Chapter 6: Working in Scarcity

6.1 Introduction

On my first visit to the Mawingu Regional Hospital in 2012, the then Nurse In Charge of the maternity ward led me around the ward on a tour. She told me they desperately needed more delivery packs, a set of essential supplies for delivering a baby, because they only had three full sets. Each delivery pack included a metal kidney dish, two forceps, one pair of surgical scissors, two sterilized umbilical cord ligatures, and two pieces of gauze. All of the materials are placed into the kidney dish and wrapped in two pieces of green cloth, drapers, and tied with a thin piece of cloth. The sets are then sterilized in the hospital’s autoclave, which was located in the main operating theater. The nurses used one delivery pack per mother and medical attendants were then responsible for soaking and rinsing the equipment in a series of buckets for preliminary sanitization. The medical attendants then repacked the equipment and took the sets to be autoclaved. Depending on the autoclave schedule and staffing numbers, there could be a long delay between the time when the delivery packs ran out on the ward and when sterile packs became available. Particularly with only three packs in 2012, the nurses operated mainly without this set of tools, considered to be the most basic essentials for a clean and safe birth by the hospital, national, and international standards for safe and skilled maternity care. While this state of affairs had improved by the time I returned to Mawingu in 2014, maternity care was highly vulnerable to stock-outs and failures of the supply chain. As one of the highest volume wards at the hospital, maternity was a constant drain on resources, which led to tense interactions—among providers and between women and the hospital staff—delays in care, and the deaths of women and their babies. Two main factors drove the scarcity that characterized this environment—lack of financial resources (of the institution, the region, and the state) and the
expansion of biobureaucratic demands and procedures, which complicated access to the supplies that were physically available. When these two factors combined, they served to create a setting with an insurmountable sort of inertia, resistant to efforts at reform and limiting possibilities for changes that might have improved care for women and the work environment for the nurses and doctors.

6.2 The Material Needs and Inevitable Inertia of the System

In 2014 and 2015, the maternity ward delivered an average of between 450 and 600 babies per month. In addition to the delivery packs, each woman who came to give birth required a number of other supplies in order to receive care that was of high quality and conformed with hospital and international guidelines (Tanzania MoHSW 2013). From admission through the birth of the baby, nurses required an absolute minimum of three pairs of sterile surgical gloves, though they often used many more pairs. Perhaps most critically, the maternity ward was supposed to also stock oxytocic drugs, most commonly oxytocin, though ergometrine was often present as a backup. Women received an injection of oxytocin immediately after they gave birth in order to help prevent post-partum hemorrhage.¹ Other items needed for the care of the expectant mothers included personal protective equipment for the nurses, such as boots, gowns or aprons, goggles or face masks, and caps to cover their heads. The ward must also always have IV (intravenous) fluids on hand and the giving sets² and cannulas for starting an IV. To give a picture of what was used on a daily basis I present the following list: medical tape (also called plaster), antibiotics, anti-hypertensive medications, basic pain relievers for post-partum mothers,

¹ This has become a standard part of Active Management of the Third Stage of Labor (AMTSL) and oxytocin works on the smooth muscles of the uterus to help it contract, thereby causing the blood vessels to close, preventing more prolonged and serious bleeding.
² The tubing that connects the IV fluid container and the cannula, which is inserted in the vein. There is also a part that regulates the speed of the fluid flow.
ketamine for surgeries, nasogastric tubes (NG) in both infant and adult sizes, resuscitation equipment, vacuum for assisted deliveries, sutures of various types, various antiseptic solutions, syringes, magnesium sulfate, blood pressure cuffs, stethoscopes, urinalysis dipsticks, cotton swabs, gauze, sterile water, catheters and urine bags. All of these supplies and several more were integral for providing care to women during their pregnancies, labor, and the immediate post-partum period. They had to be on hand at all times in order for the staff to be prepared for emergencies or unexpected changes in a woman’s condition, in addition to routine care. During a C-section or laparotomy, as in the case of a woman with a ruptured uterus, in addition to the IV fluids, cannulas, catheters, and surgical blades, the operating theater also needed to have a machine to help monitor the woman’s vital signs while she was under anesthesia, and either drugs or other means of resuscitation in case something should start to go wrong (see Marwa and Strong 2015). Without resuscitation equipment, such as Ambu bags and face masks, oxygen, or adrenaline injections, women died on the operating table and babies did not recover from the effects of severe asphyxiation. In other cases, lack of antibiotics pre and post-surgery increased the woman’s chances of contracting a life-threatening infection.

Nearly every morning I arrived at the hospital between 7:30 and 7:45am. After the clinical meeting was finished around 8:00 or 8:30am, I headed to the ward. If it was early and the night shift nurses had not yet finished handing over to the morning shift, I would often find the ward in a state of disarray after a busy night of caring for patients, as compared to the level of tidiness and cleanliness that was the norm during the mornings and afternoons. The nurses and the hospital’s Quality Improvement Team emphasized the use of the Kaizen 5S system, in

---

3 This system was originally developed in Japan and used in Toyota manufacturing plants as a way of increasing efficiency and reducing waste of all sorts. It has been implemented in a number of sectors across Tanzania since 2010 (JICA 2013).
which each item was given a labeled standard location, making it easy to find supplies when the
ward was busy. I had helped to lay colored tape around the ward, marking off designated areas
for notebooks, gloves, trays, and the color-coded trashcans. While the nurses generally thought it
made the ward look neat and several remarked, “inang’aa” or “it’s sparkling,” one of the senior
nurses, Mpili, skeptically scoffed that I was wasting my time and the nurses would simply
disregard the tapes and continuing placing notebooks and items wherever they landed. Dr.
Charles also expressed the same opinion, doubting it would be possible to change the ward’s
prevailing habits. While a seemingly small change, 5S, Charles’ and Mpili’s lack of confidence
in even the possibility of change struck me, at the time, as a particularly unproductive and
defeatist point of view. I was still only two months into my research and operating with my
personal love of efficiency and optimism when approaching problem solving, all things they
probably viewed as incompatible with the inevitable inertia of their ward. Now, I read this same
exchange with an understanding that they had been conditioned through many years of work, in
Mpili’s case, and several efforts at change, in Charles’, that seemed to undeniably demonstrate
the impossibility of lasting transformation. Their previous efforts to solve problems that would
result in better care were all too often met with nothing—no change, no attention, no investment
from administrators, no physical resources. Therefore, they spent less time trying to solve
problems, than I, because the environment of their workplace had, historically and presently,
made it extraordinarily difficult to do so. This impossibility was, in itself, a form of violence
against the women, but also the nurses and doctors working to perform care practices in an
environment that barely supported the technical forms of care and severely strained workers’
affective resources. Those who continued to try to reform the hospital or the habits of its staff
members were the exception and not the rule, which was why the Medical Officer In Charge
often lamented to me that he felt as though he was dragging others along as he sought to improve the hospital, working as he was against, what many others saw to be, the impossibility of change.

First thing in the morning there were often wrappers from gloves strewn about, empty boxes, sticky footprints on the floor from where tea or IV fluids had splattered, and broken glass ampules from used oxytocin injections. Both the nurses and the cleaning staff on the morning shift embarked on tidying up the ward first thing after the shift handing over occurred, so long as there were not women in need of immediate medical attention. There were three trolleys in the labor and delivery rooms on which sat the most immediately necessary and most commonly used supplies (Fig. 6.1). I always glanced around to see what was missing or almost out, cleared away the paper wrappings from gloves, and straightened the medications before heading to the Nurse In Charge’s office to collect the missing items we would need for the day shift. Unless inundated with new arrivals or women needing immediate care, straightening the ward and restocking supplies was usually the first task for the morning shift nurses.

Fig. 6.1 Supply trolleys after a busy shift
The stock-taking and the daily act of collecting and documenting supplies became a litmus test for the health of the hospital’s supply chain and finances. The maternity ward was noticeably better stocked when I arrived in 2014 than it had been on my first visit a year and a half earlier in 2012. However, as 2014 progressed, the availability of supplies did not continue to improve and, indeed, many days the nurses struggled to provide care in the absence of drugs and equipment. Some days, the cabinet in the Nurse In Charge’s office would be nearly empty when I went in search of bottles of IV fluids, gloves, or catheters, and weekend shifts were unable to procure more supplies from the main pharmacy.

6.3 The Origins of Material Scarcity: Decentralization, Budgets, and the Medical Stores Department

Shortages in facilities at all levels were common and could, in some cases, be related to the decentralization of healthcare services in Tanzania, which placed the burden for procurement on a more local level. This allowed districts and facilities, such as the Regional Hospital to determine their supply needs, but also required them to pay for equipment and supplies out of their budgets, the income for which came from the central government, as well as user fees and insurance reimbursements. Decentralization placed the locus of control in the regions and districts, but also put the fiscal burden of the healthcare system on the shoulders of economically disadvantaged populations in peripheral areas of the country, such as Rukwa. As discussed previously (chapters 3 and 4), peripheral regions of Tanzania have a history of decreased access to healthcare resources due to the logistics complicating the supply chain (e.g., difficult geography, long distances without roads, places only accessible by boat), as well as being, what highly trained medical personnel often considered, inhospitable places to live and work due to their remoteness.
In this way, inequality has continued to grow between large urban centers and the rural periphery. Throughout the 1990s, healthcare policies continued to evolve in Tanzania and the nation implemented user fees and then, shortly after, created exempted groups: pregnant women, children under 5, elderly patients, HIV/AIDS patients, and those severely impoverished patients seeking care. Policy makers instituted these exemptions in order to encourage vulnerable populations to utilize healthcare services and lower mortality rates. However, at many levels, these exemptions were essentially an unfunded mandate, lacking specific budget lines or any sustainable financial plans for continuing to pay for the care these populations need. While the central government budget does include maternal healthcare, the funds for these services are often supposed to come from outside donor contributions.

