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The maternity ward as mirror

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

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Publication date

2017

Document Version

Other version

License

Other

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Citation for published version (APA):

Strong, A. E. (2017). *The maternity ward as mirror: Maternal death, biobureaucracy, and institutional care in the Tanzanian health sector*.

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Chapter 8: “Bad Luck,” Lost Babies, and the Structuring of Realities

8.1 Introduction

Simple technologies that can be rolled out in low resource settings continue to be a major focus within the fields of public health, medicine, and engineering. Another, more recent focus, has been on evidence-based interventions, which are predicated on the results from vast amounts of data across a variety of settings. Data also serve to bolster plays for resources or to support institutional and state claims about improvements in healthcare services. However, in this chapter, I challenge the straightforwardness or neutral aspects of data and simple technologies by demonstrating the ways in which they can be, and must be, manipulated for different purposes in different settings. Separated from the places in which technologies and data collection tools are concocted and planned, nurses often must work harder to use these items in ways that come close to complying with their intended purposes. In the process, healthcare providers in these low resources settings manipulate documents and technologies to serve other purposes and accomplish other social or institutional goals, beyond the intended use of the item. Primarily using the example of the partograph, I argue that these documents and technologies cause nurses to act in certain ways or do certain things but the nurses, in turn, appropriate these tools for alternative purposes which are dictated by the unpredictable, under-resourced, and demanding environment of the maternity ward. Their appropriations often have both intended and unintended consequences, serving the needs of different actors at different times and enacting different modalities of accountability and responsibility, and drawing, in the process, on differing conceptions of what makes good care.

8.2 The Case of Pendo's Baby¹

We were crowded into the Nurse In Charge's office, in a meeting the doctors had called to address a case that had unfolded over three days. Normally, these types of meetings did not draw many of the nurses. Most did not view the often long and meandering meetings as sufficient reason to give up their precious time on their days off or did not relish the idea of coming to the ward in the morning when they were already scheduled to report for the evening or night shift later the same day. However, in this instance, the small office was fuller than usual, with nurses squeezed onto long wooden benches and sharing chairs, each one half on and half off, which was at least better than standing the entire time. The Medical Officer In Charge, who also worked on Maternity, had called the meeting and the mood was serious.

I had more information about the meeting and the case than others because I had been present since the beginning. I had been helping to care for Pendo since she had arrived at the hospital two days before. She was a pleasant, quiet client in her first pregnancy. She had come from Dar es Salaam, where she was living with her husband, to give birth at Mawingu in order to be closer to family during this important event in her life as a woman and in their lives as a married couple. She had arrived at the hospital in early labor, with more than enough time to spare before giving birth. I often saw nurses reprimanding women for arriving in the second stage of labor, as she was almost ready to give birth. However, Pendo was in the early stages of active labor and therefore avoided any possible accusations from the nurses that she was late to report to the hospital. The nurses would complain that women in the region often did not want to be at the hospital for long periods of time and therefore delayed arriving until well into active labor. Sometimes this meant a woman would arrive on the ward and almost immediately give

¹ Portions of this section have previously appeared on my blog as part of the post entitled "Ethical Dilemmas and Medical Malpractice," (Strong 2014).

birth. The ideal, as the nurses suggested, was for a woman to arrive while in early active labor, giving plenty of time for monitoring and ensuring the nurses would be able to identify and address any potential complications. The day Pendo arrived, the nurse on the ward responsible for admissions had written her name in the admission notebook, examined Pendo, and started a partograph² for her. I had seen her later in the afternoon when she was quietly walking around the ward, waiting for a nurse to tell her to enter the labor and delivery room. I remember noting to myself near the end of the morning shift that we would not need to examine her again but the evening shift would definitely need to conduct another vaginal exam to check her progress and cervical dilatation. Hopefully, she would give birth sometime in the night. The nurses had asked one of the doctors to review Pendo because they were concerned perhaps she would need a C-section. The doctor deemed her likely to give birth vaginally without complications and so, there was nothing else for us to do but settle in to wait for Pendo's body to decide it was ready for the baby to come out.

The next morning, I arrived around 8am and, having missed the shift change report that day because I had been in the morning clinical meeting, started looking around the ward for any signs of activity. I went to fetch supplies from the In Charge's office, carefully signing out the quantity of each item in blue pen inside the battered, worn notebook. Eventually, I found a moment to look over the antenatal clinic cards and current partographs sitting on the desk in the labor room. This was the paperwork of the women who were now either under observation or in the last stages of labor before giving birth. Pendo's paperwork caught me by surprise. I looked around and, sure enough, she was the same woman who had been present with us the day before.

² A graph on which nurses plotted the progress of the mother's labor, most importantly cervical dilatation and the descent of the baby's head into the pelvis, which are rough indicators of how long until the woman gives birth. Delays in progress can be indicators of problems that healthcare professionals need to address. More details on the partograph can be found later in the chapter. (See Fig. 8.1)

I thought that seemed odd, especially because the doctor had told us he thought she would give birth without any problems. Added to that fact was the absence of any further information on the partograph, as would be required by best practice³. The oft-repeated phrase “not documented, not done” rattled around in my head. Although, what one of the nurses later called “neglect,” seemed possible, my first thought was perhaps they had just been very busy in the evening and overnight. Maybe the nurses on these shifts had examined Pendo again but had simply failed to find the time to write down the results as sometimes happened. Nurse Gire was working the morning shift that day and I drew her attention to the nearly blank partograph. She also remembered Pendo from the day before because we had been working together then, too. Nurse Gire examined Pendo and the following is from my field notes:

Pendo, a patient from yesterday, is still in labor and by 12pm she still hadn't delivered. Gire did a [vaginal exam] again and decided Pendo was at 9cm and was obstructed... She has long passed the action line⁴ and should probably have had a [C-section] last night or evening. Now, she no longer has a discernable fetal heart beat ... It seems likely the baby was in distress and has already died. I asked Gire why the other people ... might not have detected that it was cephalopelvic disproportion (CPD)⁵ and why other nurses don't use partographs? ...Pendo is just finishing in the theatre now at 1:45pm and the baby was stillborn. [Nurse] Rebeca says the baby was macerated⁶ but I'm skeptical.

³ As throughout the dissertation, I use “best practice” to refer to hospital, national, or global guidelines for care, which had been taken up by the Mawingu Regional Hospital as the standard for ideal practice. The nurses and doctors often referred to these guidelines and the hospital (and each ward) had a Quality Improvement Team (QIT), which was responsible for ensuring they were implemented.

⁴ The action line on the partograph is based on the premise that when in truly active labor, one centimeter of cervical dilatation takes one hour. If a woman's progress is appropriately plotted on the partograph and crosses the action line, it indicates that her labor has stalled and something may be wrong. The line is so named because action needs to be taken to investigate and rectify the situation so mother and baby can be safe and healthy.

⁵ Cephalopelvic disproportion is a primary cause of obstructed labor and is a mismatch between the size of the baby's head and the mother's pelvic outlet, determined by the bony structures of the pelvis, making it difficult, if not impossible, for the mother to give birth vaginally.

⁶ Macerated stillbirths were those in which the baby had died some time prior to delivery and the tissue was often starting to break down and decay *in utero*, leading to the name.

After her surgery, I stopped by Pendo's bed to see how she was doing. At the time, it was visiting hours and her mother-in-law, Mama Hassani, was present. We exchanged some words about how it was a very sad situation and Mama Hassani told me Pendo's husband had been very upset about everything but she, as his mother, had been trying to explain to him that these things happen and it was just bad luck, *bahati mbaya*, and the couple would have another baby. Pendo had not awoken yet after her surgery but Mama Hassani was there, looking after her. In that moment, as we were chatting, Mama Hassani's phone rang. It was her son, Pendo's husband, across the country in Dar es Salaam. I was the only "staff person" around and so she passed the phone to me when he wanted to talk to someone who worked at the hospital. Immediately, he began demanding answers, wanting to know how a baby who was fine could suddenly be *not* fine and why hadn't his wife had an operation sooner and he did not believe it was *bahati mbaya*, bad luck. He wanted to know if I had done the surgery. I explained that no, I had not. In fact, the surgeon was the Medical Officer In Charge of the entire hospital. Nothing had gone wrong during the surgery. I tried to tell him that I was not the one to whom he should be talking, that he should talk to the Nurse In Charge of the ward or the Medical Officer In Charge and they would be better able to explain to him what had happened.

The truth of the matter was that I knew exactly what happened and had been involved since the very beginning, though the course of events that transpired had nothing to do with anything I did. All I felt I was able to do, due to my position as a researcher at the hospital, was to tell him he needed to talk to someone other than me, someone who actually worked for the hospital. While he was still on the line, I tried to hand the phone to the Nurse In Charge of the maternity ward who was sitting in the labor room. She waved her arms, refusing to take the phone, as did Gire, who was sitting next to her. I then called the Medical Officer In Charge who

suggested Pendo's husband call back in two days, on Friday. The next day, I told Pendo her husband could call again on Friday to talk to the Medical Officer In Charge. She told me he didn't want to talk to anyone anymore and they had been able to explain to him that this kind of "bad luck" happens.

