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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 10: Conclusion and Recommendations

10.1 Introduction

I sat in the hall at the hospital where we normally had the morning clinical meeting. It had been transformed into a festive event hall for the evening in celebration of International Nurses Day, May 12th, Florence Nightingale's birthday, with brightly colored bunting and rows of plastic chairs facing the head table which was covered in various beverages in glass bottles. In the midst of the din from the enormous speakers, I looked around at the hospital staff members, everyone dressed up in evening finery, patterns and colors filling the room. With less than a month left in Sumbawanga, I began to feel like I was disembedding from the maternity ward and the hospital. I had begun interviewing the maternity ward nurses and was feeling humbled and honored by what they chose to share with me and to which they had allowed me to bear witness. While I was absolutely unable to begin to analyze the full complexity of everything I had heard and seen over the preceding fifteen months, I did feel, more than ever, a need to put forth the voices of the healthcare workers who were so often demonized in popular press in Tanzania or written about as the opposition in women's stories of interactions and experiences during pregnancy and childbirth. Instead, it might be more appropriate to think of them as a sort of antihero; unkind at times, yes, selfish, surely, but also with the strength, tenacity, resilience, and ingenuity that kept a system moving along. All the hospital staff members were undeniably human, with all the attendant needs, desires, flaws, and aspirations. I hope that I have shown some of their individual characters while also demonstrating the ways in which a system constrained by political economic processes with deep roots shaped their (in)ability to enact change or provide care that fulfilled both the technical and emotional needs of their patients, colleagues, and subordinates.

Here, I briefly put forth some conclusions of this research and its contributions to the field of anthropology, as well as outlining the work's implications for further analysis and investigation. I have also included a section on recommendations for policy and administration across the hospital, district, regional, and state levels. Some of the recommendations are those I presented at a Hospital Management Team meeting in May 2015, while others are products of subsequent analysis after returning to the United States.

10.2 Putting the Care Providers Back into Healthcare

While others have sought to put the “M” back in MCH (maternal child health) (Rosenfield and Maine 1985) or the “mother” back in Safe Motherhood (Berry 2010:190), I started from a different point entirely because, as Berry (2010:192) points out, interventions have come to target improving the skills of biomedical providers. These people are the ones who “would encounter the failing pregnant, or birthing bodies” (Berry 2010:192). But while anthropologists have been busy conducting research with women and their families, exploring the meanings of pregnancy and birth, they have had a tendency to flatten out healthcare personnel, separating these providers from their social connections and their broader political economic milieu, even as researchers were working so hard to explicate these very factors and their influences in the lives of pregnant women. The direction of policy has not shifted to be more woman-centered, if anything the new Sustainable Development Goals and strategies for Ending Preventable Maternal Mortality focus even more explicitly on healthcare facilities, promoting systems approaches to improving care and reducing deaths (WHO 2015a). And yet, there is still much work to be done in order to build more comprehensive and accurate understandings of the ways in which healthcare providers are just as embedded in networks and

systems that fundamentally affect their care practices and what they are able to offer to their patients.

In September 2016, *The Lancet* published a series on maternal mortality that focused on “the mismatch between burden [of maternal death] and coverage” of biomedical healthcare services for women and girls. As part of this series, Lynn Freedman (2016:4) writes, “this mismatch exposes something else as well: a dangerous disconnect between the way the global health community has framed problems, exposed strategies, and pushed solutions, and the lived experience of people and providers” and she calls for a greater range of empirical data which will be able to “speak a different truth to power.” That, then, is what I have sought to do here by demonstrating that even though policy planners or experts at the WHO, in charge of designing recommendations for best practice, and the nurses and doctors at Mawingu Hospital share a common belief in the powers of biomedicine, there is a wide gulf separating them. Freedman goes on to state, “the point is not that global strategies, evidenced-based guidelines, or high-level monitoring and accountability initiatives are inherently wrong or unnecessary. But when they consume most of the oxygen in the room, drowning out voices and signals coming from the ground, they distort both understanding and action” (Freedman 2016:5). Here I have presented an antidote which has made clear many of the forces behind deviations from WHO or Tanzanian Ministry of Health guidelines and initiatives. I have also sought to demonstrate the ways in which much broader systems have, in fact, necessitated these deviations and continue to incentivize accounting for these deviations over actually improving care in significant and lasting ways.

