The maternity ward as mirror

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

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Chapter 7: “No Zebras on Your Fingernails!”: Uniforms, looking “smart,” and the professional comportment of “good” nurses

What kind of work will you do, really? Nail polish, colors, I don’t know, little pictures, zebras, I say! What kind of work will you be doing as a nurse? This, nursing work that you’re doing isn’t like this.

-RMO in a maternal death audit meeting, December 2014

7.1 Introduction

Building on the previous chapter’s description of Mawingu Hospital’s environment and the working conditions, in this chapter I delve into some of the ways in which the maternity ward nurses and the hospital administration conceived of what it meant to be a “good” nurse. Here, I use the word good to include a number of concepts related to nursing including, but not limited to, a nurse’s ideal core attributes (moral, technical, and social), her skill set, her comportment, her mannerisms, and the ways in which the community perceives her. I draw on Goffman’s (1959) dramaturgical theory of the self and impression management, as well as Hardy and Corones’ (2016) suggestion that nursing uniforms are ethopoietic fashion—character making. For nurses, the image they present to community members and other medical professionals was important for accomplishing a number of goals, both those officially stated, such as professionalism, but also more informal goals, such as increased social status in the community. Goffman (1959:238) writes that “within the walls of a social establishment we find a team of performers who cooperate to present to an audience a given definition of the situation” and, in the context of Mawingu Hospital, the nurses were the largest group of performers upon whom the reputation of the hospital depended. Hardy and Corones (2016:16) write, “Wearing the

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1 I will often refer to the nurse as “she” due to the fact that in Tanzania, still, the majority of nurses are women. However, there were a number of male nurses working at Mawingu Hospital during the period of my fieldwork and I will touch on some of the gendered aspects of this profession, as well.
[nursing] uniform is a complex experience encompassing the projection, reception and awareness of nursing identity,” which I present through the discussion in this chapter. The complex valiances of meaning associated with nursing uniforms, and the nurses’ prominent role in care provision in the hospital, produced an environment in which the individual nurse’s dress and behavior could threaten to undermine the legitimacy of the entire institution. It is with this in mind that I analyze the importance of debates over nursing uniforms and dress.

Ultimately, this chapter serves to highlight an ongoing conflict centering around the ways in which the nurses on the Mawingu Hospital’s maternity ward were wearing their uniforms but it was a clash that illuminated much deeper struggles between nurses and hospital administrators. The conflict surrounding proper uniform wearing epitomized, more broadly, the hospital’s refusal to acknowledge, accept, and accommodate the uniquely complex nature of maternity work. The regional and hospital administration tried to administer the maternity ward like every other ward of the hospital. This approach created blind spots that did not accommodate the needs of the providers engaged in this work, thereby affecting the care women received and, ultimately, their outcomes.

In their analysis of a conflict over nursing uniforms in a unit in an American hospital, Pratt and Rafaeli (1997:863) suggest the conflict was rooted in a fundamental conflict over “why the nurses were there (their mission), whom they served (their patients), what services they provide (their roles), how they were to be seen in the medical hierarchy (their status), and who should be making key decisions regarding the organization.” Of these points of tension, issues related to the mission of nursing, the unique medical needs of maternity patients, status and hierarchy, and roles all resonate with the conflict that ensued on the Mawingu maternity ward. Uniforms, in this context, were about an enactment of state power and nursing hierarchies, but
also allowed for new hierarchies and prestige among the nurses, as well as between the nurses and the women present on the maternity ward as patients. The conflict was also about roles and about administrative recognition for the demanding, risky, and uncertain work of providing care for pregnant women without the desired levels of supplies, medications, infrastructure, and administrative support. That is to say, the conflict was also about institutional care for employees.

On a state and global level, this conflict over uniforms was a microcosmic representation of all the ways in which a fixation on bureaucratic guidelines, a lack of flexibility in the execution of certain guidelines, and failure to attend to local realities could thwart the success of maternal health interventions. These guidelines and policies related to uniforms did not attend to the practicalities of maternity work, specifically, but also failed to encompass more fundamental issues at the heart of uniforms, such as how these conflicts could be, in fact, over “issues innate to the social identity” (Pratt and Rafaeli 1997) of nurses, and the ways in which this identity could be in flux, contested, or actively renegotiated through bodily practices and clothing.

7.2 Nursing Origin Stories

In all of the in-depth interviews I conducted with the healthcare providers in the Rukwa region, I asked them how they had come to be in their current profession- why had they wanted to study nursing? Or go to medical school? Or become a medical attendant? In many cases, the nurses responded to this question by telling me that since a young age they had had their hearts set on nursing. Despite what the older generation of nurses suspected, even the younger nurses gave this as an answer. Across both age groups, a very common origin narrative centered on the nursing uniform, or at least, made reference to it, similar to the way one of the older nurses, Aneth said:
During that time, I didn’t know what was inside nursing [the profession]. The clothing just made me happy! [She laughs.] The clothing made me happy because in those days we were wearing caps on our heads. Therefore, I was seeing nurses, if she passes by she is wearing shoes and socks, her white gown, and cap. That is, my heart was really lighting up [when I saw them]!

Significantly, this fits with what Roper (1976, cited in Bridges 1990:850) writes about why a profession’s image is important, “Projection of the profession’s dominant image is considered by psychologists and sociologists to be important because career choices are made early in life,” which is a claim supported by the narratives of many of the nurses and other health professionals with whom I spoke. The “smart” uniforms of the well-kept nurses portrayed an image of cleanliness, expertise, and professionalism, which, particularly for women with few similar routes to professional recognition in the past, would have been very appealing. Nurses were immediately recognizable and community members could tell that the nurse was someone who had studied and who was responsible for caring for others.

7.3 Uniforms and the Nursing Profession

Uniforms, within the medical professions, have long been the site for the performance and enactment of professional expertise, status, and authority. In the United States, for example, walking into a teaching hospital, one is presented with a variety of uniforms including scrubs of varying colors or patterns, white coats of varying lengths, different types of shoes and head coverings, name tags and ID badges, to name just a few items. Simply conducting a search online or in a research database leads to thousands of articles in nursing journals about the role of the uniform in various settings and across time periods. The dress of nurses and doctors both helps to create and reinforce the wearer’s professional comportment and expertise. Many of the more contemporary articles on the subject in nursing journals are concerned with the ways in
which the public and clients perceive nurses, their level(s) of competence and professionalism, and, more broadly, the reputation of nursing as a profession.

Throughout time, as nursing developed into a profession, the women who chose to serve in a capacity that society would later recognize as nurses were often subjected to a number of stereotypes, which have remained, due to the media, well into the 21st century. Some of the stereotypes can be traced back to Florence Nightingale to whom scholars and nurses themselves often refer as the founder of modern nursing. Nightingale was said to have had a saint-like commitment to her work and patients, putting their needs before her own (Bridges 1990; Mhamela 2013). Florence Nightingale’s influence in nursing was prominent during the Crimean War. Nurses gained more attention in the subsequent American Civil War and, afterwards, World War I. Nightingale laid out tasks that were to specifically be the domain of the nurse and act as a complement to the work of the doctor. She also trained her students in submissiveness, encouraging them to adhere to the patriarchal norms of the Victorian era through unquestioning subservience to the doctor in their quest for a cure for patients (Bridges 1990). Nurses often learned to emulate her dedication and this reverence of her commitment led to what scholars and researchers of nursing call the “angel” stereotype (Bridges 1990). This stereotype depicts women- for it was women who were best suited to the nurturing subservience needed in this line of work- as selfless and comforting, hardworking and without self-centered career ambitions for advancement, but focused only on the work of caring for patients (Bridges 1990). The angel stereotype seems to also reference and draw upon the religious roots of much of nursing (Bridges 1990). Indeed, in Tanzania, both historically and in the contemporary period, women from various religious orders have often been involved in nursing or nurse training- a natural
extension of ideals of Christian charity and care for the sick. In their roles as subservient to (male) physicians, nurses came to fill the role of doctor’s “handmaiden.”

