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The maternity ward as mirror

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

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Chapter 9: The Stories We Tell About the Deaths We See

9.1 Introduction¹

The meeting always ends with the same question: was this death preventable? Nine times out of ten, the answer is yes, this death was preventable. What varies vastly between deaths is the way in which it occurred, what transpired on the woman's slow or rapid road to death, and who is, ultimately, responsible for ensuring such a death does not happen again in the future. Despite the fact that maternal deaths in Rukwa, in Tanzania, and many parts of the world, have declined since the 1990s, nearly 300,000 women still die each year, most in low resource settings, and most from just a small handful of causes. Since the advent of the Safe Motherhood movement in the 1980s, there has been a focus on measuring maternal deaths more accurately. Counting maternal deaths was one of the first steps the global health community took to elucidate the extent of the problem of maternal death and address it. In Tanzania, the Ministry of Health and Social Welfare issued standardized guidelines for facility-based maternal and perinatal death reviews in 2006, though these have been taking place in some facilities since as early as 1984 (Commonwealth Secretariat 2008; Tanzania Ministry of Health and Social Welfare 2006).

During a maternal death audit meeting, the designated healthcare providers and/or administrators go over the details of women who have died due to pregnancy-related causes. A WHO publication (Mills 2011:1) describes the maternal death audit in this way:

A maternal death audit is an in-depth, systematic review of maternal deaths to delineate their underlying health, social, and other contributory factors, and the lessons learned from such an audit are used in making recommendations to prevent similar future deaths. It is not a process for apportioning blame or shame but exists to identify and learn lessons from the remediable factors that might save the lives of more mothers in the future.

¹ A table with all the deaths that occurred while I was at the hospital in 2014 and 2015 is located after the text at the end of this chapter.

And the WHO (Danel, Graham, and Boerma 2011:779) suggests, building on its seminal text on maternal death audits from 2004:

A national maternal death surveillance and response system should draw upon two main sources of information. Within the health system, facilities should be required to report all deaths of women during pregnancy, delivery and the postpartum period. All such deaths should be routinely reviewed or audited as an integral aspect of healthcare quality improvement... This approach not only takes advantage of innovations in statistics reporting, but simultaneously improves response mechanisms to avoid future deaths. Over the past years, many low-income countries have introduced action-oriented review mechanisms, described under various names including maternal death enquiry, review, or audit. These require analysis of the circumstances of each death, identification of avoidable factors and action to improve care at all levels of the health system, from home to hospital. Much of the responsibility for follow-up actions lies with district and local health authorities.

While this process can be employed in any setting, in any country, it is particularly useful in countries that lack reliable vital statistics and civil registry systems or where a lack of resources may make it difficult to accurately diagnose the cause of death in a more immediate way. The audit process provides a picture that extends beyond the individual healthcare facility in which the woman died. During the meeting, the participants also discuss potentially contributing factors extending from the woman's family, community, or referring health facility. These types of discussions also allow district health administrators to analyze the ways in which the referral system, infrastructure, and communication can be improved in the future in order to save more lives. At the end of the discussion of each woman's case, the group would agree on an "action plan" to be carried out in the ensuing months in order to address the preventable aspects of the woman's death. These meetings play an important role in collecting data, legitimating state efforts to reduce maternal deaths, and demonstrating the efficacy of individual healthcare institutions.

Since 2012, I have participated in or been present at a total of four such meetings. While Tanzanian Ministry of Health guidelines, as told to me by the administrators and providers at

Mawingu, suggest hospitals or regional health administrations hold these meetings on a quarterly basis, in practice, the meetings occurred much less frequently. Sometimes the regional hospital would go for more than seven months without convening such a meeting. By the time the Maternity Ward In Charge, a physician, called the meeting and notified all the appropriate district and regional-level administrators, the details of each woman's case were long forgotten, turned into an indistinct blur by the passing time. The women were, in a sense, brought back to life in the meeting through their patient records, the files that had been compiled over the course of their treatment and stay at the hospital. No two women's deaths followed the same trajectory, making each case unique but with all too common underlying similarities. It is these commonalities that the death audit system is designed to pick up and turn into action plans and points of intervention.² In this way, no death is in vain; each woman leaves behind lessons that can be carried forward to prevent the death of another from the same breakdowns.

In an era of audit and accountability, of counting and an obsession with metrics as the next global health panacea (Adams 2016:23; Erikson 2012), the maternal death audit meeting holds a new space, a new and loftier spot as a way to track these deaths, count them, enumerate the "true" extent of the problem that is maternal death, and collect data on the on-going causes of these deaths. These data are purported, by extension, to provide policy makers, governments, and global health practitioners with the keys to reducing or eliminating such deaths. While the numbers and the forms are meant to strip the dead women's lives down to their clinically important constituent parts, these tools of audit culture are in no way value free, no matter how much their inventors might wish this to be so (Adams 2016:36).

² A number of institutions and countries use this audit system, including the UK, which periodically produces reports based on the findings of their confidential audit meetings (Knight et al. 2015).

Much like the partograph, a mutable document twisting and morphing, becoming and being, disappearing and reemerging, reconstructed in new form, the numbers and tick-boxes of maternal death audit meetings cannot be divorced from the values, ethics, and social and institutional powers which brought them into being in the first place. These forms are meant to standardize but, in fact, what they do is strip down, reducing complex lives to “yes” or “no” answers, stuffing bodies-mothers and babies- into check boxes that cannot possibly contain the messiness and conflicting narratives of lives lived and died through different lenses, from different perspectives, and within diverse contexts. When I read Form B, the second form of a two form set sent to the Tanzanian Ministry of Health after each audit meeting, with one copy kept in the maternity ward records, I could discern almost nothing about the course of the woman’s illness, how she came to be at the hospital, the context in which she had lived, and, ultimately, anything about her interactions with the government hospital other than her diagnosis. Armstrong et al. (2014:1089) also noted that, in Tanzania, despite an emphasis on a qualitative, in-depth analysis of each death, the Ministry of Health forms do not provide much space for elaboration of details and, “the structured reporting forms...are designed to collect mostly medical causes of death and as such are less suitable to guide the team through an analytical discourse on the gaps in service provision, nor stimulate action-oriented dialogue in the forum.”

Typically, the meeting started with some opening remarks from the RMO and then the Maternity Ward In Charge, the physician, would begin going through the case files. He read through each woman’s medical record from beginning to end, pausing for questions or comments on her diagnosis or course of treatment, as others present in the meeting asked for clarification. People would point out delays in the care, question the quality of history-taking, or ask about the events that preceded the woman’s arrival at the hospital. The first cases received more careful

consideration and discussion, with the district level administrators interjecting with comments about a facility lower down the referral chain, or how we might determine if the woman had received adequate prenatal care. However, I, too, like Armstrong et al. (2014) found, particularly as the meetings dragged on for many hours, the attendees began to focus more and more on simply filling in the blanks on the form. The action plans began to be copied from one woman's form to the next by rote, without any commensurate discussion of the plan's appropriateness. This was also due to the fact that the meeting's attendees identified similar problems in many of the cases. Even the diagnosis is not the thing of certainty that it is meant to be, that the medical sciences conceive it to be. Without much of the diagnostic equipment that would be needed, and in the absence of a pathologist, even these determinations, sometimes presented as facts, were merely interpretations based on experience, gut, and best guesses due to the ways in which a woman's illness presented itself, what little information could be gleaned from accompanying relatives, and the woman herself before her death. More an art than a science.

These interpretations composed the narratives of the deaths that pass through the Mawingu Hospital maternity ward. The deaths leave traces on families, on healthcare providers, and on communities that continue to retell the most gruesome or heartbreaking accounts long after the woman herself is gone, telling me stories of tying the limbs of a corpse to your own when driving a pregnant woman to a health facility on a motorcycle only to find en route she has died and must be secured to the vehicle in some fashion. These narratives discussed in the hospital ward, sanitized and transformed in the meeting room, lovingly kept alive in communities, intersected with policies, documentation requirements, and care to make their marks on the minds and bodies of those whose lives they touched.

In this chapter, I deconstruct some of the narratives which community members and healthcare providers told me, or that I witnessed first-hand, in order to examine how we³ make meaning out of the deaths of pregnant women. In returning to some of the themes I discussed in earlier chapters (see Part II), the process of maternal death audit meetings is derived from a larger global health project related to amassing vast quantities of data- primarily quantitative- related to a wide swath of global health challenges. Without much of a stretch, it is plainly clear that maternal death audit meetings are one cog in the global health audit culture- a machine churning out data, based on the gold standard of the randomized control trial (Adams 2016:34), with a relatively new goal of producing profits in addition to improved health outcomes (Erikson 2012). Armstrong et al. (2014:1089) note that Tanzanian MoH audit guidelines include very little description of the actual review meeting, instead focusing much more extensively on “hierarchical reporting structure, technical committees, and administrative management of the data.” As the authors in Vincanne Adams’ 2016 edited volume suggest, the metrics of global health have come to have paramount importance, overshadowing or precluding more concerted consideration of the complexity of the lives of individuals and even institutions. Wendland (2016) clearly deconstructs the mathematical formula used to sanitize, extrapolate, and “smooth” the number produced by statistics in countries such as Malawi and Tanzania, which have incomplete vital registry systems and political-economic structures badly in need of the support of outside donors. The numbers never tell the whole story.