10.3 The Complex Reach of Scarcity and Imperfect Care

The scarcity with which nurses and doctors struggled everyday generated an expectation that ideal care was nearly impossible to provide. This environment led to reduced expectations that providers and hospital administrators could solve clinical or systemic problems, constrained as they were by a system that currently, and historically, makes it so difficult to do so. Acting within a complex of demands for data collection and metrics, combined with the scarcity around them, improvisation and the justification of deviation from guidelines became a fact of everyday life. Providers shifted their efforts from providing care to accounting for deviations from ideal care, which was set out in guidelines and standard operating procedures generated in other parts of the country or world. Good outcomes often happened by chance and could not be replicated, defying the bureaucratic policies and procedures in place meant to standardize, which instead resulted in uneven, unpredictable results (Gupta 2012). An accounting culture, focused on justifying deviations from high quality care or collecting data, replaced a caring culture, one in which both patients and hospital staff members received the care they needed in order to survive and thrive.

The dissertation demonstrates the ways in which biomedical institutions characterized by a level of scarcity that permeates all aspects of the healthcare system are frequently unable to break routines or implement new initiatives to improve maternal healthcare. Situated in a global and national health complex that emphasizes data collection, healthcare providers find themselves constrained by an “accounting culture,” as opposed to working in a “caring culture,” like the vision presented to them during their education and training. Nurses, in particular, also desired to be part of a “caring culture” on the institutional level in which administrators demonstrated their care for and appreciation of nurses. Nurses particularly wished for this caring

culture, for institutional care, when they were putting their own bodily and professional integrity on the line in the course of caring for pregnant women during emergencies, exposed to potentially infectious bodily fluids without the necessary personal protective equipment. Nurses provide the vast majority of the care to pregnant women but had access to the least amount of power within the hospital hierarchy— their efforts often were undervalued and overlooked. They used alternative means to try to gain certain outcomes or resources for their patients (chapter 8), drawing on informal routes to influence or social capital through manipulating documents or other means, such as strategically wearing their uniforms in public, non-hospital settings (chapter 7). An institutional lack of care contributed to the continued production of nursing care that gave the appearance of lacking motivation and compassion as nurses said they were demoralized by their lack of visibility within the hospital structure. The care nurses were able to provide and the care practices in which they engaged were also influenced by the demands of the personal lives, which they were not always able to leave behind them when they walked out the door for work. Interactions with hospital administrators conditioned nurses to be secretive and self-regulatory when they made mistakes in care, further producing an environment in which open discussions about care practices and nurses' needs were not discussed.

Healthcare providers at all levels were forced to modify, to improvise, and cut corners so that women get at least some care, care that is good enough (Mol, Moser, and Pols 2010:12). The constraints of their work environment produced conditions that were not amenable to quick action or early intervention; the nurses and doctors came to see early, efficient intervention as a near impossibility. In other cases, global guidelines about respectful maternity care might hold nurses in violation of the idealized forms of practice. In their lived experience, nurses believed they were indeed caring for women, engaged in a set of actions and practices—yelling, hitting a

woman— that they have employed solely for the purpose of making sure a woman’s baby emerges alive; what good are kind words and comforting touches if a woman’s baby is stillborn? Yet, patient trust in the system was undermined by these negative interactions which they did not always fully understand. Women entered the hospital setting after a lifetime of gender inequity and differential access to education, respect, and decision-making powers. They came to the ward conditioned by their own stories, and those of other women, about biomedical providers, which too frequently centered on cases of neglect, negligence, extortion, or corruption. Collective memory recited stories of blood being sold to families when a life was on the line, or village nurses telling families they needed to buy gloves and then magically producing a pair for sale, or conjured images of drivers carrying pregnant women’s lifeless bodies back home, limbs strapped to limbs, to keep the corpse on the back of the motorcycle.

In villages, on the hospital ward, and on the national stage, Tanzania continues to play out the battle first recorded in the colonial era: where is the proper site for childbirth— the home or the hospital? While global public health studies and interventions have disavowed the skills, knowledge, and social roles of local indigenous midwives, they have uncritically accepted young, barely trained, healthcare providers of the biomedical tradition. Because it is nearly impossible to predict who will develop a complication during an otherwise problem-free pregnancy and childbirth, the government, and the global community, has adopted the stance that every woman should be under the supervision of institutional biomedical care. In the colonial era, the biggest barrier to allowing all women to give birth in facilities was a lack of trained personnel and infrastructure, buildings, that would not accommodate so many women. Nearly 80 years later, the same problems continue to plague the Tanzanian government, whose push to send women to institutions outpaced its recruitment and support of the necessary providers.