8.3 To Know His Face: Stillbirth and Coping

About a month before Pendo's arrival, Zuhra had been in the hospital. She had come after already visiting her local, village dispensary where the providers⁷ had sent her on to the hospital without any documentation or proof that a medical professional had even seen her. Due to the way the regional hospital organized and documented referrals, Zuhra slipped in, looking like someone who had just come from home because she lacked official referral paperwork. Busy nurses bustled through the ward and admitted Zuhra without taking time to ask if she had come straight from home or had sought care elsewhere before arriving. They assumed she had come from home, as most women did, and therefore did not ask her the questions that might have elicited the fact that she had been in labor for more than 24 hours before her arrival at the hospital. This one fact might have changed the trajectory of her care because it would have been a sign that her labor was not progressing as would be expected for a woman in her fourth pregnancy. When they examined her, she had not projected the image of a woman in active labor-she was too quiet, too calm- therefore, she did not receive a more thorough examination of the current state of her labor. Despite comprehensive guidelines for the initial intake exam and interaction (see Tanzania MoHSW 2013), the maternity ward often had a heavy patient load and not enough nurses, which led to these shorter-than-ideal exchanges in which experienced nurses

⁷ Without knowledge of the specific facility, it is difficult to know if these providers were nurses, clinical officers, or medical attendants. Many village facilities were staffed by medical attendants who had less (or no) training in midwifery and often struggled to appropriately diagnose complications and danger signs.

relied upon their quick assessment of the woman to guide their opinion of her state. While every woman was examined physically, it was often the medical history that was left to the wayside with the justification that it took too long to go through all the questions for every woman.

The nurse then sent Zuhra to the antenatal waiting room and, according to Zuhra and corroborated by her medical file, no doctor came to see her for more than 24 hours. The nurses never again conducted a vaginal exam to see how she was progressing. In the middle of her third night at the hospital, Zuhra told me she had gone into the labor room to tell one of the nurses that her contractions were getting stronger, the only time she had been bothered by the pain. Zuhra told me prior to that moment, her contractions had not been like in other pregnancies, they came and went without any strength or regularity. The nurse brusquely waved her off and told her that they would examine her in the morning. The nurse told her, “It’s not you who decides when you should be examined! We will tell you when!” This interaction demonstrated how the nurses reinforced their expertise as authoritative, dismissing Zuhra’s knowledge of her own body’s needs (Jordan 1993; Davis-Floyd and Sargent 1997).

When the doctor finally reviewed Zuhra on ward rounds on her third day, he was struck by how soft her belly was, different from the taught skin and hard, contracting bellies of other pregnant women. Her uterus had ruptured and the baby was floating in her abdominal cavity, no longer contained and protected by her womb. Due to delayed diagnosis, poor communication, and inadequate history taking, Zuhra’s baby died. The family had whisked away the baby’s body while Zuhra was half awake, still coming out of anesthesia from the operation needed to save her life. For many weeks afterwards, Zuhra’s relative, a nurse on another ward of the hospital, told me that Zuhra was in a depression, unwilling to leave the house and constantly sad. Zuhra’s greatest cause of sadness? She had not seen her baby boy and, therefore, could never know what

he looked like, would never “know his face,” as she told me. Despite the hospital staff’s neglect in her case, Zuhra and her family never decided to pursue any action against the hospital⁸. This was despite the fact that her relative, who was a nurse, told me she could have easily provided medical insight into the course of events. She told me she knew Zuhra’s care had not gone as it should have, as evidenced by delays in getting a blood transfusion after surgery and Zuhra’s reports of not being seen by the nurses in the night. Poor documentation and shift hand-overs may also have contributed to the lapses in her care.

Based on this previous experience with Zuhra, I thought Pendo might like to hold her baby, to know his face, or at least to have the choice. I asked her and she looked at me with gratitude in her eyes and said, yes, she would like to hold him. I went with Mama Hassani to retrieve the small corpse that had been bundled in bright *kitenge* fabric and was lying on a counter near the door, looking like a healthy newborn except that the fabric had been pulled up over and around where the baby’s face was and the bundle was not moving. I transferred the small body to Mama Hassani’s arms and she carried him back to Pendo. As I watched the 22-year-old taking pictures of her stillborn son with her cell phone camera and asking her mother-in-law to see the baby's feet, I contemplated the key role the simple partograph had (or had not) played in this case. There was no electronic fetal monitoring to alert nurses to a baby in distress, there were no call buttons to push in an emergency, only the vigilance and diligence of the nurses, who were overworked and understaffed. Less than thorough reports during shift changes

⁸ The idea of legal action was mostly hearsay in this region but a medical student visiting from the much more affluent Kilimanjaro Region in 2013 told me that people were starting to take medical providers to court with the help of attorneys. A more likely outcome of complaints at Mawingu would have been an investigation of the provider by their national governing and licensing body, which could have resulted in the revocation of their license to practice in the country.

and inconsistent use of partographs as a key technology to chart a woman's progress in labor seemed to be contributing factors, among others, to this baby's death.

But now, in Pendo's case, the partograph had gone missing. Without that documentation it would be virtually impossible to prove any wrong doing, as the doctors in the meeting discussed. The Nurse In Charge of the ward was certain someone had hidden the partograph or otherwise disposed of it, and told me this happened every now and again. The very lack of information on the partograph after her admission was an indication that Pendo's care had not proceeded in a way that complied with standard operating procedures and, in fact, might have been a case of neglect and malpractice.

Back in the meeting to discuss Pendo's case, the partograph became of central importance. According to best practice, regularly monitoring the mother's vital signs, including the duration, strength, and frequency of her contractions, in addition to the baby's heartbeat, were essential and simple techniques used to quickly identify fetal (or maternal) distress before it became dire. All this technique required was some kind of watch with a secondhand (or a cell phone stopwatch) and a fetoscope (a.k.a. Pinard horn), usually wooden or plastic and available in every facility I visited, including the most remote dispensaries, which was used to listen to the fetal heartbeat. The nurses (or other providers) were then supposed to record the information from this monitoring on a partograph (Fig. 8.1⁹) to plot the woman's labor progress. If properly used, the partograph was a reliable tool for tracking the advancement of a woman's labor and ensuring that nurses or doctors intervened at the first sign that there might be a complication. The partograph traveled through the ward with the woman and providers conceived of the piece of paper as a continuous record of her labor, despite shift changes. It was the one mode of

⁹ Figure included after the text.

communication that was supposed to be present even if, as the Medical Officer In Charge accused the nurses in the meeting, verbal communication at shift changes was less than ideal or proved to be ineffective.

In Pendo's case, the partograph could also implicate the hospital staff in the death of her previously healthy baby. Many women never questioned the "bad luck" that resulted in the death of their babies while still *tumboni*, or "in the stomach." Unfortunately, this is because intrauterine and neonatal deaths have historically been so common in Tanzania and continue to be so (Afnan-Holmes et al. 2015; McClure, Nalubamba-Phiri, and Goldenberg 2006). Pendo's husband's adamant insistence that healthy babies do not *just* die made him more of a threat to the hospital staff, particularly when combined with the blank partograph which would not be able to refute any of Pendo's husband's claims that the nurses had neglected his wife. He might act on this hunch and initiate some type of investigation or lodge a formal complaint with the Medical Officer In Charge. This suspicion that Pendo's husband demonstrated was not uncommon for patients' families, however it was, as medical personnel told me, usually brought up by families or patients who were more educated or were from the urban district of the region. These parties often had more experience with the hospital setting and healthcare providers. Additionally, many women told me they were afraid if they made a complaint about a nurse, that nurse would refuse to help them if they ever had to return to the hospital again in the future. Nurses exerted their power over patients or their relatives in this way, often by forcing people to wait for care. Throughout my time in both the Rukwa and Singida regions of Tanzania, I have witnessed this play out in healthcare facilities ranging from village dispensaries to regional hospitals. On the maternity ward, these social sanctions and punishments sometimes resulted in women giving birth unassisted, alone in the midst of a full ward.

For these reasons, even if they suspected something had gone wrong with the care their relatives had received in the hospital, the Medical Officer In Charge told me most people never moved much beyond suspicion to make a formal complaint. This was often due to strong cultural norms related to not embarrassing others, maintaining smooth social relations, and saving face. This extended to the point that not receiving redress, even in the form of an apology, for suffering, neglect, or malpractice was preferable to the act of naming a negligent provider or initiating a case against them. Other researchers have documented this same preference and face saving ethos in other East African settings. Whyte and Siu (2015:28) write that in Uganda, “open criticism is often suppressed at intimate, institutional, and broader political levels,” which was also reflected in the institutional context of the Mawingu Regional Hospital. As I suggested in the previous chapter surrounding the uniform conflict, even top hospital administrators were loath to name names of specific individuals who had violated uniform regulations, a much less dire problem than neglecting patients. In any instance of mistakes in patient care, the nursing administrators and the ward Nurse In Charge usually met privately with the person who had made the mistake. These values related to minimizing public embarrassment were integrated into the hospital’s management style at all levels. The social value placed on minimizing conflicts and not directly accusing others of wrongdoing made it especially difficult for families, already lacking power and authority within the biomedical system, to come forward with accusations of neglect or complaints about bad care.

