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"Bad Luck," Lost Babies, and the Structuring of Realities

In this chapter and the next, I use examples of three women's stillbirths to explore how a document-as-technology, the partograph, and health care providers' deviations from the partograph's guidelines for use, work to create different social and ethical care situations in maternal health care settings. The partograph plays several roles as a technology, a bureaucratic document, and a social tool. When interacting with the current technologies of documentation and intervention that are in use in the field of maternal health in the global South, health care providers often are forced—through circumstance, lack of resources, personnel shortages, or lack of fit with the local environment in any number of other ways—to appropriate them for off-book purposes. Much like the care procedures highlighted in the last chapter, documentation practices deviated from guidelines and standards.

For the nurses, particularly once it was clear there had been a gap in, or deviation from, good care for one of the pregnant women on the ward, there proceeded a complicated weighing of the benefits and costs of various forms of accountability and degrees of honesty in reporting, revealing, or withholding mistakes. In this chapter, it is not necessarily the deaths of mothers that bring these complicated realities to light but the much more common stillbirths that help to reveal gaps and ethical maneuvering.

Bureaucracy and its demands shape interactions and produce or reify specific forms of authority. In the setting of clinics and maternity wards, this authority is biomedical. "Bureaucratic inscription and technological intervention . . . mark the patient body and the hospital wards as sites of biomedical authority" where "care work done by nurses and doctors revolved around their mastery of hospital processes (*most prominently visible through activities involving writing*)."[1] The writing of bureaucratic documents, then, itself becomes care work but is also an integral aspect of performing biomedical authority for individuals, as well as for clinics,

organizations, and, ultimately, governments.[2] Documents enter into the equation of stillbirth as the nurses manipulate them to protect themselves and their authority, question others, or respond to accusations of neglect. As these documents, here embodied by the partograph, and the broader bureaucracies that produce and collect them become objects of fixation, the documents take on more and more power in structuring interactions in clinical spaces.

STILLBIRTH AND THE PARTOGRAPH

On a sunny day in March 2015, Sarah approached me after the end of a community focus group discussion in her village. Somewhat timidly she said, "What's wrong with me? What could be wrong that is causing all my babies to die?" I asked her more questions about what had happened during her last pregnancy, and she explained, "When I went to the dispensary, I was lying on the [delivery] table and I could still feel the baby moving inside of me. Then, when the baby was born, it was already dead." Two other pregnancies had ended similarly for her. I told Sarah it sounded as if she was experiencing stillbirths as a result of some lack of provider experience or knowledge in her local health care facility and recommended she try to plan to give birth in another facility in the future, if at all possible. Sarah's likely cases of stillbirth, as well as the case of Pendo related later in this chapter, exemplify intrapartum stillbirths, which were often a result of delayed recognition, or improper treatment, of delivery complications. These types of stillbirths were prevalent throughout the Rukwa region and did not occur only in the regional hospital.

If a woman came to the maternity ward and the nurses were able to discern a stable fetal heartbeat upon arrival, that meant the baby was alive. Subsequently, a number of clinical problems could later result in fetal distress and, if not addressed with an appropriate intervention, could end in what the hospital staff members called "fresh stillbirths" or "fresh SBs." The baby's death was due sometimes to obstructed labor or rarely to a very tight nuchal cord or some other complication.[3] The social dynamics of the maternity ward and the structural processes at play intersected with these clinical symptoms and could easily turn a relatively treatable problem into a life-threatening crisis for both mother and baby. Nurses struggled to remember which women needed to be monitored at what times, because each woman was on a different schedule and the nurses continued to be shorthanded. Sometimes more urgent cases occurred that could take all available nurses away from the less immediately critical work. A woman might not have her cervix or fetal heartbeat checked because the nurses were dealing with another woman who was hemorrhaging, for example. However, at the very least, the nurses listened to and recorded every woman's fetal heartbeat during the shift handover procedures.

To explain the centrality of the partograph in the discussion of the cases that follow in this chapter, as well as in the daily life of the maternity ward at the regional hospital, I first outline the official uses of the partograph, how to fill it in, and the informal, improvisational ways in which the nurses often employed this piece of paper. In a setting in which other technologies could not be relied upon and were in short supply, photocopies of partographs made their way into nearly every health facility. The district medical officers and the district reproductive and child health coordinators were responsible for distributing these papers, sometimes even if providers did not request them.

The most basic function of the partograph is to form a graphical representation of a woman's labor. Every four hours a provider should examine the woman and plot measures on the graph, including cervical dilation, the baby's head level or descent into the woman's pelvic opening, fetal heart rate, and the strength of the woman's contractions. There are also spaces to record blood pressure, fluid intake, urine output, and the woman's pulse. The World Health Organization (WHO) recommended wide use of the partograph starting in 1993 and 1994.[4] Since the 1970s, the partograph has included an "alert" and an "action" line.[5] The action line is based on the premise that when a woman is in truly active labor, one centimeter of cervical dilatation takes one hour. If a woman's progress is appropriately plotted on the partograph and crosses the action line, it indicates that her labor has stalled and that something may be wrong. The line is so named because a provider needs to "take action" to investigate and rectify the situation so mother and baby can be safe and healthy (figure 11). Paper-based partographs are still common in many low-resource settings, though they have been replaced by electronic fetal monitoring and other technologies in many high-income countries.