The “battle-axe” stereotype became more apparent in the 1960s and 70s, and offered a stark contrast to the nurse of the Nightingale ideal. The “battle-axe” is used to refer to authoritarian senior nurses who wield their power, over junior nurses and patients alike, to enforce discipline among the nursing staff and demonstrate their position over (male) patients (Bridges 1990). Jinks and Bradley (2003:122) suggest the battle-axe stereotype is the “modern day inheritor of the Victorian ‘lady nurse’ figure and the mid-twentieth century Matron type character.” This often includes the portrayal of middle-aged, unmarried women who are controlling and dowdy, for which they were often made fun in media portrayals, because they did not conform to ideal gender roles of the time (Bridges 1990).

The last stereotype is that of the “whore.” Without much further explanation regarding the origin of this stereotype, Bridges (1990:851) writes, “During the late 19th century, a need was recognized to raise the status of the nurse above that of the drunken prostitute commonly recorded,” and goes on to describe how this led to the recruitment of women and girls with “the most excellent of personal qualities.” There is evidence that in some areas, like Bellevue in the United States, women who were picked up as prostitutes were allowed to serve a ten-day sentence caring for the sick at an adjoining hospital as their punishment; this institution in Bellevue later became a nurse training school (Houweling 2004). Much of the anxiety about nurses being whores likely revolved around the fact that nurses worked outside of their homes and mixed with both female and male patients. This idea extends from a particular historical period in which the sexuality of women and girls was constructed as something to be feared and tightly regulated. In the second half of the 20th century, and beyond, the whore stereotype is often
reinforced in popular media portrayals of nurses as sexual objects-think skimpy nurse “uniforms” sold as Halloween costumes or intended for use in role playing during sexual encounters.

In a comprehensive letter written in 1946 about the state of nursing and midwifery care in Tanganyika (TNA 108/9/169C), Dr. Esther Jackson, posted in the Western Zone (of which Sumbawanga and Ufipa was a part; see chapter 3) wrote about nurse training schools, saying:

Residential, well-supervised accommodation for girls in training is an absolute prerequisite for getting a comparatively decent type of girl for training. The freedom of student nurses in 1946 in England is out of place in Tanganyika and the girls here need supervision of their ordinary lives, as strict as that of Florence Nightingale’s day. In such an institution not only is there opportunity for character training but we may hope to recruit girls of good family and good character and in time raise the idea of serving the sick and of health visiting from the present standard which accepts as satisfactory a woman half sweeper and half prostitute. Parents’ fears of girls becoming prostitutes is not a mere bogey of pious missionaries; pagan, moslem [sic] and Christian fathers have all expressed their fears for their own daughters and their scorn of the present “ayah.” It will probably be necessary to make some sort of financial agreement with parents. To pay a price to the family so that the date of marriage may be postponed for a few years would be better understood and more readily accepted than the present system of paying a girl a monthly wage and leaving her to fend for herself in a town.

Here, Dr. Jackson acknowledges the concerns community members in Tanganyika may have had about their unmarried daughters taking part in a boarding school situation at nursing schools. Dr. Jackson also refers to Florence Nightingale, always the paragon of nursing. She references the “whore” stereotype in Tanganyika but in relation to missionaries and their invocation of this trope. Of note is the fact that Dr. Jackson feels the student nurses of Tanganyika required more supervision than their counterparts in England. Here, she seems to be invoking the “savage” trope, which was used broadly throughout the colonial period to question the extent to which indigenous people were civilized and autonomous, capable of good comportment. In suggesting girls in a training school in Tanganyika would require greater supervision than those in a similar situation in the metropole, Dr. Jackson highlights the thinking of the time related to the inferiority of African colonial subjects.
Historically, particularly in countries with a British colonial history, the nursing profession carried a multivalent identity and was often portrayed by British colonial health planners and policy makers as a key route for the dissemination of “civilized” morality and behaviors, including those involved in personal hygiene and education. The rest of Dr. Jackson’s paragraph on nurse training programs goes on to say that even if trainees soon leave the service to be married, the programs will have already served the purpose of educating more girls about hygiene, childcare, and midwifery, which she says, “is [money] well spent in educating a woman to properly care for her own children, the future citizens of the Territory” (TNA 108/9/169C) (see also chapter 3).

With an understanding of these historical stereotypes attributed to nurses, it is possible to see the significance of the uniform in either supporting or negating these ideas. Women’s clothing marks them (Tannen 1993, in Cohen 2007:409-15) in particular ways, sending non-verbal messages about who they are and what they believe. This non-verbal communication extends to uniforms, which went through a numbers of changes over the course of the mid-19th century to the present day (Houweling 2004). These changes evolved to accommodate changing desires, ranging from modesty and appropriate female dress in the 19th century, to the increasing demands of cleanliness to prevent the spread of infections, and comfort and utility needed for the physical demands of the profession (Houweling 2004). Fundamentally, the uniform acts to “deindividualize” the wearer (Lurie 1981:18) and acts as a form of social control (c.f. Parsons 2006 on boy scout uniforms in colonial Kenya). With less concentration on these attributes of control and deindividualization, which might be construed as less positive, Hardy and Corones (2016) focus more on the productive role of uniforms. Nursing uniforms are, they suggest, generative, helping to demonstrate the roles and status of nurses, while also affording them, in
the early days (in the Victorian era), a sense of security and safety in public, even when unaccompanied, due to the uniform’s wide recognizability (Hardy and Corones 2016).

7.4 Development of Nursing Uniforms in Tanzania

In Tanzania, the Tanganyika Nurses and Midwives Council (TNMC) decided initially, in 1953, that they did not need to regulate nursing uniforms and individual training institutions and hospitals were allowed to decide what was suitable so long as the uniform complied with the very general guideline “that the dress had to be of washable material with short sleeves” (Fig. 7.1) (Mhamela 2013:285). Beginning in 1951, the start of more formal nurse training programs by the British colonial government, nursing students who passed their final exams in the preliminary course wore a pink and white striped gown (Mhamela 2013:287).

For copyright reasons, fig. 7.1 is not included in the online version of the thesis.

Fig. 7.1 Caps nursing students wore (Mhamela 2013:287)
As far as nursing students go, a letter from July 8th, 1952 (TNA 46/19/413) mentions that student nurses spent three years in training for their certificate in General Nursing, “during this time she receives board, lodging and uniform, and a training allowance.” If the student, at that time only women were accepted into nurse training programs, wished to become a midwife, she would continue with one more year of training. In 1954, TNMC did require all nurses to start wearing uniform badges (Mhamela 2013:288). Generally, from this time until nearly 50 years later, there were less comprehensive and cohesive uniform requirements governing the nurses and midwives of Tanzania, with no records of any standardized guidelines, beyond the most basic requirements for short sleeves and washable material, mentioned by Mhamela (2013) in his account of the history of nursing in the country. It was not until 2005 that the TNMC standardized uniforms, including the material from which they were to be made, and abolished the caps (Mhamela 2013:289). Despite the fact that, at the time of my fieldwork, the cap had not been a part of nursing uniforms for nearly ten years, many nurses and administrators invoked the cap in a number of ways, particularly in nostalgic allusions to a remembered past in which nurses were less casual about their profession and dress.