8.4 Informal Systems of Accountability

Zuhra’s case was another example of the ways in which a number of small lapses in communication or care could result in dire consequences. I include it here to provide more details about the ways in which care unfolded on the maternity ward and to highlight the fact that

Pendo was not the only woman to lose her baby through a series of unfortunate events. Zuhra's case also serves as another example of the ways in which women, their relatives, and the hospital staff struggled with the consequences of stillbirth and issues of accountability. In Zuhra's case, the family told me they did not feel like it would even be useful to complain. They were, instead, resigned to the hospital's status quo and lacked faith in the hospital administration's ability to create change within their institution. Zuhra's relative, who was a nurse, intimately knew the administrative workings of the hospital and was not convinced filing a complaint would be useful. I also suspect she may have been concerned doing so would affect the way she was perceived within the hospital by her fellow staff members and superiors. Reporting on the mistakes of one's fellow providers was not well received and one nurse told me it was common to not report mistakes, unless the administration somehow found out about them. I asked all of the nurses to tell me what occurred if someone made a mistake. Nurse Peninah told me,

If the employee makes a mistake, the first thing, if she hasn't already gone to Patron, or to the In Charge, you find that we ourselves, if we are there on the ward, we'll sit and ask each other, 'man, here we messed up, you did this but let's do this.' And if you see that it's not entering [into a person's head], what they should do, you find that other people will tell the In Charge that, 'This person, is like this and this and this and we have been there with her.' The In Charge will call her personally. You see? In Charge, if she isn't able to handle the person at all, then she goes to the leadership now. But things like that take place rarely, really everyone finishes here but now, you find those things that have been called by Patron there, either a person went out from [the ward] and they have gone to tell about it there or Patron himself has arrived here and encountered someone doing something and called them there [to his office]. But, many times, you find that the issue is finished here, here inside. Maybe only if a person is really violent or argumentative [the issue goes to Patron].

Peninah's description was not so much about the formal procedures for disciplining employees who made mistakes as it was about the informal ways in which the maternity ward nurses worked to regulate themselves and their colleagues in order to keep their ward issues within the family, so to speak. The maternity ward drew enough criticism and negative attention as it was

that they did not also need to bring further criticism for mistakes. These sorts of self-regulatory mechanisms also helped to maintain smooth social relations among the nurses on the ward, as well as reducing conflict between management levels within the hospital.

Peninah's comment about the infrequency with which issues were called to the Patron's office suggests that for a maternity nurse to report directly to the Patron was a violation of an unspoken agreement the nurses had to keep their problems or mistakes to themselves. This *modus operandi* was largely for practical purposes, in order to protect themselves professionally and not have to spend a long period of time sitting in a meeting in the Patron's office. But, this standard way of handling mistakes within the nurses also was most certainly a reaction to Patron himself and the administration more generally. Past interactions with the hospital administration had demonstrated to nurses time and again their low position in the institutional hierarchy, nearly always prioritizing the accounts of physicians and patients' relatives over those of the nurses until an inquiry was initiated and the nurses were brought into a meeting to account for the details of a case. In these meetings, the nurses would repeatedly assert their innocence, often in opposition to the accounts of lay people (relatives) who were not present in the meeting. The system truly seemed set up in a way that systematically disadvantaged the nurses and reinforced their sense of powerlessness in the institution. With these interactions in mind, it is no wonder that the maternity nurses had questionable trust in their superiors and sought to deal with mistakes among themselves first by enacting a more informal system of accountability.

8.5 The Partograph and Good Care as Documented Care

By making the partograph disappear, the nurses had irrefutably protected themselves from possible disciplinary or legal action, which could not advance without evidence, even if someone should overcome their social reluctance to embarrass, name, or punish. Reluctance to

name transgressors was pervasive and often appeared to debilitate the hospital administration's efforts to address subordinate's bad behavior. Indeed, a number of nurse managers told me of their frustration with this practice. For example, instead of saying "Nurse X verbally abused a patient on Saturday, the 23rd," the nursing Patron would tell the maternity ward's Nurse In Charge, "People are using bad language" and then expect her to prevent her staff from committing the same sin again. A number of different healthcare personnel told me they felt this type of behavior was not helpful in improving the quality of the services provided.

In the meeting about Pendo's case, the Medical Officer In Charge (MOIC), however, was insistent that the nurses produce the partograph from wherever it had been hidden,

MOIC: Where have you all hidden the parto[graph]? I'm asking you all for the parto[graph]. I want that parto[graph].

Nurse 1: I was given these [partographs] by a person from the night shift, they were [over] there.

MOIC: Look for it for me.

Nurse 2: Me, I didn't encounter it.

MOIC: Now, there, we are being destructive. Now, bring it, let us see it. Here we are not talking about it to argue.

(Many people start talking)

MOIC: Now, fine. But I remember [what happened], even if you all have hidden it. Me, I have to tell you, you all should know that, for this, I am not happy at all.

The meeting continued and the issue of the partograph emerged again and again, deployed in order to question the nurses' practices during shift changes. During these times the nurses were supposed to give complete reports on each patient and then the nurses on the incoming shift were responsible for the continued monitoring of the women, including vital signs (pulse, respiratory rate, blood pressure, and temperature) and progress of labor as indicated by the fetal heart rate and cervical dilatation. Maintaining organized documentation and handing it over to the incoming shift was a key part of interactions between incoming and outgoing shift members. One of the ward doctors also reminded the nurses,

Then, another thing, the partograph can be a legal thing, that is, actually, if you fill it out it helps you. Now, if you examine the patient and then you haven't filled it out- not documented, not done. This is in the open, therefore, even if you have examined her, [if] the results aren't available, you could start the way [for legal consequences]... (Dr. Deogratus)

In saying they could start the way for legal consequences, the doctor was alluding to the possibility that a patient or her relatives could bring a lawsuit against the hospital, taking the responsible providers to court. The lack of documentation, the missing information on the partograph, was in and of itself evidence of wrongdoing, of treatment and care that did not comply with the guidelines and failed to meet the larger biobureaucratic demands for documentation and data. Erikson (2012) also relates the ways in which healthcare providers in Sierra Leone used ledger of data as “proof” that women and infants in the clinic were receiving maternal care that met international standards” and that, less formally, the record books served as “hedges against any future accusations of corruption and mismanagement” (Erikson 2012), much in the same role as the partograph when properly filled out. In instances when information was missing, or the partograph was blank, the document that could protect the nurses and doctors could also undermine them, their actions and decisions, throwing their professional expertise into question.

While I heard mention throughout my time at the hospital of the possibility of such “cases,” which were called such in English, I never heard of a case ever actually reaching the court system. Usually any complaints against the staff members that moved beyond simply notifying an administrator were mediated and the hospital providers preferred to sort out the sequences of events in meetings, the findings of which were relayed back to the people who had made the complaint. I saw this happen particularly in regards to the availability of supplies (see chapter 6) and was most often simply due to misunderstandings or miscommunication on both sides, as

opposed to what might be termed malpractice. However, both doctors and some of the nurses expressed distress about Pendo's case in which they said there had been a clear error in medical judgment and which they named as neglect.

The meeting about Pendo's case continued with impassioned explanations from both the Medical Officer In Charge and the nurses who had been on duty while Pendo had been on the labor ward. I have spent an extensive portion of this chapter explaining the events that occurred in Pendo's case because it is a representative example of what thousands of women in the Rukwa region, and Tanzania more generally, underwent on a regular basis. In the remainder of the chapter, I analyze the ways in which providers used the partograph and the significance of these uses, as well as discuss the ways in which the providers attempted to create accountability in the absence of easy to use formal procedures.

Hospital procedures and healthcare provider actions often served to deny women and their families answers when their babies did not survive. It was clear from Zuhra's case, too, that women's subjective experiences of loss were not allowed to be made manifest. Sometimes women found it hard to come to terms with the loss of their child who was stillborn. Nurses did not routinely give women the option to see or hold their stillborn babies, instead whisking away the body and then repeatedly instructing the mother to stop crying, not make noise, and wipe away her tears. Cecil (1996:2) writes, "The feelings concerning simultaneous birth and death, the death of one who never was, may be virtually impossible to convey," and, indeed, in this setting, the nurses were not in the habit of creating a space for women to express their thoughts, feelings, and needs during this experience. Part of this *modus operandi* can perhaps be attributed to constructions of the origins of personhood and socially acceptable physical spaces of mourning, as well as, perhaps, the concept of toughening de Klerk (2013) mentions in Northern Tanzania. It

was not particularly appropriate for a woman to openly mourn in front of strangers in, what was essentially, the public space of the maternity ward. I would also argue that what is often termed compassion fatigue¹⁰ (Boyle 2011) most likely contributed to the ways in which nurses appeared to disengage with these women, allowing them to cry silently after taking away the baby. In their interviews, nurses told me, “If I concentrate too much on the deaths, how can I keep caring for the other women and their babies?” Creating emotional distance between themselves and the patients was a way for the providers to protect themselves and to enable them to keep providing care for hundreds of women every month, particularly in an environment that was physically, mentally, and emotionally draining due to shortages of human and material resources. Another nurse told me, “What would the patients think if they see a nurse crying? They will say, ‘Is that really a nurse?’” thereby arguing showing any kind of sadness about these deaths might, in effect, undermine the nurses’ professional credibility. All of the maternity ward staff members with whom I spoke told me they did, in fact, feel these deaths deeply and often ruminated for days on ways in which they might have prevented these types of stillbirths or the deaths of the mothers themselves (see also chapter 9). However, what often appeared, from the outside, to be nurses limiting compassion for the women caused many community members- men and women- to accuse nurses of not caring for or about pregnant women who were in the hospital. These suspicions and beliefs led to a deep cynicism and dissatisfaction with the only care available to most community members. Instead, this lack of free emotional response to the deaths of women or babies was more part of how nurses saw their professional responsibilities. By remaining

¹⁰ Compassion fatigue is said to often result from the secondary trauma of treating or working with patients who are suffering. Apathy, cynicism, desensitization, callousness, disorderly work, absenteeism and a desire to quit may all be symptoms of compassion fatigue in nurses (Boyle 2011). There are others who would argue that compassion is not a resource that can be depleted and therefore this is not an appropriate term (L.L. Wall, personal communication October 2015).

stoic, they sought to reassure women that they were in the hands of capable nurses who would not lose the ability to think clearly and calmly, even in the face of a death.

