The maternity ward as mirror
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Chapter 5: The Mawingu Regional Hospital Maternity Ward: Site of Care, Site of Violence

5.1 Introduction: Hospital Tour

The painted blue walls of the Mawingu Regional Hospital compound usher people into Sumbawanga Town, located on the Ufipa Plateau, approximately 1200 kilometers from Dar es Salaam. The large plot of land is the same one on which the hospital has sat since at least the 1920s when the “hospital” was no more than a few dilapidated buildings badly in need of repair, far away from the nearest British colonial outpost in Tabora some 600 kilometers to the northwest. At that time, the hospital was headed by an Indian Sub-Assistant Surgeon and these men were eventually rotated out on a yearly basis. The officers in Tabora cited the remote location and “lack of an Asian or White population” as reasons why healthcare providers were reluctant to accept posts in, what was then called, Ufipa (see chapter 3).

Now, the Mawingu Regional Referral Hospital has grown to be a conglomeration of numerous buildings, the oldest of which dates from the 1970s, according to the collective memory of the hospital staff. The blue outer walls of the compound sport the faded white outlines of the Vodacom logo, a telecommunications company which, at some point, had most likely sponsored the fresh coat of paint in return for this free advertising. However, as an extension of the government, the regional hospital compound was not allowed to display sponsorship of this sort and the walls had been scrubbed, leaving behind the faint ghost of the company logo.

Coming from my house to the hospital, I passed the district offices, turned left at the post office onto another road that hosted a waiting area for patients’ families, some concrete benches with an aluminum roof that provides shade during the dry season and shelter from the wet in the
rainy season. Here, relatives waited for the hospital’s visiting hours, which happened three times per day for approximately one hour each. Some people passed the entire day in this waiting area, having come from a village and lacking a place to stay in town or any relatives with whom to pass the time when they were not allowed inside the hospital wards. This waiting area could sometimes act as a litmus test for the state of the hospital. If I passed relatives crying or if there was commotion in this area, I nearly always could expect to hear reports of a death or some other extraordinary event when I sat down in the morning clinical meeting. Near the hospital walls were a number of billboards sporting public service announcements related to health. One that was in place for several years, until a strong storm blew it down, notified passersby of the symptoms of tuberculosis. Another, visible from inside the hospital walls, advertised the availability of family planning, proudly showing off the green star used countrywide to indicate the availability of these services at a facility.

Security guards manned the gate and occupied a guard house, which consisted mostly of empty rooms, a couple of broken chairs, and a telephone. Usually there were between two and four guards at the main gate, depending on the time of day or night. The guards were responsible for ensuring relatives did not roam about the hospital at unsanctioned times. They also inspected all cars for stowaways, ensuring that no patients left the hospital without the proper receipts confirming payment and their discharge cards signed by a doctor. Despite the fact that most of them knew me, my car was also subjected to search, particularly when I would leave in the middle of the night shift. The guards would ask me to turn on the interior light or open the door so they might look inside the back seat and the trunk to ensure I was not smuggling any patients out of the hospital.
Once past the guards at the main gate, I was confronted with the hospital compound opening up in front (Fig. 5.1).

Fig. 5.1 View of the Mawingu Hospital

A dusty turnaround cum parking area in the dry season, it turned into a muddy and cratered expanse during the region’s long rainy season. A sign announced that I have arrived at the Mawingu Hospital and listed the departments to be found within. To the far right side of the compound was a meeting hall, used for the morning clinical meetings, which were similar to grand rounds, which take place at many hospitals. In the morning meetings the hospital staff members gathered to hear reports on the state of the hospital from the previous 24 hours, including the number of patients (bed state), the number of deaths, admissions, and discharges, as well as a report on the money collected and spent. They also discussed particularly difficult cases in order to decide on subsequent treatment and they also presented cases in which a patient
had died. The Medical Officer In Charge presided over the meeting and it usually ended with any announcements or, occasionally, a continuing education session.

This hall was also host to other meetings, as well as parties, and trainings. Behind the hall, was the hospital canteen, complete with small kitchen and the toilets which served those eating or participating in events in the hall. To the left of the hall was the hospital’s administrative block, a low compound in a U-shape, housing the Medical Officer In Charge, the hospital secretary, a couple of doctors’ offices in which they held consultations or weekly clinics (such as diabetes or gynecology clinics), employees of a couple of non-governmental organizations that had partnerships with the hospital, an information technology person, and a few regional administrators who did not have office space in the Regional Administrative block on the hospital grounds. This included the Regional Reproductive and Child Health Coordinator (RRCHCO) and her deputy. To the left of this block, was the Out Patient Department (OPD), the point of entry for nearly all patients, except those who may have been going straight to the laboratory or the maternity ward.

To the left of the OPD was the Regional Administrative block, which housed the offices of the open registry, the Regional Medical Officer and his secretaries, the Regional Health Secretary, the Regional Nursing Officer, the hospital accountant, and the Regional Environmental Health Officer. The open registry housed the personnel files of all of the hospital employees. Next door to this building was the dental department. Finally, back near the guard house, was the medical records department, which was a small, two room building with an office and shelves upon crooked shelves of thousands of medical charts and files.

Passing through the main door to the OPD, I had to pass the cash office where there was often a line of patients or relatives waiting to pay the fees that were required at various steps of
the hospital visit or stay. Chipping paint in the uniform colors of government health facilities in Tanzania: a pale yellow on top and a bright blue from waist level down to the cement floors, spotted the walls of the OPD. The OPD itself was a narrow waiting room with several wooden slat benches on which patients and those who accompanied them would wait. The benches were arranged in front of the doors that opened onto the small doctor’s rooms. Patients usually jostled each other through the narrow doorways, barely waiting for a patient to emerge before trying to elbow their way through the entryway, eager for their brief visit with the doctor after what was often hours of waiting. This area of the hospital could be particularly crowded and hectic but was also supposed to be the first stop for any emergency cases, because the hospital lacked an emergency department.