Nor do the narratives we produced in these maternal death audit meetings because, for a variety of reasons, we distort the truth to ourselves and most certainly for the consumption of

³ I use “we” here to include myself in these narratives because I witnessed many deaths and was witness to the trauma of those who had experienced many more. I also was observer, and then active participant, in four maternal death audit meetings. Therefore, I cannot extricate myself from the process of story-telling in the wake of maternal death in its various forms.

others. Mattingly and Garro (2000:15) suggest that examining underlying narrative structures can help researchers see more clearly the underlying “imprint of institutionalized practices and ideologies,” which is what I seek to do here. “Narratives shape action just as actions shape the stories told about them;” stories also “suggest the course of future actions” (Mattingly and Garro 2000:16-17). The narratives we construct about maternal deaths operate and perform on a variety of levels, including the interpersonal, the institutional, the regional, national, and international, each of which I address here. In this chapter I examine the ways in which these narratives were constructed in the maternal death audit meetings, but also by individual nurses and doctors, and how these narratives could work to normalize poor reporting or the number of deaths that occurred in the region.

9.2 Reporting and Data Collection

I had a chance to observe these reporting structures once in January 2015 when I was in Dar es Salaam. In May 2014 I had met a woman working in the Ministry of Health’s Reproductive and Child Health Section headquarters in Dar. In January, I visited her in her office and we discussed what types of activities she did as part of her job. At that particular time, her boss was away and she was in charge of compiling the weekly reports based on data coming from the regional level. These reports are available online from the Ministry and are distributed on a regular basis. As I was sitting in her office she received an email with the data from the entire country. There were two deaths under the Rukwa region and under location it said Sumbawanga. I asked her if there was any other information about these deaths because I had just come from Sumbawanga and would have been present during the time period represented in the report. She speculated the deaths had occurred at Mawingu, while I knew of no deaths that had occurred at the hospital during that same period. While it is possible the deaths under the

heading of Sumbawanga could have occurred elsewhere in the municipal district, I told her those data made me uncertain about the rest of the information she must have been getting. She told me she would call the Rukwa region Reproductive and Child Health Coordinator to clarify the details of the deaths and where they had occurred. This was a particularly clear demonstration of the uncertainty that can be part of these reporting structures. If I had not been present to question the data due to my experiences in the region in question, she would not have made a follow-up phone call and the deaths could have been misattributed to the regional hospital.

Reporting requirements were routinely a challenge for many of the healthcare facilities in the Rukwa region. Some of the doctors at the regional hospital told me they were unsure about how to properly fill out the MTUHA (Mfumo wa Taarifa za Utoaji Huduma za Afya, System of Reporting of Provision of Healthcare Services) books for the end of month reports for their wards. The hospital was often late in submitting reports to the regional or Ministry levels and this was a major area targeted for improvement during my time there. Maternal death audit meetings also often opened with the Regional Medical Officer reminding the district administrators to submit their reports of deaths in a timely fashion. At the meeting held in May 2015, the RMO said⁴ that everyone was to report the number of maternal deaths every week and if the report was reaching the Ministry, it should also be reaching the RMO's office. He said it was very important to be following these reporting guidelines because it was an order that came directly from the mouth of the President himself in 2014. Even if the districts reported zero, the Ministry would be satisfied. After this proclamation, two of the District Reproductive and Child Health Coordinators (DRCHCOs) admitted they had not yet turned in all of their data and one

⁴ All the quotes from the meetings that I use in this chapter are paraphrased. Due to the confidential nature of the audit meetings, I was not allowed to record the discussions and frequently do not have verbatim quotes. All such paraphrased quotes are not in quotation marks.

had been late to the meeting because she was trying to find the relevant information from her office.

He went on to draw attention specifically to the Sumbawanga Rural District (Sumbawanga DC) for their consistently later reporting, which had been a problem for more than a year. The RMO then proceeded to relate a story highlighting the important role these data could play. He said that in 2014, when the Regional Commissioner had been at a Parliament session, she sent a request back to the RMO asking for the number of maternal deaths in the region. RMO told her that the maternal mortality ratio (MMR) was 116 per 100,000. Later, when he finally received the tardy data from Sumbawanga DC, he had to tell the Regional Commissioner that actually, the real number for the year was 142 per 100,000, which was, in fact, an increase over the previous year's rate of 139 or 138 per 100,000. The RMO then pointedly asked the Sumbawanga DC representative at the meeting if she thought the Regional Commissioner would be understanding if they continued to provide her with bad data to use in front of Parliament and the President. With the arrival of the late data, the RMO and Regional Commissioner were forced to admit their region had not seen any significant reductions in maternal mortality despite the passing of another year. Not only did the RMO consider Sumbawanga DC's tardiness to be problematic and disrespectful, but he saw it as a threat to the region's reputation on a national stage. By providing the Regional Commissioner with data of dubious veracity, the RMO was also threatening her credibility while in public and in front of her superiors.

There were any number of ways in which reporting could go wrong. There were a number of instances in which I became confused about how the hospital was counting deaths and who was supposed to take responsibility for which deaths. In theory, any woman who died at the

hospital was supposed to be counted and documented as a hospital death. This sounded, to me, like a fairly black and white system. Either she was alive when she arrived, or she was not. However, in practice, there was a much less distinct line. The hospital did not want to look as though they were also not making progress in improving care and reducing deaths and so they often were selective in the way they counted the deaths.

Below, I quote at length from my field notes from July 2, 2014 to demonstrate some of the difficulties of accurate reporting and accounting of maternal deaths. I had been away from the hospital in the end of May 2014 due to a trip back to the United States and then, after returning to Sumbawanga in June, participated in two weeks of supportive supervision trips with a multi-NGO project. At the beginning of July, I began to try to follow-up and collect information on the maternal deaths that had occurred while I had been away from the hospital.

7/2/14

I'm trying to follow-up on some of the deaths from the end of May and beginning of June before I got back. I asked Dr. Charles first and he said if the deaths hadn't occurred here in the maternity ward, she hadn't been technically admitted already, then the death would be recorded in OPD, not here. It's hard to follow-up with deaths in OPD but maybe a good place to start would be to go to supervision and see if they have a record because they usually write down all the deaths that occur. I wanted to know then who is responsible for discussing the death and making follow-up, doing the death review. He said it depends on where the woman came from, but the districts are supposed to do death reviews to follow-up, too.

So, I went to supervision, found the supervisor, and she told me to ask another nurse who is in charge of data collection. She said we should go together to OPD to try to follow-up. We went to ask Dr. Salome. Dr. Salome said she remembered one case from April, the woman arrived from the village, was treated for [pregnancy induced hypertension] and went home to stay with relatives in Edeni, here in town. She then developed further problems, relatives brought her back to the hospital and she died on the way [to the hospital]. Dr. Salome verified the death and wrote on a piece of paper and sent the body to the mortuary. Technically, then the death didn't occur at the hospital and the death is sent to the district from which she came.

Dr. Salome doesn't remember any similar death from June or the end of May but she said maybe it was someone else, another doctor, that had received the case. They said they don't have an MTUHA book for deaths there in OPD. The nurse said these OPD deaths are really difficult to trace. If I knew the dates, we could look at the roster to see who was working there. But I don't know the dates, so then what am I supposed to do? She told me I should go back to the maternity

ward to check. But I said they didn't reach maternity to be admitted so where are these deaths counted? Deaths *za wapi?* (deaths from where?) All the doctors in the OPD office at that moment agreed that it was an OPD death but it would be difficult to find even the woman's name. I asked, what about a report from supervision? The nurse told me that often those reports are given orally, if the person hasn't been admitted to the hospital, so there probably wouldn't be any further documentation on the part of supervision. And with that, she told me to come back to maternity and to look to make sure there was no documentation here. They haven't yet gotten the data from June because the month just finished. And I return here [maternity] to the start with no further information about these two deaths. I still want to know who gets the pertinent info about the death and who is then responsible for the follow-up and discussion??

Back in the ward, I was ranting to Nurse Gire about this problem. She said she was there for the one who arrived here and almost immediately died, it was eclampsia she thinks. Dr. Charles said, just now on my way back to maternity, that the woman came and was already "gasp, gasping" and then died after only a very short time. Gire said that if the woman hadn't been included in the admission book then perhaps it wasn't recorded here. If she was in the book, then it's required that her death be recorded here. If she dies in OPD, then the info, her files, etc., go back to the district she came from and they are supposed to follow-up there.

Gire was telling me that at one point she was the Reproductive and Child Health Coordinator and at that time she started a form to collect better data at the village level about maternal and neonatal deaths. She got better info and requested the forms be brought to her every 1st of the month for the previous month. She got much higher numbers than other were getting and told the RMO at the time that this was a severe problem that needed to be addressed. She says now she doesn't think those forms are still being used and the data that is being reported currently is certainly not accurate. She doesn't believe that deaths have been reduced and even the number for Tanzania seems like it is unbelievable. "We see here in this hospital!" She said she does this work related to maternal mortality from her heart but that it's hard and makes your heart heavy.

Gire then asked me if we've done the maternal death audit meeting yet and I said, no, still not yet since last year in October or November and we probably have about 20 cases to discuss, we can't finish them in one day anymore. She said we should check if the RMO is around and get him to push the meeting so it happens within the next week or so, to bring some pressure so it finally happens. The longer we wait, the more details of the cases that have been forgotten. I agreed and said then it's not very useful for us in order to improve care (if no one remembers the details of the case)...