8.6 The Partograph as Uncertain Technology and its Role in Constructing Realities and Responsibilities

In a different setting, a woman, Sarah, approached me after the end of a community focus group discussion in her village. She said, “What’s wrong with me? What could be wrong that is causing all my babies to die?” I asked her more questions about what had happened during her last pregnancy and she explained, “When I went to the dispensary, I was lying on the [delivery] table and I could still feel the baby moving inside of me. Then, when the baby was born, it was already dead.” Two other pregnancies had ended similarly for her. I told Sarah it sounded like she was experiencing stillbirths as a result of some lack of provider experience or knowledge in her local healthcare facility and recommended she try to plan to give birth in another facility in the future, if at all possible. Pendo’s case at the regional hospital exemplified these types of intrapartum stillbirths, which were often a result of delayed recognition or improper treatment of delivery complications. These types of stillbirths were prevalent throughout the Rukwa region and did not occur only in the Regional Hospital.

If a woman came to the maternity ward and the nurses were able to discern a stable fetal heartbeat upon arrival, then that meant the baby was alive. Subsequently, there were a number of clinical problems that could later result in fetal distress and, if not addressed with an appropriate intervention, could end in what the hospital staff members called “fresh stillbirths” or “fresh SBs.” Sometimes the baby’s death was due to obstructed labor, as was most likely the reason in Pendo’s case, or to a very tight nuchal cord,¹¹ for example. The social dynamics of the maternity

¹¹ A nuchal cord is simply when the umbilical cord becomes wrapped around the baby’s neck. In relatively rare cases, the cord becomes very tight and essentially cuts off the baby’s oxygen supply.

ward and the structural processes at play intersected with these clinical symptoms and could easily turn a relatively treatable problem into a life-threatening crisis for both mother and baby. Nurses struggled to remember which women needed to be monitored at what time, because each woman was on a different schedule and the nurses continued to be shorthanded. Sometimes, more urgent cases occurred which could take all available nurses away from the less critical work. A woman might not have her cervix or fetal heartbeat checked because the nurses were dealing with another woman who was hemorrhaging, for example. However, at the very least, the nurses listened to and recorded every woman's fetal heartbeat during the shift handing over procedures.

In order to understand the centrality of the partograph in the discussion of Pendo's case, as well as in the daily life of the maternity ward at the regional hospital, I will take a moment here to outline both the official uses of the partograph, how to fill it in, and the informal, improvisational ways in which it was often employed. In a setting in which other technologies could not be relied upon and were in short supply, photocopies of partographs made their way into nearly every health facility. The District Medical Officers and the District Reproductive and Child Health Coordinators were responsible for distributing these papers, sometimes even if providers did not request them. Despite their ubiquity, during a total of five weeks of supervision visits during which I accompanied clinical experts from a multi-NGO project operating in the Rukwa region, it became clear there were many healthcare providers who might be described as hazy on the details of proper partograph use, often due to lack of knowledge or training. There were many others who simply could not be bothered, either due to lack of mentoring and monitoring, or due to being overburdened with other vital tasks. This, then, meant that healthcare providers were often not employing the first line tool for preventing stillbirths. Healthcare

providers across all levels were almost universally overburdened in the Rukwa region. This partially derives from a recent expansion of healthcare facilities which was a central goal of Tanzania's president, Jakaya Kikwete when he was reelected in 2010. The shortage of healthcare providers in Rukwa can also be traced back to the region's long history of isolation (see chapter 3). Even in places where the providers had more time to spend with each patient, sometimes women arrived late in their labor and the provider had to begin delivering the baby before having the opportunity to start documenting the woman's progress with the partograph.

Though a deceptively simple piece of paper, we should not ignore the ways in which partographs not only became key technologies in the care of women, but also in accomplishing a number of diverse social goals, which I outline below. As a technology, it was only accessible to certain people and was employed with greater or lesser degrees of success and expertise by different actors. When problematic bodies defied the order of the partograph, by not following the convention of one centimeter of cervical dilatation in one hour, nurses and doctors had to use their judgment and experience to decide if they should let a woman continue to labor or if they should do something to intervene. The partograph was also a central aspect of teaching nursing and clinical officer students during their time on the maternity ward. Nurses and physicians presented the partograph as the anchoring tool in the midwife/obstetrician's toolbox and they imbued it with an almost occult power to predict when a woman or her baby needed help. But, there was always one caveat- the partograph must be used properly in order to be effective.

Sometimes, nurses would use the partograph, and their careful documentation on it, as a way to make a bid for the doctor's attention in an effort to secure care for the woman. If the nurses felt a woman should have a C-section or that the doctor needed to examine her in order to rule out the need for a C-section, they would write on the partograph "Dr. to review" and then

wait for his judgment call. On the day or evening shift, the doctor would usually come to the ward within a short time of receiving a phone call from the ward nurses notifying him of a patient. On the night shift, this process worked in a different way. The nurses had to call the Nurse Supervisor who then called the doctor on call. The Nurse Supervisor sent the hospital car and driver to pick up the doctor at his house and bring him to the hospital. This could take more than an hour depending on where the car and driver were and on the (un)willingness of the doctor to return to the hospital after having worked the entire day. Instead of calling the maternity doctor on call, the Nurse Supervisor could also notify the Out Patient Department (OPD) doctor on the night shift and s/he would review the woman. This was problematic because, though already present at the hospital, the OPD doctors had significantly less expertise in obstetrics and several were Assistant Medical Officers with less training than the Medical Officers.

More than once, nurses felt a doctor needed to review a woman but there were delays in his arrival or, once on the ward, he refused to examine the woman. In one case, the nurses reported he had passed through the ward, refusing to even touch the patient, but still proclaiming that she would be able to give birth without problems (this was not, in the end, true). In such cases, the nurses used the partograph's back page to document the events that transpired in order to protect themselves from accusations of inaction when the inaction was, in fact, due to some delay or refusal on the doctor's part. Nurses frequently expressed that doctors were never blamed when things went wrong. Nurses took to using the partograph and other documentation as a way to protect themselves and to prove the doctor's culpability. Nurse Peninah told me about such documentation practices she had learned at her previous posting before coming to Mawingu and continued to do, "The doctor, you have called him at such and such time, you write it. I started to

look for him at such and such time. He hasn't arrived since several hours have passed, you write it: 'Since I called for him, maybe two hours have passed, he hasn't arrived.' Therefore, you're on the safe side." In this way, Nurse Peninah sought to protect herself and strategically draw attention to the role doctors played in provision of care that was delayed or otherwise not up to standards. Faced with these constraints and their dependence on physicians, as well as operating theater staff members, the nurses might even have strategically neglected to say a woman needed to be reviewed if they thought she might be borderline and able to give birth vaginally. I suggest this as a possibility given the number of barriers nurses faced when trying to obtain care for the women in their charge. Combined with material and personnel shortages that often delayed the start of a C-section (chapter 6), the Medical Officer In Charge was constantly talking about trying to reduce the number of C-sections in order to save supplies, pointing out that the surgeries were not always necessary but often due to impatience on the part of the nurses or other physicians. The Medical Officer In Charge stressed that C-sections were not supposed to be quick fixes for recalcitrant patients, but carefully considered interventions that took place only when 100% necessary in order to reduce the already considerable strain on the hospital's resources.

Peninah's strategic use of the document to record the roles and responsibilities of other actors in the patient's care was also a way in which she was utilizing the little formal power available to her within the hospital's hierarchy, which tended to privilege the more specialized or technical knowledge of the doctors. Additionally, the hospital desperately needed to retain as many physicians as possible and, I would suggest, the administration was unlikely to reprimand them unless they grievously endangered a patient's life or directly caused their death. On another level, within biomedicine's paternalistic system, the hospital Patron, a man, managed the mostly

female nursing staff in a way that played to gendered stereotypes and undermined the nurses' female perspectives, needs, and considerable knowledge.