The OPD also included a small room designated as the minor theater where minor surgeries, such as cleaning and suturing small wounds, could be performed. At the end of the OPD was the pharmacy. A painted iron lattice separated the pharmacy worker from the waiting patients, relatives, or hospital staff members. Papers and medications were passed between these parties through the lattice or via a small opening at the level of a wooden ledge that served as a counter, well worn by elbows and hands. A doorway near the pharmacy led out into the hospital compound. Straight in front, as I exited those doors, were toilets for public use, pit latrines in a small building. To the left of that building, the district medical offices, and then the pharmacy store rooms from whence hospital staff requested and retrieved supplies and medications for use on their wards. From this vantage point, I could also look out over the yard, past a large and flamboyant poinsettia, to the hospital kitchens and, behind that, the laundry and mortuary.

At the opposite end of the OPD was the doorway to the rest of wards. The Mawingu Hospital was structured like many other hospitals in tropical countries that were built in a style
derived from colonial hospital plans, meant to facilitate the flow of air and patients, preventing dangerous miasmas (Chang and King 2011). The different wards were offshoots of the main walkway (Fig. 5.2). You turned off the main walkway and then entered each of the wards. This walkway was the same cement as the rest of the floors of the hospital, in some areas cracked or chipped, other areas smooth and polished. For some time, the only portion of this walkway connecting that wards that was not covered by an aluminum roof was the piece that connected the rest of the wards to the maternity ward, one of the buildings that the hospital administration had most recently completed. The eventual construction of this last piece of the roof made an enormous difference and provided shelter from rain and sun for both patients and staff members as they moved between the maternity ward, laboratory, ultrasound room, the major operating theater, and other hospital wards, sometimes pushing heavy gurneys or carrying paperwork and blood samples.
The oldest wards consisted of individual rooms, barely large enough for a twin bed, chair, and small cubby, which also served as a table. Most of the wards were simply long open rooms, some of which had cubicles around every two beds, as well as two small rooms for the nurses. The nurses usually used one room for official purposes, such as filling out and storing paperwork, storing essential medications and files, or consulting with patients or relatives in private. The other room was generally the nurses’ changing room which they might also use for tea breaks during the work day or a place in which to exchange gossip, money, wedding invitation cards, conduct side business (such as selling water, snacks, or secondhand clothes) or discuss private issues. The pediatric, maternity, and psychiatry wards were each singular in their layout and design. Since the hospital built the maternity ward and moved services into that location in 2011, pediatrics has been housed in the ward previously occupied by maternity. This meant that pediatrics was a much larger ward than the others, with several connected rooms composing the larger whole. This made privacy easier, but also made it slightly harder to monitor patients from a central nursing station. The pediatric ward was almost always full during my fieldwork period.

Maternity, the major operating theater, and the laboratory were the newest buildings when I arrived first at Mawingu in 2012. As of May 2015, the hospital administration was not, to my knowledge, considering any imminent additions to the hospital, preoccupied as they were with maintaining the existing infrastructure and procuring enough supplies to keep the hospital running. However, wards such as maternity and pediatrics were in need of further expansion. The increase in the number of women who were coming to the regional hospital to give birth had already outpaced the physical capacity of the ward and limited the care women were able to receive and providers were able to give. The number of admissions far outpaced the number of
available beds, which often led to women lying two, or even three, to a bed. The only place in
the maternity ward where this was not allowed was in the labor room. An increase in clients
without the concomitant increase in investment, budgeting, and infrastructure had dire
implications for actors at all levels.

The Mawingu Hospital also had a private ward, called Grade I, for which patients paid
higher prices out of pocket or, if they had it, were paid for by their insurance. Grade I was set
slightly apart from the other wards, though still connected by the same covered walkway. You
entered the door and immediately found yourself in a dimly lit hallway, a shock after the bright
sun outside. The entrance was opposite the nurses’ station and on either side were individual,
private inpatient rooms. Passing through another door to the left of the nurses’ station, it was
possible to walk out into the rest of the ward, which was arranged in a square around a central
courtyard type area, full of trees and flowers. The general feeling was one of verdant
peacefulness. The whole area had a feeling of being less harried and calmer than the other wards.
Patients quietly queued up outside the doctors’ rooms, the pharmacy, the small lab, or the records
office. Grade I was the larger hospital writ small in order to provide faster and more personalized
services to these clients who brought in more revenue for the hospital.

Leaving Grade I, you passed the X-ray department and the ultrasound room, moving on
past old storerooms and the newer psychiatry building. The psychiatry ward never had any
patients actually in the building but was the home to a psychiatric nurse who also assisted with
social work cases. When the hospital hired a new obstetrician/gynecologist in May 2015, his
office was in the psychiatry building. Finally, you walked down the now entirely covered
walkway to the maternity ward doors. After walking through the main doors, you faced the ward
arranged in an outer square around a center area which included greenery and small trees, as well as the Nurse and Doctor In Charge offices (Fig. 5.3a, b, c).

![Fig. 5.3a](image1.jpg)

![Fig. 5.3b](image2.jpg)
5.2 The Maternity Ward

The Regional Hospital’s maternity ward is the top level of care in the region and therefore serves a catchment area of more than one million people. The maternity ward saw an increase in the number of births from 4,153 in 2012 (PMORALG 2015:12) to 5,825 in 2015 (ward monthly report books). This amounts to between 450 and 600 births per month, with the busiest months seeing around 20 births per 24-hour period, on average. However, maternity care is not an area ruled by averages; some days an entire morning shift of eight hours, could pass with only two births. Other days, the same eight-hour period could be non-stop deliveries, including multiple Cesarean sections, entirely overwhelming the staff members on duty and quickly exhausting supplies and equipment. Work on the maternity ward, like nursing care throughout the hospital, was arranged into three shifts-morning, afternoon/evening, and night. The morning shift was eight hours long, the afternoon/evening shift approximately four, and the night shift approximately eleven to twelve hours long. By the time I left Mawingu in the
beginning of June 2015, the morning shift generally had about six assigned nurses, including the Nurse In Charge; the afternoon shift usually had about three nurses, as did the night shift- two on labor and delivery and one assigned to the postnatal portion of the ward. The ward could quickly become understaffed if even one nurse left the ward to run an errand, attend a meeting, or return home to tend a sick child or a funeral unexpectedly. There were perhaps around 40 beds on the ward, at least half of which almost always were occupied by at least two women. Therefore, a conservative estimate might be that there were between 40 and 60 women, plus the babies of all those who had already given birth, on the ward each day, overseen and cared for by just six nurses, at a maximum.