Criminalizing home birth by charging fines to those who do not manage to give birth in a health facility, due to accident or intent, serves no purpose other than fostering additional ill-will in communities with already strained relations between women, their families, and healthcare providers.

Governments and NGOs alike seem to be looking for quick fixes, for the magic bullets that will stop the more than 8,000 maternal deaths that occur in Tanzania every year and send shockwaves into families and communities. Yet, maternal health is a systemic problem and when a woman dies in a health facility, her death is a culmination of all the structures that have influenced her life to that point, as well as a product of the complex, bureaucratic, and socially tense environment of the facility itself. Sending ever-increasing numbers of women to facilities that are poorly stocked, suffer from supply chain problems originating at the national level, have inadequate funding mechanisms due to the unequal effects of decentralization, and which systematically perpetrate violence against the staff members by keeping them living in poverty, subject to abuse by superiors, denigrated on the basis of their gender, and kept in ignorance due to poor communication, lack of transparency, and lack of respect, will do nothing to reduce the numbers of women dying. After all, without the supplies and skills, a hospital is just a guest house—full of beds and nothing else; it is, essentially, home.

10.4 Unintended Consequences and Perversion of the System

In the end, each of the chapters demonstrates a different example of the ways in which a system meant to prevent death and suffering can, in fact, result in worse outcomes for women and their babies. Chapter 4 shows that more and more women were accessing biomedical services as the government makes it impossible to access any other forms of care, such as the services of *wakunga wa jadi*, or TBAs. Through discourse and attendant regulations that have

imposed fines on women who give birth outside the biomedical system, the power of biomedicine is instantiated over and over again, effectively creating these facilities as the only safe place for a woman to give birth. However, the increased demand for these services has outpaced the supply of skilled providers and the material goods—medications and equipment—needed to sustain biomedical practice. With the expectation that women will receive high quality care in these facilities, community members were frequently disappointed when their expectations were not met because of a system that could not support the level of demand at village dispensaries. The poor care at these most proximate facilities drove more and more women to bypass them for the services of higher level facilities, such as the Mawingu Regional Hospital. The hospital's maternity ward then became flooded with patients, assisting in more and more deliveries every year yet struggling to keep abreast of the demand with necessary physical infrastructure and human and material resources (chapters 5 and 6). When Mawingu was unable to keep up, women's care suffered, effectively making the safest place increasingly less safe, in an ironic perversion of government and public health goals. Beyond just unintended consequences, the increased demand without the necessary increase in resources made the hospital more dangerous in cases when women arrived without money or relatives and catheters, antibiotics, sutures, or anesthesia were out of stock.

In other instances, the accountability and monitoring systems the hospital and the Tanzanian government put in place to help ensure high quality care that met international standards actually helped to undermine care and was subverted for other, social purposes, as with the partograph in chapter 8, or in order to perform effectiveness through maternal death audit meetings, in chapter 9. Often, these monitoring or accounting techniques were imposed from above, by NGOs or the central government, and the healthcare workers on the ground at

Mawingu tried to make space for themselves and their lived realities in between the lines of the graphs and in the blanks of the forms and log books. In the end, the data making its way to the central government was highly unreliable, produced with important social histories that were concealed by the “objective” numbers on the page.

This evidence suggests that institutionalizing birth is not, in and of itself, the solution to reducing maternal deaths in any setting. Clearly, many of the ways in which the system in the Rukwa region and Mawingu Hospital was undermined and perverted, to the detriment of high quality, guideline-compliant care, concerned a level of scarcity that was deeply engrained and entangled with the rapid expansion of biomedicine in Tanzania. Through efforts such as reducing the training time for Enrolled Nurses the government sought to improve services by increasing the absolute number of skilled providers. However, the real result was the proliferation of new graduates who had official certificates, book knowledge, and little else in the way of problem solving skills or training in handling obstetric emergencies. Quick fixes such as that continue to undermine the system and care for women. The government must move beyond rhetoric and draconian punishments that prevent women from plural forms of care when what they propose women use instead systematically disempowers both women and those healthcare workers meant to be assisting them and protecting their health and lives in times of emergency. Mawingu itself was a flawed institution, struggling with competing demands and the proliferation of government-imposed bureaucratic guidelines but, it found itself in a much more broadly dysfunctional system, the country’s healthcare sector as a whole. Within this context, the individuals at the hospital, and the hospital as an organization, sought to make due and provide care that was good enough. Pervasive scarcity often undermined their efforts to improve maternal health outcomes but, until the central government prioritizes solving supply chain

problems, and improving the candidate pool for nursing training, for instance, hospital birth with remain an incomplete solution to the problem of decreasing the deaths of pregnant women.