7.5 Uniform Requirements

Beginning with the TNMC meeting in 2005, uniforms for nurses and midwives working in the government system, the public sector, were to follow certain standard regulations. Mhamela (2013:289) (Fig. 7.2) cites the following from the meeting minutes:

Taking into consideration the social changes, weather conditions during night duties in some parts of the country, and the global movement for change of nurses’ uniforms, the TNMC ruled that the type of the uniform that nurses should be wearing, irrespective of the institution in which they work, should be as follows (Minute item 47: 2005): ‘Nurses will no longer be required to wear caps as part of the uniform. Female nurses to have the option of wearing either a gown or pair of trousers with a tunic. Male nurses will wear a “kaunda” design suit. The type of fabric to be used in making the uniforms will be “tacron” cloth material. Nurses-in-charge of hospitals (Matrons and Patrons), District
Nursing Officers, Regional Nursing Officers and Heads of schools of nursing to wear dark blue uniforms; and all other nurses to wear white uniforms. Nurse teachers to wear white uniforms when mentoring in clinical areas. Female student nurses to wear pink gown uniforms and male student nurses to wear white trousers and white shirts. Health attendants to wear light green uniforms.
Fig. 7.2 Clockwise from upper left: “Kaunda” uniform; Gown uniform style; Examples of head coverings
These continue to be the guidelines for nursing uniforms and, at the Mawingu Hospital, the hospital Patron regularly referenced the standard rules and regulations in order to highlight the ways in which specific nurses or, more broadly, an entire ward was failing to comply with these regulations. At the Regional Hospital, nurses were supposed to embroider their rank (EN or RN) on the epaulettes of their uniform in blue thread so those with different levels of training and expertise could easily be recognized and differentiated. In addition to the different colored fabric, as described above, this requirement highlighted and reinforced the difference in ranks between nurses. However, on a practical level, this was more meaningful for insiders (i.e. the hospital personnel themselves), as opposed to helping patients and family members recognize the skill levels of providers. Beyond the EN (enrolled nurse) and RN (registered nurse) designations, there was a third class of nurses who were called Nursing Officers (NOs) and had a higher level of education and specialized training than the RNs, usually a university degree or completion of upgrading courses. The maternity ward’s Nurse In Charge at the time told me that they were not supposed to indicate NO on their epaulettes, only RN, despite the fact that there was a meaningful difference between these two ranks. She told me in other hospitals, the nurse leaders (wauguzi viongozi) all were allowed to wear the dark blue uniforms but in Rukwa it appeared only those nurses who “sat in the offices” wore these uniforms that clearly distinguished them from their subordinates. She continued to tell me that it was not clear why only certain nurse leaders were allowed to wear these dark blue uniforms and they had received no explanation of why NOs could not write “NO” on their epaulettes; she suspected it was in an effort to homogenize the nurses but did not offer a reason as to why this might be desirable for the administration. I probed further and she told me that other regions of the country, east of Mbeya (the neighboring region), the nurses wore different color uniforms to indicate status.
Administrators clearly used uniforms to connote status and their higher position in the ranks of the hospital but they did not allow ward nurses access to these same forms of prestige. It is unlikely that most patients knew the difference between the blue and white nurses’ uniforms but the different colors conveyed a world of meaning to insiders. The administrators’ strategic use of the different colored fabrics allowed them to further limit the ways in which ward level nurses might seek to gain more recognition within the system, even if their technical expertise and educational background might have allowed them entry to higher levels of status. Those nurse administrators sitting in their offices had a vested interest in reinforcing their higher position particularly, as the maternity nurses accused, if they did not any longer have accounts of their prowess in everyday patient care practices on which to draw for respect, prestige, or recognition.

In practice, many of the nurses improvised on the uniform requirements for a variety of reasons. Some made aesthetic improvements to their uniforms, adding ruffles or lace, belts or more embellished buttons. In lieu of the blue thread to embroider their rank, I watched many maternity ward nurses draw on their letters with blue ballpoint pen. Due to the cool weather in the Ufipa plateau where the hospital is located, many nurses wore a variety of types of sweaters or jackets with their uniforms, most of which were not white, thereby violating the guidelines. On the night shift, when temperatures could dip into the 40s (Fahrenheit), I often saw nurses wearing sweatpants or jeans under their gowns for warmth. In the above quote, there is no mention of hairstyles, make-up, or fingernails, but all of these came to play an important role in the uniform conflict that took shape starting in September 2014 and ebbed and flowed over the next nine months while I was still at the hospital. During this time, a number of the requirements became the basis for accusations of unprofessional dress and administrators used nurses’ sloppy
dress as evidence that their other professional qualities might not be up to standard, such as their technical abilities, but also their deference to the hospital authorities, with proper respect for their position lower down in the hierarchy.

**7.6 Maintaining a Professional Image for the Community**

There were other guidelines which the Patron frequently referenced, including the suggestion that nurses not wear their uniforms on their way to and from work but, instead, change into their uniforms after arriving at the hospital. As Martin (2009:33) writes of Ugandan nurses changing into their uniforms while already at work, “according to the nurses themselves, the reason is to maintain a high level of hygiene, but there is also a concern that nurses’ off-duty behavior might discredit the profession, giving nursing a bad public reputation and leading people to lose confidence in the nurses’ medical authority.” Poor behavior while wearing the uniform which easily identifies someone as a healthcare professional, specifically a nurse, would violate the desired ethos these performers sought to portray about healthcare personnel and services, one which conveys integrity, experience, and quality. In September 2014, the Regional Medical Officer told those hospital employees gathered at the morning clinical meeting that the nurses should leave their uniforms at work, changing when they arrived and again before they left. He said, “On the way [to work], it’s not necessary that every person along the way knows that you’re a nurse or doctor by your uniform!” However, many nurses continued to routinely wear their uniforms on their commute, often wrapping a *kitenge* cloth around their waists to prevent dirtying their white uniform while on public transportation.

Aside from pragmatic concerns about being late due to changing into their uniforms before reporting to the morning clinical meeting, I propose there are a variety of other reasons nurses might choose to wear their uniforms outside of the hospital setting. Due to their
recognizability, members of the public could easily tell who was a nurse. In town, nurses gained a certain amount of social capital from their positions as government employees, particularly in a profession connected with healing ailments. Additionally, it is a strategic move to try to befriend healthcare providers in the hopes of gaining access to treatments or advice outside of the hospital setting or for receiving preferential treatment when reporting to the hospital for a more major illness. Nurses were capitalizing on these perceptions in order to garner more prestige in the community. This quest for social capital and prestige helps to explain why it was that nurses often wore their uniforms to the bank or the regional offices if they decided to go during their shift, which they often did due to the times at which these places were open during the day, which coincided with the morning shift. In addition to social capital, nurses wore their uniforms in public, non-hospital spaces in order to advertise their professional status, which might have helped them to gain customers for private pharmacies, thereby bringing in additional, badly needed revenue.