In other cases, nurses filled in the partograph *ex post facto* due to a push by the hospital administration for better documentation or due to a supervision visit from an outside agency (Ministry of Health representatives or NGO program officers, in most cases). During these visits, the outsiders entreated the ward staff to try harder to check off the boxes in the record book of births, making sure to appropriately write "yes" or "no" in the column about whether or not they had used a partograph. Nurses would, by rote, simply write "yes" regardless of the actual existence of a partograph for that particular woman, copying what they saw in the row above their entry. In this way, the *idea* of the partograph was being invoked in order to accomplish bureaucratic documentation requirements and in an effort to project high quality care that complied with national and international recommendations and rules. Good care came to be synonymous with good documentation regardless of the particulars of the care that women actually received. By writing that they had used the partograph in the officially sanctioned government record book, the nurses legitimated their care practices and conformed with guidelines. In these moments, a culture of accounting for compliance with guidelines overshadowed a culture of actual care practices in which the nurses could have been engaged.

While an ideal tool due to its simplicity and ready availability, the environment of the maternity ward forcefully limited and redefined the ways in which the nurses were able to use the partograph. Some of the examples above were inevitable due to the low staffing levels of the hospital, as well as poor communication. Particularly when there were nursing or clinical officer students present on the maternity ward, it was often unclear who was responsible for filling out each woman's partograph. Students frequently neglected to sign their names or ask a nurse if

they were unsure about how to complete the paperwork. In the spring of 2015, several newly graduated nurses joined the maternity ward. They often left the hospital as soon as their shift was over, without properly completing the paperwork for their patients and they did not take an active part in delivering reports to the incoming nurses at the shift handing over. This was to what the Medical Officer In Charge was referring in the meeting when he was telling the nurses to make sure there was good communication between shifts. Other nurses were unsure about when to start the partograph due to their relative lack of experience in maternity care. If the nurse started the partograph too early, when the woman was not actually in “active” labor with regular contractions, they opened the door to a host of potential problems. A woman who was in active labor should progress regularly, again, ideally following the rule of one centimeter per hour. If she was not in active labor when the nurse started her partograph, it could appear as though the woman was spending much too long in labor and needed an intervention to help her. Collectively, these problems all constructed a great deal of uncertainty.

This uncertainty was productive (Cooper and Pratten 2015:2) and, as Cooper and Pratten (2015:2) suggest, uncertainty “produce[s] new social landscapes and social horizons.” Instead of being an objective technology which nurses and doctors employed to track women and tame their laboring bodies, the partograph became a form of improvisation and a relational strategy, open to interpretation, re-creation, and disappearance. In terms of the nursing and clinical officer students, they often did not have the skill level to measure cervical dilatation and determine the relative strength of contractions in order to accurately determine if a woman was in active labor, and therefore indicating that they should start the partograph. These cases often resulted in the more experienced nurses correcting the students’ mistakes in measurement by redrawing the partograph lines or starting a new one entirely. If the partograph started at the wrong time, when

a woman was not actually in active labor, it could skew the nurses' reading of the graph and their interpretations of when they should undertake some action in order to ensure the mother was able to give birth to a healthy baby. Though a simple technology on the surface, only those nurses with sufficient skilled expertise were able to access the multiple meanings and uses of the partograph in an artful and improvisational way. In the hands of students, the partograph was more a piece of paper with uncertain veracity used to record numbers.

In Pendo's case, the partograph became, or had the potential to become, a legal document, as Dr. Deogratus noted during the meeting. One way the nurses dealt with this was to make the partograph disappear. In this case, we never did find it though, Nurse Gire and I both mentioned in the meeting that we had seen the blank partograph before Pendo went for surgery. In other cases, I saw nurses reconstructing an alternative partograph that hid either mistakes in measuring cervical dilatation, as with the nursing students, or delays in care, most often without any malicious intentions. In so doing, they were reconstructing an alternate reality, one in which the woman's care followed the expected trajectory. After rewriting the partograph, the nurses would often throw away the original and would tell me they were doing so in order to reduce confusion or correct mistakes from when someone had initially started the partograph. These actions were an example of Annemarie Mol's (2002) interpretation of the ways in which realities are constantly being formed and reformed. The act of re-creating the partograph was a way in which the nurses attempted to reshape their reality on the maternity ward, bringing it into line with desired bureaucratic or best practice expectations and goals. Similarly, we should view the partograph itself, a document and technology, as having productive capabilities. The partograph contributed to the production of care on the maternity ward, as well as actively constituting

social realities¹². The document, due to its origins as a way to prevent prolonged labor and poor fetal outcomes¹³, enlisted providers in a broader fight to reduce intrapartum stillbirths. The partograph created the nurses to be disciplined providers and subjects of the global public health complex.

Often, the people who arrived on the ward for supervision visits may have been trained in maternity care but most recently were stationed in offices, creating protocols and reviewing care guidelines. In their offices on the other side of the country, far removed from this remote hospital, they, and their protocols, constructed worlds in which maternal healthcare was dispensed along straight lines, in wards and hospitals with enough staff members and a slow, evenly distributed stream of patients, which allowed for long interactions and exchanges between woman and provider. The lived reality on the ward at the Mawingu Regional Hospital was that care was dispensed in fits and spurts, along lines that deviated from protocols and included and required vast amounts of improvisation due to the scarcity that characterized the work environment. The environment in which they were working created a space for nurses to improvise the use of the partograph in order to accomplish more goals than simply tracking and preventing possible obstructed labor. The nurses on the maternity ward of the Mawingu Regional Hospital had to work significantly harder than policy planners and public health practitioners realized in order to make the partograph function in their environment.

¹² For a similar example of the productive capabilities of bureaucratic documents, see Hull, 2012.

¹³ The World Health Organization (WHO) recommended wide use of the partograph starting in 1993 and 1994 and a WHO working group subsequently implemented a study involving over 35,000 pregnant women to determine the effects the partograph had on labor management and maternal and fetal outcomes (World Health Organization Maternal Health and Safe Motherhood Program 1994).

8.7 Modalities of Accountability

Pendo and Zuhra's cases illustrate the on-going challenges facing the healthcare system in Tanzania. Work environments were characterized by scarcity of people and supplies (see chapter 7), as well as sometimes poor communication practices and few routes for holding healthcare providers accountable for mistakes due to bureaucratic and structural constraints. Stillbirths like those of Pendo, Zuhra, and Sarah were a particularly grim consequence of these challenges. Afnan- Holmes et al. (2015) write that, while Tanzania seems to have made progress on the Millennium Development Goals related to reducing child mortality, there were other areas in which Tanzania did not fare as well, including, "poor progress in reducing stillbirths, with around 47, 550 stillbirths per year, of *which 47% are intrapartum, which is a sensitive indicator of poor-quality care at birth*" (emphasis added). This statistic indicates that the challenges leading to stillbirth were not confined solely to hospitals such as the Mawingu Regional Hospital, but were occurring throughout the country.

The state and global guidelines expect healthcare providers such as those at Sarah's village dispensary and in the regional hospital to be partners in the reduction of these stillbirths, the fresh stillbirths that Pendo and Sarah experienced. "Macerated stillbirths," another classification, were displaced onto other forces. This type of stillbirth, macerated, received its name due to the appearance of the baby, who had usually died sometime prior to birth as a result of intrauterine fetal death, most times of unknown cause. The baby's flesh was often mottled, peeling off, or necrotic, and sometimes the small body was severely misshapen. If in an advanced state of decay, women were at a heightened risk for infections. These births, the

delivery of a macerated stillbirth, often took much longer¹⁴ and were emotionally, as well as physically, difficult both for the mother and the nurses involved in assisting the woman.

Sometimes the woman had to stay, lying on her back, for hours while the deceased baby's body was partially protruding from, but not fully expelled by, her body. Instead of the nurse's quick, deft movements which often freed the living baby at this stage, both mother and midwife steeled themselves for the tortuous appearance of a being who had long since ceased to live. However, there was never any talk of who was to blame in these cases; it was generally accepted that the fetus had died of unfortunate causes, natural or otherwise, that were unrelated to the actions of the providers at the health facility.

8.8 Accountability as Viewed from the Outside

People working in NGOs and in the government on maternal and neonatal health projects and policies told me that they thought nurses fabricated the state of stillborn babies, writing down more macerated stillbirths than "fresh" as a way of protecting themselves and producing statistics that showed themselves in a more favorable light. Here, providers were acting in a way that sought to comply with the demands for documentation of improvement, as well as complying with national, and global, demands for data collection. However, they were subverting the original purpose of these data collection initiatives by fabricating outcomes and events, thereby throwing into question all data produced by similar facilities throughout the country. Fewer fresh stillbirths implied, as Afnan-Holmes et al. (2015) suggest, that there was better care during the intrapartum period of the woman's labor and delivery. I did not, in fact, have to look even to outsiders of the maternity ward for this insinuation. One of the Nurses In

¹⁴ In the normal mechanics of birth, the baby actually assists the mother's body in moving it through the birth canal. A dead fetus is unable to do so and the process is often much longer in the second stage of labor- from full dilatation (10cm) to the complete emergence of the baby.