Despite the partograph's ubiquity, during a total of five weeks of supervision visits during which I accompanied clinical experts from a multi-NGO project operating in the Rukwa region, it became clear that, as shown in findings from several other countries, many health care providers were not entirely certain about the proper technical uses of the partograph.[6] Many other health care workers simply could not be bothered, because they lacked mentoring and monitoring or were overburdened with other vital tasks. In other instances, women, preferring to spend as little time as possible in their local, often-dilapidated village dispensaries, arrived late in labor, and the health care worker had no time to monitor their labor via the partograph before the baby arrived. In contrast, the ideal, as nurses suggested, was for a woman to arrive while in early active labor, giving plenty of time for monitoring and ensuring that health care workers would be able to identify and address any potential complications. In all these cases, health care providers were often not employing the first-line tool for preventing stillbirths.

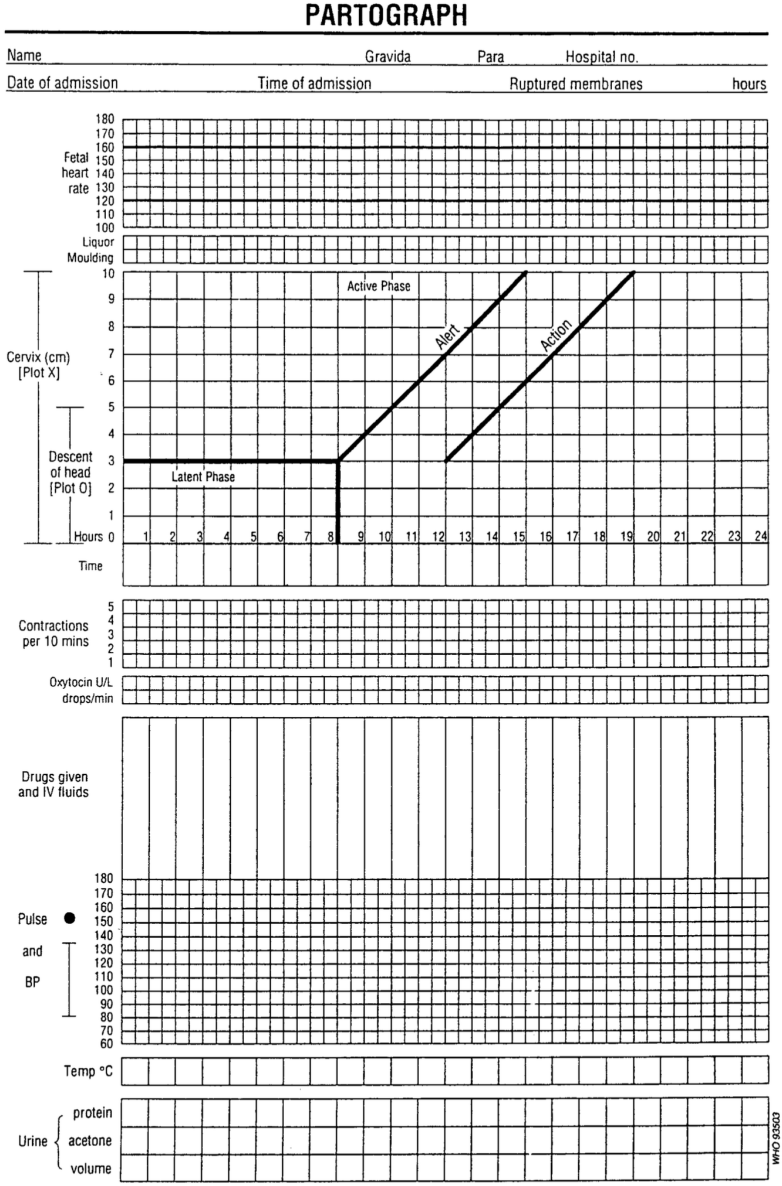

FIGURE 11. A partograph identical to the version the health care providers in the Rukwa region were using. There are spaces to chart vital signs, the descent of the baby into the pelvis, the fetal heartbeat, and cervical dilation, among other things, all on the y-axis. The x-axis is time in hours. Reprinted with permission from *Preventing Prolonged Labour: A Practical Guide. The Partograph Part I: Principles and Strategy* WHO/FHE/MSM/93.8 p.6, Copyright 1994.