A week later, after the RMO’s comments, in the clinical meeting, the hospital Patron again reminded the nurses to properly wear their uniforms while on duty at the hospital. This was only one day after he had met with the entire nursing staff of the hospital and reminded them about the importance of properly wearing their uniforms. He said that not wearing their uniform, or not wearing a proper one, was disrespectful. I was particularly intrigued by this comment because Patron did not continue on to describe what or who nurses were disrespecting when they did not properly wear their uniforms. However, I understood this comment to mean that it was disrespectful to the profession or office of the nurse more generally.
7.7 Uniforms and Village Healthcare Providers

Outside of the regional hospital, uniforms were equally important and, sometimes, at least to administrators, seemed to be even more so than at the hospital, as other markers of difference between healthcare providers and their patients broke down or ceased to exist in the community setting. While on a supportive supervision visit to several villages throughout the Nkasi District, I witnessed the District Reproductive and Child Health Coordinator (DRCHCO) reprimand and question a number of providers working in village dispensaries. One young man became quite distraught as the DRCHCO continued to question him about the state of his hair and whether or not he had brushed it that morning. Despite his insistence that he had, she continued to accuse him of neglecting his duty to look clean and, thereby, neglecting his duty to uphold and perform the image of respectability, cleanliness, and competence that was to characterize the medical profession and its denizens. In many villages, especially those that had not received prior notification of our visit, we would see the dispensary personnel wearing only part of their uniform (e.g., the pants but not top) or some modified version of their uniform. When my research assistant and I traveled to the eleven villages I selected for more extended research (see chapter 3), we almost always saw at least one of the providers in street clothes (Fig. 7.3). Sometimes, they were entirely indistinguishable until some other person from the community introduced us.
For the healthcare providers working in communities, their uniforms played different roles in different settings. Within their communities, they might not have felt the uniform was entirely necessary to distinguish them from other people, because the village was small enough that everyone knew who the healthcare professionals were. However, these providers would come to the regional hospital and we would interact with them on the maternity ward. This usually came about as a result of an official, formal referral they had initiated at the dispensary level. These providers would often arrive on the maternity ward, still in their street clothes, with their patient, a woman with a condition or complication they did not feel they could manage at the dispensary (or health center), and stay until the woman had gone through the admission procedures on the ward. These providers ideally arrived with a formal letter of referral and they
had, hopefully, initiated any possible basic management before or during the trip to the regional hospital.

More than once, I happened upon a stranger, usually a woman I did not recognize, sitting in the labor room or wandering about. The hospital had a strict policy which prohibited anyone other than the nurses and doctors of the ward to wander through the labor room where women were often in various states of distress and undress. In a maternal death audit meeting in December 2014, the meeting participants were discussing referral procedures and the trouble with certain aspects of the process, which referring providers did not often follow. One of the nurses present, representing the maternity ward, commented that many of the referral cases came to the hospital without an IV or a catheter and were often accompanied by a medical attendant, or other unskilled personnel, and often these people were not wearing their uniforms. She said, “You find others come in pajamas and their hair is like this! They’re frightening!” As she motioned to show the untamed nature of the person’s hair. Here, not only did she emphasize the lack of uniforms from the standpoint of being able to recognize the accompanying providers as such and not a relative, she also emphasized the way in which she felt some of these providers’ disheveled appearances were off-putting. The way in which these providers came to draw attention and criticism is representative of the way in which nurses often talked about those would did not present themselves well and were, as an extension, poor representatives of the profession. Returning to Goffman (1959), I view these comments, and the conversation itself, as a way of policing the members of the healthcare professions whose refusal, inability, or unwillingness to comply with ideal uniform wearing so as to reduce the damage they might do in the future (or were currently doing) to the image of competent and reliable medical expertise in the medical spaces.
Using this frame of spaces, from my extensive experience since 2008 in village dispensaries, it is also possible to see the ways in which the boundaries between medical space and community space may blur in these community-level facilities. This is because the providers lived within the community, often for many years, may have had extended or immediate family from that community, and were often engaged in other income-generating activities that also served to blur the boundaries between medical person/space and community space. In these settings, the dispensary staff members were on-call 24 hours a day, seven days per week and community members often went straight to their places of residence in times of emergency if it was after normal government working hours (7:30am to 3:30pm). At the regional hospital, it would be unlikely for a patient to be able to go directly to a provider’s home, unless they were already a neighbor and therefore knew the person worked at the hospital. This created more of a separation between the medical and community spaces, even if the activities that took place in each domain bled into the other (see also the discussion of this in Martin 2009:103).2

From the point of view of healthcare administrators, given these prevailing circumstances in the village setting, it became all the more important to distinguish oneself as a provider from non-medical community members and to represent the broader profession in a way that upheld its loftiest ideals deeply rooted in the history of nursing. In all settings, these providers were also representatives of the Tanzanian government because of their employment in public, government-run healthcare facilities. This meant that, in addition to representing the medical professions, they were also representing the government. This may be another reason why administrators considered it highly inappropriate or disrespectful to not wear a “smart”- looking

2 Here she discusses the ways in which nurses often use their professional skills at home in service to relative or neighbors, and are often considered resources for the use of family members, thus blurring the boundaries between workplace and home-place.
uniform, despite the reduced significance uniforms seemed to hold for the village healthcare providers themselves in determining their mission, roles, and status (Pratt and Rafaeli 1997).

7.8 Maternity Care Necessitating Variations

Nursing care on the maternity ward differs in significant ways from nursing on other hospital wards. The maternity ward nurses were often engaged in physical work and frequently exposed to bodily fluid. The very act of delivering a baby often caused me to break out into sweat and nurses not infrequently mounted steps and climbed up onto beds in order to get a better angle and more leverage from which they would be able to assist the mother giving birth. From my arrival at the hospital in early February 2014 through the end of that year, the maternity ward used the main operating theatre whenever there was a C-section or other surgical procedure. Until the ward’s operating theatre began functioning in later 2014, the nurses were often responsible for pushing heavy gurneys across the hospital, along concrete walkways that had rough patches and holes, and uphill to reach the working set of doors of the main theatre. This was also very physical work that required, minimally, two people.

Additionally, nurses on the maternity ward were exposed to far more bodily fluids than those working in any other area. Vomit, urine, feces, amniotic fluid, and vast amounts of blood were all a daily fixture on the maternity ward. On my first day on the maternity ward in 2014, I was on rounds as the night nurses handed over to the incoming day shift nurses. We went woman to woman and in the course of these proceedings we came to a woman who had been throwing up throughout the duration of her labor since she had arrived at the hospital. Not knowing this, I was standing near her bed, under which she had tucked her requisite plastic basin from home, when she once again began to vomit. I happened to be within vomiting range and found my shoe and left pant leg spattered. This was, I knew from previous experience, not an isolated encounter
with bodily fluids. One had to adopt a sort of nonchalance about these encounters while still attempting to protect oneself as much as possible. Throughout my time at the hospital, there were many incidences in which I or the nurses only had barely enough time to hastily pull on one sterile glove before catching a baby or, while walking a woman to an empty bed, were splashed with amniotic fluid as her waters broke. Other times, nurses did not have the elbow length gloves they needed and would engineer elbow length protection from two wrist length gloves. They would then proceed to insert their arms nearly up to the elbow in a woman’s body, in search of a placenta that had not fully detached from the woman’s uterus. As one nurse told me, describing the ways in which amniotic fluid could splash or spray long distances when a woman was in the midst of a contraction while giving birth, “If you don’t know the taste of amniotic fluid, you haven’t worked long enough on maternity.” Because it is impossible to predict when any woman might start throwing up or when water might break, there was a constant risk of coming into contact with unanticipated fluids.