The Medical Stores Department (MSD) is a public, non-profit organization that was created in 1993 by an Act of Parliament and began functioning in 1994 (Sikika 2011: 4). MSD has long been the target of criticism. Particularly with the decentralization of healthcare administration, the supply chain has become reliant on MSD but also on District Medical Officers and their resources. A relatively new plan would have MSD delivering supplies all the way to the primary level of the dispensaries, instead of making large deliveries to district medical headquarters, as is now the case. This plan might reduce the cost burden of transportation for the districts, but it only shifts it to MSD and presents a number of complications in peripheral regions with poor infrastructure, which are located far from the zonal MSD headquarters, as is the case with Rukwa. These debates continue to evolve and form something of a background to the daily working life in the Mawingu Hospital and in all the lower level facilities, affecting the availability of supplies, but often only people directly involved in supply procurement knew the intricacies.
During my time in Tanzania, MSD was facing an incredible unpaid balance for supplies already dispensed. In October 2014, Muhimbili National Hospital in Dar es Salaam alone had an unpaid balance of close to $4 million (US) (Tanzania Daily News 2014). The collective debt of all the healthcare facilities in the country was around $50 million (US) or 108.6 billion TZS as of June, 2015 (The Citizen 2015). It was this enormous amount of accumulating debt that caused MSD to issue a statement limiting (or, in some cases entirely stopping) distribution until the government reached a plan to settle the balance. This debt alone accounts for .01% of the country’s GDP in a country that spends approximately 7% of the GDP on healthcare each year (WHO 2014). In 2010, the WHO estimated the Tanzanian government spent $223 million on rehabilitative and curative services (WHO 2014). Using this number solely for the purposes of putting MSD’s debt in perspective, the debt would (in 2010) represent 22.4% of the government’s total health expenditure. Health facilities relied on money from the central government and in-kind agreements to fund their supplies of medications and equipment. If the government was slow to disperse these monies, either due to lack of funds in the budget from low revenue generation or delayed contributions from donors, facilities could be left without the means to pay MSD.

6.4 The Hospital Budget

At the Regional Hospital, the Hospital Management Team (HMT) and the Regional Health Management Team (RHMT) created an annual plan and budget for the hospital’s goals and operating expenses. They forwarded this plan to the Ministry of Health and Social Welfare and the Ministry of Finance for approval. The Ministry of Health then disbursed funds into the hospital’s accounts. Some of this money went into an account the hospital had with MSD, which was a significant source of funds for the purchase of supplies and equipment. When this account
was empty, in the absence of supplies being issued on credit, the hospital had to use the cash collected on a daily basis to pay for more supplies.

The daily clinical morning meetings at the hospital always started with a reading of the accounting from the day before. This included going department by department and reading out the number of patients served, the amount of cash collected, and the amount of money used for patients in the exempted categories. The maternity ward was far and away the largest source of exemptions, with a patient flow that surpassed that of any other ward or department. This was the main reason the amount of money spent on exemptions was always around three times the amount of cash brought in on any particular day. For example, on February 9th, 2015, the report read said that on the 8th the total cost of the exemptions was 1,273,127 TSh. Of that, 1,073,000 TSh came from the maternity ward, the remaining 200,000 was from services provided to the elderly, children under 5, HIV patients, or the destitute, combined. The total cash collected for the 8th was 380,000 TSh, which leads to a total cost of services provided for February 8th of 1,650,000 TSh. This was representative of the trend- free services were generally three times the amount being brought in through daily cash collection of user fees. Even so, this level of cash collection was an increase over the past and an improvement.

This all combined to mean that the hospital was operating at a loss every single day. Understandably, the financial losses led to cash flow problems, particularly when compounded with the MOH’s delays in dispersing funds for the fiscal year 2014-15. The fiscal year ended in June and by March 2015 the Tanzanian Treasury had only released 58.4% of the fiscal year’s budget (The Citizen 2015). What this all meant for the Mawingu Hospital was that supplies were scarce and the hospital was essentially only operating on the cash they could collect each day from patients because most of their budgeted funds for fiscal year 2014-15 arrived in May, just
one month before the end of the fiscal year. In the beginning of May, before this payment came through, the hospital had been operating on very limited funds and the shortage of money was a constant topic of conversation within the hospital’s morning meeting and among the administrators. The Regional Medical Officer explained:

AS: [Is there a supply problem] Well, for example, on maternity these days it’s hard for us to even get catheters or IV fluids.

RMO: Yes, well, we requested 286 million shillings for the fiscal year that is ending in the end of June and until last week [first week of May] we had only received 6 million from the government. Last week they told us that 100 something million has arrived for us. It had been dispersed but it went somewhere, we don’t know where, just what they say, but now it has somehow made its way back to our account at MSD. There they tell us we had a debt of about 80 million shillings so now we have 30 million shillings to buy new medications and supplies. But up until then we really only had 6 million shillings to run the hospital. The money that we collect every day can only be used for certain things, for example for medications, but we’re not allowed to use it for things like paying “other charges” or on call or things like that. You see the exemptions every day, it’s hard to continue to run a hospital with only 6 million shillings for the year. We’ve already made an order to MSD, we should get more supplies soon.

Here, his answer demonstrates the complicated ways in which funds flowed through the bureaucratic fiscal systems of the healthcare sector, enhancing the feelings I had, echoed by many nurses, that the entire process was rather opaque and subject to detours, as when the money “went somewhere.” Here again, the RMO shows that the hospital personnel had extremely little control over the fulfillment of their needs and the resolution of problems and shortages. The RMO anticipated the imminent arrival of a large shipment of supplies from MSD that would significantly replenish the stocks at the regional hospital. This shipment did eventually arrive but was somewhat delayed because MSD did not have any vehicles available to transport the supplies the nearly 400 kilometers from Mbeya, where the zonal storehouse was located, to Mawingu. The RMO also said that sometimes the amount of money the hospital received from the Ministry was only enough to cover the hospital’s most basic bills, including electricity and water, which had to be paid in order for the hospital to keep operating.
All of these constraints led the hospital to try to manage funds and reallocate them whenever possible. It often meant suspending extra pay\(^4\) for the staff members or delays in the delivery of supplies, including medications, and delays in other crucial activities such as car maintenance for the hospital ambulance or repairs to buildings. The delay in the allocation of funds from the Ministry of Health and the Treasury meant the regional hospital was unable to continue paying on-call allowances for nurses, because the government had increased the required pay amounts and the hospital no longer was able to find the money for these payments in their budget. The nurses often told me they counted on on-call and extra duty allowances as a consistent supplement to their (low) salaries. The loss or delay of these payments was always a source of much indignation and complaining. On the other hand, if these payments were released, the entire hospital seemed to be in a good mood. The RMO told me that they tried to prioritize these extra duty or on call allowances, particularly for the physicians, when the money was available because “this way doctors can be able to do their work, not say ‘Oh, I’m not coming right now [to the hospital] even if I’m called because I haven’t been paid.’ So this money comes.” However, it was often the nurses who experienced the cuts that were due to new regulations or guidelines regarding the use of funds or due to the increased amount of extra duty allowances that made it no longer feasible for the hospital to pay them.

6.5 Budgets and Hiring New Personnel

Such budget constraints also affected the hospital administration’s ability to hire new staff members or promote those who had been working at the facility for many years. The hospital administration sought ways to deal with these constraints as the nurses and doctors continued to provide care to the best of their abilities. The Regional Medical Officer also

---

\(^4\) Extra duty (for additional shifts) pay or on call pay (for shifts on which a person reported for part of the time or could be on standby and depending on patient load, they might be called into work or not.)
explained that though the hospital had succeeded in increasing the amount of money it was collecting from patients on a daily basis, the Mawingu Hospital would never be able to collect as much money from user fees as some other regional hospitals, which were located in more prosperous areas of the country or served large numbers of insured patients. To drive his point home, he said,

> Therefore, even to compare us, to make us competitive [with these other hospitals], is not an easy thing. Because if you do a competition, it should be that each [competitor] is on a level playing field, then you can say you are competing. But this person, you give them good athletic shoes, equipment, and this other one doesn’t have any and he is running barefoot, then you say he is competing with the first one, how? It’s not possible.

Here he was clearly using the metaphor to demonstrate that Rukwa was lacking good shoes and could not possibly be compared to other regions that had access to sustainable and robust cash collection through insurance coverage or a wealthier population in their catchment area. This concern with the availability of cash for healthcare services in the Rukwa region was a theme that emerged repeatedly in discussions among the hospital staff members in meetings and informal discussions after the hospital raised the fees for services. Nurses repeatedly said they were afraid patients from the region would forego follow-up care, such as bandage changing, in order to try to save their money, such was the level of poverty in the area. The lack of family resources to pay for healthcare, even when the fees were still low in comparison to other regions, was also a common theme and very real barrier to care in the villages I visited.