10.5 Limitations of the Study and Implications for Further Research

In the future, it would be useful to examine hospitals within Tanzania that have succeeded in significantly improving the care they are able to provide. In a comparison with lower resource settings, or those hospitals with worse outcomes, new variables or lost cost changes might become clear. The findings from the current project reveal a number of avenues for further research, particularly related to topics such as the role of NGOs on maternal health and healthcare worker retention. Additionally, the research findings from Mawingu Hospital may not be generalizable to hospitals in other, more urban or higher resource settings, even within Tanzania. The specific regional identity of Rukwa also influenced many of the events that occurred, as well as the development of biomedicine in the region. Therefore, in other regions, the trajectory and specific challenges of similar institutions, are bound to be different, with regionally particular implications for maternal healthcare.

This research has a wide variety of implications for the study of institutional dysfunction across sectors because many of the variables—communication, bureaucracy, disciplinary procedures, routinization, motivation, staff morale—are common to many types of complex organizations. Better understandings of the ways in which lower-level workers negotiate institutional hierarchies of power and control can inform research in a variety of settings, for example.

10.6 Recommendations

The following recommendations are based on my experiences at the regional hospital and while traveling to communities throughout the Rukwa region. They have also been informed by

my analysis presented in herein and I have shaped them in ways that may be useful to providers, administrators, and policy makers at a variety of levels both within Tanzania and globally.

10.6.1 Communities

The main challenges in communities were related to poor infrastructure, lack of resources for education, oversight mechanisms for teachers and healthcare providers, and gendered expectations that affected both men and women. In communities that lack formal mechanisms for teaching sexual education in school or other venues, healthcare providers should organize youth education days in which they either attend schools or host informational sessions at the dispensary. A number of organizations have sought to implement “youth corners” and youth friendly spaces in health centers and other facilities, but these activities need to be made available on a wide scale. Along these lines, health administrators could work with community and religious leaders to build support for teaching teenagers, and other unmarried people, about the different forms of birth control that are available. Women most wanted to ask questions about birth control and this is another serious need at the community level. The number one way to prevent maternal deaths is to prevent pregnancies. Providers need to continue to receive training that is comprehensive and enables them to answer questions, suggest alternatives, and inspire confidence in the proffered methods. In addition to better education about birth control, communities and the Tanzanian government need to find ways for adolescents to have access to meaningful and productive life options after the end of schooling. This might mean extending free education by creating a track for students who do not pass the exams necessary for entrance to government secondary schools. It might mean greater access to vocational training in rural areas. The bottom line is that youth need options other than staying at home and farming or being sent to towns to work as house help because, in both situations, teens are more likely to start

exploring sexual relations and girls can become pregnant at an early age, another risk factor for dangerous complications in pregnancy and childbirth.

Additionally, gender norms and ideals continue to influence the ways in which both men and women seek care, interact with each other, and contribute to their households and communities. There needs to be more attention concerning the ways in which masculinity and masculine identity formation contribute to intimate partner violence, demanding workloads for women, and inequity in household decision making in which women often expressed their partners did not listen to their voices even if the women had more information about the necessary healthcare services. Bridewealth is a deeply rooted and highly respected institution throughout society in Tanzania but it appears to have ambiguous effects on gender relations and women's empowerment. More research is necessary in this area to further understand the multiple effects of bridewealth exchange in the contemporary setting.