THE PARTOGRAPH'S ROLE IN SOCIAL INTERACTIONS

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

While, on the surface, this might seem to be a purely good technology that can function to save women and babies from complications and life-threatening situations, this paper technology's shadow side is that women whose bodies do not conform to the rule of thumb of one centimeter of dilation per hour set in motion a cascade of clinical, social, and ethical quandaries for health care workers. The documentation on each woman's partograph is a record of her care and a record of the competence of her health care providers, who must accurately measure the data to be plotted on the graph. Partographs form an important record of the health facility's proficiency in providing high-quality maternity care. Indeed, as part of a woman's medical record, the partograph is a piece of organizational infrastructure,[7] but one that facilitates interactions between different worlds. These worlds include, in this case, those of patients, nurses, doctors, the hospital as institution, the Ministry of Health, and international donors, but, more broadly, the worlds of surveillance, bureaucracy, and care. The partograph makes up one part of the expanding bureaucratic system that the Tanzanian state uses to try to improve quality of care in its public health facilities.

Sometimes, moving beyond its official uses, nurses would use the partograph, and their careful documentation on it, to bid for the doctor's attention in an effort to secure care for the woman. If the nurses felt that a woman should have a C-section or that the doctor needed to examine her in order to rule out the need for an operation, they would write on the partograph "Dr. to review" and then wait for his judgment call. On the day or evening shift, the doctor would usually come to the ward within a short time of receiving a phone call from the ward nurses notifying him of a patient. On the night shift, the nurses had to call the nurse supervisor, who then called the doctor on call. The nurse supervisor sent the hospital car and driver to pick up the doctor at his house and bring him to the hospital. This could take more than an hour depending on where the car and

driver were and on the (un)willingness of the doctor to return to the hospital after having worked the entire day.

More than once, nurses felt a doctor needed to review a woman but there were delays in his arrival or, once on the ward, he refused to examine the woman. In one case, the nurses reported that the doctor had passed through the ward, refusing to even touch the patient but still proclaiming that she would be able to give birth without problems, which was not, in the end, true. In most instances, the doctor's refusal to do an exam was because, upon hearing the details from the nurses, he decided the information did not suggest an emergency. He might decide the nurse's assessment of the woman's progress was sufficient, thereby expediting his return to bed. In such cases, the nurses used the partograph's back page to document the events that transpired in order to protect themselves from accusations of inaction when the inaction was, in fact, due to some delay or refusal on the doctor's part. Nurses frequently stated that doctors were never blamed when things went wrong. Nurses took to using the partograph and other documentation as a way to protect themselves and to prove the doctor's culpability. Nurse Peninah told me that she had learned such documentation practices at her previous posting at one of the zonal referral hospitals and that she continued to use them. She explained, "The doctor, you have called him at such and such time, you write it. I started to look for him at such and such time. He hasn't arrived since several hours have passed, you write it: 'Since I called for him, maybe two hours have passed, he hasn't arrived.' Therefore, you're on the safe side." In this way, Nurse Peninah sought to protect herself and strategically draw attention to the role doctors played in provision of care that was delayed or otherwise not up to standards.

Peninah's use of the document to record the roles and responsibilities of other actors in the patient's care was also a way in which she was utilizing the little formal power available to her within the hospital's hierarchy, which tended to privilege the more specialized or technical knowledge of the doctors. Additionally, the hospital desperately needed to retain as many physicians as possible, and the administration was unlikely to reprimand them unless they grievously endangered a patient's life or directly caused the patient's death. The nurses also would not necessarily have supported disciplinary action against a doctor that was based on their notes on the partograph. Rather, they were first and foremost concerned with protecting themselves and deflecting any allegations of their own wrongdoing. Peninah's strategy also sought to protect the nurses on the maternity ward from unpleasant encounters with the patron should the ward nurses' actions come under scrutiny on account of a woman's death or severe complications.

In other cases, nurses filled in the partograph ex post facto because of a push by the hospital administration for better documentation or a supervision visit from an outside agency (Ministry of Health representatives or NGO program officers, in most cases). During these visits, the outsiders entreated the ward staff to try harder to check off the boxes in the record book of births, making sure to appropriately

write "yes" or "no" in the column about whether they had used a partograph. Nurses would, by rote, simply write "yes" regardless of the actual existence of a partograph for that particular woman, copying what they saw in the row above their entry. In this way, the ward collectively was able to invoke the *idea* of the partograph to accomplish bureaucratic documentation requirements and to project high-quality care that complied with hospital, national, and international recommendations and rules.

Good care came to be synonymous with good documentation regardless of the particulars of the care that women actually received. By writing that they had used the partograph in the officially sanctioned government record book, the nurses legitimated their care practices and conformed with guidelines. In these moments, a culture of accounting for compliance with guidelines took primacy over a culture of actual care practices in which the nurses could have been engaged. Systemic fixation on documentation of care drew providers away from "deep compliance" in favor of surface-level documentation of compliance meant to appease bureaucrats and fulfill reporting requirements.[8] This fixation then opened up myriad opportunities for manipulating these powerful documents.[9] Additionally, data fabrication helped nurses to accommodate reporting requirements in the context of resource and personnel scarcity.[10] Data fabrication or falsification on forms like the partograph created parallel realities or "paper maternities" based on documented care but diverging vastly from the care women received in actuality.[11] Analyzing some of these instances in which nurses manipulated the partograph or the idea of the partograph makes visible how forms of caring emerged or re-formed. It becomes clear that more surveillance and more bureaucracy may create less care of the type policy makers imagine but more care of a previously overlooked kind—that of health care workers for each other. Documentation requirements responded to and structured formal ethics of care, but these requirements undermined the more relational caring that could have engendered *actual* high-quality care instead of the paper appearance of it.