In light of these conditions, it is clearly apparent that the conflict between the Patron and the maternity ward nurses over the uniform regulations was also about different interpretations of the patients for whom the nurses were caring. On other wards, the patients did not expel bodily fluids with such unpredictability and at such a high concentration. On the maternity ward, patients’ bodies acted differently and, as such, demanded different forms of preparedness and care. In not allowing the maternity ward nurses to protect themselves and modify their uniforms in response to the patients they were serving, Patron was privileging his interpretation of the “normal” hospital patient for whom all nurses cared, without attending to the deviations from these norms presented by the bodies of women in labor. This normal patient certainly looked different that the hundreds of women who made their way through the maternity ward on a
monthly basis. Instead, this normal patient might be chronically ill, male, and older, suffering from high blood pressure or a severe case of malaria, and perhaps more in control of his own bodily processes.

7.9 Improvising the Standards

All of these conditions, combined with the sometimes cold weather of the region, meant the maternity ward nurses often donned a number of types of aprons, gowns, improvised scrub tops, masks, caps, or pants as they performed their daily duties. These items often helped protect the nurses from the bodily fluids with which they came into contact and they used what was available in lieu of more standardized items that were only unreliably present. Many of these items came from donations that individuals or organizations had made to the hospital in the past. This meant the pieces were often mismatched and often were meant, in other contexts such as the higher resource settings from which they came, to be disposable and were not washable. However, due to budget constraints, the nurses (rightly) feared if they disposed of their light plastic apron or gown they would never receive another one.

The lack of reliable personal protective equipment (PPE), such as boots, caps or aprons, also had other consequences, some of which were directly related to patient care. In order to protect herself, a nurse might wear a scrub cap from the operating theatre or she might awkwardly stand as far away from the patient as possible so as to prevent dirtying her shoes or her legs which were left exposed after the hem of her uniform skirt because there were not enough boots for everyone working on the ward. Certain uniform requirements limited range of movement and, because nurses were concerned with getting their uniform dirty, especially when they only had one or two sets, they limited their close physical contact with women in labor. Fearing contamination due to this lack of PPE, nurses also lashed out at women who touched
them while in the throes of a contraction. Nurse Peninah said a nurse might “fight with a woman, saying, ‘You, mama, don’t get blood on me! Why do you want to grab me?!’” for fear of getting blood or feces on her uniform. The lack of PPE, therefore, could contribute to a nurse’s reluctance to touch a woman or even stand next to her in close proximity.

The PPE items that were available often hung in the ward break room or on hooks in an anteroom near the ward operating theatre. Sometimes they were spotted with blood, meconium, or other (unidentifiable) stains, highlighting their unsanitary nature. Some items were washable, such as dark green tops, bottoms, and caps that were intended for wearing in the operating theaters (and could be washed and sanitized in the hospital autoclave), but many other items were originally manufactured for one-time use and could not be sanitized appropriately. Some of the nurses would wear these green scrub-like tops, pants, or caps during their regular work on the ward. In other instances, a nurse would be assigned to discharge duty and come to the ward for one or two hours in the late morning to discharge women and their babies. These nurses often arrived from home in their street clothes which they wore while completing the discharge procedures and therefore they blended in with the mass of women and relatives who inundated the ward during the late morning visiting hours, which occurred at the same time.

If it was the case that a nurse was wearing some other item over her white uniform, she would often remain this way throughout her shift. In the event of a C-section or emergency surgery, the nurses would often go to the main operating theatre still wearing these protective gowns or aprons. Sometimes this was due to time constraints or simple practicality. In a discussion on the maternity ward about Patron’s criticisms of the ways the maternity nurses wore their uniforms, one nurse emphatically stated she was not going to waste time changing her clothes during an emergency. Others agreed and decided Patron’s criticism was most likely
because they sometimes wore the various non-white gowns, aprons, and caps outside of the maternity ward, as in when they went with a patient to the operating theatre across the hospital. Sometimes, upon arrival in the theatre, the doctor operating would ask the nurse to take blood samples to the laboratory for testing blood type and hemoglobin levels or to fetch blood for a patient who was losing too much. This required the nurse to again travel across the hospital. In their conversation as a group, the nurses decided it must be this walking about the hospital and *being seen* in non-regulation clothes to which the Patron objected. However, emergencies, more likely to happen in maternity than almost any other ward, necessitated quick action and most of the nurses agreed they would not waste time changing clothes and shoes before going to the lab or theatre.

The nurses were angry and offended that the guidelines related to nursing uniforms were given precedence over the immediate, and sometimes emergent, healthcare needs of the patient. The expectation that they would avoid being seen outside the ward in non-regulation clothing implied they would take time to change into their white uniforms every time they knew they were going to walk out the doors of the ward. However, Patron’s expectations in this regard seemed to be fixated more on the symbolic importance of the white uniforms than the actual utility of the clothes the nurses in maternity wore. To the nurses, their primary role in the ward was to deliver timely, life-saving care and to be prepared to do so in whatever clothing they needed to protect themselves and care for the patients, particularly during surgery. This fundamental role was in conflict with what Patron appeared to be privileging in his discourse about uniform regulations—nursing identity related to appearance, over the active engagement in care and the improvisational clothing it necessitated. Here, too, the conflict was about who had the power to make decisions in the context of patient care, as well as in terms of priorities. To the
Patron, the priority, as delivered to and interpreted by the nurses, seemed to be wearing a white, unsullied nursing uniform for the purposes of upholding appearances. The nurses themselves wished to prioritize patient care and needs, which, when done successfully, would arguably accomplish much more for the ward’s legitimacy, and the hospital’s by extension, than merely wearing certain, specific forms of clothing.

A lack of standard and readily available personal protective equipment (see chapter 6) meant the nurses did sometimes look mismatched, with each person using what they could get their hands on. Many of the nurses, including me, hid the best masks or protective gowns and aprons we could get our hands on. If I did not either take them with me or hide them in my box, I would find my hospital Croc shoes in a different place because someone else had worn them. Each nurse had a box in the changing room in which they stored such items (Fig. 7.4 and Fig. 7.5). I took to keeping my shoes, scrubs, surgical cap (brought from the U.S.), white clinical coat, stethoscope and blood pressure cuff in my box. However, putting shoes that had traipsed through blood or amniotic fluid in the same box as one’s shirt was not ideal, particularly from an infection prevention control standpoint.
7.10 Continued Evolution of the Conflict

Though the hospital’s Patron often made general remarks about proper uniform wearing in the morning clinical meetings, the maternity ward Nurse In Charge frequently received pointed criticism about her staff members. Sometimes, and with seemingly increasing frequency throughout the end of 2014, Patron would use the maternity ward as an example of what not to do. He brought up the maternity ward staff members as examples of ways of dressing that were not to be emulated by the other nurses. Through this repeating discourse and the use of the maternity ward as an example of uniform deviance, the hospital administration constructed the maternity ward and its staff members as problematic and entrenched in their noncompliant
defiance of uniform norms. While seemingly inconsequential, this conflict occurred against the background of conversations about the hospital’s finances, which often focused on the degree to which maternity services were a drain on the institution’s resources (chapter 6). On both levels, the prevailing institutional rhetoric was one which signaled that maternity was problematic, nonconformist, and a barrier to institutional solvency. By constantly focusing on the uniforms, the hospital administration also sent the message that maternity nurses were a threat to the legitimacy of the institution because of what they were signaling to the public when they traversed the hospital in non-regulation wear—sloppiness, carelessness, and, even, poor hygiene because of the fluid-stained gowns they wore over their white uniforms, all of which undermined the goals of professional nursing.