Charge told me quite frankly that she was convinced her subordinates were writing down babies as macerated when they had not been. Nurse Rebeca had been in Pendo's surgery and commented that she thought the baby was macerated, which would have shifted the responsibility for the baby's death away from the ward staff and onto other forces, before Pendo had arrived. Differing interpretations of whether or not a stillborn baby was fresh or macerated could have accounted for many of the misattributed stillbirths. After all, how mottled and necrotic does a baby have to be to be macerated? Sometimes it was abundantly clear, as when the small body oozed fluids and the skin easily peeled off, and, other times, the distinction was rather less easily made and the nurses had to use their best judgment to decide if the baby should be classified as a fresh or macerated stillbirth. Rather than a reading of the nurses' actions in a more duplicitous light, which suggested they were purposefully trying to fabricate the numbers, perhaps sometimes it was simply a matter of different interpretations of the state of the stillborn baby's body. Nurses with more training or experience would have been able to more accurately differentiate between a truly macerated stillbirth and one that was more borderline fresh. Regardless of the degree of interpretation required, the bottom line was that nurses had an incentive to conceal fresh stillbirths, which would reflect poorly on the care they had been able to provide.

I suggested, in January 2014, that the maternity ward set some goals for the coming year, which they might design together as a group. Dr. Deogratus asked me for an example and I suggested working to reduce these fresh stillbirths. He thought it was a good idea but, because I did not type anything up or get the opportunity to present the idea in a meeting, nothing more happened with this idea. Certainly, the nurses and doctors would have all liked to see a reduction in the number of fresh stillbirths but it was easier for them to switch their priorities to accounting

for poor care by concealing the true number of fresh stillbirths, or by hiding partographs that would indicate neglect or other wrongdoing, rather than fundamentally change their operating procedures. This was, at least in part, due to the difficulty they encountered on the procedural, administrative, and bureaucratic levels every time they sought, as a ward, to initiate changes. Such resistance from individuals and the system further disincentivized efforts to improve outcomes and reduce deaths. At the hospital level, a real commitment to fundamentally improving care in order to reduce intrapartum stillbirths would have required prioritizing maternity care and investing in continuing education, mentoring, and supervision. All of these needs would have been inconvenient, as well as simply being unsustainable due to budget constraints and lack of personnel.

8.9 Accountability, Language Use, and the Making of Morality and Ethical Responsibility

Even in Pendo's case in which the nurses and doctors admitted neglect, they still skirted around the issue of blame and there were no direct consequences for the providers' actions or lack thereof. The Medical Officer In Charge told everyone gathered in the meeting, "So in fact... take it that way that there isn't a person who is going to come here to take action against you, nor will we write you a [disciplinary] letter, now we will not do anything." In the same monologue he touched not only on communication, handing over practices between shifts, disciplinary procedures, the trust patients had in the hospital's services, motivation, and staff scarcity, but also spoke in a pained manner about the ethical consequences of their collective (in)action in Pendo's case. These were pervasive themes that arose in all aspects of my participant observation and interviews. Here, he invoked these themes all at one time in an attempt to motivate his staff to work for improved care. His rhetorical techniques also aimed at awakening

the nurses to the repercussions of their actions and care for the women and families directly affected.

I came to know the Medical Officer In Charge to be a man who often, if not continuously, thought about ways to elicit the complaints and grievances of clients and their families in order to improve the care his hospital offered. In other discussions, he confided that he wished someone would encourage a patient who had been wronged to come forward with a formal complaint, demanding some form of restitution for, in these types of cases, the loss of their child. He suggested that even one such legal case against a provider at the hospital would awaken all the providers anew to their responsibilities, hopefully making them more careful and compassionate in the future. The fact of the matter was that the Tanzanian Ministry of Health and Social Welfare had strict guidelines and protocols for disciplining healthcare providers. As a doctor working for an NGO told me, his family was surprised when he chose to leave the government system because there were no real ways to fire people; the job security was excellent. They asked him if going into the private sector was a good choice due to leaving his job “that is almost guaranteed [he] would have until [he] chose to retire.” The Medical Officer In Charge explained this situation further to me, giving these disciplinary procedures as an example of the ways in which the bureaucracy above him, over which he had no control, affected how he was able to work:

Some of them completely misbehave, ok, but I cannot take action. I would comment that this person is misbehaving, but I have to start with a lot of issues; say, ok, from the department, make sure you document his mistakes, and thereafter, when you feel like now you are tired, you bring it to me, I have again to sit with him, discuss once, twice or thrice. From there, and then I have to give some warnings- verbal, then written, then thereafter I cannot say ‘Now! You’re fired!’ I have to recommend that, ‘I have this employee who had so and so, please take action against him,’ or I just bring him before you for your attention. And then you will decide. Yeah? And then you will decide, whether to take action or not. You see?

The people who would ultimately decide the fate of the employee in question were the Regional Medical Officer (RMO) and, as the last step, the Regional Administrative Secretary (RAS) who was responsible for the hiring and firing of all government employees in the region. What most often seemed to be the result of these procedures, if they were even initiated, was the transfer of an employee from one department or post to another in which the Medical Officer In Charge or the nursing administration felt he or she would be able to do less damage. For example, while I was present, one lab technician was suddenly moved to the medical records department and then to the mortuary. The prevailing rumor was that he was constantly drunk while at work and, being unable to fire him, the hospital leadership had transferred him to departments in which less expertise and specialized competency were necessary. Speaking generally, the Medical Officer In Charge told me that he had recently been dealing with an employee who had been unable to fulfill his duties but they were also unable to dismiss. He was continuing to look for ways in which the situation might be best resolved so as to protect patients and the other staff members who might rely on that provider.

Left without an official avenue through which to discipline his staff, the Medical Officer In Charge, back in the meeting, instead entreated the maternity ward nurses, telling them,

But me, I'm telling you, if we continue on this way, you should all really know that this heaven, it's there, just we aren't going there. We help a lot of people but we will do just one mistake and we won't go there, there, where all those who believe in God should go, but *even if* we don't believe in God, humanly [as humans] it is not acceptable. Therefore, I saw that I should deliver this message, that let's just not continue this way or we see that there is no punishment that we can get and we just do that but it's not a good thing. Why should you *not* do something [only because] you will be punished?

In the last sentence, he was making an effort to center the responsibility for the events squarely on the nurses, instead of employing other rhetorical devices to provide them with a more

comfortable distance from the neglect and negligence. Instead of a mindset in which one only refrains from doing something because he will be punished, the Medical Officer In Charge wanted the nurses to start thinking in a more positive way, using their actions to accomplish good care, as opposed to simply refraining from providing bad (or no) care because there was not incentive (or disincentive) for doing otherwise. He went on to tell them that they should make changes in the way they think of patients and share reports, particularly during shift changes, so that no patient was forgotten again in the way they forgot about Pendo. No woman should become lost in the shuffle of the busy ward as had happened to Pendo and her baby.

In an earlier effort to explain to the nurses, to try to convince them to sympathize with Pendo, and other, similar, patients, he told the nurses two metaphors about why one person might be able to do a bad thing to another. In the first, he suggested that people without children might be jealous and resent other people having children, thereby preventing them from doing so. He likened this to two people who are trying to share a 10,000 Shilling bill but, unable to share one bill, they tear it in half so that instead of one person having money, they now both have none. In the second metaphor he said,

Second scenario, me, I have money or isn't that right? Yes. Therefore, you don't feel the pain of a person that doesn't have money, okay? So similarly, you have a child, you don't see the pain of a person that doesn't have a child. You think, like, a baby, you can go to the market and buy a baby and so you are being comfortable.

All of these quotes were rhetorical tools the Medical Officer In Charge employed in an effort to persuade the nursing staff members that their actions were unacceptable. Within Swahili speech patterns, metaphor is very common. In the most practical sense, speakers often employ metaphor in order to criticize another party. The use of metaphor is crucial for the social act of saving face because the veiled nature of the criticism leaves room for the speaker to remove

themselves from the criticism and creates a space for the listener to not understand the veiled implications (Vierke 2012). He also drew on religion, something to which all the nurses and doctors told me they ascribed, as well as humane practice (“humanly, it’s not acceptable,” using the Swahili word *kiubinadamu*, which is derived from the word for humanity) and invoked their own childbearing or reproductive pasts.

In an effort, once again, to impress upon the nurses the gravity of the situation, the Medical Officer In Charge said,

“I had already finished writing my lie here ‘poor progress of labor’ and I conclude¹⁵ [it was due to]... but I’m protecting people here. You all should know I’m doing it because I don’t want it to get out of our hands, out of this house, OK? But I’m sure, me, I’m taking on another sin for writing a lie and I vowed that I shall not relay this but, friends, if we do this, it is not good.”