UNCERTAINTY AND THE PARTOGRAPH

While the partograph was an ideal tool on account of its simplicity and ready availability, the environment of the maternity ward forcefully limited and redefined how the nurses were able to use it. Because Mawingu is a regional hospital, there were often students on the maternity ward doing rotations or "practicals" as part of their training. Their presence complicated some of the unspoken routines and norms on the ward. It was often unclear who was responsible for filling out each woman's partograph when these visitors were on the ward. Students frequently neglected to sign their names or ask a nurse if they were unsure about how to complete the paperwork, preferring instead to try their best on the basis of their nascent book knowledge of the partograph.

In the spring of 2015, a second batch of newly graduated nurses joined the maternity ward. They often left the hospital as soon as their shift was over without properly completing the paperwork for their patients, and they did not take an active part in delivering reports to the incoming nurses at the shift handover. Poor handover procedures led the incoming shift to sometimes overlook women or assume that a patient was fine because the outgoing shift had not indicated otherwise. Like the new graduates, other nurses were unsure about when to start the partograph because of their relative lack of experience in maternity care. If the nurse started the partograph too early, when the woman was not actually in "active" labor with regular contractions, they opened the door to a host of potential problems. A woman who is in active labor should progress regularly, again, ideally following the rule of one centimeter per hour. If she was not in active labor when the nurse started her partograph, it could appear as though the woman was spending much too long in labor and needed an intervention to help her. Students and new nurses often did not have the skill level to measure cervical dilation and determine the relative strength of contractions in order to accurately ascertain if a woman was in active labor and also to subsequently take accurate cervical measurements that would appropriately reflect the woman's labor progress. In some cases, I saw the more experienced nurses reconstructing an alternative partograph that hid either mistakes in measuring cervical dilation, such as those made by nursing students, or delays in care, most often without any malicious intentions. In so doing, they were reconstructing an alternate reality, one in which the woman's care followed the expected, ideal trajectory. After rewriting the partograph, the nurses would often throw away the original and would tell me they were doing so to reduce confusion or correct mistakes from when someone had initially started the partograph.

Recreating the partograph was a way in which the nurses attempted to reshape their reality on the maternity ward, bringing it into line with desired bureaucratic or best-practice expectations and goals. The partograph contributed to the production of care on the maternity ward, as well as actively constituting social realities.[12] The document, because of its origins as a way to prevent prolonged labor and poor fetal outcomes, enlisted providers in a broader fight to reduce intrapartum stillbirths and maternal morbidity.

Collectively, measurement and handover problems constructed a great deal of uncertainty. Instead of being an objective technology that nurses and doctors employed to track women and tame their laboring bodies, the partograph became a site of improvisation and a relational strategy, open to interpretation, re-creation, and disappearance. The more experienced nurses were able to use the partograph not just to record labor progress and spot potential problems early on but also to tap into the document's social elements; they used it to invoke protection (for themselves or their colleagues), record blame (for doctors' delays), and solicit care for their patients.

Structural constraints recreated technologies and documents in ways that throw into question their veracity and efficacy as evidence of idealized forms of care: for example, they resulted in nurses either "cooking" the data or using the partograph as a "postograph" after the woman had given birth or even departed the facility.[13] All data are inherently cooked through the activities that bring them into being in the first place, and "Data reflect the capacity and expertise of all their handlers."[14] At Mawingu Regional Hospital, the nurses cooked the partograph data when they filled in partographs after a woman's birth or when they replaced a partograph showing that a woman had long passed the "action" line with one that demonstrated a more moderate, desirable labor progress. They often engaged in this cooking to achieve goals for care or surveillance well beyond the originally intended use of the partograph. Knowing that their colleagues, and they themselves, were engaged as partograph chefs, nurses and doctors had to know when to take the partograph in front of them as fact and when to see it more as a representation or performance of idealized care. Holding open this space of uncertainty, regarding the partograph as an accurate reflection of care or as a re-creation, allowed the partograph to fulfill the most capacious role as record, re-creation, and social tool. Outsiders might think increased certainty would improve the partograph and its efficacy. In fact, more certainty would close off some of the most critical aspects of the partograph's functioning. Currently, the partograph's uncertainty works for nurses, in particular, in much the same way Alice Street suggests doctors in Papua New Guinea used uncertainty in medical files: to create "a device that distributes agency and perpetuates contingency"[15]—perhaps the most important function of the document. This role of the partograph becomes quite clear in the following cases of two women, Pendo and Zuhra, whose babies were stillborn at the hospital.