For people unfamiliar with this region, they would often suggest the hospital just try to increase their collections, or make a better budget, or lay out better plans. This, however, was far easier said than done due to the structural constraints of the region’s economy, bureaucratic cost-sharing guidelines that were outdated and severely limited the ways in which hospital funds could be used, and the national-level supply chain problems and financial shortages.
Scarcity has long been a characteristic of healthcare facilities in many places in sub-Saharan Africa (c.f. Livingston 2012; Mkoka et al. 2014). What follows in the rest of this chapter is an account of the ways in which healthcare providers and administrators in Rukwa, and particularly in the Mawingu Hospital, dealt with this material scarcity and sought to mitigate its effects on their care practices through the implementation of new systems, and via creativity, improvisation, and ingenuity. I also demonstrate the ways in which this environment of scarcity affected providers’ motivation levels and morale. Though most of the healthcare providers working on the wards may not have known the details and extent of the healthcare system’s lack of funds, they certainly saw, felt, and lived the shortage on a daily basis.

**6.6 Increasing burden on regional-level healthcare services**

The healthcare situation in communities throughout the Rukwa region directly affected the regional hospital, most obviously by increasing the number of patients seeking care at the hospital when services were lacking at the village dispensary level. While I was at Mawingu, the timing of the crisis at MSD coincided with particularly low market prices for maize in 2014. There was a bumper crop, with some farmers producing more than ever before but, the government had already amassed a surplus that could feed Tanzania for a projected three years. Therefore, this meant the government was not buying maize from farmers at prices even remotely close to those of the harvest of 2013. In November 2014, members of Parliament questioned the delay in payments for the more than 3 million tons of maize the government had purchased on loan (Tanzania Daily News 2014). For many months following the harvest, as I traveled around the Rukwa region, I could see stacks of maize in gunny sacks piled high under blue tarps, waiting for buyers who never came. In other villages, as late as April 2015,
community members told me they were still waiting for the cash from the government for maize bought on credit or loan from many farmers more than six months prior.

What this all meant for healthcare services was a perfect storm. Delayed or no payments for the maize harvest led to cash poor families who could barely pay for the essentials, let alone unexpected costs at healthcare facilities. Due to MSD’s refusal to disperse supplies on credit any longer, healthcare facilities became increasingly bare. Without cash, community members could not contribute to community health insurance schemes, known as Community Health Funds (CHF), which were another product of decentralization. Without the money from these funds, most dispensaries and healthcare centers were unable to stock essential medications and supplies. The lack of equipment in these lower level facilities shifted the burden of care from primary level dispensaries to the district health center and designated district hospitals but, primarily, to the regional hospital, which struggled to stay afloat throughout this time. Patients and their families lacked information about the healthcare system and the CHF due to poor communication throughout all levels of the healthcare sector and local governments. This poor communication and lack of transparency created an environment characterized by high levels of suspicion and mistrust between communities and the professionals meant to work with and for them in order to improve their health and wellbeing. While community members bypassed their local dispensaries that only offered bare shelves, the regional hospital absorbed more and more of these clients who had often used what cash they had to get to the hospital. This meant it was often difficult for these clients to pay for any unexpected medications or other supplies should they be required to help the mother during labor and delivery.
6.7 Working in Scarcity

After witnessing the frequent stock-outs that were occurring in the end of 2014, I asked all the nurses about their experience of their work environment, hoping to understand more about how they viewed the shortage of medications and supplies, Nurse Rachel said,

Mmm, for now, the current work environment has become difficult. And now equipment. Now you are told there are no medicines. We arrive at work, you will find me, I’m on the maternity ward there in the labor room, you find that the mother you’re helping there, even to start a drip [IV], there’s nothing. You find the labor ward has dextrose, D5%, now there you encounter a mother there who has eclampsia, PPH. How do you help her? Truthfully, this environment is very difficult…Many times you find we encounter the women here, they have problems. There are no supplies. It’s necessary for them [the mothers] to buy a thing but they don’t have any money. This, it becomes a problem. The mother, you just look at her. I stay there with her, alright, it is only God that helps a person to give birth or not, the baby has come out, s/he hasn’t cried. Really, honestly the environment is hard. I don’t like it.

Rachel’s quote was representative of the views of maternity ward staff members. Almost universally the nurses and doctors felt the lack of essential supplies and equipment was the number one impediment to providing better care. They also repeatedly suggested that improving this situation would be the best intervention the hospital administration could make in order to motivate the providers working at the hospital. While the nurses were concerned with having the tools they needed in order to provide the technical aspects of care, Rachel’s description also highlights her sympathy for the woman who could not afford sending a relative running to a private pharmacy to buy supplies. Aside from staying with the mother, Rachel was unable to provide other forms of care to the woman in her charge. Her assertion that it was only God who was able to help a woman give birth reiterates staff perceptions that it was nearly impossible to provide the highest quality of care or to change the situation in which they found themselves on a daily basis.

---

5 Dextrose 5% is not used to support women with fluid loss or to help support blood pressure, therefore would not be useful if a woman was suffering from eclampsia or PPH.
In the Conditions for Work Effectiveness Questionnaire that I conducted in November 2014 with all the maternity ward nurses (n=25, response rate 96%), the questions related to access to resources received low scores, with an overall average 2.55 out of 5 for the section.

Fig. 6.2 CWEQ results for access to resources

Nurses of all levels on the maternity ward responded to the survey, which means some of the variation in ratings depended upon their position in the hierarchy of the ward and the hospital. In
question 1, less than half of the nurses said they had “some” of the supplies necessary for their jobs, which they told me was because the Medical Officer In Charge had been working very hard to improve that situation even if it was still not ideal. Questions 5, 6, and 7 all indicate that the nurses generally did not think they had much influence over the decisions made about human and material resources for the ward. Generally, only the Nurse In Charge did the ordering for the supplies. During ward meetings with both the doctors and nurses, we often discussed supplies and equipment, returning over and over again to the needs which never seemed to be met. For example, nearly the entire time I was on the ward, the suction machines the nurses used to suction secretions out of newborns’ airways was broken or only occasionally worked. Another time, it took nearly six months to get batteries for the handheld fetal heart monitor that I had brought for the ward. In the end, I bought the batteries myself due to the delays created by bureaucratic procedures and hospital’s subsequent workarounds.

6.8 Uchache as Excuse and Idiom

In addition to the material scarcity produced by stock-outs, in 2012, and even into 2014, hospital staffing levels were also a source of frustration and great concern. Nurses expressed their belief that there were simply not enough of them to conduct all of the necessary patient care and documentation activities that a ward as large as maternity required. At that time, the nurses and doctors often referred to uchache, or “fewness,” specifically of providers, as a key barrier to improving maternal health outcomes at the hospital, though the Medical Officer In Charge did not feel this was an appropriate excuse for not exerting maximum effort with every individual patient:

The Medical Office In Charge (MOIC) says, “I know we can’t avoid death but you get a death like this and see there were gaps.” Nurse Mary saying maybe the problem is documentation; maybe things were done but the documentation was bad. MOIC is saying if you say the problem is documentation, you’re doing a lot of things, then you should say
the problem is that there aren’t enough people “uchache,” just say that because that is the issue. Mary is now saying that if there are only two people working and there is a special case like this [woman who died] then there are two problems, uchache and documentation. Now they are discussing the issue of shortage of staff and the division of labor in the ward. MOIC tells them that even if they are few, he expects each provider to give 100% to the patient they are with. RMO [Regional Medical Officer] asking if right now, where we are, it still happens that women are giving birth unassisted? Everyone agrees that yes, this still happens…Eventually, MOIC makes the point here that it’s not uchache, the issue is that we are not prepared when we see the patient. We are not prepared with the equipment and documentation.

(Notes from Maternal Death Audit Meeting, July 2014)

While the nurses and other maternity ward doctors argued for the difficulties of having insufficient numbers of providers on the ward, the Medical Officer In Charge continued to challenge them, insinuating that the number of providers was not the issue, but their lack of skill or preparedness and, by extension, their commitment and motivation to their work. This was a topic which he brought up many times throughout discussions with the maternity ward staff. In light of the fact that the maternity ward received at least eight new nurses during the duration of my fieldwork, it would appear as though the number of people was not so much a cause of poor care as invoking uchache was a way to locate the source of the problem of on-going sub-standard care or deaths on something outside the direct control of those on the ward. Maintaining this discourse accomplished a sort of status-quo that served the nurses by not requiring, as the Medical Officer In Charge asserted, higher levels of preparedness or commitment. Even as the hospital and regional health administrators sought to continue hiring greater numbers of qualified providers, the problems of miscommunication and delays in care that staff members had been attributing to their few numbers did not disappear. Additionally, I argue that the continued use of uchache can be read as an idiom for more general lack of workplace empowerment and professional efficacy.
6.9 Collecting Cash and the Expansion of Biobureaucracy