Prevailing social and organizational norms (see also chapter 8) often prevented administrators from making direct accusations about the behavior of individual nurses. This meant the criticism they provided to the maternity ward Nurse In Charge was in vague terms that were difficult to translate into action or change. One morning in September 2014, after the clinical meeting, the Nurse In Charge went back to the maternity ward to report on the discussions that had occurred in the clinical meeting. She called most of the present nurses into the changing room and we gathered there to hear what she had to say. Some of the nurses continued to change their clothes, looking forward to going home after a long night shift. Others had ducked into the room on the way to or from other locations, such as the lab or the storeroom. Once the fidgeting had died down a bit, the Nurse In Charge reported that the Patron had accused the maternity ward nurses of all just wearing their uniforms however they wanted or felt like wearing them, without regard for the regulations. The nurses erupted into indignant disagreement at this accusation, which came on the tail of the several other recent announcements warning the
nurses throughout the hospital to wear their uniforms properly, to not wear them to and from work, and to wear them in a respectful manner. The ward Nurse In Charge told everyone that the previous In Charge had told her of plans to provide everyone on maternity with green gowns to be worn over, or in lieu of, their white uniforms. However, these plans never materialized and only a couple of these outfits were ever available. Other nurses chimed in here, saying that even if they had green clothes, these would most likely create conflict if they wore them to the operating theatre (OT). This was because the OT staff members all wore green scrubs and the maternity ward nurses thought the OT staff would accuse the maternity nurses of stealing OT clothes, because this had occurred in the past. In the course of the conversation, it became apparent that the previous In Charge had decided to remedy this situation and prevent any such accusations by ordering light blue cloth for the maternity ward scrub clothes. This cloth had never materialized and even the idea of its existence was news to most of the nurses present in the office that morning. One of the most senior nurses, Mpili, who would later in 2015 become a second In Charge of the ward, suggested they request a meeting with Patron himself in order to learn more about the specifics of his accusations. An appointed spokesperson had delivered these criticisms to the Nurse In Charge of the ward because the Patron himself had been out of town at the time.

7.11 Gender, Bodily Embellishment, and Nursing Identity

Beyond just the wearing of the actual uniform clothes, Patron had also told the ward In Charge that some of her nurses were wearing their hair in styles that were not appropriate for nurses. Hairstyles became a recurrent theme and often led to nostalgia for the days of the nursing caps. The Regional Medical Officer said in a meeting in December 2014 that he preferred it when the nurses had had to wear caps because you could only wear your hair in a limited number
of styles and still have the cap sit properly atop your head. The caps, therefore, prevented the more exuberant and elaborate hairstyles that some women preferred to wear. Hairstyles was an issue that almost exclusively affected the female nurses. Males on the hospital staff almost always had very short cropped or shaved hair. Women, on the other hand, would go to salons to have their hair braided in the newest style, sometimes including weaves, other types of synthetic hair, or wigs. There were a few styles that made the hair stick out away from their heads and the administration did not feel this was appropriate, nor was hair that supervisors thought looked unkempt or uncombed.

In addition to hair styles, the RMO said, “What kind of work will you do, really? Nail polish, colors, I don’t know, little pictures, zebras, I say! What kind of work will you be doing as a nurse? This, nursing work that you’re doing isn’t like this.” By these comments the RMO was emphasizing the ways in which certain behaviors, modes of dress, and personal embellishments were not befitting to those in the nursing profession. In addition to hair and nail polish, the RMO also brought up nurses who wore too many rings on their fingers, what he considered to be excessive amounts of make-up (specifically mentioning lipstick), and suggested it was better for the female nurses to continue wearing dresses, as opposed to pants, as in the past. He emphasized that all of these modes of self-presentation were tied to the legitimacy of the nursing profession as a whole. Despite the unanimous laughter that erupted as a result of the RMO’s comments about “zebras” on nurses’ fingernails, the underlying message was that improper dress and self-presentation undermined the nursing profession and distracted from the profession’s core goal of caring for patients: “...But when you are nearing work here, these things [makeup, high heels, elaborate hairstyles] are a lie. Such a lie. I don’t know, you’ve encircled your lips until they have been colored, then you go to a patient! The patient is sick, is she going to look at these lips?
What time is she going to look at them? She doesn’t see them!” Here, the RMO was also emphasizing a separation between domestic and professional space. It was acceptable for nurses to wear make-up, high heels, and the like, but only when they were not on duty because the role of the nurse was not to look pretty, but to provide care. In speaking against any forms of bodily embellishment, the RMO was also indirectly drawing on nursing ideals of the “angel” stereotype in which modern-day Florence Nightingales subsumed personal identity under their identity as nurse in order to selflessly serve patients. However, in only referencing forms of bodily embellishments or clothing worn by women, he was perpetuating nursing stereotypes, exempting men from criticism and these norms, and continuing to collapse the complexity of nursing, and who is a nurse, equating the field with the feminine.

When the Patron did meet with the maternity ward nurses in the middle of October 2014, after the nurses requested a meeting to address his comments, he said that nurses were wearing jackets and coats that did not comply with uniform regulations, as well as open-toed or high heel shoes (unsafe for nursing work). He also accused nurses of wearing short clothes and wigs that were inappropriate, though he did not specify what made certain wigs appropriate and others not so. In talking about short clothing, Patron joked, “Do the patients need to see short clothes to get well?” Here, he was also alluding to gendered categories, implicitly suggesting female nurses were dressing in any overly sexual way in the workplace, presenting temptation to patients who were, ironically in his telling, unable to appreciate their seductive charms, in the form of short hemlines. These veiled references to nurses’ sexuality also bring to mind the “whore” stereotype, where the sexy nurse uses her physical and emotional proximity to (male) patients while engaged in the acts and practices of caring in order to seduce him. Though the Patron surely thought he was making a joke, he was, in effect, actively dismissing the concerns of the nurses while
drawing on sexist stereotypes that called into question the expertise and professionalism of the all-female staff of the maternity ward.

And that was the end of the conversation related to uniforms; he provided little space for dialogue and effectively concluded that portion of the meeting without giving the nurses any real opportunity to respond to his accusations. In a different context in the same meeting however, Patron brought up the importance of wearing a uniform in good repair as part of “recognizing oneself” and he said, “… but also, as the Patron, it is necessary, like as a rule, that I wear clothes like the Patron…. As Patron, I should wear closed-toe shoes, it is necessary I wear those. Therefore, if I recognize myself this way, other people will see that that person is Patron, isn’t it so?” In this way, he clearly outlines how he views proper dress and uniforms to be an integral part of identity formation and a key piece of the performance of the role of Patron, allowing others to recognize him in this role. By extension, the uniform requirements would have this same effect for the rest of the nursing staff, helping them to embody the role of good, competent nurses whose knowledge and expertise could be legible to and respected by patients and community members.

More broadly, the term “to recognize oneself,” kujitambua, often surfaced in conversations among, particularly, government employees. Later, while writing, I asked the Medical Officer In Charge more specifically what the term meant. He told me,

[It] means you should respect your job and the norms guiding it. Think of it this way, I’m a medical doctor. Kama sijitambui (if I don’t recognize myself), I can’t do what I’m really supposed to do! That is, I will mistreat my clients and my clients will mishandle me because I have accepted to be ‘cheap.’