THE CASE OF PENDO'S BABY

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

I had more information about the meeting and the case than others because I had been present since the beginning. I had been helping to care for Pendo since she had arrived at the hospital two days before. She was a pleasant, quiet client in

her first pregnancy. She had come from Dar es Salaam, across the country, where she was living with her husband, to give birth at Mawingu in order to be closer to family during this important event in her life as a woman and in their lives as a married couple. She had arrived at the hospital in early labor, with more than enough time to spare before giving birth. I often saw nurses reprimanding women for arriving late, just as they were transitioning to, or were already in, the second stage of labor. However, Pendo was in the early stages of active labor and therefore avoided any possible accusations from the nurses that she had been late to report to the hospital.

The day Pendo arrived, the nurse on the ward responsible for admissions had written her name in the admission notebook, examined Pendo, and started a partograph for her. I had seen her later in the afternoon when she was quietly walking around the ward, waiting for a nurse to tell her to enter the labor and delivery room. I remember noting to myself near the end of the morning shift that the evening shift nurses would definitely need to conduct another vaginal exam to check her progress and cervical dilation. Hopefully, she would give birth sometime in the night. The nurses had asked one of the doctors to review Pendo because they were concerned she would need a C-section. The doctor deemed her likely to give birth vaginally without complications, so there was nothing else for anyone to do but settle in to wait for Pendo's body to decide it was ready for the baby to come out.

The next morning, I arrived around 8 a.m. and started looking around the ward for any signs of activity. I went to fetch supplies from the nurse in charge's office, carefully signed out the quantity of each item in blue pen inside the battered notebook, and carried everything back to the labor room. The ward was relatively calm, and I found a moment to look over the antenatal clinic cards and current partographs sitting on the desk in the labor room. This was the paperwork of the women who were now either under observation or in the last stages of labor before giving birth. Pendo's paperwork caught me by surprise. I looked around, and, sure enough, she was the same woman who had been present with us the day before. I thought that seemed odd, especially because the doctor had told us he thought she would give birth without any problems. Added to that fact was the absence of any further information on the partograph, as would be required by best practice. The oft-repeated phrase "not documented, not done" rattled around in my head. Internally shrugging my shoulders, I thought even documentation might not necessarily indicate the realities of care that had transpired given the ways in which written reports often elided the much messier care practices that were the ward reality.

Although what one of the nurses later called "neglect" seemed possible, my first thought was that perhaps they had just been very busy in the evening and overnight. Maybe the nurses on these shifts had examined Pendo again but had simply failed to find the time to write down the results, as sometimes happened. Nurse Gire was working the morning shift that day, and I drew her attention to the nearly blank partograph. She also remembered Pendo from the day before because

we had been working together then too. Nurse Gire examined Pendo, and the following is from my field notes:

> Pendo, a patient from yesterday, is still in labor, and by 12 p.m. she still hadn't delivered. Gire did a [vaginal exam] again and decided Pendo was at 9 cm and was obstructed. . . . She has long passed the action line and should probably have had a [C-section] last night or evening. Now she no longer has a discernible fetal heartbeat. . . . It seems likely the baby was in distress and has already died. I asked Gire why the other people . . . might not have detected that it was cephalopelvic disproportion (CPD)[16] and why other nurses don't use partographs? . . . Pendo is just finishing in the theatre now at 1:45 p.m. and the baby was stillborn. [Nurse] Alvina says the baby was macerated,[17] but I'm skeptical.

CPD might have been the cause of Pendo's unusually long or obstructed labor and could have explained the poor dilation of her cervix. If the baby is unable to enter the pelvic opening, perhaps because of this mismatch, or because of the formation of the bony processes of the pelvis, the baby's head cannot exert pressure on the cervix, helping it to open. If the baby cannot fit in the opening, the uterus is contracting without being able to accomplish its goal, and instead the baby comes under great stress from the squeezing, which does not result in the baby moving into the pelvis. This stress can eventually cause the baby to be stillborn.

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

While he was still on the line, I tried to hand the phone to the nurse in charge of the maternity ward who was sitting in the labor room. She waved her arms, refusing to take the phone, as did Gire, who was sitting next to her. After I hung up, I called Dr. Joseph, who suggested Pendo's husband call back in two days, on

Friday. The next day, I told Pendo her husband could call again on Friday to talk to the medical officer in charge. She told me he didn't want to talk to anyone anymore and they had been able to explain to him that this kind of "bad luck" happens.

TO KNOW HIS FACE: STILLBIRTH AND COPING

About a month before Pendo's arrival, Zuhra had been at Mawingu. She had come after already visiting her local, village dispensary where the providers had sent her on to the hospital without any documentation or proof that a medical professional had even seen her.[18] Because of the way the regional hospital organized and documented referrals, Zuhra slipped in, looking like someone who had just come from home in the absence of official referral paperwork. Busy nurses bustled through the ward and admitted Zuhra without taking time to ask if she had come straight from home or had sought care elsewhere before arriving. They assumed she had come from home, as most women did, and therefore did not ask her the questions that might have elicited the fact that she had been in labor for more than twenty-four hours before her arrival at the hospital. This one fact might have changed the trajectory of her care because it would have been a sign that her labor was not progressing as would be expected for a woman in her fourth pregnancy.