On the morning shift there were also usually two medical attendants and two to three cleaners who helped fetch supplies, prepare delivery packs, maintain cleanliness, and generally run errands for the ward, including opening patient files in the medical records department and taking samples to the lab. In March 2014, there were 22 nurses on the ward, 13 RNs and 9 ENs. By May 2015, the ward overall included about thirty nurses across the cadres- enrolled nurses, registered nurses, and nursing officers—as well as about three medical attendants, and three to four physicians at any given time. Starting near the end of 2014, physicians were rotated through the maternity ward much more frequently than had been common in the past, when the same three doctors had been working on the ward for about three years.\(^1\)

The maternity ward was designed with a number of different rooms, which would be suitable for the different phases of a mother’s time at the hospital. The ward managers, the Nurse In Charge and Doctor In Charge, had decided to arrange the ward into prenatal, labor and

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\(^1\) This occurred because one had been promoted to Medical Officer In Charge, one had gone back to school to specialize in Obstetrics and Gynecology, starting in the end of September 2014, and a long-time Assistant Medical Officer from the ward was away from work for a prolonged period due to illness.
delivery, and postnatal sections. In April 2015, they also decided to divide the nursing administrative responsibilities and created a second Nurse In Charge position. One was to lead and coordinate the prenatal and labor and delivery sections of the ward, and the second was to lead the postnatal section of the ward. The prenatal section of the ward consisted of one room in which mothers waited if they were in very early labor or had arrived before the onset of labor due to other health conditions—perhaps they had a history of needing Cesarean sections, for example. Moving clockwise around the ward, the next rooms were a storeroom, which also doubled as a changing room for the ward cleaners and the male nurses. After that, was the main nurse changing room, which the ward staff members used for a variety of purposes. Other rooms of the ward included the admission room, labor and delivery room, operating theatre, post-Cesarean section recovery room, a staff toilet, postnatal recovery room, a small room for neonates who had been admitted or readmitted after birth, and the Kangaroo Care room for premature infants and those who needed close monitoring for feeding and climate control.

5.3 Patient Flows in Time and Space

Women flowed through the ward in different ways but generally in the same direction. Upon arrival, the woman and her companion, nearly always a female relative, reported first to the admission room. This large room was divided into two sections by a chest height tiled wall. To the left, were a number of beds occupied by women in active labor but not ready to give birth, as well as the more critically ill patients or those who needed close monitoring. Women who came to the ward with malaria in pregnancy, severe anemia, infections, pre-eclampsia or eclampsia slept in these beds, where the nurses could easily monitor their condition without being far from the labor room, which was adjoining. To the right of the wall in the same room was the admission area. This area housed a large desk for filling out paperwork, a wooden bench
for arriving women, a waist-height examination bed, a trolley with necessary supplies (gloves, cotton swabs, antiseptic, urine dipsticks), and a hand washing station made out of a plastic bucket with a spigot and a plastic basin on the floor. All women started at this point, in the admission room of the ward. They were then funneled into the appropriate other rooms, sorted and marked out depending on which stage of labor they were in or what other health problems they did or did not have.

While those women who lived in the areas surrounding the hospital were familiar with the procedures on the maternity ward and in the hospital more generally, due to previous interactions with the system either as patients or visitors, women who came from outside were often confused about how they were supposed to move through these spaces. Nowhere was it written that women in labor could go directly to the maternity ward and waiting in line in the OPD could cost valuable time. Additionally, when women or their accompanying relatives asked for instructions, they were often met with gruff responses from harried hospital personnel. Sometimes it was the security guards at the front gate who were most useful in navigating the flows of the hospital. More than once, I witnessed maternity ward nurses harshly telling women they had skipped some portion of the designated procedures and instructing them to return again after they’d done it properly—getting the appropriate paperwork, for example, once the hospital had implemented a new accounting and file system. This resulted in much consternation as women in the midst of contractions or a painful pregnancy complication were forced to traverse the hospital, and sometimes more than once, in search of the prescribed piece of paper, stamp, or receipt. These delays and bureaucratic procedures which, to women and relatives unfamiliar with the hospital, seemed opaque and unintuitive, could produce dissatisfaction with care but also reinforce a woman’s sense that she was not in control and she would do best to simply be quiet
and listen to the instructions of the nurses. This instantiation of the women’s lack of power within the epistemological structure and hierarchy of the hospital served to silence her voice, figuratively, and literally, as when she did not tell a nurse she was experiencing a problem she thought was abnormal. In this way, the hospital hierarchy and bureaucratic processes produced in women a sense of uncertainty about when, and how, they could ask for attention from the nurses or doctors. These experiences paved the way for women who remained silent as they began to hemorrhage or felt a change inside their bodies, which later the nurses and doctors might identify as the cause of the woman’s death: infection, embolism, shock, life-threatening high blood pressure, cardiomyopathy, or uterine rupture.

5.4 The Admission

Upon finally entering the ward, passing through the doors of the admission room, which bore a sign forbidding admittance to anyone not in labor, each woman handed a nurse her antenatal clinic card, which included basic health information, a rudimentary obstetric history (number of previous pregnancies, miscarriages, living children), and had check boxes about chronic or pre-existing health problems, with boxes next to categories such as heart problems and diabetes. According to guidelines, healthcare providers at the prenatal clinics were supposed to test every pregnant woman for HIV/AIDS and while most were tested, sometimes the woman’s village dispensary did not have the necessary reagents, test strips, or trained providers for carrying out the rapid tests. In one village, the providers told me that they had received a delivery of the test strips and reagents but neither of them had received comprehensive training in HIV testing and counselling. Therefore, they had refrained from testing anyone, much to the consternation of the community members who were forced to travel to a neighboring village for
testing, even though the supplies were present. In other places, the reagents ran out more quickly than the test strips or the kit had been close to expiring when it arrived at the dispensary.

Nurses at the Regional Hospital also repeatedly told stories they had witnessed or heard in which women had changed their HIV status on their cards or had pretended to lose their card in order to receive a new one which did not indicate their HIV status, which was usually positive in these narratives. Nurses suggested women might do this switch out of either denial about their status or due to the stigma attached to being HIV positive. In fact, the cards did not say “positive” or “negative” but instead, the healthcare system used the number “1” to mean HIV positive and “2” to indicate HIV negative in order to maintain some sense of privacy. Theoretically only those who knew what the numbers stood for would be able to know a woman’s status. The system was in place seemingly under the assumption that only providers would know what the numbers meant but nurses’ stories indicated that at least some women also knew how their HIV status was being recorded on these documents.