I just asked Nurse Kinaya about those deaths and she said the MOIC knows about them and he's the one who said not to document them because "*tunaongeza vifo, siyo vya kwetu*" [we are increasing deaths that are not ours], it looks like we've killed them but they came already in a bad condition, said Nurse Kinaya. I'll have to ask the Medical Officer In Charge.

That day I did not receive other information about the women's names, where they had come from (i.e. their home villages) or any other details that would have made it possible for me to

follow-up. When I asked the Medical Officer In Charge, he simply explained that they kept no records of such deaths at the hospital because the women had not been alive long enough after arriving at the hospital to actually be officially admitted. He, and others at the hospital with whom I spoke, did not feel the hospital had any responsibility to count these types of deaths of women who arrived “already dead,” either literally or figuratively. I asked him if there was even any record of the names of the women or where they had come from and he said no. I suggested perhaps it would be useful just to have a record in order to be able to verify later that her death had been accounted for at the district level. As the system currently functioned, it was feasible that her name would be impossible to find again and her death might go unrecorded at any level. This experience was another instance that caused me, and others such as Nurse Gire, to be suspicious of any reported declines in maternal death at the hospital, in the region, or in Tanzania more generally. This narrative that the women arrived “already dead” was one which would surface over and over again in both maternal death audit meetings, but even more so in the narratives the nurses and doctors constructed when they gave me a more individual explanation of the phenomenon of maternal death in the regional hospital. I will return to this below.

9.3 Rukwa region maternal death audit meetings

In the Rukwa region, maternal death audit meetings were the responsibility of the regional hospital. I asked more than once if the districts, three rural and one urban, also were supposed to hold such meetings to discuss the deaths in their settings, those that occurred in district-level health facilities or in the community, but I never received a clear answer on this. Some people told me the districts were also supposed to discuss the deaths that occurred at that level, while others were unsure. The only aspect of the protocol that was readily apparent was the role of the regional hospital. The maternity ward In Charge was responsible for calling the

meeting and, with the support of the Regional Medical Officer's office, he sent letters to all of the District Medical Officers (DMOs), District Reproductive and Child Health Coordinators (DRCHCOs), the Regional Reproductive and Child Health Coordinator (RRCHCO), and the relevant regional hospital staff members. The regional hospital was generally represented by the Medical Officer In Charge, the Maternity Ward Doctor and Nurse In Charge, a selection of approximately three maternity ward staff nurses, the other physicians assigned to maternity, and perhaps a representative from the pharmacy or the laboratory. After attending my first two death audit meetings, and spending significant time on the maternity ward, I began to strongly recommend the Outpatient Department (OPD) In Charge be included in the meetings. This never happened while I was present in 2014 and 2015. I firmly believed this to be important for the continued improvement of the obstetrics and gynecology services at the hospital because it was often the OPD staff who received women in crisis in the middle of the night or who were the first to triage her during the busier morning shifts. Without including the OPD, it would be, in my observation, impossible to reduce the wait times between OPD and admittance to the ward, the time needed for sometimes critical blood tests, and continuity of care that would ensure a woman in critical condition did not become lost in the shuffle of busy wards. The essential nature of the OPD is also clear in the above description from field notes about my quest to locate information related to the two women who had died at the hospital but of whom there were no records.

For those deaths that occurred at night, the first person to see the woman, if the maternity ward nurses were faced with an emergency, was often from the OPD. The OPD also was responsible, particularly at night though, technically at all times, for triaging incoming patients and determining whether or not they should be admitted to the maternity ward or gynecology ward, or elsewhere. At this time, as part of triage, the OPD personnel would write a preliminary

diagnosis and differentials, as well as order lab tests and any medications or procedures they thought necessary. Therefore, in order to understand delays and their part in the process, I always felt the OPD doctor In Charge would have added a great deal to the conversations that took place during the maternal death audit meetings. Likewise, laboratory personnel were important because they were the ones responsible for ensuring there was blood available for emergency transfusions. The lab was also responsible for confirming any of the diagnoses put forth, most notably malaria in pregnancy or infections. Without including representatives from all of the departments with which maternity worked, it was difficult to adequately address any delays or gaps in care that had occurred at the hospital.

Due to the large number of people who were supposed to be present at these meetings, it was no surprise that they only occurred infrequently. When one of the officials was traveling on other business or on their annual leave, the meeting might either be postponed or the official would send someone else in their place as their representative. As of July 2016, there had been only one maternal death audit meeting for the entire year, the one prior was held sometime in the end of 2015. The infrequency of the meetings was easier from a scheduling standpoint but the infrequency made the individual meetings more of a burden. Instead of spending an hour discussing one or two cases, the meetings generally lasted for six or seven hours and sometimes were supposed to include a discussion of nearly 20 deaths. What I found this meant was that the cases we discussed in the beginning received full and thorough consideration, while those towards the end were treated in a cursory manner, at best. It also meant that, for the sake of time, the oldest cases were not discussed at all, or those present tried to make a case for one or more of the deaths not “really” being a maternal death. They might try to suggest this if it appeared the woman had had preexisting or underlying health problems. However, the WHO also includes a

category of deaths called pregnancy-related deaths for cases when the cause of death is difficult to determine precisely. Physiologically, nearly any preexisting health problem can be exacerbated by pregnancy due to the increased demands the pregnancy places on all of a woman's systems (D.A. Schwartz, personal communication August 2015). For example, to accommodate the fetus, a woman has expanded blood volume throughout the pregnancy, which can put extra strain on her heart or lungs. Once again, deciding to not include a pregnant woman's death in the data on maternal deaths from the hospital was as much strategic as it was borne of a genuine belief that her death had not been caused by her pregnancy. In other cases, the determination to exclude a woman from the count of maternal deaths could be a result of inadequate knowledge of pathology and the complex physiological effects of pregnancy. During these meetings, until the last one I attended in May 2015, we did not have a doctor who was specialized in obstetrics and gynecology and the hospital has never had, to my knowledge, a pathologist. The doctors were already too shorthanded to even consider taking on the additional work of post-mortem examinations of women who had died as a result of pregnancy related causes. Once again, the system itself prohibited some of the very processes that could have helped the hospital gain access to the additional information necessary for improving care.

9.4 Case Files

While it was the physician in charge of the OBs/Gyn department who was responsible for calling the meeting, it was his nursing counterpart who was responsible for maintaining the paperwork and preserving the medical records of the women who had died. In theory, the maternity ward Nurse In Charge was to keep the files of the dead women together in one place, maintaining them until such a meeting happened. However, before almost every meeting, there was a panic as the In Charge came to realize one or more case files had gone missing. In these

instances, perhaps differently than in the case of missing partographs (previous chapter), there were rarely any accusations about foul-play involved in these disappearances. Instead, it was poor organization combined with poor communication and a lack of standard procedures for the storage of these files. Inevitably, one or more files would have made their way back to the Medical Records department or been lost in a hand-over that was never completed. In practice, the files were never allowed to leave the hospital grounds but it was not at all uncommon to be unable to find a patient's records. Doctors borrowed the files to do a more thorough case review or to try to puzzle out why a particularly difficult case had "defeated" them. Sometimes the medical attendants were responsible for opening a patient file after the woman had already died, carrying the papers that might perhaps have been stapled together (or not) to Medical Records. She was then supposed to return to the maternity ward with the new file, the loose papers now tidily constrained, held within the card stock covers with staples or piece of string onto which hole punched pages were strung. It was more than possible that some files never made it back to the maternity ward after this detour to Medical Records. Or, alternatively, they may have made it back to the ward but were then subsequently misplaced when no one knew why a file had been left lying around. I once cleaned out the cabinet in the large, worn wooden desk in the admission room and found unopened lab results, antenatal cards, partographs, referral letters, and files of women who had long since passed through the ward. There was also at least one box in another cabinet on the ward that housed abandoned antenatal cards from women who had either not taken them back or had lost them or, sometimes, had left the hospital without being discharged. Joining these stacks of inexpensive paper notebooks and worn antenatal cards would be the occasional file that had been misrouted or, for some other reason, had been "filed" in the box instead of some other more formal filing system. No one working on the ward wanted to go

through this box either because it was in a part of the ward that became the home to swarms of mosquitoes, particularly at night and during the rainy season. Looking for a card or file that had gone astray often made me feel like, in an ironic twist of fate, I was more likely to contract malaria while *inside* the hospital instead of other locations stereotypically considered to be less salubrious by healthcare providers and public health officials (poorly ventilated, dank houses; swampy, poorly drained fields, etc.).

These files were, themselves, characterized by missing information- the wrong times or dates, written hastily while doctors buzzed from one patient to the next on ward rounds. Incomplete medical histories neglected to include details of previous pregnancies and their outcomes. Scrawled doctors' notes in, at least, three different handwritings wove a carpet of barely legible English instructions, differential diagnoses and observations on the patient's condition. In every audit meeting we had a discussion about the quality of the medical histories and were implored to improve intake interviews and time keeping- often portrayed as a systemic problem keeping the hospital from further improving care. Herein, between the cardboard covers upon which the woman's name was often misspelled at the will of the Medical Records personnel, was brought into being a woman in critical condition- a life, or death, hanging together or falling apart on the pages.