10.6.2 District Health Administration

The primary need at the district level which the study revealed was the need for better community education about the Community Health Fund (CHF). Community members and village leaders did not know enough about how this program was intended to work and the mechanisms whereby the CHF was intended to improve services. As a result, the entire program is debilitated due to a lack of buy-in from communities with only a very low percentage of households contributing to the fund. This disconnect is a self-reinforcing problem. Community members do not contribute, therefore the dispensary cannot buy sufficient supplies, community members who have contributed find they are still purchasing their own medications in private pharmacies due to the lack of supplies, and subsequently decide to not reinvest in the CHF. The problems related to adequate supplies at the dispensary level create aftershocks that travel

through the healthcare system and are magnified as they move up the referral chain. A lack of supplies and a failure to adequately explain why there are not enough supplies in the dispensary undermines the community's trust in the government healthcare system. These feelings of mistrust are amplified when pregnant women and others seeking care interact with healthcare providers who illicitly engage in activities such as selling supplies or charging bed fees for exempt populations. Improving community education about the ways in which the CHF is supposed to function, and could function with high levels of buy-in, could significantly improve community willingness to contribute, particularly if these explanations are combined with transparent discussions of the funding problems which delay or limit the availability of supplies.

In order to retain more, and more highly qualified, providers in remote areas, district health administrations need to reevaluate their retention efforts. For example, many providers use significant portions of their salary just trying to *reach* their banking town in order to access their funds. In an era in which mobile banking and programs like M-Pesa have significantly reduced the need to access banks, district health administrators should consider more streamlined ways to deliver salaries. Not only is there significant expense related to traveling to banking towns, but many providers in remote areas use these trips as an excuse to spend time in town. Even if they do not prolong their stays, they can still lose minimally one week of work, *every month*, simply trying to obtain their salary. Absenteeism is a chronic problem in these remote locations. Increasing supportive supervision visits to healthcare providers in village dispensaries, particularly those who are newly appointed and lack experience, would also greatly improve morale and has the potential to improve provider skill levels.

10.6.3 Regional Hospital

The change with the potential for the greatest impact is also free. Communication was the number one problem that, if improved, could prevent a host of challenges related to intra-organization strife, mistrust, and employee dissatisfaction with their work environment. Currently, nurses expressed a desire for more information across all levels about the hospital policies, budget, and goals. Administrators used lack of attendance at regular staff meetings as an excuse for the nurses' lack of information about the hospital. Instead of taking poor attendance as a given and subsequently improving communication via other methods, the administrators shifted the responsibility for information-seeking onto the already-overburdened nurses. For any non-confidential information, a simple solution could include just posting budget information on a bulletin board which is accessible to all staff members. Similar feelings of discontent surrounding the issue of continuing education and training seminars. Nurses were generally unclear on the selection mechanisms, which led to rumors of favoritism and unfair selection bias by the hospital leadership. Again, posting the selection procedures in a visible, public location and making rosters of upcoming participants available to the staff members could improve understanding and help decrease the nurses' feelings that the hospital leadership was systematically discriminating against certain wards or individuals.

Also, in regards to continuing education opportunities and trainings, the hospital should foster a culture of reporting back via presentations and other information dissemination activities. While the hospital has, in the past, irregularly tried to implement continuing education activities in which each ward rotated the responsibility for presenting a new topic, this was only taken up by two departments. Unless the Medical Officer In Charge was present and constantly reminding people to present, these brief seminars did not occur. Instead, the Hospital

Management Team should be responsible for constructing a unified hospital policy regarding the frequency of such continuing education opportunities and expectations for presentations meant to fit this purpose. Aspects of the policy to consider should include: How long should the presentation be? How many presenters will there be? How will staff receive relevant handouts? Who should attend? What are the consequences for not following the schedule or failing to present within X number of days after return from a seminar or training? Once again, this is a low cost change that could improve providers' knowledge and access to up to date information.

Functionally speaking, the hospital should prepare an on-call room for maternity doctors and theater staff members. By having a place at the hospital for a doctor to sleep at night while he is on-call, could significantly reduce the delays in initiating emergency C-sections or other procedures at night, the time when many patients die. Convincing doctors to use this room would constitute a significant change in current hospital culture but would be incredibly beneficial for patient outcomes.

The interviews with the maternity ward nurses and doctors revealed that many providers have had at least one incident in which they were exposed to HIV positive bodily fluids, generally due to a stick with sharps or a cut from a surgical blade. However, even though post-exposure prophylaxis (PEP) is available, the majority of providers did not complete their PEP protocol. Given the fact that providers viewed lack of institutional support for personal protective equipment, and lack of administrative recognition of the risk inherent in maternity care, as major indicators of the ways in which the hospital did not care for or value them, increasing support for PEP should be considered an important priority. Staff members did not follow through with PEP because of the side effects, some of which could have been minimized or prevented if they had had institutional support. This support could have come in the form of allowing the providers to

have a more flexible work schedule during the course of the PEP treatment, which would allow them to plan and time appropriate meals, for example. Accommodating tardiness as a result of drug side-effects could also help providers feel more able to complete their treatments and ensure they do not contract HIV through occupational exposure. Generally improving the availability and quality of personal protective equipment would also improve interactions between nurses and their patients, as well as increasing nurses' perceptions that the hospital administration cares for and about them and the risks they face in their work environment.