Often, the nurses told me, and I witnessed, delays in care occurred as family members tried to find the monetary resources to buy medications or essential equipment for their patient. Some mothers waited on the ward for several days before receiving the first dose of a prescribed drug while others did not have the luxury of time. Emergency C-sections resulted from a number of clinical conditions, which commonly included pre-eclampsia or eclampsia and obstructed labor with suspected fetal distress. In these cases, providers, women, and their family members could not wait. Surgeries could not commence without ketamine, the anesthetic drug most commonly used, or sutures, or IV fluids, or a catheter and urine bag. Hospital protocols for the distribution of such supplies changed multiple times throughout my stay at Mawingu. For many months, the cabinet in the ward Nurse In Charge’s office housed all of the ward’s supplies save for those needed for anesthesia. At another point, all the supplies were no longer allowed to be housed in the wards but the ward staff had to report to the pharmacy with prescription forms signed by the physician who had ordered the procedure or medication. This change was related to the implementation of a new accounting system at the hospital in September 2014. While in many ways this computerized system helped to significantly increase the amount of money the hospital was able to collect each day, crucial for its continued operation, it also brought with it a host of new complications. The new system impacted the maternity ward in ways that were unique and unheard of in other wards. This was primarily because nearly 100% of the care provided on the maternity ward was exempt, which means it was paid for by the government. Therefore, prior to the new cash collection and accounting system, the maternity ward had never dealt with receipts or the collection of funds from the women who came to give birth.
Prior to the automated system, nurses on each ward that did not serve exempted categories of patients collected money from clients as the need arose. This meant the corner of a patient’s file often sported a stack of multi-colored rectangular pieces of paper that served as receipts for items such as ward admission fees, bed fees, laboratory tests, wound dressing, medications, IV fluids, and more. This system often created confusion, particularly for patients, who were unaware of the prices of services and supplies and did not know who was legitimately allowed to collect cash. I was present once on the gynecology ward when a distraught group of relatives came in with a patient in a wheelchair. The nurse and two of the women accompanying the patient engaged in a prolonged discussion about whether or not they had paid for IV fluids and if so, where was the receipt to prove it. Many community members felt this collection process encouraged corruption and bribes because it was unclear who was supposed to be paying what, to whom, and when. Nurses could arbitrarily deny care, citing unpaid balances, and delay potentially life-saving care. To me, as a bystander that day on the gynecology ward, it also appeared to be a system perfectly designed to take advantage of the ignorance of arriving patients and their family members, rife with possibilities for extortion and corruption. Nurses, on the other hand, told me they would provide care for a woman before looking for the receipts if they felt she really was in the midst of an emergency. But, many nurses were unsure of the current prices to charge the patients, nor were they certain whose responsibility it was to do the actual collecting. This confusion could be compounded by poor communication during shift changes. From an administrative perspective, this system more than once resulted in patients and

---

6 Only women who were pregnant and at a gestational age of 28 weeks or later were exempt from the hospital fees, i.e. labor and delivery services were free. Prenatal care was free to women throughout their pregnancies at the maternal-child health clinics but services related to spontaneous abortion (miscarriage) or ectopic pregnancy, for example, were not considered exempt. The woman and her family were responsible for these fees.
their relatives sneaking away from the hospital at night or during the chaotic visiting hours, leaving their debts unpaid. The hospital had already incurred the cost of the physical and human resources expended and now had very little recourse for recouping the loss when a patient “absconded” without paying.

The new computerized system significantly and rapidly increased the amount of money the hospital was able to collect for services on any given day. However, it also drastically changed how the maternity ward staff members conducted their work and requisitioned and accounted for supplies or services rendered. Despite the fact that the women on the maternity ward never had to, officially, pay for care, the administration began to require a daily tally of the supplies used in the course of caring for each patient. This was to help with the ordering of supplies at the level of the hospital’s main pharmacy and stores department, as well as to limit waste. The maternity ward nurses primarily saw this as yet an additional burden and part of a more general proliferation of required documentation. Now, before a nurse could take a patient’s samples to the laboratory for testing, she had to go to the accounting window to get a receipt, have it stamped with the word “Exempt,” have the person in this office staple it to the lab test requisition form and only then could she proceed with the sample to the lab. This was not generally a problem at night when there was not a line of people waiting at the OPD’s cash collection window, or nurses from other wards waiting for receipts, but the process of actually getting blood test results could be significantly delayed at the accounting window.

However, even at night, I myself experienced this delay when I wanted to take blood samples to the lab for a patient we thought might need an emergency blood transfusion. The person on duty was a medical attendant who had previously been assigned to the maternity ward. Her time on the maternity ward was short because the nurses thought she was argumentative,
generally difficult, and not a good worker. She would frequently deny responsibility for tasks or refuse to do work that she thought was beneath her, counter to the ways in which the nurses told me they thought of necessary tasks, i.e. each person must do any and everything necessary to help the ward function; no task was below even the most highly educated nurse. This particular medical attendant then had started working at the cash collection window and brought to that work the same argumentative and generally unhelpful attitude. Regardless of the patient waiting back on the ward, she would take her time, pecking out names and the ward number with one finger on the computer’s keyboard. Before beginning to stamp any of the pages she would wait for all of them to emerge slowly from the printer. These types of inefficiencies seem relatively harmless on the surface but could add up to life-threatening delays for mothers and babies when combined with all the other opportunities for delay. These delays did not necessarily produce scarcity but the expanded bureaucracy within the hospital made it ever more difficult for the nurses to access what supplies were available, compounding their work and, often, frustration levels.

At the same time that Tanzania’s healthcare system and Medical Stores Department were suffering from steep financial shortfalls, the demand for biomedical services in facilities continued to expand at a rapid rate. The RMO suggested that with an improvement in the quality of care, the hospital has seen an exponential increase in the number of people seeking care at the facility:

AS: I’ve noticed that since last year in about October we have had fewer medications and equipment here. Is there a problem with equipment here at the hospital?
RMO: No, really I don’t think so. What you are seeing is that more and more people are coming here because they see that the care we are providing is high quality. It used to be that not a lot of people were coming here, but now many of them come even if they should be going to the health centers or the district hospitals because they see the care here is better and it’s more in demand so we are using more medicine and equipment.
His explanation demonstrated his confidence in the improving quality of care, at least in comparison with that which was offered at dispensaries and other lower level facilities. There was not a commensurate increase in cash collection and central government funding that could provide the necessary increase in demand for supplies, but the hospital was able to implement systems to manage this increased patient flow. With the expansion of services in the hospital came a concomitant expansion in the bureaucratic systems employed to track, order, and process this new patient flow moves through the facility. The implementation of the automated accounting and cash collection system is another example of the biobureaucratic expansion that has accompanied the expansion of healthcare services globally. While construed as an improvement or advancement because the system relied on computers, it brought with it a number of unintended consequences, such as the medical attendant’s gatekeeping.

On the maternity ward, biobureaucratic expansion very often manifested as yet another notebook or oversized data collection book appearing on the stack on the labor room nurses’ desk; yet another notebook appeared with the advent of the new accounting system. The nurses were meant to use this new notebook to record the supplies used for each woman and they were supposed to take the notebook with them at the midnight report to the Nurse Supervisor. These books continued to multiply to accomplish the objects of biobureaucratic institutions and the proliferation of their efforts to track, monitor, supervise, train, and constrain the healthcare providers working both in urban centers and the periphery. In addition to the accounting and supplies book, the ward regularly received new HIV testing logs and logs for documenting the provision of family planning services, for example. Handbooks and workshop participant activity books seemed to reproduce in desk drawers as the nurses attended various trainings related to
BEmONC, Helping Babies Breathe (HBB), the NASG, HIV testing, cervical cancer screening, or TB prevention.

The nurses felt the effects of this expansion through the added tasks of documenting the number of syringes and pairs of gloves used each day in service to each patient. They felt it in their interactions with newly empowered gatekeepers in the form of medical attendants who controlled the processing of receipts and “exempt” stamps and, by extension, critical laboratory tests, medications, and vitally necessary equipment for patient care. While one might argue all healthcare providers in a government system are “street-level” bureaucrats (after Lipsky 2010), these medical attendants were, additionally, embodiments of continuing biobureaucratic expansion. In a classic study of the relationship between location in an organization and access to power, Mechanic (1962:352) argues “within organizations one makes others dependent upon him by controlling access to information, persons, and instrumentalities… power is a function not only of the extent to which a person controls information, persons, and instrumentalities, but also of the importance of the various attributes he controls.” In this way, it is clear the medical attendants, despite low access to formal forms of power within the hospital’s organizational structure, became quite powerful with the expanded bureaucratic procedures involved in producing more accountability and improved cash flow. They came to control money, medications and other supplies, access to laboratory tests, and, ultimately, the speed of all the myriad interactions now required before the actual treatment of patients. The computerized system simplified certain interactions, perhaps increasing transparency and subsequently reducing allegations of bribery or corruption on some wards. However, the system’s unintended consequences included opening new spaces of inefficiency, new opportunities for delay, miscommunication, and social maneuvering by the gatekeepers.
6.10 Delays in Care and Social Tension

For those women on the maternity ward who needed C-sections, the process for getting all the necessary equipment eventually became much more convoluted. The nurses could not start preparing a woman for surgery, even if they were certain she would require a C-section, until the doctor had officially written up prescription forms for all of the specific, individual supplies. This resulted in multiple pieces of paper and the nurses then had to go both to the cash collection window, as when taking lab samples, and then to the pharmacy window. The person on duty at the pharmacy was often a medical attendant and could be incredibly inefficient, and overly fastidious, refusing to hand over supplies until all of them were in a pile, taking the individual prescription forms and painstakingly entering them into the log book by hand, refusing to accept only one copy of the forms, and then sometimes disappearing for long periods in search of less common supplies. There were times when even the most basic supplies were out of stock, particularly IV fluids or catheters and the nurse would return to the ward empty handed. At this point, the surgery could not proceed and nurses or the doctor would direct the woman’s relatives to quickly go outside the hospital gates in search of the needed supplies. This resulted in further delays as relatives sought out money, then an open pharmacy store, and then the correct equipment. Sometimes, the instructions they received were not explicit enough and the relative came back with the wrong size or strength of a medicine or catheter, which then the hospital staff could not use.