When I returned to Mawingu Hospital in May 2016, it had been at least seven or eight months since they had held a maternal death audit meeting. As I spent time in the ward nursing office looking over the records from mid-2015 through May 2016, the Nurse In Charge was scrambling, once again, to find files and understand the Ministry of Health forms that were the required output of a maternal death audit meeting. She was relatively new in the position, though had been working on the maternity ward for several years. She was the fourth Nurse In Charge

the maternity ward had had since May of 2014. Once, in 2014, during a period of handing over between the incoming and outgoing Nurses In Charge, we discovered the files meant for the maternal death audit meeting were locked in the ward store room, the keys to which only the outgoing Nurse In Charge possessed, and she had traveled out of the district. Instances such as this, and a lack of more formalized training on the purpose and conduct of maternal death audit meetings, led to a great deal of lost or missing information as the ward staff members scrambled to prepare for these infrequent meetings.⁵

It is against this backdrop of uncertainty and barely contained file chaos that the actual meetings themselves were held. Due to the length of time that often passed between a woman's death and the review of her case, the files were all the meeting attendees had when assessing the progress of the woman's clinical condition, overall health, decision making skills, family dynamics, and her reception and treatment at the hospital. Needless to say, a certain amount of extrapolation occurred based on where she was from, how many previous pregnancies she had, or the state in which she arrived at the hospital. For example, the antenatal clinic cards and several of the hospital forms, such as the doctor's notes page, include a line at the top for the patient's religion. The woman's religion was also one of the blanks that needed to be filled on the Ministry of Health forms. Often, the woman's antenatal card did not indicate her religion and the meeting attendees would infer her religious affiliation based on her name or that of her husband, i.e. Asha, married to Mohamed was almost certainly a Muslim, whereas Anna was

⁵ As an aside, technically the hospital should also have been conducting perinatal death audit meetings but, as I was once told by a ward In Charge, there were so many of these deaths (drastically more than those of pregnant women) that it would have drastically increased the number (or duration) of death audit meetings. Never once did I see or hear of one of these meetings being held at any point from 2012 through 2016. Perinatal death reviews would have provided insight into the causes of neonatal deaths that occurred in the hospital, as well as intrapartum stillbirths, giving the hospital some insight into how to further improve services to reduce these deaths, too.

more likely to be a Christian. Once, during one of the audit meetings, a couple of the participants carried on a side conversation about whether or not the woman's religion really mattered, the doctor asking, "OK, what illness do Christians get?" and the nurse maintaining religion mattered. In my reading of these forms, the woman's religion could be more helpful in coding important clues about the kinds of support she might have had, the number of children she planned on having, or the woman's ability to engage in autonomous decision making. However, the government of Tanzania does not record religion as part of national censuses and is generally reluctant to make statements about the religious composition of the country in order to prevent divisions based on this classification system. As it was, in both the Rukwa and Singida regions where I have worked, people of either religion tended to have strong opinions about those in the opposite group. While I never witnessed religion playing a part in whether or not a woman received timely care in the hospital, several of the nurses were highly religious and would pray loudly over patients or, on the other hand, lecture women about family planning based on their particular religious ideals.

In addition to the uncertainties about such missing individual attributes or demographic information, there was often some uncertainty about the way the course of the woman's obstetric emergency had unfolded. If the details of her treatment within the hospital were certain, those events which preceded her arrival often were not clear, aided only by what had been gleaned from relatives or the woman herself before her condition had taken a turn for the worse. Occasionally, the woman arrived at the regional hospital accompanied by a referral letter and, maybe, even a representative from the referring health facility. In these cases, more information about what occurred before arrival at the hospital was available but there were also many times when the person accompanying the woman knew little about what had transpired or, even if a

health provider, did not have many details about the woman's condition. This was sometimes due to the short period the woman had stayed at the referring facility or, in other cases, was due to a lack of skills and knowledge on the part of a referring provider. If they did not have training in the recognition and treatment of obstetric emergencies they might not even have been able to identify the exact complication beyond the fact the woman was bleeding, or she had been unable to give birth after a prolonged period of time, for example.

In other instances, the woman arrived at the hospital perfectly healthy and her death came as a sudden and unexpected shock even to the healthcare providers involved in her case. While no one ever expected a woman to die, there were some women who arrived at the hospital in obviously poor health, perhaps with Stage IV HIV, whose decline and subsequent death were less of a surprise to the ward staff members. In one particularly bad week in March 2014, just one month after I had arrived at the hospital, several women died within the span of a few days. The most shocking of these deaths was that of a woman, Paulina, who had reported to the hospital for a scheduled C-section before her labor started (also the subject of the Preface). She was in her mid-20s and had had her previous two children via C-section, which was a standard indicator for another surgical delivery. With increased scar tissue in the abdomen and multiple previous incisions in the uterus, there is a greater risk of uterine rupture if the woman experiences strong contractions during labor. The doctors also took into consideration the cause of a woman's previous C-sections. If it was because the baby had been lying transverse, as opposed to head down, or maybe even breech, then it was not a given this would occur in a subsequent pregnancy. However, if the previous operations had been done due to concerns about CPD (cephalopelvic disproportion) then it was likely to be a concern for later pregnancies, too. In this case, Paulina had arrived early and I was with the doctor on his rounds when he saw her

and decided to schedule her surgery for the following day. When I arrived on the maternity ward the next day after attending a meeting and making a trip to the gynecology ward to follow-up on any deaths that had occurred there, I was told Paulina was still in surgery. I had seen her as the nurses were taking her to the operating theater at 8:30am and, when I returned to the ward after collecting some information from files on a different ward, it was already 1:15pm. The fact that she was still in surgery after nearly five hours indicated to me there were probably complications. Ordinarily, the doctors sought to complete C-sections in the shortest time possible in order to expose the baby to as little of the anesthetic drugs as possible and reduce the time the mother was open on the table. Often, from start to finish, the operation could take less than an hour total.

The nurse who had gone with Paulina to the operating theater in order to take care of her baby came back to the maternity ward around 1:45pm, at which point Nurse Lucy told us Paulina had died. They had had to take her back to the theater after the initial C-section when they realized she was continuing to bleed internally. This second operation, a laparotomy was done to locate the source of the bleeding and after closing her again they took her to the ICU. She needed a blood transfusion due to the amount of blood she'd lost but she was blood type O negative, a rare type that is only compatible with other O negative blood. There was not enough blood available at the hospital because there was also another patient on the gynecology ward at the same time requiring the same blood type for a transfusion. Therefore, Paulina only received one unit of blood and subsequently died, perhaps due to hypovolemic shock due to her prolonged internal bleeding. The nurses who were present on the ward that day were clearly shaken by the way in which Paulina had rapidly descended into death when she had been so apparently healthy. The nurses were dazed and, in the days afterwards, the doctor who had seen Paulina from the

time of her arrival at the hospital, was adamant about implementing changes to procedure to make sure such a death did not occur again in the future. He had told me he would be suggesting that in all cases of non-emergency C-sections the clinical staff needed to have the results of blood typing, Hb levels, and cross-matching tests, as well as an indication of the availability of blood for transfusion, before even starting the surgery. To my surprise, when we later discussed Paulina's case in the audit meeting, there was no mention of this protocol, nor was it included in the action plan created at the end of the discussion. It was clear to me that once a death lost its immediacy, the nurses, doctors, and administrators quickly returned to the status quo and often there was little visible follow-up to address the changes that might have reduced future deaths from similar causes.

The hospital's Quality Improvement Team (QIT) should also have participated in organizing on-job training to improve skills, as well as follow-up on the requisitioning of needed supplies, such as resuscitation equipment. However, during the majority of my time on the ward, the QIT was more of an idea than a functioning body, at least within the confines of the maternity ward. No one was 100% positive about who the maternity ward representatives were and it was unclear about whether or not they were actually meeting and/or implementing any activities. This lack of certainty about who was responsible for following up or for implementing new protocols or guidelines led me to feel as though the paperwork resulting from the maternal death audit meetings was lost in an opaque and unknowable bureaucratic quagmire. The amount of bureaucracy constructed, at both a national and local level, around systematically measuring maternal deaths, accounting for them, and implementing programs to reduce these deaths would lead one to believe that the outcomes of such efforts would be consistent and replicable declines in pregnancy-related deaths. After all, dependable replicability is, or was at one time, the

objective of bureaucracy- systematization for replicable, predictable, and efficient outcomes (Weber 1947:215). However, the outcomes were more often arbitrary (Gupta 2012:24-25), under-analyzed, and lacking causal certainty; perhaps declines in maternal death were due to actions on the part of the healthcare providers and administrators or, just as likely, any declines were simply a chance occurrence upon which a facility, region, or the country could not depend to repeat itself again in the future.

9.5 The Futility of Action (Plans)

The outcome of the maternal death audit meeting was supposed to be action plans decided upon by all the people present during the meeting. The underlying premise, once again, was that these action plans could structure next steps within the hospital and at the district health level which would prevent reoccurrence of maternal deaths from the same causes. As an example, if a woman was delayed in arriving at the regional hospital because the staff at a referring facility needed to call an ambulance from the district but did not have a working radio call system, the action plan might look something like the following:

Problem: no working radio call so later referral

Solution: Fix radio call

Person responsible: District Medical Officer

Timeline: Within six months

Outcome indicator: Will be able to call for ambulance with a working radio call system.

Sometimes the woman's death could have been prevented by the presence of a specific supply or something as easily remedied- i.e. there was no adult resuscitation equipment in the operating theatre nor anyone with the knowledge of how to prevent the woman open on the table from aspirating secretions she started to produce during the surgery into her lungs. She died, they speculated, due to this aspiration of fluids into her lungs. A relatively straightforward problem with an equally straightforward solution- make sure the resuscitation equipment was present and

in good working order and ensure there were adequately trained surgical nurses or others who were versed in recognizing the signs that would necessitate intubation, suction, or other forms of resuscitation (see Marwa and Strong 2015:197-213 for further discussion of this particular maternal death).