Motivation and morale should continue to be key areas of importance for the hospital administration. Without successfully improving morale, the hospital stands to continue losing many of their most highly skilled providers across cadres. First of all, on the maternity ward, generating and posting yearly and/or monthly goals for improving care could help to anchor staff members and present a visual account of their efforts via graphs or charts of the incidence of stillbirths, for example. The nursing staff, together with the maternity ward Doctor In Charge could design such goals at the first department meeting of the year. The hospital administration could also use the CWEQ survey throughout the other departments in order to assess the nursing staff's perceptions of their work environment and key areas for improvement. On the maternity ward, the survey data suggest that nurses would like to receive verbal recognition for their work, particularly if they successfully managed a difficult case or went the extra mile in providing care. The situation, while I was present at the hospital, tended more towards a reliance on punishment instead of recognition. The only time nurses thought their superiors "saw them" was when they had made a mistake, even if this was only one time out of one hundred. Implementing a more robust system hospital-wide for recognition of high performing staff members might help improve staff morale. However, this system should not include monetary incentives, which, due

to NGO programs such as those to recruit staff to HIV testing and counseling programs, have created the expectation that all work should be compensated even if it is within the bounds of the employee's normal job description. What has resulted is the expectation that all activities, beyond the most basic nursing functions, deserve extra monetary compensation. Changing this "seminar culture" which permeates other initiatives, as well, can only effectively and sustainably be done if the central government also increases the base salaries for healthcare providers. Additionally, due to convoluted and bureaucratic disciplinary mechanisms, most nurses and doctors do not necessarily worry about consequences for unprofessional or medically negligent actions. A lack of consequences has created an environment in which nurses skip ward meetings that are, ostensibly, mandatory because they know they will not suffer any consequences as a result of their absenteeism. Actions such as these contribute to the poor communication that abounds within the hospital.

In order to improve relations between the hospital administrators and the ward nurses, the nurses expressed a desire to see the administrators spending more time on the wards. Their presence alongside the nurses, even for thirty minutes once in a month, would help the nurses to feel as though the administrators have an accurate picture of the situation on the ward. Currently, the nurses perceive the administrators to be out of touch and disconnected from the daily realities of patient care, particularly as related to the consequences of new, bureaucratic hospital procedures and supply chain problems. While administrators are significantly overburdened with work themselves, it could be possible to rotate such an observational duty, with them paying particular attention to the maternity ward, which is a good litmus test for the state of the rest of the hospital.

Last, the hospital should continue to strive to improve patient feedback mechanisms to ensure patients and their relatives feel their healthcare providers are listening to them and their concerns are being met and dealt with, leading to improved care and satisfaction. One approach might also include more active community outreach and engagement. The hospital could work with community and religious organizations or NGOs to educate patients about hospital procedures and their rights in the hospital. This will increase accountability among the staff if patients start to demand their rights and follow-up if they feel they have not gotten them. The hospital administrators and providers should not be afraid of this, but help to encourage it so community members can be partners in improving quality of care. For example, on the maternity ward, if women feel more empowered about hospital procedures and ward flows, they might be more likely to say something when they have not received care for several hours or experience a change in their condition. This is not a change that will happen quickly but should be a longer term goal for the hospital and the region, and will go hand in hand with community-level initiatives, as well.

10.6.4 Regional Health Administration

The regional health administration in Rukwa has been striving to continually improve services and organization throughout the region, particularly with number of initiatives the current Regional Medical Officer started since his appointment in 2012. Therefore, I have less to say about the regional efforts to reduce maternal health. However, one outstanding area for improvement remains the maternal death audit meetings used to review the cases of death at the regional hospital. Stakeholders from the district and regional levels also participate in these meetings so I am treating them as a regional-level issue. Improving the audit process would certainly generate more work for the region, across all levels, not just within the regional

hospital. However, reforming this system would also create the possibility of real, and lasting, improvements in lowering the maternal mortality rate in the hospital and across the region.