When they examined her, she had not projected the image of a woman in active labor—she was too quiet, too calm—so she did not receive a more thorough examination of the current state of her labor. In cases in which a woman was visibly in pain or distress that would suggest active labor or the impending need to push, the nurses generally conducted a more thorough exam sooner. Nurses often told other women who did not seem to be in active labor, or close to pushing that they needed to wait while the nurses completed other miscellaneous but necessary tasks before a nurse would be available to examine them. While nurses examined every woman physically, the medical history was often left by the wayside with the explanation that it took too much time to go through all the questions for every woman—time that the nurses could not justify when other women were waiting on the slatted wooden bench, just having arrived from home, or had been admitted on the ward and were due for their next vaginal exam.

After admitting her, the nurse sent Zuhra to the antenatal waiting room and, according to Zuhra and corroborated by her medical file, no doctor came to see her for more than twenty-four hours. The nurses never again conducted a vaginal exam to see how she was progressing. In the middle of her third night at the hospital, Zuhra told me she had gone into the labor room to tell one of the nurses that her contractions were getting stronger, the only time she had been bothered by the pain. Zuhra told me that prior to that moment her contractions had not been like ones she had experienced in other pregnancies: they came and went without any strength or regularity. The nurse brusquely waved her off and told her that they

would examine her in the morning. The nurse told her, "It's not you who decides when you should be examined! We will tell you when!" With this pronouncement from the nurse, Zuhra went back to her bed and silently waited for the nurses to tell her when. No one came to see her that night.

When Dr. Charles finally reviewed Zuhra on ward rounds the following morning, he was struck by how soft her belly was, different from the taut skin and hard, contracting bellies of other pregnant women. Her uterus had ruptured, and the baby was floating in her abdominal cavity. Because of delayed diagnosis, poor communication, and inadequate history taking, Zuhra's baby had died, floating there in the remnants of her womb and the quickly dispersing amniotic fluid. Dr. Charles immediately ordered an emergency laparotomy, which, in the end, included a hysterectomy, since he was unable to save her uterus. The family had whisked away the baby's body while Zuhra was half awake, still coming out of anesthesia from the operation needed to save her life.

Zuhra had a very bad obstetric history, including miscarriages, and at least two of her older children had died tragically. This baby had been her hope for one more chance to raise a healthy child to adulthood. For many weeks afterwards, Zuhra's relative, a nurse on another ward of the hospital, told me that Zuhra was in a depression, unwilling to leave the house and constantly sad. Zuhra's greatest cause of sadness? She had not seen her baby boy and therefore could never know what he looked like, would never "know his face," as she told me. Despite the hospital staff's neglect in her case, Zuhra and her family never decided to pursue any action against the hospital.[19] This was despite the fact that her relative, who was a nurse, told me she could have easily provided medical insight into the course of events. She told me she knew Zuhra's care had not gone as it should have, as evidenced by delays in getting a blood transfusion after surgery and by Zuhra's reports of not being seen by the nurses in the night. Poor documentation and shift handovers may also have contributed to the lapses in her care.

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

that guidelines mandated take place minimally once per hour but ideally every fifteen or thirty minutes. Less-than-thorough reports during shift changes and inconsistent use of partographs as a key technology to chart a woman's progress in labor seemed to be, among other factors, contributors to this baby's death.

In the aftermath, Pendo's partograph went missing. The nurse in charge of the ward was certain someone had hidden it or otherwise disposed of it, she resignedly told me: "Yes, it happens like this now and then. They are afraid the partograph shows their mistakes, so someone decides to hide it or throw it away. I don't know what they do with it."

Back in the meeting to discuss Pendo's case, the partograph became of central importance. The partograph always traveled through the ward with the woman whose labor it documented, and providers conceived of the piece of paper as a continuous record of her labor, despite shift changes. It was the one mode of communication that was supposed to be present even if, as the medical officer in charge accused the nurses in the meeting, verbal communication at shift changes was less than ideal or proved to be ineffective. In Pendo's case, the partograph could also implicate the hospital staff in the death of her previously healthy baby.

MOURNING AND STILLBIRTHS AS "BAD LUCK"

Many women never questioned the "bad luck" that resulted in the death of their babies while still *tumboni,* or "in the stomach." Unfortunately, this was partly because intrauterine and neonatal deaths have historically been so common in Tanzania and continue to be so.[20] In addition, many people throughout Tanzania did not consider it socially appropriate to mourn the loss of babies who were not fully mature or fully human.[21] Hospital procedures and health care provider actions often served to deny women and their families answers when their babies did not survive. Despite cultural norms, women often found it hard to come to terms with the loss of their child who was stillborn. Nurses did not routinely give women the option to see or hold their stillborn babies, instead taking away the body and then repeatedly instructing the mother to stop crying, to not make noise, and to wipe away her tears.