More often than not, the problems the meeting participants decided to include in the action plan boxes on the last page of the Ministry of Health's audit form were not so concrete and self-contained. The needs the meeting participants identified often went along the lines of "better education of pregnant women during the antenatal clinic" and the corresponding outcome indicator was simply left as "a decrease in maternal deaths." Beyond simply being impossible to measure the success of prenatal education in this way, the plan did not actually delineate specific steps to be taken in order to reach "better education," nor any intermediate indicators that the plan was on the right track. Clearly, this method of creating action plans that are unactionable most serves the administrators who would be in the responsible position. That is to say, those who would be in charge of reevaluating the way their subordinates conduct themselves and the services being offered to pregnant women, were the ones who were creating such action plans. With little to no time dedicated to actually producing steps that would lead to the accomplishment of the action item, the administrators sitting around the table at the maternal death audit meeting were ensuring they did not generate more work for themselves. On-job training was another popular action item, meant to increase providers' skill levels or knowledge of particular procedures, conditions, or interventions. However, actually conducting on-job training meant coordinating nursing and clinical staff who were often unmotivated to attend meetings, and rarely invested their time in continuing education unless there was a financial incentive on offer. This environment created preconditions for any attempt at on-job training.

Most administrators felt any sort of long meeting or training required, at the very least, food for the participants in order to incentivize attendance. In a region and a hospital that was financially precarious, the prospect of having to provide food for thirty or more maternity ward staff members in order to conduct a training severely limited the possibility of in-house trainings without additional support from NGOs or the Ministry of Health.

Less cynically, if we assume district health administrators did implement the action plans, in one way or another, in their districts after the audit meetings, it would have been only those administrators who were privy to what had been done or the outcomes of said activities. The audit meetings were held so infrequently that they only barely had a standard format. In most other, formal meetings at the hospital, the meeting had a typed agenda and nearly always commenced with the reading of the minutes from the previous meeting. During the course of discussing the previous meeting minutes, responsible parties would often report on what they had accomplished with their assigned tasks. However, due to their infrequency, there were so many cases to discuss at each new audit meeting that, due to time constraints at the very least, the Maternity In Charge did not dedicate any time to reviewing steps taken since the previous meeting. Never once did I hear a report on whether or not progress was being made towards accomplishing the action plans created in a prior meeting, nor did I ever hear any reports on the stated outcome indicators. Therefore, I came to the conclusion that the action plans primarily fulfilled reporting requirements and were treated largely as rhetorical documents, as opposed to plans with the real potential to generate change in the system and prevent deaths.

9.6 Audit Meeting Outcomes and Ward Nurses

In general, the proceedings and outcomes of these meetings were never available to the maternity ward staff members, other than those who had actually been present during the

meeting. I specifically asked the nurses what they knew about the number and causes of maternal deaths on the ward in the previous year and all responded with very vague comments, indicating a lack of access to this information. Nurse Halima said,

Because, if you tell me- me I've seen that the deaths are few. Why? Because I don't know. Today, I'll be on duty, I see one, because it's possible that last month, maybe I know it's only one [death] that occurred last month. But if you ask me for the year, I can't know. For the whole year, I can't know because I don't have data and those people, we aren't told, we aren't welcome to participate in their meetings. Their meetings they do themselves, those who aren't even doing work [on maternity]. Therefore, they themselves have cut themselves off in secret, they talk, they talk and it's finished. But those of us whom this issue concerns, we aren't there in those meeting. Therefore, you can't know unless maybe you go to the records or are doing a report.

Halima reflected more than some of the other nurses on the reasons why she did not have access to more information about the number of deaths that occurred on the ward but her answer is representative. What follows is a representative conversation that was repeated multiple times in my interviews with the maternity ward nurses:

AS: How do you feel about the number of maternal deaths on the ward?

Nurse: I haven't really followed-up very much but I see that there are only a few.

AS: Mhm. I can tell you that last year we have nearly thirty pregnant women who died.

Nurse: Hmm that's a lot. It shows there is still some *uzembe*, laziness that is continuing.

Most of the nurses were unaware of the number of deaths that had occurred but because they may have only been working on the ward during a couple of the deaths that had transpired, they felt it to be a small number. When I told them the actual number of women who had died at the hospital of pregnancy-related causes in 2014, most of the nurses were surprised and felt the number still seemed high. In the first five months of 2015, there were significantly fewer women dying than during the same period in 2014. However, no one was able to say if they thought there was a particular reason for this decline in deaths on the ward.

Another conversation went as follows:

AS: Deaths of pregnant women. How do you see the number of deaths?

Nurse Neema: Last year we had about 5 deaths of mothers.

AS: You think it's only 5? Here together with ward 5 it was close to 30.

Neema: Eh?! Well, that's really a lot if it's for a whole year. I think I have remembered 5 because those were the ones discussed in the meeting in February and that also is a challenges that when they do a maternal auditing, staff from the maternity ward never participate like is supposed to happen. You find maybe only the In Charge and two nurses therefore we are lacking accurate data. But also feedback about why the deaths took place. But for this month I remember it is two, again they died in the following way: there's one who died with her baby inside, another it was PPH, it was in the beginning of April. I don't know before that.

Neema was able to remember the deaths for which she had be present or that she had more recently thought she'd heard about during a meeting. However, most of the ward staff members had no concept of how many women were actually dying every year or the causes of the deaths and how they could be prevented. This gap in communication or lack of reporting back to the ward rank and file after a maternal death audit meeting was not only frustrating to the ward staff, but also prevented them, those who were in the closest proximity to patients, from having the answers about the causes of deaths so that they could try to prevent similar deaths in the future.

The lack of feedback and communication about action plans, progress made, or interventions planned amplified the sense that any changes in the number of maternal deaths was simply a random occurrence. Perhaps it was luck. Perhaps it was due to different staff members. Perhaps it was due to the weather in the region. The Doctor In Charge of the maternity ward, as well as the Medical Officer In Charge of the hospital, repeatedly told me I was the only person in the entire hospital who actually used any of the data that the hospital collected in order to try to draw attention to trends within the hospital. I repeatedly suggested that the ward try to use the data they collected, and had to use for reports every month, to help them set goals for care on a quarterly or yearly basis. When I was working in the Singida region, the Nurse in Charge of maternity had had great success in reducing the incidence of intrapartum stillbirths on his ward through a committed tracking of data and by using it to show his staff trends in the number of

these stillbirths, which are nearly always an indicator of bad care during labor and delivery (see chapter 8). Instead of using this data, being produced to service the demands and reporting requirements of the central government, as well as NGOs and multilateral programs, for their own ends, the hospital logged these data in the officially required books and rarely looked at them again.

9.7 Coping with Maternal Deaths Through Narrative

Several nurses repeatedly told me they thought the women who died primarily came from far off villages and arrived in such a poor state that their deaths were not so much attributable to the hospital or the ward as opposed to the community or family from which she came. Out of curiosity, in May 2015 I went back to the records of all the deaths that had occurred in 2014 and 2015 to see from which districts or villages the women had come. In direct opposition to what the nurses had told me, the majority of the women who died at the hospital had listed their home as someplace within the urban district in which the hospital is located. Some cases were of women who had traveled long distances to arrive at the hospital but these were rarer. There are a number of ways to read this line: 1) They actually believed this to be true; 2) In reframing deaths as women who were unable to be saved by the time they arrived, the nurses effectively divested themselves of responsibility; and 3) The nurses used this discourse as a way to alleviate the personal emotional burden that was the result of being unable to prevent women's deaths due to systemic constraints, lack of resources, and support.

Common responses that emphasized the fact that women arrived already dead tended to follow this comment from Nurse Peninah who flatly stated, "Let's say, for this year maybe, since we have started in January, we have had only two deaths. And a lot of them that happen aren't of here. You find there are referrals, they come from far away and they come here and they do

what? They die.” While Nurse Rukia went into greater depth with her insistence that these deaths came from afar,

Rukia: The number of pregnant mothers who are dying, it’s decreasing. If you compare with the past, it’s decreasing. Another time we, we get deaths, patients are brought, they’re not from inside here. Eh. She comes that way in critical condition, you’ll do top to bottom but you can’t do anything.

AS: So deaths come from-

Rukia: They come from the villages, honestly. Those people in the villages, many times they always have the habit of always delivering them there, at the *wakunga wa jadi*, they deliver them there, if they deliver they see that they have been defeated...I mean, they are there, it’s too late. And those, a lot of times, we get cases like that.

...

AS: OK, why do you think- even if the number is decreasing, why do you think women continue to die here, along with babies?

Rukia: The reason is just that. People come in late condition. Mhm. That is, pregnant women come in very bad condition. Eh. People die. Maybe another thing, maybe another time she has come with a severe infection, you can use an antibiotic and whatnot, but it’s not possible because she is in the severe [stages] of the disease. You see, yes? They die.