Here, his open transparency about his actions was a shift away from veiled, metaphorical language as he tried to make an example of himself. Again, in the repetition of “sin,” he used language heavily laden with religious significance, which was his particular frame of reference for morality. Before studying to become a doctor, he had started studying to become a priest and was still, when I met him, an observant Catholic. In these attempts to express upon the nurses the gravity of the situation, we can see what Michael Lambek (2015: xi) so aptly refers to as “living the gap,” or “what it means to live in a world with ideals, rules, or criteria that cannot be met completely or consistently.” The Medical Officer In Charge often struggled, in a deeply personal way, with the constraints of the bureaucratic system in which he worked and how they prevented him from enacting the highest ethical standards of patient care and discipline. Instead, the system itself increased the probability of poor service or more extreme cases of neglect, such as Pendo’s.

¹⁵ I have intentionally left out the specifics of what he wrote in the rest of the post-operative report in order to protect him and because these details are not important for the point I am putting forth here. However, poor progress of labor was an accurate diagnosis, regardless of the ultimate cause.

In the development of this argument, it is of the utmost importance that we remember these were not simply personal faults of individual providers but clashes of many groups of individuals and facilities with far mightier institutions. Financial, medical, and sociocultural processes and institutions constrained and limited the ways in which care came to be practiced in the Mawingu Regional Hospital.

The Medical Officer In Charge also told the nurses in the meeting that even if they made mistakes, mistakes were not a reason to stand on the sidelines the next time they encountered a difficult case. Instead, each nurse or doctor was responsible for putting forth their best efforts to care for patients but, they were additionally responsible for reminding their colleagues to complete tasks such as documentation. Here, again, he was attempting to impress upon his listeners, the nurses, that not only were they responsible for their own actions, but they were also responsible for the actions of their colleagues and everyone was collectively accountable for the care the hospital provided to patients. (See chapter 6 for other ways in which structural constraints limited care possibilities.)

In a divergent manner of speaking about the case, Nurse Gire asked to make a statement before they concluded discussing Pendo's case. She said they should also acknowledge the good work they do and she proposed the "compliment sandwich" in which you deliver good news, bad news, good news, always making sure to end on an encouraging note. She then proceeded to say,

...Those challenges, what do they do? They stimulate you all to build yourselves anew. This case is a challenge. I think, now, it has already balanced us, if we were already starting to slack off... it's necessary for there to be challenges so you all do well. Don't depend on it, that every day you will do everything well, this philosophy doesn't exist. Therefore, take the challenges as challenges and let us not be content for them to repeat and repeat themselves. If it happens through *bad luck*, like these, we can't avoid bad luck, friends. To break a cup, aren't you holding it? You want it not to break but you find that it slips away from you... Therefore, challenges like these, let us accept but let us not entertain them [happening again] apart from accepting them. (emphasis added)

There are a number of significant differences in the ways in which Gire talked about the course of events that contributed to the death of Pendo's baby. Gire was involved in Pendo's care from the very beginning but, though she earlier in the meeting clearly stated they neglected Pendo, she did not use the same impassioned rhetoric as the Medical Officer In Charge. Gire's comments were much more representative of the ways in which providers commonly discussed stillbirth. Instead of calling these events a tragedy or sin as the Medical Officer In Charge had, she used the much more neutral term "challenge" (*changamoto*) which speakers often employed throughout my time at the hospital to present areas for improvement but which they did not wish to convey as the more negatively construed word "problems" (*matatizo*). In her comments, Gire also used metaphor to convey the inevitability of "bad luck" (*bahati mbaya*), which was likely to befall the ward from time to time. Using metaphor here may have had the same saving face application. It was perhaps a poetic way of reassuring her colleagues that they needn't feel too bad for what happened to Pendo.

Gire's use of the term "bad luck" is especially significant here. At no time in the discussion of the case did either of the doctors use bad luck as a way of explaining what had happened. They were much more clearly focused on dysfunction in the ward, particularly as related to documentation and communication practices. In all of the doctors' comments, the responsibility for the death of Pendo's child was laid clearly at the feet of the nurses and, more generally, the maternity ward staff. Gire, whose comment was the last in relation to Pendo's case, displaced some of the blame from the nurses. She much more gently told them that sometimes cases like these were inevitable but that they should not be satisfied to let such things happen over and over again. By using the term bad luck, she very clearly was acting to move responsibility and blame onto other, less controllable and more indeterminate forces.

Gire's use of "bad luck" was much more similar to the ways in which Pendo and her mother-in-law were using the term. The term drew upon feelings of resignation regarding events that have long been common experiences for women and families in their childbearing years. This resignation was a common response for women and their families, who might not have shared healthcare providers' exposure to or belief in the authoritative biomedical explanatory models, or may not have experienced other possibilities for pregnant women. However, for the nurses, who were trained in the management of difficult births and abnormal deliveries, when they employed the term bad luck, it was not in the absence of other ways of understanding the event. It seemed to be a way to shift responsibility and blame away from themselves and onto larger, more diffuse forces during these tragic events, possibly as part of the face-saving strategies discussed earlier. Likewise, nurses often referred to stillbirths as "missing" the baby (*amemiss mtoto*). This term is a bit more difficult to decipher and, while clearly a carryover from English, the meaning could be very different in another context in which the speaker might mean the woman "misses" her child (because she has not seen them in a long time, etc.). This construction is also a particularly interesting way in which to disembody the actions or events that led to the stillbirth, simply suggesting the woman "missed" her baby like how one might "miss" out on an opportunity.

When providers, patients and their family members called neglect or malpractice "bad luck," they were effectively enabling providers to continue to evade accountability and responsibility for their actions, which was part of a broader bureaucratic and systemic challenge regarding accountability. In the Tanzania Nurses and Midwives Council's (2009) *Code of Professional Conduct for Nurses and Midwives in Tanzania*, it clearly states, in section 4, that:

The nurse and midwife is responsible for maintaining professional standards for quality care and *be accountable* for her action. Therefore, she shall observe the

following: ...4.3 accountability for her actions or omissions through formal lines of authority and responsibility, 4.4 respecting and complying with rules and regulations in a manner that promote *public confidence*, the integrity of nursing and midwifery services and profession... (emphasis added)

However, as the Medical Officer In Charge wrestled with nearly every day, how can nurses be held accountable through formal lines of authority and accountability in meaningful ways when the government and Ministry of Health have effectively constructed disciplinary procedures that were so bureaucratic and prolonged as to be nonthreatening and absolutely ineffective? Matthew Hull (2012:36) suggests that (bureaucratic) documents are “mechanisms for protecting the integrity of the government,” but, “are often the means through which it is undermined.” In the hospital maternity ward, the partograph played a similar role. Various healthcare providers and experts idealistically conceived of the partograph as a way to protect their integrity because it helped them to make timely and accurate diagnoses of problems. When the maternity ward doctor referred to the partograph as a legal document that could protect them, he was referring to this component of the technology. However, alternatively, these very documents were also the perfect evidence of wrongdoing, either as left blank or inappropriately filled in. The partograph then undermined and called into question providers’ expertise, communication skills, decision-making and, ultimately, public confidence in their services, in direct violation of the *Code of Professional Conduct* cited above. Documents and documentary practices, such as those surrounding the partograph, sometimes took on a life of their own, “returning in the transitional moment to incriminate their producers,” despite providers’ other intentions and goals for the document (Hetherington 2011:77).

In an effort to provide a framework for ethical action and caring in the absence of easily accessible formal mechanisms for enforcing sanctioned ethical standards, the Medical Officer In Charge drew on his own morality. In a singular and truly unique manner, he tried to embody and

convey the moral and ethical physician who takes responsibility for his actions, even as he lives the gap. Despite being unable to initiate a case against the nurses due to bureaucratic constraints, he reflected on the ways in which his actions (or lack thereof) eroded his moral scaffolding. The way the hospital treated Pendo shook the foundations of goals he valued, such as the ultimate goal of reaching heaven, and his responsibilities to his patients. In the absence of formal lines of authority and responsibility to ensure ethical and moral conduct, the Medical Officer In Charge was attempting to construct another avenue for impressing upon his staff how unacceptable their actions had been. Were his words weakened without the force of concrete disciplinary consequences behind them? Perhaps. However, through his rhetoric he was embodying the caring physician who was deeply wounded by this neglect of Pendo. My interpretation of part of the reason why so many of the hospital staff members respected and liked the Medical Officer In Charge is because he was not afraid to face these types of cases head on and was a genuine person as well as an authentic leader. In his discussion of Pendo's case, he did not simply yell at the nurses, reprimanding them for their inaction or incompetency but he put himself into the conversation, placing his moral being on the line together with theirs.

8.10 Conclusion

As I have demonstrated through the cases of Pendo, Zuhra, and Sarah, subjects interpreted stillbirth in multiple ways. Providers and women imbued this unfortunate event with different meanings that, then, had different consequences for their projects of constructing morality, responsibility, and accountability across different levels. As policy makers and experts conceived of the partograph, it was meant to be a tool in reducing stillbirths and complications for the mother. The partograph invoked the healthcare providers as allies in this struggle and in the global health goal of reducing preventable stillbirths, holding providers accountable for

providing good care that would reduce these deaths. Data on these intrapartum stillbirths, or a *documented* reduction in them, then worked to help states account for healthcare policies that conformed to global initiatives, such as the Millennium Development Goals. The partograph was a technology that monitored bodies but it could also be problematic if a woman's body and labor did not follow the prescribed pathway of birth, one centimeter of cervical dilatation in one hour. Her body could be difficult to interpret and plot on the partograph if she gave birth extremely quickly or if her labor became delayed in some way, thereby complicating understandings of who was skilled enough to be in charge of these deceptively simple pieces of paper as technology.

