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**The maternity ward as mirror**

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

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### **Part III: Maternal Death in Present-Day Rukwa, Tanzania**

### **Introduction to Part III**

In the following chapters I often refer to best practices, standards of care, “high quality” care, or standard protocols and operating procedures. The Mawingu Hospital, like the Tanzanian Ministry of Health, was influenced by and worked to adhere to national and international sets of guidelines related to providing care for pregnant mothers and newborns. These guidelines for best practice often were derived from internationally sanctioned, World Health Organization recommendations, which the Tanzanian Ministry of Health and Social Welfare (MoHSW) then took up and reviewed. Pending approval by their experts, the MoHSW would then reproduce these guidelines either in English or Swahili (sometimes both), affix the seal of the government of Tanzania as official endorsement, and then disseminate these recommendations and protocols throughout the country. This was one avenue by which the state continued to act as a gatekeeper for external interventions and continued to prove its vital importance in healthcare despite a landscape of increased projectification and the explosion of NGOs (see Geissler 2015). In one instance, a new poster appeared on the maternity ward bulletin board, illustrating the use of a new device. The poster did not bear this seal from the MoHSW and one of the nurses immediately became suspicious of those who were sponsoring the device, a conglomeration of NGOs. She picked up her cell phone and called a friend who worked in the Ministry in Dar es Salaam in order to inquire about the legitimacy of the project and ensure the women of Rukwa were not to be guinea pigs for an untested intervention of questionable origins. In the days thereafter, it became clear it was a legitimate project but her concerns were not unreasonable.

Nongovernmental organizations were often involved in suggesting or developing new guidelines or protocols. These would be based on evidence from international trials of devices or

drugs, such as with changing guidelines related to the use of misoprostol<sup>1</sup>, treatment of eclampsia with magnesium sulfate, and the more recent introduction of a device called NASG<sup>2</sup> for the management of postpartum hemorrhage. The MoHSW, together with USAID, Jhpiego, WHO, UNICEF, UNFPA, and other NGOs, developed a set of assessment guidelines related to Basic Emergency Obstetric and Neonatal Care (BEmONC). These guidelines are entitled *Standards-Based Management and Recognition for Improving Quality in Maternal and Newborn Care* (Tanzania MoHSW 2013). There was a version for use in hospitals and a separate version for use in the lower level health centers and village dispensaries. These are most often the standards of care to which I refer.

The role and influence of these standards and guidelines will continue to arise throughout the dissertation, as they have already permeated the chapters in part II, shaping women's and men's expectations of care, as well as their roles as biomedical subjects. As part of the global health development complex, these types of protocols, guidelines, and standards for care are the yardstick by which individual providers, facilities, regions, and countries are measured. Their deservingness for aid and investment, as well as proclamations about their individual and collective efficacy, is judged by an individual's, facility's, or country's ability to successfully implement and adhere to these measures despite widely varying access to resources—both human and material—as well as varying infrastructure and differing effects of geographic surroundings. Global health organizations and governing bodies often present these guidelines as the solutions to improving healthcare outcomes and reducing morbidity and mortality, including

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<sup>1</sup> Misoprostol is used to control or prevent bleeding by encouraging the smooth muscles of the uterus to contract after labor. International views on the use of misoprostol have changed from recommending universal use to now making it a second or third line drug for the treatment of postpartum hemorrhage, when other, more preferred drugs, are not available. Misoprostol can also be used to induce labor and is a common abortifacient globally.

<sup>2</sup> Non-pneumatic anti-shock garment, (Bixby Center for Global Reproductive Health 2009)

the deaths of pregnant women. While they are constructed as solutions, I present an alternative view of the ways in which these guidelines were nearly impossible to meet

I refer to these particular guidelines of best practice throughout the dissertation because the hospital staff members and other healthcare providers with whom I worked referred to them and aspired to provide care in full compliance with these guidelines. They were also measured against the *SBMR Tool* by outsiders and via internal, self-assessment activities. I am not a clinician and if I refer to the care that was provided as being of a low quality, it is always as compared to these guidelines that my informants were using or based on their views of the care they or their institution were able to provide, and not a result of my own personal judgments of the quality of care. Conflicts arose and providers sometimes became demoralized due to their inability to fully implement these standards of care due to a number of constraints that shaped their working and living environments in the Rukwa region during my time in the region from 2012 through 2015. Throughout the coming chapters, I demonstrate the ways in which it was oftentimes not even possible to implement these guidelines, let alone uphold them every day for every patient. I outline the pathways and social circumstances, as well as the institutional and systemic attributes, that contributed to making these standards an impossibility at the Mawingu Hospital.