Throughout the conversation, Rukia resolutely denied the idea that women died because of the care being offered on the maternity ward. There were other nurses, like Nurse Halima, who were much quicker to admit that there were serious delays or a lack of emergency care at the hospital. When I asked these nurses what the hospital would need in order to continue reducing the number of maternal deaths, they focused on concrete suggestions and the locus of control was very much within the hospital itself, though not often actually centered on the staff of the maternity ward. Their responses tended to focus on supplies and medications, or in the Halima’s response, the need for better triage at the OPD because the hospital lacked an emergency department.

There were, without a doubt, times when women arrived in very poor condition due to long delays seeking help, finding transportation, or being referred to the regional hospital. However, many times these deaths were not even counted in the number the hospital recorded, as explained earlier in this chapter. Therefore, the nearly thirty deaths I was mentioning to the

nurses did not include those of these other women whose deaths had not been recorded at the hospital. Therefore, the narrative itself must be examined in order to understand how the nurses were employing it.

Halima described her process of acclimating to the maternity ward and how she learned more about how deaths were occurring once she was assigned to work on maternity. Halima said,

...I was feeling really sad. Fine, after that, I was moved here to maternity. [I] came to see, to discover more. The deaths that happen, here, here at this regional hospital are few, I mean those that are caused [by things] here, and they die here. And those, those that occur, I'm always sad, but many of the deaths, really they come from the villages. Now, there in the villages, I don't have the ability to do anything, to go and do what? I don't have anything I can do.

She remained pragmatic about the situation, framing the deaths of the women coming in poor condition from the village as those over which she had no control and, therefore, she tended to not feel quite as bad when confronted with one of those deaths. Halima's explanation suggests that, in addition to removing the locus of institutional control and responsibility from the regional hospital, the nurses might also have been using this narrative of "already dead" women in order to help lessen the more personal burden of these deaths. The fact that no one at the hospital made data available to the ward staff or reported on the quarterly or yearly number of deaths in a venue that was open to all staff members allowed this narrative to continue in the maternity ward. The continued presence of this narrative made it easier for the maternity ward staff to remove themselves from accountability for the deaths that occurred and simply continue to hold the districts, or individual women and their families, responsible for the woman's death.

The fact of the matter was that the vast majority of the deaths in 2014 and 2015 were of women who listed their home residence as a location within the urban district, immediately surrounding the hospital (see Appendix D for maps). Table. 9.1 at the end of this chapter

indicates from which district each woman came. Fully half of the deaths, 17 of 34 on which I had data, were of women who came from within the urban district. This means that transportation and bad roads, long distances, and access to facilities were not the causes of these women's deaths. There were, oftentimes, other delays that slowed a woman's arrival at the regional hospital but the truth was that these women were not coming from the far reaches of the region; they were from the hospital's own backyard.

9.8 Self-Reflection and Remembering

When I first arrived on the maternity ward in February 2014, there was a spate of deaths in my first month. To me, it felt as though I could barely process one death before another woman died. I was still trying to gather the information to reconstruct the trajectory of the first woman's demise when another would arrive and subsequently die. It felt as though it was a veritable flood. However, the nurses only once ever let on that they too were moved by the number of deaths on the ward and, in fact, were sometimes deeply affected. As an outsider, it more often appeared as though the nurses were barely touched by the deaths of women and even less so by the daily deaths of neonates. In interviews, we discussed why it might look like, from the outside, that the nurses were unaffected by these deaths when, in actuality, they told me they were all pained by the deaths of women on the ward, as well as the deaths of the babies. Their responses generally coincided with the responses from the two nurses below:

Nurse Sokota: Meaning, that now you, there's that sympathy and empathy, right? A nurse shouldn't, you know, shouldn't be really sad, to the point that...[chuckles] well therefore you can be sad, alright, finish with that mother, continue with another. Therefore, it's not that maybe you've left one mother and continued with another, maybe you're not hurt, really you're hurting. I don't show a lot...[because] the women will say the nurse has started to cry tears on the ward, now you, you're not a nurse. You see?

Nurse Peninah: Yeah. So it is always which? You should wear the shoes of that patient. It's empathy. Usually empathy, I don't know, sympathy, one of those. Therefore, yes, the patient; when you are said, don't show her a lot, that sadness to take her there. If she

loses the desire and you, you lose the desire, there's nothing that can be done to help. Therefore, you reach a time a person just takes that, honestly it hurts a lot. But now, this mother, let's not show her so much that even I am hurting then she herself won't be able to cope "[with the fact] that my child has died, the nurse too she is sad, therefore you find there isn't any help." Therefore, a person should be hurt but she stays there at that time to help that other person who is doing what? Who has the problem.

In both their responses, Sokota and Peninah described the ways in which they could feel bad for the woman, or her family, and experience sadness but outright demonstrations of this sadness were antithetical to the nurses' needs for professional comportment. Crying in front of patients could undermine their professionalism and expertise, while also closing the distance between the women and their providers, an undesirable outcome that could, in other encounters, undermine the nurse's authority in the ward setting. Instead, the nurses saved the outward manifestations of the internal upset for other venues and more domestic, as opposed to professional, spaces.

Additionally, the nurses primarily ascribed to the idea that pregnancy is not an illness. Due to this thinking, pregnant women were not expected to die when they came to the hospital for care. This was different from patients on some of the other wards, as Nurse Happy explained,

Honestly, it's really painful. Because a pregnant mother, honestly- it's not good if she dies. Nor her baby. Because a pregnant mother isn't sick. It should be that a mother comes and she leaves safely. Therefore, this death, it takes us by surprise. Honestly, I worked on ward 10 [male medical ward] and there they were dying just normally. We say, 'this man came with his illness, it wasn't possible [to heal] and he has die.' But for a pregnant mother, it really hurts, it hurts a lot. It's painful for us, all of us nurses, because even if I wasn't on duty today, like today I'm resting at home, there [at the ward] if a death happens, I find that the news spreads, you're called on the phone, 'Today we have a death!' So, it surprises every person.

Repeating the idea that pregnancy is not a condition from which a woman is expected to die,

Nurse Aneth said,

Of course, I can't feel good. It's a death that, ok, she died, and other people, on other wards, they died. Fine. But that death [of a pregnant mother] is one which is somehow exceptional because if you tell me a man on ward 10 [male medical] died, a woman on ward 8 [female medical] died, obviously s/he came and s/he was sick, indeed that's the reason s/he came to the point of being admitted. But pregnancy is not a sickness.

Pregnancy is not an illness. We usually depend on the fact that this mother comes when she's pregnant, she gets her baby, and she returns home. Without worrying about where she got [the baby]. Therefore, it's- of course, I always feel bad. It's not nice. And you think about a lot of things. Yeah. You really think about a lot of things. You will think this, you'll think this, you'll think this. But enough, it has happened.

The fact that the nurses remarked upon the deaths of women whenever they happened, and called each other on the phone to spread the news of a death, suggested that the deaths were still a relatively rare occurrence even despite the comparatively high numbers of maternal deaths in the hospital. The deaths also took nurses by surprise because of the sometimes sudden onset of complications and the woman's rapid demise, which differed from other wards on which patients might linger, suffering from the effects of a chronic or slowly progressing condition.

While they clearly were impacted personally by the deaths of women on the ward, the nurses found it important to maintain this professional comportment in front of the patient and her family (in the case of a baby's death, chapter 8) or in front of a deceased woman's family, in the case of her death. The nurses saw their stoicism in the face of a tragedy as part of demonstrating to the patients that they were in control of the situation and they could be the ones on whom to rely for continuing care. The nurses told me if the patients saw nurses who had broken down and were crying in front of the patients it might undermine the patients' faith in the professionalism and skill of the nurses. The good nurse suppressed her own feelings and any outward show of them until a more appropriate, private time. Nurse Peninah said, "People have become used to it because every day- let's say, what have people gotten used to? That every day you encounter deaths? You see people have died, babies have died, but... [when] they [the nurses] are sitting ... alone, for example like there in the tea room, they start 'why did this baby die? This baby, why did he died?'" This reflection that the nurses mentioned most often occurred

while they went about their daily activities and could follow them home as they continued to think on the events that had transpired and what they might have done differently.

During the interviews in April and May 2015, I pointedly asked the nurses how seeing these mothers die on the ward made them feel and if they had any type of coping mechanism. I was also interested to learn if their experiences with a relatively high number of deaths caused them to ever question their line of work or their desire to continue working in maternity care.

Nearly every nurse related at least one account of a woman for whom she had been caring who had died. Nurse Faraja told me in vivid detail,

I feel really bad, you can even cry. I mean, if you see a mother, she came here, she was speaking well and then she dies because she doesn't get blood, PPH, or her condition just changes, it really hurts a lot. I remember there is one day when all the nurses that were on shift, we cried. One mother came, she was in the second stage. She was a grown woman, with her health. So, anyway, she was delivered, she pushed out the baby. I mean, in the act of just pushing the baby, she straightened out right there and died. And she had come talking a lot and really we remained there asking ourselves what was this thing. OK, there was another day, she came, one sister, now and her child is the same as my daughter Ester. It was her first pregnancy, she had come and stayed two days on the ward. The third day her contractions increased and she gave birth to a baby girl who weighed 3.5kg. After that, we were talking with her like normal. Now, she got PPH, yeah and there was no blood in the blood bank, no relatives. Well, we were talking with her and then she said, "Nurse, I'm feeling tired." She had been sitting drinking tea so I told her to lie down. I say, that lying down, it was silence right away. It hurt us so much and her baby was crying so much, like she knew her mother had died. So that was last year in March. Her baby is still there, she's called Enjoy and now she's learning how to walk.