Nurse Halima expressed to me the difficulties of the work environment at the Mawingu Hospital. She was a young nurse who had only been working at the hospital for less than a year at the time of our interview and she had spent the first several months of her employment working on the private ward, Grade I. Her short time at the hospital had already been sufficient
for her to perceive the lower economic means of Rukwa’s population, as compared to other regions, as well as the monetary constraints at play in the hospital:

The [work] environment is just normal. Except that another time it is difficult. You find maybe that there is no equipment. … The supplies really are bothersome for the success of the work. [It] can be that you have studied how to do this procedure but you can’t do it and because why? Because of the shortage of those supplies that you need to do work. And if you use more than is necessary, that is, more than has been put in the budget, it means you will do what? You ruin the entire system. It means that the supplies absolutely are not enough. For example, they have said to use maybe six drapers. After only half an hour the mothers that have already given birth, maybe ten or twenty, you find there aren’t any drapers, not even one. She will come, a serious person, for a [wound] dressing or she needs suturing, [and] you find that you are defeated, unable to do it because you have already used everything that you needed to use, but because there is a shortage, you find that you yourself have caused this other patient to not be worked on. Really, you were doing the thing that was proper therefore this other work will really bother us a lot. You find someone comes, she needs to be cared for, you fail to care for her like is necessary. And many people from here [Rukwa] they don’t have any [economic] means. To say, maybe, go, buy something, bring it for your patient, maybe, for example, you say Ringers Lactate right now there isn’t any, if you tell [the relatives] to go find Ringers, they will be distraught, they don’t have any money, and the baby there will continue to get tired. So, this environment is difficult. But, at the end of the day, the [relatives] can’t criticize that there are no supplies, they will blame you like, “You, nurse, what have you done?” Or that you have caused something. But to look if the environment in which you work is difficult- they can’t look.

This quote from Halima exemplifies the frustration many of the nurses and doctors felt when supplies and equipment were out of stock. She also notes that when the nurses must tell patients something is unavailable within the hospital and their relatives must purchase it at a private pharmacy, it was often the nurses who took the blame. More than once, while I was present, the hospital Patron held meetings with many of the maternity ward nurses to address patients’ allegations of corruption or extortion.

While there is certainly a history in Tanzania of underpaid and overworked healthcare providers accepting or demanding bribes from patients and their relatives (Maestad and Mwisongo 2011), the majority of time I was at the hospital the supplies were, indeed, out of

---

7 A type of intravenous fluid, one of the two most commonly used fluids on the maternity ward.
stock when nurses said they were; this was not simply a ploy for money. Still, more than once, patients or their relatives offered me bribes, trying to slip me a few bills in their palm as they shook my hand. As they tried to hand me this money, a woman’s relatives would explain that they wanted to make sure I looked after her and helped her. Other times, as I was helping during a delivery, I watched as a new mother tried to give one of the nurses money as thanks for her help. In most cases, the nurses refused the money, telling the mother to put it back in her handbag. Occasionally, if the mother continued to insist, the nurse would take the proffered money. Once I watched this happen when the then Nurse In Charge of the ward, Kinaya, was handed money. She explained to me that nurses were not supposed to take money of any sort, citing the Nursing Code of Ethics but, it was allowable if they reported the money to the Nurse Supervisor and used it for collective or ward purposes. In that instance, she sent one of the cleaners to buy a crate of sodas and some cookies for all the ward personnel to share. Despite her proclamation about not accepting bribes, Kinaya had accepted the money and none of the nurses complained; even something as simple as a free soda during a long shift was a welcome bonus. I was nearly always uncomfortable when I saw a woman reaching for money, or if it was visible inside her bag of belongings, because I always wondered what the nurses would do. I can only know what I witnessed but I did think it was not a far stretch of the imagination to picture a nurse, alone on the night shift, accepting, after a long delivery, some few bills that might pay for a ride home after her twelve-hour shift. A long history of corrupt practices in the healthcare sector, even extending to the sale of blood to desperate patients and families in the past, led many women and their families to suspect the nurses were only saying medications or supplies were unavailable in order to line their own pockets.
One day on the maternity ward I was discussing the issue of possible misunderstandings and perceived corruption with Nurses Peninah and Rukia. Peninah told me,

You know, me, I think it’s really the fault of the hospital- from the beginning there, if in the past they were training those people [patients] that ‘you, if you go to the big hospital, it’s necessary that there are these and these and these and these necessary items or you will have to pay,’ they would prepare early, but right now it has come suddenly that things have run out and they got used to if you go to the hospital everything is free, and now they have been told ‘go buy this.’ She will see you, you are telling her to buy it and that you are eating [the money]--.

The saying “to eat money” (kula hela) is a common expression denoting corruption or bribery.

These misunderstandings between the nurses and the women they cared for were often a source of annoyance but also consternation because the accusations went against the ethical codes to which most of the nurses ascribed and sought to practice daily. Most of the nurses were offended by the suggestion that they might be corrupt and were particularly incensed anytime the issue of blood surfaced. The blood bank often had only a limited supply and therefore encouraged family members to donate a unit of blood as a replacement unit for the one their patient was receiving. However, the lab employees did not always communicate this clearly or the relatives did not always understand and, instead, heard that they were being charged for blood or the lab personnel were withholding the desperately needed unit until someone donated. A sort of blood donor blackmail. In the preface, I described the care and ultimate fate of one woman who died due to a lack of blood. Sometimes the urgently needed units were unavailable in the blood bank or, if they were, family members saw no need to donate. This could mean that, for a woman like Paulina, whose life was threatened by an absolutely unforeseen surgical complication during a scheduled, non-emergent C-section, death was the result.

Figure 6.3 is a poster that was up in the maternity ward when I returned in 2016, which I had seen in other health facilities previously. It states, “Blood isn’t sold, it’s always free,” which
is in direct response to these misunderstandings and previous blood-selling practices. The posters sought to empower community members by informing them of their rights and the norms of blood donation so they could report corrupt practices.

Fig. 6.3 Sign reading, “Blood isn’t sold, it’s always free” in red and below it, “If you are sold blood, report it at the following numbers.” The numbers listed include the “hospital leader,” the “Safe Blood Center” in Mbeya Town, the zonal headquarter, and the number for the Taasisi ya Kuzuia na Kupambana na Rushwa- Bureau for the Prevention and Combating of Corruption.

In the same conversation, I suggested to Nurse Peninah that I thought the government had started making services free for pregnant women because they had seen that a lot of women in poorer areas were not giving birth in health facilities. The Tanzanian government particularly
thought this to be the case in the 1990s after they instituted user fees for the first time in the country’s history. In response Peninah told me,

Indeed, it was that that started this, I’ve seen, but instead its second effect those people [government officials/policy makers], they didn’t see it. They are coming to discover it right now. Now [the money] it has finished [run out]. How will you tell that person that doesn’t have any means there in the village “hey, there is no equipment for service”? Will she understand you? She doesn’t understand you! Again, us, we that deal with patients, we’re seen to be bad [people]! Better that person who sits at administration, they don’t see him, but us, we who tell her to go buy, she tells you you’re delaying her because she was looking for supplies.

She went on to give an example of how these delays might affect the care of a woman who had come to give birth, “Just say that she’s prime. Yeah, if she’d had contractions she would have already ruptured. But the blame will come back to the nurse who stays with the patient, you’re told first you delayed treatment, second why didn’t you inform someone? But you’re waiting for important supplies.” A “prime” patient is a woman in her first pregnancy. It is very uncommon for a woman in her first pregnancy to have a ruptured uterus and Peninah used this as an extreme example of delay- a woman in her first pregnancy must be experiencing severely obstructed labor and a long delay in initiating a C-section if she got to the point of uterine rupture. In her example, the woman’s uterus only did not rupture because she was not having contractions. The main point of the example was to demonstrate the ways in which the nurses often felt they were blamed for delays or poor outcomes and unsatisfactory care because they were the ones who spent the most time with the patients. They were visible and therefore within reach when women, their relatives or hospital administrators sought to attribute responsibility for a woman’s death, poor care, or other unexpected outcomes of her stay at the hospital.

To the conversation, Nurse Rukia added, “They go to the doctor, they come to beg for her, yeah. ‘We have brought her to the hospital and everything is free!’ You see? But rather somebody brought maybe just one small box of DNS and it’s already been finished.” to which
Rukia and Peninah both agreed, showing that nurses were often blamed for supply shortages but, in actuality, they had little control over their availability, depending on lengthy and bureaucratic ordering procedures. This particular conversation occurred in February 2015 but was only one of many times when nurses would complain about the lack of supplies, as well as the way they were blamed for causing this shortage. Martin’s (2009) study of nursing in Uganda suggests that this is not an isolated phenomenon; while nurses or doctors see referring patients to outside pharmacies as a necessary byproduct of more systemic shortages, patients might read this same act as “corruption, greed or indifference” (Martin 2009:128). Women’s and their relatives’ expectations that care would be free and available at the hospital was often an ideal constructed against the background of their experiences with stock outs in their village dispensaries. They assumed that the regional hospital, the top level of care in the area, would be able to provide the needed care and equipment lacking in their communities, which was often why they incurred the expense of the transportation to and stay in town near the hospital if they had traveled from outside the urban district.