Part of this outwardly brusque standard operating procedure can perhaps be attributed to constructions of the origins of personhood and socially acceptable physical spaces of mourning.[22] In northern Tanzania, the concept of toughening by which those close to people who have lost relatives encourage the bereaved to bury feelings of loss when outside designated mourning spaces (funerals) to concentrate on remaining kin relations, also provides insight into local forms of caring.[23] It was not socially appropriate for a woman to openly mourn in front of strangers in the public space of the maternity ward. However, what often appeared, from the outside, to be nurses limiting compassion for the women and not allowing

them to mourn caused many community members—men and women—to accuse nurses of not caring for or about pregnant women in the hospital. This community perception led to a deep cynicism and dissatisfaction with the only care available to most women.

In some cases, the woman or her relatives might suspect the death of the fetus in utero to be related to malevolent witchcraft or jealousy. In these instances, hiding the death from other, nonfamily members could be more socially beneficial. In such cases of suspected witchcraft, women and their families might not find it appropriate to reference their witchcraft suspicions in the biomedical setting even if they did harbor such feelings. For other women, their "bad luck" was the result of the will of God or Allah and not something within their control and therefore also not something to protest. Explanations about bad luck that draw on fatalistic views of the fetus's death are a common strategy that may serve to preserve women's social status and psychological well-being in light of high rates of reproductive loss.[24]

Instead of thinking it was witchcraft or bad luck, Pendo's husband adamantly insisted that healthy babies do not *just* die. This made him more of a threat to the hospital staff, particularly when combined with the blank partograph, which would not be able to refute any of his claims that the nurses had neglected his wife. He might act on this hunch and initiate some type of investigation or lodge a formal complaint with the medical officer in charge. Pendo's husband's suspicion was not uncommon for patients' families. However, as medical personnel told me, usually families or patients who were more educated or were from the urban district of the region were the ones who tended to harbor these suspicions of misconduct. These parties often had more experience with the hospital setting, health care providers, and expected care trajectories, which helped them spot instances of possible mismanagement.

Several strong fears and social norms acted to prevent many women or their relatives from bringing formal complaints against health care workers even if they were fairly certain something had gone awry during care. Many women told me they were afraid that if they made a complaint about a nurse that nurse would refuse to help them if they ever had to return to the hospital again in the future.[25] Nurses exerted their power over patients or their relatives in this way, often by forcing people to wait for care. Throughout my time in the Rukwa, Singida, and Kigoma regions of Tanzania, I witnessed this play out in health care facilities ranging from village dispensaries to regional hospitals. Though this practice is entirely at odds with the ideals of compassionate care embodied in Florence Nightingale or other paragons of nursing, in the daily reality of the ward, desperate, tired, frustrated nurses with little formal power sometimes exerted the power they did have in this way. On the maternity ward, social sanctions and punishments sometimes resulted in women giving birth unassisted, alone in the midst of a full ward. Nurses did not generally immediately abandon a woman in labor but did so after

proclaiming her to be noncompliant or otherwise difficult, combative, or unsuited to the norms of a biomedical delivery on account of her unruly behavior. The nurse would then move on to other work with other patients. While withdrawing assistance from a woman in labor might appear to contradict professional ethics, the nurses were preserving their capacity for care for more grateful or willing recipients, determining, in the moment, where their care might have the greater impact. Because of the constraints of their work environment, the nurses' actions in these situations conflicted with their own ideals of professional self-presentation but were part of a broader negotiation surrounding effort and effect. If a woman did not engage in the intersubjective care relationship as a compliant recipient, the nurse would move on to another.

THE PARTOGRAPH AND GOOD CARE AS DOCUMENTED CARE

By making Pendo's partograph disappear, the nurses had irrefutably protected themselves from possible disciplinary or legal action, which could not advance without evidence, even if someone should overcome the social reluctance to embarrass, name, or punish. Reluctance to name transgressors was pervasive and often appeared to debilitate the hospital administration's efforts to address subordinates' bad behavior. Indeed, a number of nurse managers told me of their frustration with this practice, saying it made it difficult to improve the quality of services. For example, instead of saying, "Nurse X verbally abused a patient on Saturday, the twenty-third," the nursing patron would tell the maternity ward's nurse in charge, "People are using bad language" and then expect her to prevent her staff from committing the same sin again. In the meeting about Pendo's case, however, Dr. Joseph insisted directly that the nurses produce the partograph from wherever it had been hidden. The nurses who had been on the morning shift told him they had not seen the original partograph since Pendo had gone for surgery. More agitated and impatient, Dr. Joseph said, "Now, there, we are being destructive. Now, bring it, let us see it. Here we are not talking about it to argue. . . . But I remember [what happened], even if you all have hidden it. Me, I have to tell you, you all should know that, for this, I am not happy at all." The meeting continued and the issue of the partograph emerged again and again, deployed in order to question the nurses' practices during shift changes. During these times the nurses were supposed to give complete reports on each patient, and then the nurses on the incoming shift were responsible for the continued monitoring of the women, including vital signs (pulse, respiratory rate, blood pressure, and temperature) and progress of labor as indicated by the fetal heart rate and cervical dilation. Maintaining organized documentation to be handed over to the incoming shift was a key part of interactions between incoming and outgoing shift members.