Nurse Rachel told me,

Honestly, I always feel bad because it has even happened to me that one night I was on the night shift and I was working with a lot of new people [nurses]. Honestly, I struggled with that mother from admission until she passed away and it was during my shift [that she died]. Honestly, I lost the desire to work. I felt totally like I couldn't do work after that mother died. Then she died around the time of midnight therefore I felt the work was really hard until it came to be 6:30 am [end of night shift].

In their explanations, it is clear that these cases often stuck with the nurses and caused them to ruminate on the details of the woman's care and illness, or the events leading up to her death.

Many nurses explained this was their coping mechanism for coming to terms with the deaths of women on the ward. Rachel even suggested that she might lose the motivation to work due to being preoccupied with the details of what had gone wrong and emotionally frustrated due to the lack of information she had and the lack of ability to more effectively aid the woman in order to save her life. The nurses consistently worked in this same environment that hobbled along as best it could. For most women, who did not have any complications, they were able to give birth and leave the hospital without any adverse events; they received care that was *good enough* and the system operated similarly. However, it was in the cases of complex problems or emergencies that the fault lines and weaknesses that were always present, on the maternity ward and throughout the hospital, became obvious, resulting in death.

The nurses nearly all told me they tried to *fuatilia*, or follow-up, when they saw there had been a death. It seems as though this task was mostly done in the case of a stillbirth or neonatal death, but the nurses nearly all mentioned following-up as what they did in the wake of any death. In talking about maternal deaths, Nurse Rachel said,

Me, I always really try to do that follow-up, like what did I miss? What mistake did I make? What should I correct? Maybe for that mother, what should I have given her so that she didn't die. Like that day I was supposed to give her hydrocortisone but there wasn't any. I sent a person to the pharmacy but there wasn't any, but I was feeling like if I could give this mother hydrocortisone it would be able to support her. I mean, I really worried about all her treatment but it wasn't possible (*imeshindikana*). Therefore, another challenge for maternity is supplies... it should have all the important medications and everything that has to do with care, I mean, we would at least be able to save lives.

One important linguistic note, in many of the original transcripts the nurses used the word "*imeshindikana*," which I have translated as "it was not possible." However, this translation does not effectively capture the nuance and the sense of the original Swahili. In the original Swahili construction, the sentence does not indicate a subject or responsible entity. This is perhaps indicative of another move on the nurses' part to remove the locus of control from themselves

and onto some external entity be it chance, bad luck, the will of God, or some other force. I prefer to think this turn of phrase reflects the general state of the system. It was not something such as luck that prevented the woman's life from being saved but, instead, it was the broken healthcare system itself that impeded her treatment and possible recovery, together with the bureaucratic, under-resourced environment of the hospital. Rachel specifically mentioned the poor availability of supplies which had caused her to be unable to resuscitate the woman on her deathbed.

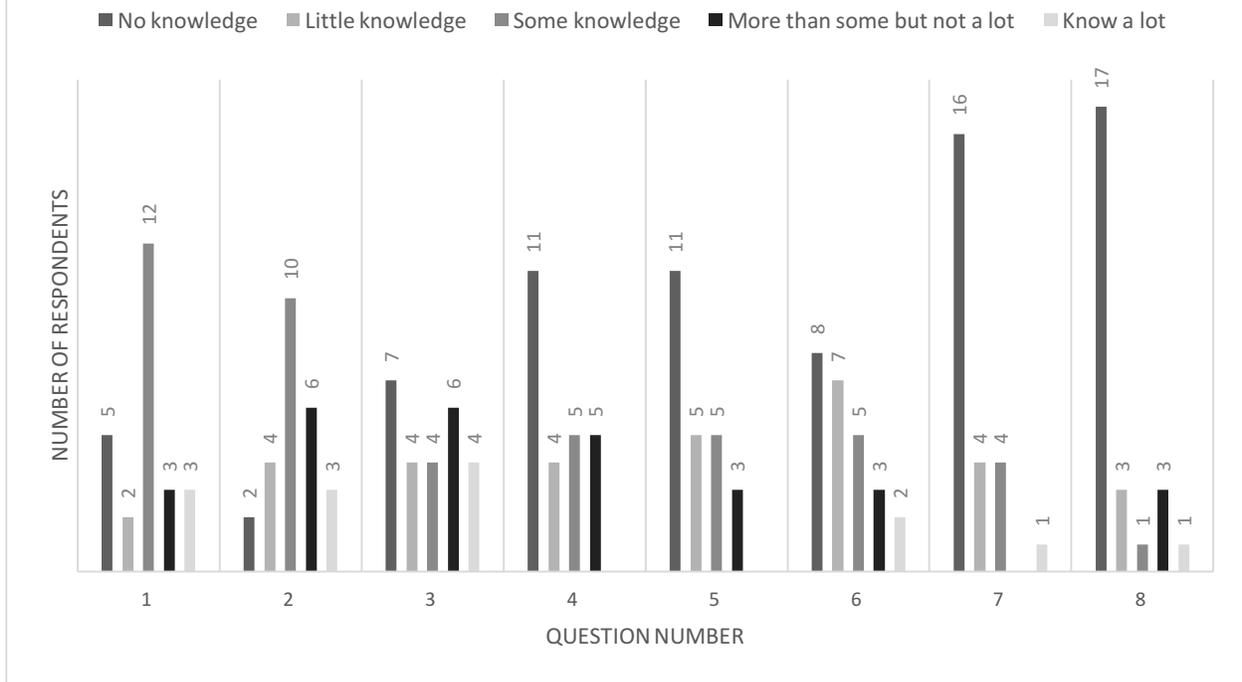
Nurse Aneth, when talking about the deaths of babies, started by saying, "Mm well here, really the thing to do is- you know, a lot of people, these questions that you're asking me, I don't think that my colleagues, how they answered you but I think a lot maybe have answered you theoretically. She just thinks, 'I can do- I can do-'but that thing, has she ever done it even once? The thing that you do, first you follow-up." She went on to give me an example of what she would do to try to make sure a woman got some answers about why her baby had died in utero, including suggesting testing for the woman and her partner. This explanation about following up was nearly universal for the nurse with whom I discussed this topic. Problematically, because most of the nurses were not included in the maternal death audit meetings, most often they did not even have the opportunity to go over the case of a woman's death with the physicians or their fellow nurses. While they were left ruminating on the deaths to which they may or may not have contributed, the physicians and administrators were holding maternal death audits every seven or eight months, including only a couple nurses from the ward, and not returning a report of the results of the audit to the full ward staff. In the absence of answers or other mechanisms for discussing or debriefing cases of deaths, the nurses almost universally told me that their coping strategy was to go over the details of the cases with themselves, in their heads. One of the older

nurses did also mention prayer and her faith as helping her to cope with the deaths that she saw.

9.9 Access to Information

More generally, access to information was a chronic problem for the nurses in the context of the Regional Hospital. One section of questions in the CWEQ was centered around assessing access to information. This section had the lowest average score of all the survey sections, resulting in just 2.08 out of 5. The nurses' responses to the questions in this section clearly trended towards "no knowledge" or very little knowledge, 2. The nurses indicated that they did not receive the amount of information that they would like, including that which was related to the goals of the hospital, as well as their own ward. Additionally, they indicated, in question 7, an almost complete lack of information related to salary and, in question 8, little to no knowledge of how other departments at the hospital perceived them. I include these results here in order to further demonstrate the poor communication and feedback mechanisms that more generally pervaded the hospital. The outcomes and action plans from maternal death audit meetings were no exception to the rule of poor communication. Only nurses who were more senior or had leadership duties tended to participate in the audit meetings and had, more generally, more access to information about hospital policies, procedures, goals, and values.

SECTION 2: ACCESS TO INFORMATION



How much access to information do you have in your present job?

	1 = No Knowledge	2	3 = Some Knowledge	4	5 = Know A Lot
1. The current state of the hospital	1	2	3	4	5
2. The relationship of the work of your unit to the hospital	1	2	3	4	5
3. How other people in positions like yours do their work	1	2	3	4	5
4. The values of top management	1	2	3	4	5
5. The goals of top management	1	2	3	4	5
6. This year's plan for your work unit	1	2	3	4	5
7. How salary decisions are made for people in positions like yours	1	2	3	4	5
8. What other departments think of your unit	1	2	3	4	5

Fig. 9.1 CWEQ Access to Information results

In this context of little to no information about the details of women’s cases or the results of the maternal audit meetings’ analysis of these cases, it is easy to imagine the ways in which nurses could become demoralized and lose motivation as they continued to encounter the deaths of women and babies on a regular basis. Without the necessary information to confirm the ideas they had worked out in their mental walkthroughs of the cases, they were less able to act on their

ideas for improving outcomes in similar cases, even if they had come up with practical and concrete ways to do so. The poor communication back to the rank and file on the maternity ward after these audit meetings was another way in which the institutional environment of the hospital inhibited efforts to improve care and prevent maternal deaths. Nurses did not change their behaviors because the administration did not empower them with the necessary information to affirm their individual analyses of the problems that led to women's deaths. The lack of communication in these cases also suggests the hospital and regional health leaders were primarily using the meetings to fulfill biobureaucratic requirements and considered the purpose fulfilled when the paperwork was complete. This perspective created no expectation for actions beyond the bounds of the paperwork, which was why the information stopped at the administrative level. These results of the audit meetings were yet another example of the ways in which top down approaches to solving complex health service challenges were ineffective in this setting.