6.11 Supplies as the Foundation of Community Trust

Faced with the nurse’s demand that they purchase supplies in a private pharmacy, many community members concocted explanations that went beyond stock-outs because they also did not understand how the government supply chain operated and therefore did not know a large government facility might actually be out of critical supplies. The fact was that supplies were so short as to drive the Regional Medical Officer to comment one day during the morning clinical meeting at the regional hospital, sometime in early 2015, that the hospital would soon be nothing more than a guest house, full of beds but no other, additional services. Despite the reality, the perception that such a large facility, or any facility backed by the strength and size of the central
government, could never truly be out of supplies was pervasive in communities outside Sumbawanga Urban district. Village leaders and community members repeatedly told me they did not believe the government health facilities really did not have medicines available while private pharmacies continued to have them in stock- the private purveyor of drugs is so small and the government is so big [powerful], how is it, then, that the small person is able to get supplies the government cannot? A focus group participant in a village in Kalambo District told me,

…They tell you ‘go, buy those drugs’ and honestly, if you follow-up in all the dispensaries, you find that these drugs don’t go [there]. Now, the government, I don’t know. If you go to the private pharmacies you find there the strong drugs, like these gentamycin, you find them in these pharmacy stores. Now why is it that the government fails to bring these for us here so we can be treated here? If you go to town, you find these strong gentamycin, stronger than even PPF. They themselves [the government] see that we have become fruit to be harvested in the drug shops, rather than bringing us [the drugs] at the dispensary. Then, if you find the doctor has treated you, it’s aspirin, flagyl, Panadol, and amoxicillin, that’s the end. (Ngorotwa village men’s group; emphasis added)

And a second participant responded to these comments with, “Even amoxicillin it’s just one container. Now, for this entire village, you find there’s just one container …The doctors, they have their own drug store, yes, that’s the business that we see, that.” The insinuations that doctors or nurses were selling government provided drugs for private gain was a pervasive concern. In this particular community, there was palpable distrust of the government services and its local representatives—the healthcare providers at the health center—with one person even suggesting the government itself was in on the plan to extract more money from citizens by forcing them into the drug shops instead of providing them with drugs in the healthcare facilities.

The conversation in Ngorotwa continued and several of the participants agreed that their health center, and most dispensaries, were nothing more than buildings if they did not have these medications and other supplies readily available. While in communities I did not witness any examples of corruption but heard many men and women in focus group discussions provide
examples of times they had been seeking care and were charged for an item or service that should have been free (chapter 4). For many years, the healthcare sector, together with the police, was said to be one of the most corrupt sectors in the country; I have heard this as part of a more general public discourse on corruption. There have long been anti-corruption activities in Tanzania but it continues to be a challenge (Lewis 2006; Mwafisi 1999; U4.no Anti-Corruption Resource Center 2014).

This exchange in Ngorotwa village demonstrates the ways in which, through repeatedly failing to have supplies, health facilities worked to undermine the legitimacy of the state itself. Here, then, was a failure of state care for its citizens via one of its institutions with which people interacted the most, and always in times of need and states of vulnerability—sickness, pregnancy, injury. When the state failed to meet these fundamental needs, people were forced to resort to extremes, such as strapping nearly dead patients to private motorcycles (chapter 4), and great personal expense in order to make up for the state’s lack of care.

Clearly, the lack of availability of medications and supplies was prevalent at all levels of healthcare services in the Rukwa region. However, patients and their family members continued to expect the regional hospital to have medications and everything else necessary for their care. The lack of drugs aggravated the relationships between patients and healthcare providers (Martin 2009:128) and may be one of the most crucial elements of establishing the high quality of services available and for reinforcing the legitimacy of the state itself.

Community members often decided to bypass their community healthcare facility, opting to go directly to a health center or even the regional hospital in the hopes of finding more supplies and better quality medications at these higher levels. However, this just further increased the burden on these higher level facilities, without any increase in financial supportive
from the districts that were off-loading their patients on the regional hospital. Again, because care for pregnant women was, by policy, free, this increased patient load in the maternity ward was particularly worrying and an enormous drain on hospital resources. Even as the ranks of the nursing staff swelled in maternity in 2014 and 2015, more hands did not mean more supplies. Community members, sometimes coming from long distances, expected high quality, full service care at the regional hospital and were increasingly disappointed if their expectations were not met. In the meantime, the nurses and doctors continued to strive to do their best without first line medications of choice, or any at all, and improvised catheters from NG tubes and gloves or other methods.

6.12 Motivation and The Impossible Demands of Work

Nurses had to contend with the increasing scarcity of supplies, while also handling higher patient loads than ever before. This led to incredible stress that caused many of the nurses to tell me that they were often demoralized by their work environment. However, this environment also engendered impressive stories of innovation, imagination, and improvisation.

In my interview with the hospital’s Medical Officer In Charge (MOI) in May 2015, I told him since I had starting coming to the Rukwa region in 2012 people had been telling me that the hospital staff members were not motivated. Sometimes this charge was leveled by community members, other times it was the doctors talking about the nurses. I asked the MOI what he thought he, or the hospital administration, could do to improve the level of motivation and morale among his employees. He said:

I would say, number one [is] to increase the level of supplies- that will boost the morale. Because you are not being motivated if you don't have something to use, you don't have medicines for patients, the infrastructure is poor, you don't have uh supplies, you get demotivated. Then, from there, we may think of… like some competition… which departments works better, then we may recognize it by a letter or by certificate. … Probably that one would also boost the morale. But we cannot think about that sometimes
because there are these problems with supplies so your head gets congested. I think I have to manage first these…But the issue is [the] money is never enough.

He also told me in the same conversation that even if the nurses and doctors said they would like recognition for their work, even in the form of verbal praise or certificates, what they really wanted was money and the hospital simply could not incorporate higher wages or a system of monetary incentives given the already extremely difficult financial state of the institution.

I also asked the Regional Medical Officer about this issue of motivation and what he thought could help the regional hospital staff members to be more motivated in their work. First he asserted, “Ah, all these things we’ve done, honestly, if a person still isn’t doing work with great effort, well this person, that is just how they are- they won’t do it.” This was primarily in reference to all the ways in which the hospital and regional health administration had tried in the past three years to ensure the staff members received all the workers’ benefits to which they were entitled as government employees, including payment for hospital treatment, paid vacation every other year, promotions every three years, and any back pay they were owed, as well as housing allowances for the physicians. However, the RMO went on to say,

Also, to really ensure that the environment [at work] is better than where they are [home]. That is, infrastructure. If you come, maybe you encounter the Out Patient Department (OPD). I gave the example of the OPD, when you enter in there, you find that it is rundown, it’s from a long time ago, there isn’t any nice furniture in there. Therefore, even a person that is coming from home comes, she enters there, ‘Oh, I see it’s better if I just stay at home,’ but if there it is looking nicer than at her home-it’s not a secret they’re not working- the work environment should be nicer than there at her home, where she is coming from, so she is pulled to stay at work more than staying at home. This is the secret. She enters, she comes to work, she finds that she gets tea there close by, if she turns around there’s lunch like there near the laboratory8, yeah she finds that everything is there. There is nice furniture. If it’s a computer for doing work, it’s there. Equipment is there. If she turns around there is a blood pressure [cuff] right here, glucose test here, stethoscope here, yeah? Nice things. She likes to stay at work. It’s things like that.

---

8 Near the lab there was a hospital canteen that served breakfast/tea and afternoon meals to the public and, primarily, the hospital staff members.
In his view, creating a physical environment that was pleasing was an important way to help retain staff members and ensure they felt more motivated to be at their work stations. One aspect of this overall environment that did surface multiple times throughout my stay was the availability of tea, electric kettles, and sugar (at the bare minimum) on the wards. The nurses on the maternity ward, and throughout the hospital, considered this to be a crucial part of making their working environment a livable place. They variably justified it to me as making it easier to have a bite to eat without wasting time leaving their work station or being due this small comfort because of the hard work they did, or because, particularly on the night shift, no other food was readily available inside or outside the hospital grounds. Either all together or in shifts, depending on the workload, the nurses on the maternity ward would take a tea break once per shift, pausing to refresh themselves with tea, conversation, and “bites” or snacks such as chapati or maandazi or vitumbua, which were donut-like items. At almost every all-staff meeting I attended, the nursing staff members requested the hospital start providing bread, in addition to the tea leaves and sugar they already allocated for each ward. The nurses said they needed something to have with their tea. While a single loaf of bread was only about 1000 TSh (or 50 cents), providing it every day on every ward, for the more than 200 staff members, was a strain on the budget. The Medical Officer In Charge told me they once had done this and very soon the staff were no longer satisfied with the loaves of bread but began wanting a variety of snacks, at which point, the story goes, the hospital administration went back to providing only tea leaves and sugar.