With the antenatal card in hand, the nurse then recorded the woman’s demographic information and basic obstetric history in the ward’s admission book, a ragged and tired notebook that had pages falling out and was much repaired with medical tape, regular sellotape, and glue. After this, the nurse instructed the woman to take her things and lie on the examination bed so the nurse could check the woman’s vital signs, count her contractions, listen to the fetal heartbeat, conduct a vaginal examination to estimate cervical dilatation, and do a general “head to toe” assessment of the woman’s overall health. Based on cervical dilatation, the nurse then decided where to send the woman to wait out the rest of her labor, until it was time to move to the delivery room. While these examinations and measurements were all supposed to comprise the initial admission exam, nurses often rushed through them or simply wrote “normal” after
looking at a woman. While the hospital continued to increase the number of nurses working on the maternity ward, those assigned to a shift were not necessarily present, and even when they were, the number of women arriving, in labor, waiting for a C-section, or needing other forms of care could easily stretch the nurses thin. This, not infrequently, resulted in the women having only brief, truncated interactions with the nurses in which the nurses did not ask key questions about the woman’s previous medical history, problems during the pregnancy, or current health. Certainly, obtaining any kind of social history, which would have improved care by adding context to the woman’s pregnancy (Wanted? Unplanned? Supported by her family? In the context of a marriage?), and asking questions that would have eased the awkward and foreign interactions taking place, was out of the question. More than once, as a nurse expressed dismay and frustration as a mother resisted a vaginal exam, I wondered if perhaps she had been sexually abused and the encounter with the nurse was causing her previous experiences to resurface. Or, perhaps she had no idea what the nurse was doing and therefore felt embarrassed and uncomfortable due to the lack of explanation before someone tried to shove their hand up her vagina. Nurses could certainly have tempered these violations of women’s bodies but the lack of time for these interactions was itself a product of a structurally violent situation for the nurses, in which they lacked the personnel and resources they needed.

5.5 Laboring

Clinically, a woman’s labor is generally divided into three stages. The first stage is further divided into the latent and active phase and, overall, is the entire time from when the cervix is closed, until it reaches 10 cm of dilatation, considered full or complete dilatation, and the woman is nearly ready to start pushing. At this point, from the time the cervix is fully dilated to when the baby is delivered, the woman is in the second stage of labor. The third and final
stage of labor is from when the baby is born until the birth of the placenta. There are few hard and fast rules for the amount of time a woman can or should stay in any stage of labor. However, once the woman is in active labor, in the first stage, her contractions will, ideally, remain regular and increase in strength and duration, while also increasing in frequency. The general rule of thumb, at this point, is that the cervix should dilate one centimeter every hour during the active phase of the first stage. Then, the woman enters the second stage, which can last from a matter of minutes to a matter of hours depending on many factors including (but certainly not limited to) how many previous pregnancies the woman has had, the angle at which the baby’s head entered the pelvis, the position in which the woman is laboring, the size of the baby, and the mother’s own mental, emotional, and physical states. For example, a woman may have had a very long first stage of labor during which her contractions did not allow her to get much sleep. She may not have eaten much throughout her labor and when it comes time to push, she may be very tired.

Women in Tanzania often would say they did not have strength (sina nguvu) or that they were defeated (nimeshindwa) if they were feeling this way. The phrase nimeshindwa is often employed by the speaker to express a lack of control; the passive construction does not provide any idea of who or what may have defeated the speaker, while still conveying the sense that the speaker has tried and, not due to anything within their power, was unable to do something. It is, in essence, an expression of the speaker’s awareness of their lack of agency in a situation. A speaker can use this construction to describe any variety of situations, such as nimeshindwa kufika, I have failed to arrive, literally, I have been defeated to arrive. This provides the sense that, though they tried everything, it was simply not possible to arrive. Perhaps a reflection of a cultural sense of the locus of control or simply a mechanism for saving face in social interactions (see also chapter 8), this phrase is a common one, not just in the hospital but in life more
generally. In the case of the women, I suggest a reading of this phrase that takes it also as a sign the speaker, the woman, was aware of her lack of control and relinquishing it, turning it over to the nurses and biomedical intervention in all its forms.

5.6 Ambiguous Caring and the Second Stage

The nurses would often become very concerned about how long the mother was in the second stage because, they said, this was the most precarious time for mother and baby. A baby could spend too long in the birth canal which might compress the umbilical cord, cutting off the baby’s oxygen supply. Nurses said then the baby would not “score well,” referring to the APGAR score used to assess the baby’s appearance and reflexes upon birth. Babies who did not have enough oxygen during birth could develop a number of complications, including twitches which might be an indication of brain damage, as well as being at risk for birth asphyxiation, which was a relatively common cause of neonatal deaths while I was at Mawingu Hospital. In this second stage of labor, babies were also at risk for getting meconium or other secretions in their mouths, which they could then inhale deeply into their lungs when they were born and first began to cry. This created the possibility of infections, especially pneumonia.

When confronted with a woman who was defeated, or was experiencing an extremely difficult second stage of labor, the nurses would frequently resort to a handful of methods that, from the outside, often appeared to be, at the least, disrespectful and, often, downright abusive. When I asked about these behaviors, hitting or using harsh language in particular, and why the maternity nurses did so more than those working on any other ward, Halima explained it this way and her answer was generally representative:

