in pregnancy or malaria in pregnancy, ectopic and molar pregnancies, as well as post-abortion complications. If women are dying from any of those causes they should also be included in these counts. Just by looking at

the paperwork available in the office right now it's almost impossible to tell if these deaths are or are not included in the totals.

11:27am

I wonder what is going to happen with Kija's baby, the woman who died yesterday. The poor thing is still just lying in the warmer in the delivery room and it is now 11:27 am. –Later I did see her relatives come to pick up the baby. It was a group of all men and they looked a bit forlorn carrying the can of baby formula. I had actually greeted one of the men earlier but not known that he was Kija's relative. Nurse Kinaya spent about one second explaining how to read the instructions on the baby formula can. I'm a bit worried the baby might not fare very well. Sometimes these babies whose moms have died get sent to the orphanage in town if there aren't any relatives willing to take care of them. I hope this baby will be OK.

I was chatting with a Dr. Happy from Africare over tea today and I mentioned my research. I said I've been very busy because we've had five deaths in just three weeks' time. She pretty much didn't respond at all. This lack of emotional response really seems common but I don't understand why yet. This is definitely something I need to think about and discuss more with the nurses and doctors. I would like to know more about their personal feelings in connection with these cases and how they feel immediately following the death of one of the women. Maybe this is a function of them being more or less used to a relatively high number of deaths and not feeling like it can be any other way? Or feeling like they tried their best with what time, supplies, and information were available?

I went to Ward 5 (gynecology) because I was wondering about deaths from there being included in the maternal mortality audits. I asked what tends to cause the abortions—a common cause of admission, and one of the main clinical causes of maternal morbidity—i.e. are they

spontaneous or induced. Nurse Sokota, here on ward 5, said the abortions are mostly induced and that healthcare workers at dispensaries will often do it, which can tend to be problematic because abortion is illegal in Tanzania. (This, then, is why Kinaya was talking about getting cases of imminent abortion from one particular dispensary and said the district or regional health offices should send someone to investigate there.)

1:15pm

I returned to find out that we're still continuing on with lots of work here this morning! It's now 1:15pm and we just received a referral from Laela health center. She's an 18-year-old primigravida with prolonged labor and she has now started having eclamptic seizures, at least once, if not more, so they referred her from Laela to us for further management. I think she is the one with whom Kinaya was working and was only speaking Kifipa with her because she didn't understand Swahili very well.

The nurses seem to be filling out partographs after the fact and more than just filling them, it seems they often start them after the woman has already given birth. Today it's really busy so that seems somewhat excusable but usually they tell me you should start it when the woman arrives, if she's in active labor already. I wonder what else prevents them from following this rule.

We are still waiting for Paulina I., the planned C-section from this morning, to come back from the theatre. I saw her when she was on her way there around 8:30 or 8:45am. Apparently, she started bleeding excessively and they took her back to the theatre to see what the problem was. Rukia said, "Shida za bleeding zimezidi leo! Shida zimezidi leo!" (These bleeding problems have been excessive today! They have been excessive today!)

1:45pm

We are still waiting to know, here on the ward, what the issue is. It's now 1:45pm and Lucy just came back. Paulina died. After taking her back to the theatre and opening her up again they took her to the ICU. Apparently, she lost too much blood and was O- and there was only one unit of O- blood, which came from the Red Cross's supply. She was in such good health too and the baby is alive, a beautiful 3.5 kg baby girl. Dr. Deogratus did the surgery and Lucy was also in the theatre, at least initially, to take care of the baby.

After receiving the news from Lucy that Paulina didn't survive the surgery, we were all talking about what happened. Rukia said this one, Paulina's death, really hurts because Paulina was so healthy, so beautiful. She had already agreed to have a BTL (bi-lateral tubal ligation) and now she has left three children. She had two previous scars from earlier C-sections. Rukia says, "*Tabia ya huku ni mwezi wa pili na wa tatu watu wengi wanapush.*" (The habit here is that in February and March a lot of people push [give birth].) I think we are all feeling Paulina's death to be particularly painful because she seemed so healthy and had absolutely no signs of any problems. Lucy said it was a problem with her blood hemoglobin level (Hb). I'm not sure if that's really what she meant or if she meant it was a problem with her Rh factor (negative)? Apparently, this death doesn't get written down in the maternity report book because technically she died in the ICU and as "transferred out" of maternity. I will try to learn more about the cause of her death from Dr. Deogratus who did the surgery.

I'm wondering about post-partum readmissions, like the woman on Ward 8 that they were talking about in the morning meeting today. Do any of these ever result in deaths and if so, are they included in the maternal death audits? Record keeping and maternal death surveillance

seem to be challenges here, but that's not terribly surprising given how busy the ward always seems to be.

2:15pm

The woman who was our referral case from Laela just had another seizure at about 2:15pm. She already gave birth to the baby. Her name is Magreth S., first pregnancy. Kinaya has really been intensively caring for her and was really helping her to push in the second stage. Kinaya let her be in a more upright sitting position for delivery.

Nurse Peninah says that every time someone dies like this it hurts a lot. She said some people say "*ujauzito si ugonjwa*" (pregnancy is not a sickness) and Rukia retorted, "*Nani anasema hivi? Mimba ni sumu!*" (Who says that? Pregnancy is poison!) Peninah responded, "*Ni kweli. Na ni vijana sana!*" (It's true. And they are really young people!) This was the first time I'd heard the nurses openly expressing their feelings about a maternal death, usually they don't say much.

According to Kinaya, Dr. Deogratus has already gone home so I can't try to talk to him about either this case or the woman who died last night. Dr. Deogratus spent most of the last week entirely alone on the maternity ward. There are usually supposed to be at least four doctors on the ward but two were traveling and one, well, I don't know where Dr. Benard was but, I didn't see him for almost two weeks. So Deogratus alone all this past week. Having only one doctor seems to be common so far, Dr. Charles was on call essentially 24/7, alone for almost three weeks and last month he once told me, "If you're the only one here, you're fucked. Either you die or they die," meaning the patients on the ward. In these cases they basically never had time off, so they are used to slipping out when things on the ward don't seem busy but, on a day like today, we need to be able to find Dr. Deogratus!

3:10pm

I was just thinking that for this most recent case maybe there wasn't much information that is useful for my study but actually, I do want to know about her blood work. What was done and did they have the results from the lab before she starting her surgery? It often seems that the lab work requests are taken well after the woman goes to surgery so they can't possibly know Hbs or blood type beforehand. Though, Paulina was a planned C-section so they've had since yesterday to get that all done. Early blood work is definitely not the normal routine. I want to try to get a full description from Dr. Deogratus and Lucy about what happened today. I still need to find Paulina's age, place of residence, etc. I'll try to get her file tomorrow. And, as an aside, it doesn't look like the two ward 5 deaths from February 2013 were included in the maternal death audit forms that I looked through but, those would bring the number up to something like 30 deaths for 2013.