It may seem like a small demand but I read these repeated requests for bread or other snacks as a bid for care. The hospital staff members felt the provision of bread or other snacks would demonstrate that the hospital administration had validated their presence and acknowledged their hard work and humanity. In many instances, issues of motivation seemed to
center around the point that the nurses felt they were unseen and unheard. Very often, they were simply looking for some form of recognition from their superiors both on their ward, as well as within the hospital more generally, which can also be seen in the sore feelings many nurses had about seminars, as I discuss below.

Another section of the Conditions for Work Effectiveness Questionnaire focused on the nurses’ access to support, in various forms, in their work environment. The average rating was 2.498 out of 5 in the section.
The questions which the nurses gave the highest concentrations of low scores were those having to do with praise and recognition - questions 1 and 9, with 10 and 18 respondents, respectively, saying they received no information about what they did well and no rewards or recognition for
jobs well done. The nurses also largely felt they received no information about job options or educational opportunities, 4 and 5. According to Laschinger’s (2012) tool for interpreting the scales, low scores in any of the sections can correlate with a work environment that makes nurses less effectively able to do their jobs or less satisfied with them. Using the principles of her CWEQ, Laschinger et al. (2009) and Laschinger and Finegan (2005) have found that low measures of empowerment in the workplace lead to burnout, high nurse turnover, and low trust in their work institutions, resulting in poor commitment to the institution, which directly results in reduced patient safety and poor outcomes. The same was certainly true on the Mawingu Hospital maternity ward, where the nurses often felt abused or abandoned by administrators.

While the administration was often concerned that the actual infrastructure of the hospital contributed to staff member’s feeling unmotivated, this was not something that came up in the discussions of motivation and the work environment I had with nurses and physicians. Most commonly, the nurses were concerned with the availability of supplies and another important factor— with the quality of leadership and mentorship that was displayed by the hospital management, at both the ward and hospital level.

Nurse Anna started speaking about the hospital’s infrastructure and the availability of up-to-date technology and quickly moved into a discussion of money as a motivator. She described to me what she felt they, as nurses, needed in order to improve the quality of services they provided on the maternity ward,

Us, in order to improve services, we need technology. For example, other wards have computers now and we, if we had one too, it would help us, but also let’s improve the environment meaning that motivation, they should give us [to show] they care for us, the maternity ward, that’s to say, we swim in blood and you know in the blood there is HIV and hepatitis. Therefore, even if they said 10,000 [TSh] every month for each provider on maternity, it would be motivation because of the type of environment in which we work. (emphasis added)
In this answer to my question about improving services, Anna brought up the issue of extra money, rhetorically linking this extra money she would like to the risk inherent in midwifery care on the maternity ward. She also explicitly connected these extra funds to both motivation and institutional practices of caring for the staff members. Many of the nurses who had been working at the hospital for more than three or four years had mentioned to me, in other contexts, that the maternity ward staff members used to receive an additional amount of money each month that was classified as a “risk allowance.” I asked Nurse Anna what this money was for and she told me,

You know, there in the past we were very few providers. You find in the entire building you entered only two people, therefore the work was really heavy [hard]. Therefore, for this reason, work that should have been done by four people was being done by two people. Now they saw that that money they would pay six people to do the work, better they should give it to those that were present. But now, if you go there they tell you that you are many now or you don’t do the work well so, that’s it, the money is finished, like that.

Here, in addition to explaining why the ward staff members received this risk allowance in the past, Anna also gave the standard explanation the administration cited when explaining why this money was no longer given out. There were enough providers and there was, therefore, no need to pay each person more for what was a more reasonable amount of work. Many of the more recently employed maternity ward nurses simply did not know this money had ever existed and did not bring it up as something they would like to have in order to help them feel more motivated. Instead, they were more likely to talk about generally improving the work environment or, if discussing money as a motivator, were more likely to refer to the extra duty and on call allowances that they had recently not received.
6.13 Seminars to “Refresh Your Mind”

Nurses and doctors both cited a desire for more continuing education or on-job training opportunities. They felt there had been advances in technology or changes to what should be considered best practice but they said they often felt left out of these “up-dates.” The Ministry of Health and NGOs often hosted seminars to disseminate information about new techniques or practices. Often, the healthcare providers told me the chance to have a change of location and attend a seminar was important for maintaining their levels of motivation. In addition to being able to travel, often outside the region, to attend these seminars, each participant received a daily allowance as a per diem, in addition to being reimbursed for travel costs. This extra money was an attractive incentive, too. The per diems created what others have called a “seminar culture” (Boesten, Mdee, and Cleaver 2011). In my experience, the attendance itself was incentivized via these payments but the actual learning and retention of knowledge or the implementation of newly acquired skills was not. Nurses told me the hospital did not have any mechanisms in place to ensure that people who attended seminars actually shared the new knowledge or skills with their fellow providers.

When I presented some preliminary insights from my research to members of USAID in Dar es Salaam in August 2014, one of the women repeatedly assured me there were national guidelines regarding continuing education and they outlined how seminar attendees should disseminate new knowledge once back in their workplace. She and I went back and forth a number of times as I insisted that, be that as it may, people were not following the recommendations, she retorting that they should. For me, this interaction reinforced the bureaucratic fixation of many program planners. The very fact the guidelines existed seemed, to this woman, to mean they were being followed. I instead challenged her by insisting the fact of
the matter was that people were not disseminating the information gained through these sometimes high cost training programs. The woman then went on to suggest that providers at other hospitals, such as Mt. Meru in Arusha, were able to implement guidelines and were successfully providing high quality care. Here again she refused to appropriately take into account the variation within the country and the vast difference in resources between Mt. Meru Hospital and the Mawingu Hospital. I left the meeting feeling like we had spent the entire time talking at cross-purposes, a perfect illustration of what so many public health interventions continue to get wrong. In another conversation in July 2015, an NGO country director told me that while she realized seminar per diems often incentivized the wrong aspect of the programs, they were government mandated, no one would agree to participate without them, and, in fact, the government had just increased the rates.

Due to the attractiveness of extra pay and a chance to travel, seminars were a constant topic of conversation. Many nurses told me the ways in which people were selected to attend were opaque and they did not understand how certain people were selected repeatedly and others were never given the opportunity to attend even once in a year. Accusations of favoritism or ethnic preference abounded. The nurses generally thought the hospital Patron was in charge of selecting who should attend seminars but no one was entirely sure of the procedures. Therefore, many people felt the Patron simply selected his personal friends or fellow administrators or fellow ethnic group members (he was from a neighboring region, not originally from Rukwa and therefore a member of a different tribe than many of the hospital’s providers). Overall, these suspicions led to a great deal of dissatisfaction among the nursing staff throughout the hospital and, especially, on the maternity ward. In fact, when I asked the Patron and Assistant Matron, they explained the procedures in place for selecting staff members for seminar attendance. There
was a standard procedure in place; the problem seemed to be that none of the ward staff knew what the procedures were and this opacity resulted in suspicion and rumors of favoritism and bias. As in many areas of difficulty within the hospital, improved communication seemed as though it would greatly increase understanding and reduce accusations, mistrust, and the nurses’ feelings of being the victims of bias in this and other selection processes.

6.14 Driven to Outside Income Generation

Due to low salaries that had not adequately kept up with the cost of living, or because the hospital was unable to promote all the staff members every three years as was the regulation, many of the hospital employees engaged in other activities to support their families. It was common for the people with whom I spoke to be responsible for supporting numerous family members, both immediate and more extended, due to their secure employment in the formal, government sector. Their families counted on this reliable income. However, not a single hospital staff member told me their salary was enough for their needs. Many had taken loans in order to build their houses or undertake other improvement projects, the monthly payments for which were directly deducted from their paycheck, resulting in lower take-home pay at the end of every month. These financial needs were often the reason why the nurses and doctors picked up extra shifts, were so enthusiastic about participating in seminars, and lamented the loss of previous incentives such as the risk allowance. Any extra income was helpful.

I asked each of the nurses what they did to earn extra income. Rukia’s response shows the variety of activities in which even one single person might engage:

Me, personally, I do business, I mean I do business here and there. That’s to say, a lot of times it depends on the, well me, which things have been opened up for me. Maybe, maybe I can get to the harvest time, if I get money I can go to look for crops, I store them to help me maybe in December, maybe when the children are going to school. And another time, I usually like to open these store, pharmacies, in the villages. But right now I just have one. But at another point I had them here and maybe in another village, so I
was trying to do that business. Yes, it was helping me, it means because I had a large family, so it was possible to go someplace. All of them have studied from Form I through Form VI, another, another is going to university, another Form IV and then they went to a technical college, a development college [across the country]. All of them! By the route of just putting yourself in a position once there, another time there. But my salary! After all, at that time, I had a salary of 48 shillings⁹ for all those kids I was living with!

Rukia did everything she could to ensure her biological child, and those she fostered, a total of six children in all, were able to study to high levels, completing basic secondary education (Form I-IV), as well as the much more selective Forms V and VI, and even attending college, all on the money she supplied. But, she laughed at the prospect that she could have accomplished any of this on her salary alone. Pharmacies were a common business for healthcare personnel and I knew several nurses, doctors, and retired providers who ran pharmacies either in Sumbawanga Town or other communities. Another nurse raised chickens. Another sold snacks around town and to the other hospital staff members. The Medical Officer In Charge had multiple side businesses with his wife, who was also a doctor at the hospital. These included, by my count, a pharmacy in town, a sort of home goods shop, selling cow’s milk, and keeping goats, pigs, and cows, which he sold for profit or used himself. He also had a large piece of land in the Sumbawanga Urban district which he intended to try using to grow a cash crop such as wheat, which seemed to be doing well in the areas he had planted it. Additionally, he was nearing completion on a large house, which he told me he planned to use to open a private specialty medical clinic where he, his wife, and others would work after finishing their duties at the Regional Hospital.