If you yell at a person, she will understand you but, if you tell her gently- me, I have tried to admit, to admit a woman gently, if I reach labor [room], gently, every area, gently. Until I came to change, it was necessary for me to be severe, why? Because that patient, she comes there, she sees you, that you are have your gentleness and [it shows] she
doesn’t have to be serious. Therefore, she arrives there, she is strangling the baby, she arrives there, you tell her she should lie on her back and push the baby, [but] she sits, she sits on the baby’s head and the baby dies there. Therefore, if you don’t use that severity, that fierceness helps, at the end of the day, her to get her baby and at the end of the day that patient, she comes to thank the nurse, ‘Thank you, there, without you doing that to me like that, I wouldn’t have given birth.’ You see? Therefore, I see that cultures are different. Even if you go wherever, you can’t hear a nurse speaking gently to a pregnant woman because the nurse is doing that fierceness to save that baby. But I don’t believe that that severity, a person would do it to a person who has, I don’t know, maybe I should tell you maybe like an intestinal obstruction. If [the nurse] does that, we have to ask her, ‘You, why are you doing that?’ but in things with childbirth, the pregnant mother’s mind, it is as though it’s not there. Therefore, you have to scare or shock her. You have to yell at her, tell her, ‘You, you do this and this and this and here this should be this way and this way. If you don’t do these things, you will lose your baby, you will do this!’ You tell her even the complete outcome. But a person, if you tell her the truth, a person sees like you are abusing her or you have asked her for bad things, therefore, this is what it’s like. Except, the biggest thing is that we always speak in order to protect the baby. At the end of the day, a woman gives birth to a baby who is alive and then she complains about things like those, it’s not good. While for her, you are her assistance.

Ultimately, the nurses viewed behaviors such as yelling at the women, telling them they were killing their baby, or hitting them as a form of care, which they undertook in order to help the woman give birth. Brown (2010) also cites similar behaviors in a maternity ward in Kenya, where nurses suggested letting women relax during labor was disadvantageous and did not result in good outcomes for mothers and babies. Similarly, de Klerk troubles Western conceptions of care practices, demonstrating how “toughening” of those who have lost relatives (de Klerk 2013) or concealing dying patients’ HIV status (de Klerk 2013) are, in fact, locally valued forms of care, which cultural outsiders might not view as such. These descriptions of locally valued care practices lead to a more nuanced reading of these outwardly abusive behaviors in which the nurses engaged, recasting them as forms of care suitable to the environment in which the nurses found themselves. Halima had first worked on Grade I, the private ward, and when she’d had reason to pass through maternity, often remarked to herself that the nurses were using mean and abusive language with the women. She could not see why and often sympathized with the
women. That was until, she described, she was transferred to the maternity ward and quickly found her gentle demeanor did not help her in extracting the required compliance or outcomes from her new patients.

Many of the nurses described women in labor, with no access to pain medications, as “out of their minds” or unable to listen and follow directions. While some women were clearly distraught due to the pain and fear of being in labor, especially young women experiencing their first pregnancy and labor, there were many others who labored quietly and compliantly followed all the nurses’ instructions. However, I will say that we had a couple of women on the ward who continue to stand out in my mind, albeit they were extreme cases of defiance. One refused to do anything other than sit on the dirty tile floor. Every time we helped her up onto the bed, we would turn around moments later to find her back, squatting on the floor. The doctor kept walking through the labor room that day and repeatedly berated the nurses for “letting” the woman remain on the floor because he had not seen our struggles to move her up onto the bed time and again. Another woman seemed to have experienced a significant shift in her personality with the onset of labor, which even her relatives mentioned. She spoke of seeing spirits around her and she was extremely agitated. Due to her prolonged labor, the nurses started her on an IV of fluids but the woman repeatedly pulled the cannula out of her arm and quickly made her way out into the courtyard of the ward. More than once we went to check on her and found a trail of blood, from where she’d pulled out the IV, leading us to the flowerbed where she was squatting and bearing down with contractions while muttering incomprehensibly, covered in dirt.

Truly, in cases such as these, it was possible to understand how the nurses came to view hitting, slapping, or yelling as the appropriate, and needed, tools. There was, in all honesty, nothing much else they could do with women such as those, particularly as they repeatedly
defied efforts to entice them into staying put on their assigned bed, threatening to give birth in an unsanitary location with no assistance, as could have been the case in the flowerbed. These were full grown women, with pregnant bellies, whom the nurses could not easily physically remove to their beds or elsewhere, who refused reasoning and for whom the nurses had no other technical or medical options. Lacking other options, they resorted to this more aggressive form of care.

Another nurse, Martha, one of the past In Charges of the ward, looked for deeper reasons for these harsh and abusive behaviors, and responded to my question in light of her own fraught interactions with the hospital administration, which had eventually caused her to be transferred to a different ward. She believed,

There are a lot of things that cause that state. The first thing entirely is the frustration that she has, the employee. You find from January to December she hasn’t ever gone to a seminar, she hasn’t ever gotten any kind of income other than her salary that you find is 200,000 or 300,000 $2$ while she has a family and six children at home. Second is the attitude, I mean the environment that she has, the employee. You find frankly, at her home they have already become accustomed to abusing each other, I mean [where] she lives it is just swearing. Therefore, she brings that into work. Another, it’s the state in which she left her house, maybe she has left and there is no salt, there’s no what, and the children need to go to school, and she needs to do- well, there, can she really work well? Therefore, she is angry, she can’t deliver something that is good. Another thing is the harassment that she has gotten coming from the administration, maybe a person has a problem, she has gone there and encountered bad language and she has transferred it to the patient. Another thing is education that she has, you find that she doesn’t have enough education to know why this mother is being bothersome.

Her personal experience, as well as the insights she had gained from managing the maternity ward, allowed Martha to explain how poor living conditions, often as a result of low wages, in addition to tense or abusive exchanges with the hospital administrators could influence a nurse’s interactions with the women for whom she was meant to be caring. Everything Martha mentioned is an example of a failure of institutional care, beginning at the level of the central government which failed to adequately increase wages in the health sector, leading many nurses

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$2$ Approximately between $100$ and $150$ per month, as of 2015.
to remain preoccupied with the state of their home long after they had walked out the door. Nurses’ private lives continued to permeate the boundaries of the hospital, blurring the lines between domestic and professional spaces. The Patron, in charge of all the nurses, was known for his harsh language, which he preferred to see as something along the lines of telling it like it is. His forthrightness, in a culture that valued a certain degree of circumspection and tact, rubbed many nurses the wrong way, often offending them outright if he used language that was profane, or otherwise inappropriate for the workplace, in their interactions.

It is lived realities such as these that are entirely lost in the design of many public health interventions meant to improve care, decrease disrespect and abuse, and empower women in the healthcare setting. When the nurses themselves felt uncared for, were struggling in their private lives, or encountered stubborn and noncompliant patients in the absence of manpower and sophisticated technology, they resorted to hitting and yelling in order to enact some form of care that would enable the woman in question to give birth to a healthy baby.