One of the ward doctors, Dr. Deo, also reminded the nurses, "Then, another thing, the partograph can be a legal thing: that is, actually, if you fill it out it helps you. Now, if you examine the patient and then you haven't filled it out—not documented, not done. This is in the open, therefore, even if you have examined her, [if] the results aren't available, you could start the way [for legal consequences]." The lack of documentation, the missing information on the partograph, was in and of itself evidence of wrongdoing, of treatment and care that did not comply with guidelines and that failed to meet the larger biobureaucratic demands for documentation and data. In a variety of health care settings, health care providers use documentation and ledgers of data as proof for outsiders or internal administrators that women have been receiving care that meets guidelines for best practice. Less formally, these record books sometimes serve as "hedges against any future accusations of corruption and mismanagement,"[26] in much the same role as the partograph when properly filled out. However, in this case, the documentation was missing and could not protect the providers. Both doctors and some of the nurses expressed distress about Pendo's case, saying there had been a clear error in medical judgment that they named as neglect.

Matthew Hull suggests that (bureaucratic) documents are "mechanisms for protecting the integrity of the government" but "are often the means through which it is undermined."[27] In the government hospital maternity ward, in a country with a history of socialist state care, the partograph played a similar role in undermining the Tanzanian government via the hands of nurses and doctors. Various health care providers and experts idealistically conceived of the partograph as a way to protect their integrity because it helped them to make timely and accurate diagnoses of problems. When Dr. Deo referred to the partograph as a legal document that could protect them, he was referring to this component of the technology. However, alternatively, these very documents were also the perfect evidence of wrongdoing, either as left blank or as inappropriately filled in. The partograph then undermined and called into question providers' expertise, communication skills, and decision-making, and, ultimately, public confidence in their services. Documents and documentary practices, such as those surrounding the partograph, sometimes took on a life of their own, "returning in the transitional moment to incriminate their producers," despite providers' other intentions and goals for them.[28]

As policy makers and experts conceived of the partograph, it was meant to be a tool in reducing the incidence of stillbirths and complications for the mother. The partograph invoked the health care providers as allies in this struggle and in the global health goal of reducing numbers of preventable stillbirths, holding providers accountable for providing good care that would reduce these deaths. Data on intrapartum stillbirths, or a *documented* reduction in them, then worked to help states account for health care policies that conformed to global initiatives, such as the Millennium Development Goals. The partograph was a technology

that monitored bodies, but it could also be problematic if a woman's body and labor did not follow the prescribed pathway of birth. Her body could be difficult to interpret and plot on the partograph if she gave birth extremely quickly or if her labor became delayed in some way, thereby complicating understandings of who was skilled enough to be in charge of these deceptively simple pieces of paper as technology—as in the case of new nurses or students.

Sometimes the doctors and nurses created and recreated new realities by plotting and replotting a woman's labor on the partograph. Because of poor communication and differing levels of provider expertise on the maternity ward, the partograph created uncertainty. Most often, if a woman was progressing slowly in labor, the providers immediately suggested that the first person who had examined the mother upon admitting her to the hospital had measured her cervical dilation inaccurately, overestimating how many centimeters she had reached. Therefore, that person had started the partograph too early. This uncertainty about the expertise of the examiner undermined some of the power of this simple tool. In other situations, the nurses used the partograph to try to make bids for the doctor's attention, to protect themselves from a physician's lack of cooperation or judgment, or to conceal wrongdoing and neglect. The partograph was a physical reminder, in black and white, of when care did not go as imagined or desired, resulting in the death of babies. As they acted on the partograph, the nurses in particular but, also the doctors, worked within messy, thick ethical spaces to produce, call down, and recreate different types of care at different times depending on whose well-being was most at stake in the moment—either that of the mother/baby or that of health care worker colleagues. Nurses engaged in the unethical and deceptive destruction of incriminating partographs in order to engage in ethical care of their colleagues and themselves, even as this form of care foreclosed other care for the woman and her family who had lost their child. It became ethically more important for the workers on the ward to protect each other, in order to maintain their social order, than to preserve a record of mismanagement that could provide a family with answers.

Pendo's case is a representative example of what thousands of women in the Rukwa region, and Tanzania more generally, underwent on a regular basis. In the next chapter, I continue Pendo's story to analyze how the providers attempted to create accountability in the absence of easy-to-use formal accountability procedures when they knew care had gone wrong. With the proliferation of bureaucracy and surveillance comes a concomitant proliferation of care. However, this prolific new care often goes unseen or unaccounted for in this surveilling bureaucracy because it is care *for* health care workers *by* health care workers and not just care for their patients; that is, it is the *wrong* kind of care for the public health practitioners and policy makers working on improving maternal health and intrapartum care. Therefore, when the partograph works to calculate or demonstrate care given,

it is always and only the care given to women as patients that the auditors are interested in and to which they are attuned. What eludes their gaze is the care that has proliferated in the interstices and boundary lands, the ways in which nurses and doctors care for each other by protecting their professional reputations and by undergirding their colleagues' performances of clinical caring through records on bureaucratic documents.