With all this in mind, it is easy to see how many other activities might have occupied the minds of the hospital staff members and diverted their full attention from what was transpiring at

---

⁹ Because I am not certain to which time period she was referring, it is hard for me to say how much this amount might be worth in today’s currency. Rukia started work at the hospital in 1994. Nowadays, she probably made around $100-$150 as an Enrolled Nurse.
the hospital. They may have been more motivated by these income generating activities than their hospital work, and with good reason given the low return on their investments on the ward—poor communication, little recognition for work well done, low salaries, and ever-increasing patient loads. State failure to provide adequate salaries, increasingly demanding work which emphasized forms and account-keeping over patient care, and an institutional lack of care for their employees’ fiscal or emotional/psychological needs contributed to an environment that continually contributed to low motivation and providers’ sense of lack of empowerment.

6.15 Different Subjectivities, Different Motivations

Different parties throughout the hospital had, unsurprisingly, different ideas of what it meant to be a motivated healthcare provider and why their fellow providers were not more motivated. Administrators, as I have already indicated, often placed the onus of responsibility on the individual. Even if the nurses received all of their rights as government employees, even if the hospital infrastructure improved, and even if the nurses’ employer cared for them, the bottom line was that motivation came from the inside. The administrators felt they could do as much as was within their power but there would still exist providers who were not invested in their work and did not *kujituma*, or put in an effort. This difference of opinion was not unique to the Mawingu Regional Hospital and Chambliss (1996:104-5) explains the conflict between nurses, in particular, and administrators as a conflict of perceived priorities and as centering on the ways in which administrators are removed from “life in the trenches;” this distance, physically and, in terms of goals, caused administrators to fail to demonstrate the level of appreciation and recognition for which the nurses were looking.

A divide that I had not anticipated appeared between the older nurses and their younger counterparts. While the younger nurses never mentioned the older nurses were unmotivated,
every older nurse pointedly said the newer graduates did not have the same level of expertise, experience, and training they had had upon graduating. Additionally, the older nurses did not mince words when asked why the hospital staff did not seem motivated and why this accusation of low motivation surfaced time and again at Mawingu. When I asked her how nursing had changed since the time when she entered into the profession in the 1970s, Neema told me,

Those from the past, that is us, we did work by referring to the past behind us. You provide care that you know, the basics, and a person is happy. But the nurses of today, really nursing is finished! Well, let’s say that healthcare services are coming to an end because if they do- they’ve done it, the Ministry of Health, or department of health- so that health generally is like a job, like any other job. They have removed everything that was called wito [a calling]. Now, if there is no calling [to nursing], when you play with a person it is like you don’t reach the goal.

The term wito means to be called to a profession in a way that indicates a deep personal meaning to the work. The older healthcare providers all lamented that nowadays, the people who entered the nursing profession did so as a result of family pressure or due to a lack of other options as dictated by secondary school test scores. Even community members suggested that healthcare providers were not invested in their profession, which was a profession that required deep caring—affective, not just technical—and compassion, but were merely looking for money and stable employment. In her explanation, Neema went on to explain the ways in which the previous generation of nurses had started their shifts in the morning by ensuring patients had everything they needed—medications, fresh air, a haircut, or even clipped fingernails. She said now, the nurses did not work this way and had forgotten some of the very principles of nursing care. She went on to tell me about the ways in which nursing care of the past emphasized close contact with the patient, including very hands-on bodily care and even washing soiled linens. Nowadays, these tasks were left to the patient’s relatives, shifting certain forms of care practices
that required less technical expertise, but also greater emotional proximity, into the domestic sphere and out of nursing.

The Rukwa Regional Reproductive and Child Health Coordinator (RRCHCO) was also a very experienced nurse and had practiced for many years. In fact, when I returned to Mawingu in May 2016, I found her happily smiling about town as she told me she had recently retired. She echoed Neema’s observations about the current generation of nurses and added an example of the ways in which these newer nurses sought to remove themselves from direct patient care:

Me, I see that they don’t have a calling [wito]. If they had a calling, they would- first, these type of people, look at even at their client management- is she giving the client the kind of care she deserves? These days, I tell you, us that studied a long time ago, we’re different than those who have studied in these recent years… A [nurse] can stay on the labor ward, she is using her phone, she is chatting while a mother is in pain over there. Then, this same nurse will claim ‘My rights have been violated!’ What rights?! Those that studied recently, so often they have gone into this profession of nursing like they lacked another place to put themselves… A lot of them, their minds are thinking, ‘If I go to study more, I will arrive, I should be at a high level. This patient, let me not touch her.’…These trained personnel should be very close to the patient…but she who has studied a lot is far from the patient [these days] and it’s not right.

The RRCHCO’s comments show the perceived selfishness of the younger nurses but also illustrates the ways in which she thought these nurses sought to escape the more emotionally laden work of intimate care in close proximity to patients by increasing their technical care abilities. The older nurses all remarked upon the growing reliance on technology as a replacement for other forms of caring, which were more about the humanity of the patient and their needs as fellow humans, as in haircuts, instead of simply being passive subjects, receivers of care, in the form of more technically skilled expertise.

All the other experienced nurses with whom I spoke independently told the same narrative of the decline of nursing care and such practices that were in place to ensure good patient outcomes through close attention to detail; care with less distance. In *A History of...*
Nursing in Tanzania (Mhamela 2013), this type of methodical nursing is referred to as process nursing and, in this book, Mhamela writes, it has its origins in the nursing methods started by Florence Nightingale herself (Mhamela 2013). However, as time has passed and the length of training programs has decreased and the demand for more healthcare personnel does not flag, nursing education and, in turn, practice, has evolved. The younger nurses did not often speak to me about nursing more generally as a profession, though some would talk about it in terms of how their current work environments did not allow them to use all the book knowledge they had acquired in the classroom. They did not have access to the technology, tools, or experts they may have heard about while in school. Care in nursing education may now focus more on technical expertise, but nursing students still learned the ideals of Florence Nightingale, as well as up to date codes of ethics from the Tanzania Nurses and Midwives Association (2009). Their care practices began to change as soon as they stepped into the wards and sought to mirror the experienced embodied practices of the older, more skilled nurses. Sometimes these older nurses demonstrated a true calling for nursing and a commitment to close patient care. Other times, the chaotic and under-resourced environment of the hospital, combined with a nurse’s own personality, home situation, and persistent feelings of lacking care from the institution employing them, led nurses to hastily breeze through interactions with patients, with limited emotional engagement, and a type of caring that appeared, from the outside, to be emotionally distant or even abusive. Yet, these behaviors were the product of an environment with very little room for other options. Younger nurses began to mirror these behaviors, too.

6.16 Conclusion

Overall, the environment of health facilities in the Rukwa region and, undoubtedly, Tanzania more generally, strained healthcare providers in a number of ways, leading to low
morale and motivation. They were often under severe financial, physical, and emotional stress as they sought to continue striving to provide high quality care that complied with hospital and Ministry of Health guidelines for pregnant women. Nurses on the maternity ward repeatedly told me they perceived the hospital nursing administration to be uncaring, unresponsive, and out of touch with the needs of the ward staff and their very difficult working conditions. However, these same administrators were often severely constrained by bureaucratic protocols handed down from NGOs, national, and international policies that were often out of date or impractical in their setting. This conflict, for all the providers and administrators, between guidelines or protocols and everyday lived reality contributed to deep-seated feelings of resentment and demotivation. Poor communication and leadership styles that conflicted with the desires of the staff exacerbated these feeling. Many of the nurses and some of the doctors told me they found it hard to build “good” lives for themselves, in which they were able to meet the needs of their families, such as school fees and other daily needs, due to a lack of money and few opportunities for advancement and recognition in the work place.

The bottom line, as the Medical Officer In Charge pointed out, was that money was always a problem. Poor cash flow and slow disbursal of funds from the central government meant the hospital was unable to further invest in infrastructure, training, or hiring of staff members. Individuals working within this system were not necessarily uninterested in or unable to provide high quality care- very often it was a confluence of structural factors that delayed, deterred, or demotivated, thereby affecting how women and their babies experienced the hospital and the ways in which the nurses, doctors, and administrators understood what it meant to be a government healthcare provider in the Rukwa region. The ways in which the central government’s bureaucratic procedures intersected with, and caused, scarcity at the Regional
Hospital, combined with biobureaucratic expansion, took providers’ attention away from caring for women in ways that complied with guidelines. There were instances in which the delay in care or the delay in receiving a medication or procedure resulted in the woman’s death; other times she died as a direct result of a lack of a specific piece of equipment, such as an adult sized Ambu bag for resuscitation, or no way to remove the fluids from her lungs which she aspirated once on the operating table, leading to her eventual death. With their previous experiences of the bureaucracy, the shortages, and the system that forcefully resisted any change, the providers came to work in a way that suggested the environment itself precluded many forms of care, such as some of those which were required by “high quality” care guidelines.