- a. The maternity ward Doctor In Charge should discuss every death with the nurses within 24 hours of occurrence. A summary of the events as well as the content of the discussion should be written up within no more than one week. This summary can then be used as part of the hospital Maternal Death Audit Meeting. Improving the initial data collection process for each death will improve the level of details involved parties are able to remember and record. This additional information will enable the hospital, and all those present in the meeting, to more effectively and accurately evaluate the sequence of events leading to the woman's death and how to rectify any on-going problems.
- b. At the start of every Maternal Death Audit Meeting, all stakeholders should be required to give a report on progress made and points of the action plan that they have been able to achieve since the previous meeting. This includes all District Reproductive and Child Health Coordinators (DRCHC/Os). Even if the deaths occur at the hospital, they are not only hospital deaths. This is supported by the high number of referrals and the general belief among staff that many of the deaths come to the hospital from outlying areas, "already dead."
- c. Meeting participants should construct action plans using verifiable indicators and the plans should take into account the expertise of those discussing the deaths, i.e. someone with public health knowledge should contribute to the design of action plans to verify they can actually be implemented and effective. Because measurement continues to be an important emphasis throughout the health sector,

being able to accurately record data indicating improvements in care would benefit the region's standing at the national-level, which could potentially result in increased investment. While these improvements in action plan design would generate more work, particularly at the district levels, the returns on investment would be great.

- d. All discussion should be presented back to the maternity ward and Ward 5 staff as soon as possible and no later than the next monthly meeting. Nurses on both wards have no concept of the number of deaths or the predominate underlying causes of the deaths. Currently, they only remember those deaths with which they were directly involved, which leads them to continually underestimate the number of deaths that are actually occurring at the hospital. With improved feedback to the ward level, the nurses would have the knowledge and opportunity to further improve their own work. Feedback is particularly important given the fact that most nurses reported their primary coping mechanism was repeatedly examining case details in search of where they might have improved care in a way that could have prevented the woman's death. If the nurses all had access to the outcomes of the maternal death audit meetings, they would be able to see that the discussions in which others are engaged corroborate (or conflict with) their own experiences of the woman's care.

10.6.5 National Level and Implications for Global Policy

On the national level, the results from this study can offer insight into broader, systemic changes that continue to be necessary. None of the aforementioned recommendations can be accomplished without support from the central government and the Ministry of Health and

Social Welfare. Additionally, at the national level, the country needs to continue to reevaluate nurse training programs in order to produce high quality providers, not just increasing the volume of people providing services. Many of the other systemic needs are directly related to finances. The health sector is particularly sensitive to delays in funds. Tanzania also needs to ensure funds are being spent in ways that actually provide appreciable improvements in care. This means evaluating the needs on the ground in the diverse areas of the country. Rolling out one size fits all programs will continue to produce mismatches that lead to wasted time, wasted funds, and less than optimal improvements in the system or in care and patient outcomes. Once again raising the prestige of healthcare providers, like they might have felt in the early days of the Nyerere era when they were enlisted as key actors in accomplishing socialist goals in the country, could also help to improve morale and lead to the recruitment of more highly talented nursing and medical students.

On a global level, the current fixation on evidence-based interventions and data has silenced many of the voices coming from the grassroots level. Improving maternal health and reducing pregnancy related deaths is not a one size fits all endeavor. Health sector employees produce data under highly constrained systems which make much of the data unreliable, at best, and significantly misleading, at worst. Integrating the work of social scientists in the design and implementation of public health and policy interventions could improve the fit with local conditions, needs, and realities in places like Tanzania. Systems approaches which do not simply tell women to go to healthcare facilities but also comprehensively support providers would also go far in improving the situation. In order for such an approach to be a reality, states need to be actively involved in generating the needs assessments in their countries. Policy makers and health administrators should not feel as though they are unable to reject unnecessary

interventions for the fear of long-term loss of support or investment. A greater understanding of the ways in which healthcare providers and administrators are, themselves, embedded in social and kin networks, as well as networks of prestige and power, just as are the women seeking services, will help to more comprehensively address their needs. In turn, with their needs met, they will be more capable of providing care that meets with idealized, global guidelines. Quick fixes and top down interventions will not provide sustainable, lasting improvements in the healthcare system.