5.6 Birth

After the birth of the baby, the nurses would quickly cut the umbilical cord and they had all learned active management of the third stage of labor (AMSTL or, alternatively, AMTSL) (Armbruster 2006), in which the nurse was supposed to first palpate the uterus for the presence of another baby and administer an injection of a uterotonic, usually oxytocin, to help the uterus to contract. Then, using forceps, the provider should clamp the umbilical close to the mother’s perineum and pull with slow, steady pressure in a downward motion until the placenta fully detached from the uterus and was delivered. The nurse then checked the placenta to make sure it
was complete\(^3\), and thoroughly massaged the uterus to ensure it expelled any blood clots and to make sure it was contracting, a key sign that bleeding will stop. Ideally, the healthcare provider would explain to the mother how to check and periodically massage her uterus, as well as give her information about danger signs in the immediate post-partum period. Only rarely did I ever hear the nurses in the labor and delivery room give the woman any advice that went beyond how to check if her uterus was still contracted and telling her to void her bladder. The nurses in the postnatal room did provide further health education and, in the event a new mother was having a difficult time initiating breastfeeding, for example, the nurses were very willing to help.

Most often, the nurses at the Mawingu Regional Hospital were able to let the women continue to rest in the labor room after delivery so they could monitor their conditions. This was supposed to include vital sign monitoring, as well, though this particular aspect nearly never happened—sometimes due to other women needing assistance, others because the blood pressure cuff was missing or broken, or no one could find a stethoscope that was functioning. In lieu of the more technological monitoring specified in care guidelines, the nurses who were more experienced would visually assess the mother and deem her condition “normal.” Sometimes, depending on how busy the ward was, the nurses had to almost immediately move new mothers to the postnatal room on the ward because incoming women were ready to give birth and needed a bed in the labor room. These sometimes hasty transitions were not ideal and more than once led to incoming mothers giving birth on the floor near a bed, or immediately after reaching a bed, and the outgoing mothers were forced to carry all of their belongings to the other side of the ward within minutes of giving birth. When this happened, the mothers hobbled slowly along,

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\(^3\) Any remaining pieces of tissue can cause the uterus to not contract (uterine atony), which is one of the most common causes of continued bleeding. This can cause post-partum hemorrhage, a leading cause of maternal death.
sometimes with blood dripping on the floor from between their legs, plastic basins, overflowing with soiled clothes, balanced on their heads.

5.7 Directed Flows

When the nurse first examined a woman, the nurse then decided where the woman should next travel on the maternity ward. If the woman was in early labor, less than three or four centimeters, the nurse would give her a bed in the antenatal room with instructions to come back to the admission room when her contractions got stronger. If she was between four to six or seven centimeters dilated, the woman would generally receive a bed in the admission room, closer to the delivery room. In both the antenatal and admission rooms, the women almost always shared their bed with a second woman and, at particularly busy times, maybe even two other women. This was due to a lack of beds but, more importantly, a lack of a place to even put other beds. If the woman had already reached six or seven centimeters, she would go directly into the labor room. In the labor room (Fig. 5.4), women never shared a bed due to the need for enough space to conduct the delivery and the messy nature of giving birth. This, however, on busy days could mean that there was a rapid turnover in beds as I described above. Or, the lack of open beds could mean women had to wait for a bed until the last possible moment, as when one mother I was helping gave birth on the floor just feet away from a recently vacated delivery bed. Other times, women rapidly progressed through the last few centimeters and gave birth in the beds in the admission room, in close proximity to other women, without privacy, and, many times, without the assistance of a nurse, who would often come running just as the woman finished pushing her baby into the world. Through many hours of listening, I became attuned to the sounds of the women in labor in the admission room and could often tell from a change in their moans or other vocalizations that they were nearing the final stages of labor.
Once a woman had given birth, she moved to the postnatal room across the ward, near the entrance, where she typically spent 24 hours, give or take, depending on her health and whether or not she had experienced any complications. Once in the postnatal room, the postnatal nurses took over her care and were responsible for ensuring she had any necessary medications or monitoring. The postnatal nurses were also responsible for providing basic health education related to family planning, breastfeeding, personal hygiene, and basic nutrition and baby care information. On this part of the ward, the nurses also filled out another set of documents, completing documentation started by the labor room nurses in the delivery book in which all the births were recorded, as well as filling out the birth announcement form that families took to their district administrative offices if they wanted to get a birth certificate for their child. If any of the women had not already previously been tested for HIV, the postnatal nurses counselled and tested them, providing those who tested positive with medications for the baby and further
instructions for follow-up testing and alternatives to breastfeeding. The women generally also received a mild pain killer and an iron and/or folic acid supplement, as well as Vitamin A, which they received when other nurses or auxiliary staff members arrived on the ward to vaccinate the newborns.

5.8 Surgical Birth

If a woman needed a C-section, either planned or emergency, her flow through the ward differed somewhat from the norm. If the nurses identified a possible complication or previous history that suggested the woman might need a surgical birth, they would call the doctor to alert him of a patient for review. When the doctor confirmed the need for a C-section, the nurses then prepared the woman for surgery by having her sign a consent form, taking blood samples for laboratory tests (blood grouping, cross-matching, and hemoglobin levels), in case she should need a blood transfusion and to rule out anemia that might be life-threatening during the surgery, administered pre-operative antibiotics and IV fluids, and inserted a catheter to drain the woman’s bladder during the surgery and her recovery. Once new procedures went into place in the fall of 2014, nurses also became responsible for taking the doctor’s prescription to the hospital pharmacy to pick up the antibiotics, IV fluids, sutures, and anesthesia drugs for use during the surgery. This entire process could become significantly delayed if any of the aforementioned items were out of stock at the hospital. The patient’s family might then have to purchase the items at a private pharmacy outside the hospital gates.

Once in the operating theatre (Fig. 5.5), which, as of December 2014, was located within the maternity ward itself, a nurse from the labor room accompanied the mother in order to be present to receive the baby. This nurse often had to resuscitate the baby (with greater or lesser degrees of intervention depending on a number of factors) and then was responsible for weighing
the baby, recording its APGAR score, gender, and time of birth, and then carrying it back to the labor room where the baby would wait in a warmer until its mother awoke from the general anesthesia and was able to care for the baby.