9.10 Caring for the Carers

In a meeting on disrespect and abuse in maternity care held in Dar es Salaam in July 2015, one of the presenters, Dr. Brenda D'Mello, talked about "caring for the carer." In a large hospital in Dar es Salaam she had been working to implement a program for the nurses working on maternity to be able to discuss cases and express concerns, frustrations, and challenges within their environment, emphasizing "no shame, no blame, no name." Giving the nurses a formal mechanism for voicing their struggles with grief due to encountering deaths or due to working in high pressure/high volume work environments was one way in which Dr. D'Mello and her teams have been trying to grow hospital staff support programs. At the Mawingu Hospital, as of the end of 2015, there were no such support mechanisms for the nurses and physicians working on the

maternity ward. In the absence of formal avenues for coping with the stress of seeing women and babies die on a regular basis, combined with the under-resourced work environment, and overall poorly functioning healthcare system, the nurses often comforted themselves through narratives of hopeless cases, women arriving already dead from far off villages. The nurses comforted themselves by repeatedly examining the trajectory of a woman's care and subsequent death in the hospital, once again turning to narrative as a way of creating order and understanding in these tragic experiences.

The hospital missed out on another opportunity to care for its employees as they continued to confront the deaths of both women and babies. The administrators could have improved communication in order to provide the nurses with reassurance that a death was not a direct result of their care or confirmed the nurses' individual assessments of what had gone wrong. While the nurses sought to do what they could in the event of an obstetric emergency, the institutional forms of care—supplies, supportive supervision and mentoring, protective equipment, timely and responsive communication—all continued to be lacking, further demoralizing and demotivating the nurses who were left with narrative and their religious beliefs as their coping mechanisms.

9.11 Conclusion

Maternal death audit meetings are another tool, much like the partograph, that has been constructed and conceived of by people outside Tanzania and which is meant to aid providers and administrators as they work to continue reducing maternal deaths in their settings. And yet, much like the partograph, the audit meetings rarely took the ideal, immutable form they were meant to have. Due to long periods of time between the meetings, and due to the difficulty of gathering together busy, overworked administrators, the meetings threatened to become so long

that the women's cases discussed towards the end of the meeting often received only cursory attention. As the smells of the waiting rice, chicken, and chapati wafted over to the meeting table, the participants rushed through the details of cases, attempting to rule out a death as related to or cause by pregnancy and simply advising each other to copy the details of the action plan from previously discussed cases. In this way, it often felt that those present were going through the motions of the audit, fulfilling accountability and data generation requirements from the Ministry of Health and Social Welfare, but not meaningfully devising ways to change practices in health facilities throughout the region. The administrators, nurses, and doctors sitting around the table seemed to be engaging in a performativity of the meeting as bureaucratic requirement, as opposed to a tool for changing their ways of practicing care and serving pregnant mothers. Lack of reporting on activities undertaken since the previous meeting reduced the accountability of administrators and enabled them to continue on with business as usual, reinforcing an opaque system and contributing to the general feeling that any decline in maternal deaths was simply attributable to chance (or the late arrival of data), as opposed to replicable change and improvement.

Overall, while the Rukwa region was, on paper, meeting the demands of the Ministry of Health, and other organizations, for surveillance and reporting of maternal deaths, the fulfilled bureaucratic requirements belie the brokenness of the region's maternal death audit system. This is one tool that could, relatively easily, be utilized to much greater effect in the region. While I was present in the meetings, I did make suggestions for more appropriate outcome indicators, recommending ways to survey women in order to gain a true picture of the quality of education they were receiving at the antenatal clinic, for example. However, my suggestions were often met with resistance, particularly from the district reproductive and child health coordinators who

accused me of not knowing what care really looked like in village dispensaries. When I mentioned this reaction to my comments, a friend told me she felt it was most likely because those administrators did not want to admit to being responsible for the shortcomings of care in the dispensaries, nor did they want to make more work for themselves by surveying women instead of simply posting “schedules of antenatal education” in clinics and dispensaries. The status quo certainly seemed to serve some of the administrators well and they were not quick to look for ways to increase their workloads by implementing new programs, policies, or even through restructuring maternal death audit meetings in order to incorporate reports on progress to date. Other administrators talked a good game but were perhaps not directly in control of implementing other changes. They were forced to rely instead on subordinates who worked in peripheral areas of the region, often in places far from their families, without amenities such as electricity or a community of similarly educated peers. It is no wonder then that such administrators were unable to implement all the changes suggested or alluded to during the audit meetings. However, what this means is that every subsequent meeting will see the emergence of the same barriers, the same challenges, gaps, and pitfalls as have repeatedly been identified in the past. The momentum of the system is more in the way of maintaining the status quo than in favor of radical change for improvement.

Table. 9.1 Deaths that occurred during the field period.

I have also included others from 2014 that preceded my arrival. Some women’s case files went missing before I could record the details of what happened. These deaths included those that occurred on the maternity ward, as well as the few that occurred on the gynecology ward, women who were less than 28 weeks pregnant or had been admitted post-abortion.

Key

G= Gravida

P= Parity

**= Ruled not a maternal death during the maternal death audit meeting but upon consulting an obstetric pathologist in the United States, Dr. David A. Schwartz, we determined, based on the information available, the renal failure was a result of her pregnancy, thereby qualifying her death as a result of a pregnancy-related cause

***= Ruled not a maternal death during the maternal death audit meeting

APH= Antepartum hemorrhage

CCF= Congestive cardiac failure

DIC= Disseminated Intravascular Coagulopathy (causes blood to clot excessively and then leads to an inability to clot, leading to severe bleeding)

Dx= Diagnosis

IUFD= Intrauterine fetal death

PPH= Postpartum hemorrhage

PV= Per vagina

Note: It is possible there was a low number of deaths from Nkasi district because critical cases from that district were referred to the district hospital, in Namanyere, before ever making it to Mawingu Hospital. For several years the Namanyere hospital has had full CEmONC capabilities, with working theater and physicians. The hospital is also partially supported by religious organizations.

	District	Number of Deaths
†	Sumbawanga Rural (DC)	8
*	Kalambo	8
§	Sumbawanga Urban	17
◇	Nkasi	1

DATE OF DEATH	FROM	AGE	G	P	CAUSE OF DEATH	OTHER COMPLICATIONS
1/8/14	NO DATA	--	--	--	--	--
1/13/14	Kisumba Kasote*	35			APH abruptio placentae	Cardio pulmonary arrest
2/7/14	Ilesa [§]	25			Dx as anemia??	
2/16/14	Kizwite [§]	35	2	2	Malaria, Pulmonary TB	Stage IV HIV/AIDS
2/23/14	Samazi*	21	1		Eclampsia	
2/25/14	Edeni [§]	22	3	2	Hypovolemic shock	Incomplete abortion
2/27/14	Chanji [§]	23	1	0	?	Heart disease? Anemia?
3/4/14	Kasekela [†]	26			Anesthetic complications, aspiration	
3/5/14	Malangali [§]	23			PPH, surgical complications	Anemia, blood supply
4/6/14	Mkole [◇]	23	2	2	Anemia, CCF	
4/9/14	Katusa (Swanga town) [§]	24	2	1	Suspected embolism	
4/19/14	Malolwa [†]	30	5	5	PPH, retained placenta	anemia
4/27/14	Mwimbi*	34	6	5	IUFD, ruptured uterus	Late referral, DOA
5/30/14	Madibila/Ilolesha*	37	10	9	Obstructed labor, IUFD	
6/5/14	Mtimbwa [§]	30	?	?	? Suspected sepsis	Malaria suspected
6/9/14	FILE MISSING	--	--	--	--	--
6/23/14	Kifone*	22			Malaria in Preg	
7/1/14	Chelenganya [§]	24	3	3	Sepsis	Native drug intoxication
7/12/14	Kizwite [§]	20	1		Embolism	
7/31/14	Katonto [†]	20	1		PPH, eclampsia	Anemia
8/12/14	Mazwi [§]	26			Abortion, Septic shock	
8/14/14	Laela/Mshani [†]	40	7	6	APH, PPH	Anemia, shock
9/21/14	Lowe [†]	18	1	0	Sepsis	
9/22/14		30			Severe anemia, PV bleeding	
9/24/14**	Sumbawanga Asilia [§]		7	6	renal failure	
10/12/14	Kizwite [§]	35				
10/12/14	Lua/Maomba/Bakwata RC [§]	19			Malaria in preg	
10/20/14	Legezamwendo*	33	7	6	APH, ruptured uterus	Anemia
10/22/14***	Legezamwendo*	32			Intestinal obstruction	HIV/AIDS Stage 4
11/20/14	Kilimahewa [§]	28	3	2	APH, abruptio placentae	PMTCT 1
12/31/14	Sandulula [†]	21	2	1	Embolism??	
2015	From	Age	G	P	Cause of Death	Other Complications
1/26/15	Ilesa [§]	22	3	3	septic shock	cardiorespiratory failure?
2/22/15	Ilemba [†]	20	2	2	Sepsis? Malaria? Pneumonia?	HIV + obesity
2/23/15	Mpui [†]	28	3	2	Eclampsia	
3/5/15	Mazwi [§]	24	1	1	Embolism?	
4/15/15	FILE MISSING	?	?	?	--	--
4/15/15	Ilesa [§]	30	?	?	Hypovolemic shock	
4/17/15	Kanyezi*	36	9	9	PPH, DIC	Local herbs