Sometimes, the doctors and nurses created and re-created new realities by plotting and re-plotting a woman's labor on the partograph. Due to poor communication and differing levels of provider expertise on the maternity ward, the partograph created uncertainty. Most often, if a woman was progressing slowly in labor, the providers immediately suggested that the first person who had examined the mother upon admitting her to the hospital had measured her cervical dilatation inaccurately, overestimating how many centimeters she had reached. Therefore, they had started the partograph too early. This uncertainty about the expertise of the examiner undermined some of the power of this simple tool. In other situations, the nurses used the partograph to try to make bids for the doctor's attention, to protect themselves from a physician's lack of cooperation or judgment, or to conceal wrongdoing and neglect. The partograph was a physical reminder, in black and white, of when care did not go as imagined or desired, resulting in the death of babies. One way in which nurses could make the situation ambiguous, in the event of stillbirths such as these, was to either rewrite the partograph or make it disappear. This makes stillbirth a perfect case study for accountability and responsibility.

Stillbirth and the partograph demonstrate the ways in which the hospital staff and administration constructed alternative avenues for assessing morality and ethics in the absence of a formal disciplinary mechanism. They were often understaffed and lacking many of the crucial supplies needed for their ideal, best practices of maternity care. These struggles, combined with the ways in which the larger biobureaucratic system imposed standardized rules and guidelines for disciplinary proceedings, documentation, and data collection, led to incredibly difficult situations that occurred on nearly a daily basis.



Fig. 8.2: Five bodies of deceased babies lying on a table in the maternity ward of Mawingu Regional Hospital.

The tiny bodies of stillborn babies were perhaps the best indicator of how well a particular shift performed or how skilled a labor ward was, or perhaps, by extension, how well equipped physically the ward was. In the Regional Hospital's labor and delivery room, nearly every morning I was met by the tiny bodies of stillborn babies lying on a table near one of the doors (Fig. 8.2). I could always tell if it had been a good night or a bad night by the number of bundles present on that table. While the Medical Officer In Charge passionately discussed what

had gone wrong in Pendo's case and was transparent about the ways in which he tried to cover up their wrongdoing and neglect, this was most often not the case. Instead, nurses and families referred to "bad luck," a rhetorical strategy related to accountability, which allowed the nurses to not directly address the underlying problems in their department and on their ward. Several healthcare providers, working both within and outside of the government healthcare system, told me they sometimes felt healthcare providers and administrators were reluctant to name and discuss problems in a straightforward manner and that this made it difficult to address these issues and improve their care, the ultimate goal to which all of them ascribed. Instead of changing the tangled thicket of bureaucratic communication and documentation practices to ensure women did not slip through the cracks, nurses and doctors sometimes changed diagnoses, intraoperative findings, and partographs in order to hide evidence of substandard care. Sometimes, as in Pendo's case, many providers were complicit and knew of the mistakes that had occurred. However, in other cases, an individual nurse might have made a mistake and, fearing confrontation with either the patient's family or the nursing administration should her mistake become known, she would hide the evidence of her error. Due to the shortage of resources which extended beyond the sole control of the hospital, extending to regional and national levels, the providers were often severely constrained in what they were or were not able to accomplish.

What work did these actions do for the providers? In the absence of disciplinary threats or recourse, we might view tampering with evidence as more of a social act, meant to prevent criticism and embarrassment of the ward's staff members, thereby ensuring smooth social relations in this highly interdependent community of nurses and doctors. Additionally, social ideals about not losing face and not causing others to lose face (particularly through public

embarrassment and criticism), may have dissuaded patients from making formal complaints and led to discipline as an impossibility. This impossibility was further reinforced by strict and convoluted bureaucratic guidelines for dispensing warnings and disciplinary action within the government healthcare sector. All of these processes contributed to a system that did not easily adopt changes to routines. Instead of receiving acknowledgement of wrongdoing or medical errors, the patients were left with no real choice other than to engage in the cognitive work of shifting blame once again. They shifted it from themselves onto luck and God in an attempt to come to terms with a tragedy that was still all too common in their communities. Ultimately, patients were left with no other avenue for coping with these events due to the ways in which healthcare providers, administrators, the system more broadly, and its documentary accoutrements, as epitomized by the partograph, constructed the realities of stillbirth. In this environment that made change or reformation feel nearly impossible, the nurses and doctors had little possibility of revolutionizing their care practices. Instead, they were swept up into a global system that promulgated the idea that good care was documented care, incentivizing accounting for deviations from guidelines while simultaneously disincentivizing changes in practice that would result in different care for women and babies. Within this system, maternal and neonatal deaths, as well as intrapartum stillbirths, were not simply eventualities, they were nearly impossible to avoid.

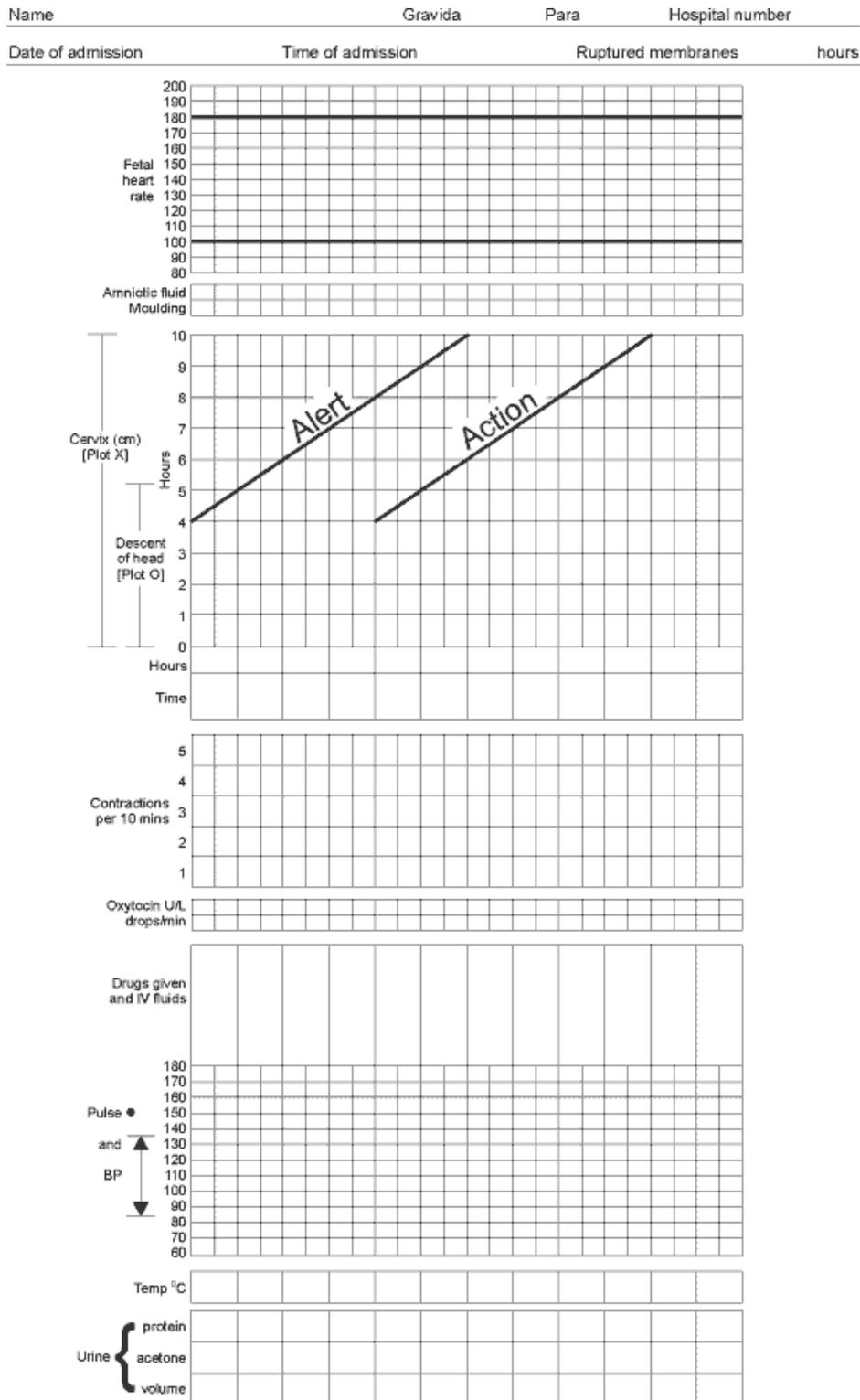


Fig. 8.1: A partograph identical to the version the healthcare providers in the Rukwa region were using. There are spaces to chart vital signs, the descent of the baby into the pelvis, the fetal heartbeat, and cervical dilation, among other things, all on the y-axis. The x-axis is time in hours. The “action” line alerts providers to the need for an intervention to help the woman give birth, if she has not done so before crossing that line. (WHO Maternal Health and Safe Motherhood Program 1994)