Fig. 5.5 Maternity ward operating theater, which opened in December 2014

At this point, the postnatal nurses took over the care of the mother and were responsible for collecting her from the operating theatre after the surgical team was finished. The postnatal nurses transferred the unconscious and/or immobilized woman to a bed in the post-Cesarean room (Fig. 5.6), changed her perineal pad, and ensured she was warm, clean, and secure. The postnatal nurses then were also responsible for the follow-up care of these patients, which included administering pain medication and antibiotics on a schedule and dispensing advice related to food and fluid intake, breastfeeding, urination, care of the incision site, and general advice about recovery. The nurses, and often the doctor too, would try to impress upon the post-C-section mothers the necessity of using a form a birth control in order to prevent pregnancy for
two to three years so their bodies would have enough time to heal and not predispose them to possible future complications, such as a ruptured uterus.

Fig. 5.6 View of the post-Caesar room on the maternity ward

5.9 The Doctors

Thus far, I have primarily explained the roles and responsibilities of the nurses. This is due to the fact that nurses, enrolled nurses and registered nurses, were responsible for the vast majority of the care on the maternity ward at all stages of a woman’s stay. The physicians were responsible for conducting patient rounds each day, ideally before noon, in order to assess each woman’s condition, monitor any changes, and prescribe next steps for her care. He, because the doctor was nearly always a man⁴, would conduct rounds with a nurse who recorded a summary

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⁴ There was a woman assigned to the maternity ward but her tenure was short-lived. Everyone agreed she was “not fit” for maternity and the work on the ward did not suit her. She was slow at C-sections, which increased the baby’s exposure to anesthesia and increased the chances of maternal complications, while frequently being late to conduct rounds, refusing to stay after hours, and generally being disagreeable. Personally, I found her attitude extremely off-putting and attempted to avoid her in the clinical setting, though she was better in social settings.
of the prescribed care, equipped him with gauze, gloves, plaster, and antiseptic as needed, and drew his attention to the most urgent cases. The doctors also personally changed the bandages of woman who had had C-sections or other operations, which the Medical Officer In Charge credited as the reason for significant improvements in the hospital’s rates of post-operative sepsis and infection. The doctor was also responsible for writing all the clinical notes for the women’s files and he saw patients in the obstetrics and gynecology clinic, which took place once a week. The doctors were also responsible for the gynecology ward, ward 5, and conducted all gynecological surgeries, as well as C-sections. They rotated on-call duties for any emergencies that occurred after the 3:30pm end of the working day, though they often stayed past that time in order to finish surgeries, paperwork, or other duties. When there were multiple doctors present, they divided the duties on the maternity and gynecology wards in order to ensure they could see patients in a timely manner and complete all their duties before the end of the day. Additionally, the doctors participated in meetings, trainings, and provided advice or saw patients who they knew perhaps through family or other personal connections, such as the time I had one of the maternity ward doctors write me orders for a malaria test when I was feeling sick so that I could bypass the procedures and long line in the OPD.

5.10 Hospital Organization and Personnel

The maternity ward was integrally connected to and dependent upon several of the other hospital departments. These included surgery, the laboratory, OPD, medical records, and the gynecology ward, which was technically part of the same service (Obstetrics and Gynecology), though geographically separate within the hospital. Each hospital department was overseen by a Medical Officer In Charge and generally each ward also had a Nurse In Charge. Several of the most experienced and more highly trained nurses would rotate on a weekly basis as the Nurse
Supervisor. The nursing staff included several different cadres of nurses including Enrolled Nurses (EN), Registered Nurses (RN), and Nursing Officers (NO) and all of these groups reported to the hospital’s Patron and Assistant Matron, the first and second in charge, respectively, of the nursing staff. The Patron also reported to the hospital’s Medical Officer In Charge who subsequently reported to the Hospital Advisory Board and the Hospital Management Team (HMT). The HMT was a collective administrative body that made many of the more complex decisions regarding issues within the hospital. The clinical (non-nursing) staff included Medical Officers (MO), Assistant Medical Officers (AMO), and Clinical Officers. The clinical staff, together with auxiliary staff, reported to the Medical Officer In Charge. The auxiliary staff included laboratory staff members of varying qualifications, medical attendants, pharmacy personnel, and other non-clinical support staff such as the hospital kitchen workers, security guards, and the hospital cleaners/groundskeepers. Figure 5.7 on the next page presents my rendering of the Mawingu Hospital Organogram from the Hospital’s Comprehensive Hospital Operational Plan (CHOP) for the fiscal year 2013/14.

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5 This was still a nascent administrative body when I left the Rukwa region in June of 2015 but the hospital administration had firm plans and a timeline for completing these plans to implement a Hospital Board.

6 Clinical Officers were more commonly present in lower level health facilities, such as health centers and village dispensaries.
Fig. 5.7 Mawingu Hospital organogram
In this visual layout, slightly different than that present in the actual printed copy of the CHOP, it is easy to see that the Obstetrics and Gynecology department was more complex, with more constituent parts than any other department at the hospital. I would point out that, at the time of my fieldwork, the department no longer had a specific ward designated as the septic ward because the hospital had seen a significant decrease in cases of sepsis starting in approximately 2010 or 2011\(^7\). Those patients who did develop sepsis or suffered from other complications leading to longer recovery times after birth were moved to the back third of the postnatal room, generally in the last four beds nearest the bathroom. However, the ward did instead include an additional post-C-section ward and a premature/Kangaroo Care\(^8\) section of the ward.

Additionally, the ward also admitted neonates, babies too young to be admitted to the pediatrics wards. While a physician from pediatrics was supposed to round on these young patients, this sometimes did not happen due to miscommunication and at all times the nursing care was always the responsibility of the maternity ward nurses.

The hospital administration, as represented in the top of the organogram in Fig. 5.7, was then responsible for coordinating activities with the Regional Medical Officer (RMO) and the Regional Administrative Secretary (RAS). The Regional Administrative Secretary was not

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\(^7\) This drop corresponded with the posting of the current Medical Officer In Charge to the Mawingu Regional Hospital. At the time, he was a newly graduated Medical Officer and joined the hospital as the lead physician on the maternity ward. He encouraged improved wound care and attention to nursing care, which led to the significant drop in sepsis cases in maternity. He considered this drop to be one of the greatest successes of the hospital in the preceding five years.