To which I asked, “OK, so this is a very important principle as a worker?” He responded that it was and it was important to “stick to the principles guiding your job.” My partner, a Tanzanian government lawyer for the Prime Minister, told me kujitambua means, “A worker understands
his duties and responsibilities and, of course, observes ethics and conducts governing his work or jobs.” And, as another example, he said, “Say a father *anajitambua* (recognized himself), [it] means he is really a father who knows his responsibilities and does exactly what he is supposed to be doing as a father.” For nurses, the uniform, and wearing it properly, was a key component of demonstrating that they recognized, and were working to uphold, all of the norms of their jobs and *respecting* the job, the office itself.

**7.12 Uniforms and Institutional Care**

While Patron, and other administrators, viewed the nursing uniform as a key piece of performing the good nurse, the ward nurses themselves had more mixed feelings and often complained that they lacked the money to be able to buy new shoes that complied with requirements or to have new uniforms sewn. Once, I watched as the ward In Charge and the weekly Nurse Supervisor confronted two of the younger ward nurses about Nurse Cecy’s black Adidas-type jacket she was wearing in the chilly, wet weather of early December. Nurse Peninah said, “This is why we nurses aren’t progressing, we are looking at sweaters and jackets!” Peninah asserted that this fixation on the strict uniform guidelines was inhibiting nurses’ abilities to uphold the more important principles of their profession, namely actual care practices. Once again, the conflict was really over more fundamental questions of why the nurses were there (their mission), how they were seen within the hierarchy of the hospital, and whom they served, as Pratt and Rafaeli (1997) suggest. This tension between administration and ward-level nursing, as well as the tensions between practice and performance, were fundamental points of disagreement.

The Supervisor and In Charge continued to say the black jacket did not conform to the requirements, which stipulate white outer garments are to be worn with the uniforms. In a
blustery, angry response Cecy said, “I say, this hospital has problems! Truly, I don’t have another jacket and my salary has already been used” to buy other items needed throughout the course of the month to sustain herself and her dependents. This was a common problem and many of the nurses complained bitterly about the fact that there was a double standard—administrators repeatedly reprimanded them for not complying with uniform regulations but, on the other hand, for at least two years, the hospital had not provided the nurses with their uniform allowance supplement to which they were entitled every few years. Nurses already struggled to make ends meet with their low salaries and having to buy new shoes, uniforms, or white jackets and sweaters was an additional burden for which the hospital was responsible. Therefore, they were being punished for something they were not being paid enough to be able to afford and for items which they could not, practically, wear in other activities outside the hospital. A white sweater, for example, would have been very difficult to keep clean and therefore would likely be reserved solely for the hospital.

Starting in 2015, nurses frequently brought up the issue of the uniform allowance. They continued to bring up the fact that, as workers, they were owed this allowance from their employer, just as the Patron continued to remind the nursing staff that they were responsible, to their employer, for wearing their uniforms in ways that complied with the guidelines. In the beginning of January 2015, Patron reminded the hospital staff during a morning clinical meeting that approximately a week earlier, on December 31, 2014, there had been an all nursing staff meeting in which they (by which the Patron meant the nursing staff as a whole) had agreed to return to the guidelines related to uniform wearing. He went on to say that if the nurses were deemed to be violating these guidelines they would be sent to Patron’s office and Patron could return them “to the one who brought them,” i.e. the one who employed them in the first place,
meaning the Regional Medical Officer or the Regional Nursing Officer. He continued,

“Everyone must be wearing their full nursing uniform. Nurses have a uniform allowance but for right now, we haven’t been given it. If you finish school, you don’t graduate with the school uniform, [but] you should sew a new one.” By this statement, Patron suggested that if even an unemployed, new school graduate could be expected to report to work in something other than their student uniform, the employed nurses should also be able to find the means to be appropriately appareled in the workplace.

The delay in the uniform allowance was because the Regional Administrative Secretary (RAS) had not given it out, most likely due to delays in funds coming from the central government and/or Ministry of Health. Patron then told the group gathered in the meeting, mostly nurse managers and physicians, that the issue of uniforms had come up in the maternal death audit meeting that had taken place in December, before Christmas. He turned to the maternity ward Nurse In Charge and asked her to tell everyone what the Regional Medical Officer had said about uniforms in the meeting. She proceeded to summarize the RMO’s comments but Patron told the group that she was sugar coating the comments. Patron said,

“RMO was talking about uniforms that people wear *ajabu ajabu*. This is why I will return people to RMO because he is the one who brought you here to be employed.” Strictly translated, “ajabu” means wonderful or extraordinary however, in this case, its meaning might be more closely interpreted as strange or anomalous, but in no way was this language that one could perceive as condoning the current state of creative uniform wearing. In a clever power play, the Patron asked the maternity ward Nurse In Charge, responsible for all of the nurses most condemned for deviant uniform wearing, to explain the comments the Regional Medical Officer had made about uniforms. The Nurse In Charge was forced to publicly discuss the RMOs
comments while knowing her subordinates, those she managed and for whose behavior she was responsible, had repeatedly been the recipients of criticism. In this venue, in front of her peers and superiors, the Patron was effectively forcing her to repeat the wrongdoings of her staff and the ways in which the highest ranking medical administrator in the region had told her that her nurses were unprofessional. In light of a culture of saving face and preventing others from experiencing public embarrassment that usually prevailed, the Patron’s demand that the Nurse In Charge repeat the RMOs criticisms was, I would argue, a way for him to publicly shame her.

Less than a week later, the hospital RNs had a meeting with Patron and were, yet again, reminded about properly sewing and wearing their uniforms. After the meeting, Nurse Peninah was back on the ward and described to the other nurses present about what they had discussed in the meeting. Two nurses who had worked at the hospital for less than a year and one, more experienced nurse were present and all lamented that they had never once received their uniform allowances. Peninah said, with great frustration, “Issues of on call allowances, uniforms, night [duty]- they are not understandable here!” The general estimate from the nurses was that they had not received their uniform allowance in at least two years. No one ever told me they had received this money more recently. When I interviewed the RMO, the issue of the uniform allowance came up as I was giving examples of the ways in which lack of transparency around money matters at the hospital had created a great deal of suspicion that the money was being used improperly and these rumors fostered dissatisfaction among the nurses with whom I spent much of my time:

A: OK. And me, I didn’t think but, you know, because people don’t have an answer they start to think “This money, why haven’t we gotten the uniform allowance for many years, or why- “
RMO: interrupting Ah now, them- it’s because they don’t come to the meeting and the In Charges don’t tell them. For example, the question of the uniform allowance, the uniform allowance, you can’t take it out of the cost sharing money.
A: Yes
RMO: Uniform allowance, it’s place is here [indicating the Other Charges section of the budget on a piece of paper he is holding]. Now, this amount, this amount I don’t want to cite it but ahh this is nothing. You can’t take money out of this little thing, this trifle here, to say you’ll take the uniform- I mean, first, even it won’t be enough for how many?
A: Uhuh, yes.
RMO: Now, it means [if you do take it out of there] you will have shut down all other work. You see? Therefore, we will be looking at the ability for them to be given- if we have the goodness of the uniform allowance, let’s say there’s another time when we’re lacking money but we use another route, a good one, such that because we are served a certain amount of money at MSD, if we see we have a balance of money at MSD until, for example, right now we are reaching the end of the financial year 2015 and it is starting another, 2016. Now, if we see we have a good balance over there for MSD, they at MSD, indeed they are the ones who supply cloth, that cloth for the uniforms. We can ask for it from there! “Sir, we ask for this cloth.” If they bring it for us, we measure them [the staff]- you, how many meters are enough for you? Two. Okay. You, how many?
There. Now, individually, you will look at you will sew it for how many shillings because the sewing here in our parts isn’t bad, it’s small money. Therefore, they should be able to be in uniform. Of course, there are who have been indicated directly by the rules they should be given 120,000 shillings so they buy themselves [clothes] and shoes they buy themselves. And if those monies, we don’t have, we will use this route from MSD. So that they don’t walk around naked all the time - Yeah?