\(^8\) Kangaroo care is where a relative, usually the mother and/or father, place a premature baby into skin to skin contact on their chest and then generally wrap a piece of cloth or clothing around themselves to keep the baby firmly attached to the parent’s body. This helps the baby to maintain a stable and more regulated body temperature, crucial for survival and a low-tech solution for settings in which infant incubators are either uncommon or non-existent. Premature babies are often unable to suitably regulate their own heart and respiratory rates, as well as body temperatures and therefore run the risk of experiencing several detrimental conditions preventing their growth and ability to thrive (Richardson 1997). Even in high resource settings, Kangaroo care is a proven method for promoting parent-infant bonding and improving health outcomes.
directly involved in the daily functioning of the hospital but was the government’s representative and, as such, the employer of all of the region’s government employees, including all healthcare personnel employed in the public sector. The Regional Medical Officer, at the time of my fieldwork, was much more involved in the daily functioning of the hospital and almost always attended the hospital’s morning clinical meetings, unless he was out of town. He was also an ally in creating and implementing hospital goals, the organization’s yearly plan (CHOP), and in ensuring policies from the Ministry of Health were implemented both within the regional referral hospital and at all other facilities throughout the region. The RMO was the head of the Regional Health Management Team (RHMT), which planned and coordinated healthcare activities throughout the region. In addition to daily functions, this body also helped to coordinate special campaigns such as male circumcision and immunization campaigns or health outreach activities to provide women living in villages with access to long acting birth control methods, such as intrauterine devices (IUDs), by sending trained providers on trips throughout the region.

Each level of care intersected with and influenced the next, just as the different departments of the hospital supported and influenced each other in ways that were crucial for the health and survival of women and their babies.

5.11 Conclusion

I have gone into such detail related to the workings of the maternity ward and the hospital more generally in order to paint a picture of the flow of patients through the hospital and the stages of care on the ward. The tour of the maternity ward outlines the sheer amount of work for which the nurses were responsible on a daily basis. In addition to the tasks which I have enumerated, the nurses also fetched supplies, attended meetings, rotated onto the HIV testing and counselling service, family planning service, and cervical cancer screening clinic, and were
responsible for an ever-increasing amount of documentation. In the absence of medical attendants or auxiliary staff members, as on the night shift, the nurses would also mop floors, wipe down beds, wash equipment, and fold gauze for use in delivery kits. They were also responsible for the documentation and reporting involved in the death of newborns and mothers.

The nurses on the maternity ward expressed their continuing feelings of being overburdened even though the hospital administrators told me they had been making a concerted effort for more than a year to increase the staffing levels on the ward. Despite these efforts, the nurses’ workloads continued to increase in response to additional documentation demands produced by the hospital itself, as well as outside agencies and the Ministry of Health. This all occurred in the context of continually increasing demand for the hospital’s maternity services. Despite efforts to task shift and enable medical attendants, for example, to complete key tasks such as preparing equipment for delivery kits, Nurse Peninah told me,

…another thing, so much work has to do with the nurse. Therefore, those responsibilities of sharing work, to say that the doctor does these things, the lab person these, these someone from wherever, there isn’t any! I mean, any of that work, the nurse does it! … Everything. So, you find that people in a lot of sectors, like the lab, a person is just sitting there, he is waiting for the nurse to do it. A person that is in the pharmacy is just sitting there, she thinks the nurse should do it. … You see? That is where the difficulty of the work comes in; there is none of that sharing of work responsibilities.

Later in the same conversation, Peninah told me that even though she was one of the most highly qualified nurses on the ward, as determined by formal education, she did not feel that any task was beneath her because, ultimately, it all had to be done and if she could do it, then she would. This resulted in the endless nature of a nurse’s work.

These multiple demands on nurses’ time occurred against the background of their home lives and domestic needs and responsibilities. More than one nurse on the maternity ward bore the primary responsibility for paying their children’s school fees or those of a younger sibling,
supporting aging parents, and supplementing the income of their spouse who often was not employed in the formal sector. All of these competing demands, in addition to low wages, and unsupportive interactions with hospital administrators, sometimes resulted in care for pregnant mothers that did not meet the guidelines of best practice, which the global health community had deemed to be the route to reducing inequalities, improving access, increasing the number of births attended by skilled personnel, and, ultimately, reducing deaths. Combined with women who entered the hospital with uncertain knowledge of the institution’s procedures, which often undermined their confidence in what they knew about their own bodies, these burdens on nurses, and the high demand for their services, culminated in an environment which allowed some women to slip through the gaps. On the night shift, as the one nurse on the postnatal ward sought a few minutes of rest, a woman silently “changed condition and died,” as the reports the nurses read the next morning often stated. During the day, the routine hustle and bustle of the ward, combined with a difficult home life or conflict with administrators, could result in nurses abusing or selectively neglecting a particularly difficult patient. That difficult patient might be the one who later died of cardiac failure after over exerting herself in the second stage, while the nurses yelled at her to push, not knowing (due to not being able to spend more time on the initial intake and patient history) or not remembering that she had a history of chronic anemia, which had contributed to heart problems while she was pregnant.

There was a tension between creating good emergency care and what happened in practice. The maternity ward sought to structure the flows of women through the ward partially in an effort to deal with being overburdened with patients. This highly structured flow, as

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9 Chronic iron deficient anemia can result in increased cardiac output, a condition which, when combined with the expanded blood volume of pregnancy, can lead to congestive heart failure (Cunningham et al. 1986; Hegde, Rich, and Gayomali 2006).
described in the beginning of the chapter, was itself a form of bureaucracy within the ward. If a woman did not fit the prescribed structure, due to having an unpredictable body—complications, or faster-than-normal labor—then she often did not receive the care she needed. This lack of appropriate or needed care could take the form of giving birth on the examination bed or without a nurse, in the admission room, or it could take the form of delayed surgeries, lack of medicine, or neglect during a severe emergency, such as the instances described in chapter 8.

With all this in mind, I shift to the next chapter which presents the complex scarcity that characterized the hospital working environment as it influenced the possibilities for care practices on the ward, further preventing improvements in working conditions for providers, and care for women.