The end of his response about uniform allowances went back to the importance of attending meetings however, his response did demonstrate that the administration was aware of the issues and looked for ways to “jump the red tapes,” as the RMO had said about his job, in order to provide the staff members with what they were owed. The nurses did not, in the 2015 fiscal year, receive their uniform allowance. The (un)availability of this money was a separate issue from that of being reprimanded for not wearing a uniform that complied with the guidelines. However, as should be apparent, rarely could the challenges facing the hospital be extricated from their financial roots. In this instance, it was the nurses themselves who pointed to the lack of the uniform allowance as yet another way in which the hospital administration was unable to appropriately care for them as employees, violated their rights as workers, and was unable to provide them with the money which was their due. To compound the injurious effects of the institutional lack of funds, which was already causing the nurses to struggle to meet their
personal and professional goals, the hospital administration reprimanded nurses for a situation—an inability to comply with uniform requirements—that the institution had created. The conflict also highlighted the primacy of appearances, of performance of professional identity, over the actual practices of caring for patients, which often, on maternity, violated idealized norms and required fast action and improvisation. The Regional Medical Officer acknowledged the importance of trying to accommodate the nurses’ needs for uniforms while also balancing bureaucratic procurement procedures and fiscal constraints. However, the hospital Patron appeared to be more fixated on maintaining strict professional hierarchies and controlling the public’s perception of nurses, thereby prioritizing actions or guidelines that would feed into his own power, prestige, and status. He may not have actively realized it, but by fixating on enforcing uniform regulations to the letter of the bureaucratic law, he was engaged in undermining the maternity ward nurses’ access to the very means of recognition and respect they sought—the provision of timely, technically proficient care.

7.13 Conclusion

Most often, it was the maternity ward that epitomized the struggles between the hospital administration and ward staff. The physical nature of maternity care, combined with a work environment characterized by scarcity, necessitated improvisation and innovation particularly as related to clothing—uniforms and personal protective equipment. In order to keep their clothes clean on a ward that saw the highest patient load and some of the messiest and most unpredictable cases, maternity ward nurses often deviated from uniform protocols, wearing aprons or blue gowns or the stray scrub top that may have arrived at the hospital via a donation and which the nurse had uncovered in a box in the store room. Undeniably, the hospital’s financial constraints while I was present partly serve to explain why there was not enough
personal protective equipment or why the elusive light blue cloth for maternity ward scrubs never arrived. The nurses were left in a kind of double bind in which their employer was not providing them with money for new uniforms and was unable to supply them with enough PPE and yet, on a fairly regular basis, the maternity ward nurses were singled out as negative examples, held up as the height of uniform non-compliance over and over again.

Maternity care was unique in its demands and processes. The maternity ward included the largest number of nursing staff members of any department in the hospital and experienced emergency situations with greater frequency than perhaps all other departments, save the operating theatre. This meant that the nurses had to focus a great deal of their attention on accomplishing complex tasks under stress or during these emergencies when truly the life of a mother and her baby hung in the balance. This may partially serve to explain why it was that the maternity ward nurses felt frustrated by the ways in which details of uniform requirements, and the ways in which they were worn seemed to, in the minds of the hospital administration, supersede the importance of the ward’s needs, which would have helped to them to work more effectively and not just perform the role of effective and skilled nurses. Particularly because these nurses worked in a government health facility, their ability to appropriately perform the role of highly skilled midwives was of interest to, not only their immediate supervisors (the ward Nurse In Charge), but also to the hospital and regional health administration. The institution of the regional referral hospital could only be legitimate when all its constituent parts served to bolster this image. Nurses who did not embody the ideals of Florence Nightingale and the professionalism expected of instruments of the state effectively undermined the credibility of the institution.
The inflexibility of the uniform guidelines, which made no concessions for different ward environments or service on different wards, had an increased effect on the maternity ward nurses. The administration’s pointed refusal to make any allowances for the anomalous uniforms in maternity can be read as a continuation of the ways in which the hospital administration, and the Tanzanian government more generally, did not make concessions for or take into account the increased complexity of maternal healthcare provision. Fixation on the appearance of legitimacy and the performance of the role of the “good,” or professional, nurse seemed to garner more attention than the actual actions or environmental factors that necessitated the deviations. Attention to those causes could have opened the way for reform of either a) the work environment or, perhaps more practically, b) the ways in which the nursing uniform guidelines were enforced on maternity. Freeing the nurses from this conflict over uniforms in order to truly address underlying working conditions or the ways in which uniform requirements were inconsistent with the demands of the work would have enabled the nurses to engage more effectively in caring practices and might have enabled them to improve the quality of the care they were able to provide to be more in line with the benchmarks, protocols, standard operating procedures, and guidelines to which they themselves told me they aspired. Once again, shortcomings of the ward and institutional environment made the realization of national and international guidelines and protocols impossible, even as it was these very bodies that created such an environment that demoralized and demotivated the nurses most necessary for improving healthcare services and caring for patients.

The conflict also demonstrated the fundamental separations between the hospital administration and the nurses working “in the trenches.” The disagreements over uniform regulations could be read simply as a struggle for appearances but it was, more fundamentally,
about questions of social and organizational identity on the ward. The conflict was about the appropriate
ess of forms of dress for the varying, and conflicting, tasks at hand. Was it more important to look like a clean, organized, professional nurse or to actually act as one regardless of hairstyle or the color of one’s uniform? Was the target audience the patients or the public, more broadly construed? Maternity ward nurses acted in ways that prioritized the needs of the women, the patients, on their ward, regardless of what types of clothing they did or did not have, including personal protective equipment. They worked to be technically skilled care givers but, in so doing, the hospital administration read the maternity ward nurses’ actions as a threat to the hierarchy and status of the institution as a whole. The Patron routinely worked to ensure the maternity ward nurses, and the Nurse In Charge, did not overcome his authority or undermine the prestige which his position brought him and monitoring (female) bodies for uniform deviance fulfilled these needs.

This conflict served to disempower the maternity ward nurses in their work environment and held them to restrictive, inflexible guidelines, while highlighting administrative blind spots in regards to maternal healthcare provision. Ultimately, this hierarchical, gendered, and inflexible environment constrained the forms of care nurses could provide to women. When combined with material scarcity, this collective environment resulted in fraught interactions between nurses and women and a decreased quality of patient care. As the quote from Martha in chapter 5 suggested, nurses were liable to take their frustrations and feelings of being abused out on women when the administrators repeatedly disrespected the nurses. Nurses might even have strategically neglected patients as they sought to undermine the administration as retribution for the ways in which they felt the administration had mistreated and disrespected the nurses who were caught in an impossible situation between performance and care in practice.