

Already Dead

In general, the proceedings and outcomes of the maternal death audits were never available to the maternity ward staff members, other than those who had actually been present during the meeting. From seeing how the nurses had reacted to Paulina's death, I knew they sometimes were deeply affected by the deaths on their ward. But particularly against the background of my conversations about using hospital data *in the hospital* and the low involvement of the ward nurses in the audit meetings, I was curious how many of them knew the extent of the maternal mortality problem at the hospital. Did they realize that the hospital's maternal mortality ratio (MMR) had been increasing in the past several years? I also wanted to know how the nurses coped with the deaths on the ward because Paulina's death was the only time I ever saw them openly express any shock or dismay; surely, the nurses felt the effects of other deaths too. So, near the end of my fieldwork, I specifically asked the nurses what they knew about the number and causes of maternal deaths on the ward in 2014. All responded with very vague comments, indicating a lack of access to this information. Nurse Halima reasoned:

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

Halima reflected more than some of the other nurses on the reasons why she did not have access to more information about the number of deaths that occurred on the ward, but her answer is representative. Throughout my one-on-one interviews with the nurses, they repeatedly told me that they did not have a good concept of

how many deaths had occurred overall because they had not tried to follow up. Most of the nurses were unaware of the number of deaths that had occurred, but because they had been working on the ward during only a couple of the deaths that had transpired, they felt it to be a small number. When I told them the actual number of women who had died at the hospital of pregnancy-related causes in 2014, most of the nurses were surprised and felt that the number seemed high. One responded by telling me, “Hmm, that’s a lot. It shows there is still some *uzembe* [laziness] that is continuing.”

In the first five months of 2015, significantly fewer women were dying than during the same period in 2014. However, no one was able to say if they thought there was a particular reason for this decline in deaths on the ward. When I went to the hospital for the night shift, one day in May, to interview Nurse Neema, we started discussing the number of deaths that occurred. Curious, I asked her, “How do you see the number of deaths?” Barely pausing to think, Neema responded, “Last year we had about five deaths of mothers.” I looked at her and said, in a level tone, “You think it is only five? Here, together with the gynecology ward, it was close to thirty.” Neema, taken aback, said, “Eh?! Well, that’s really a lot if it’s for a whole year. I think I have remembered five because those were the ones discussed in the meeting in February, and that also is a challenge that when they do a maternal auditing, staff from the maternity ward never participate the way it’s supposed to happen. You find maybe only the in charge and two nurses. Therefore, we are lacking accurate data. But also feedback about why the deaths took place. But for this month I remember it is two, again they died in the following way: there’s one who died with her baby inside, another was PPH [postpartum hemorrhage], it was in the beginning of April. I don’t know before that.”

Neema was able to remember the deaths for which she had been present or that she had more recently thought she’d heard about during a meeting. However, most of the ward staff members had no concept of how many women were actually dying every year or the causes of the deaths and how they could be prevented. This gap in communication or lack of reporting back to the ward rank and file after a maternal death audit meeting not only was frustrating to the ward staff but also shut them out, as the staff who were in the closest proximity to patients, from answers about the causes of deaths so that they could try to prevent similar deaths in the future. Ironically, in the age of metrics and the global emphasis on measuring maternal deaths, some of the people most involved—and implicated in them—never saw the data. The nurses on the ward could have benefited greatly from the audit meeting discussions of what had led to the women’s deaths. They could have learned more about their own practices, the challenges the clinicians faced, and the community- or family-level events that had contributed to each death. Instead, this lack of communication of data pointedly demonstrated that these data were not for the people involved, the ones in the trenches, but for higher levels, for bureaucrats and policy makers.

COPING WITH MATERNAL DEATHS THROUGH NARRATIVE

In the aftermath of a maternal death at the hospital, before the audit meeting ever took place, nurses and doctors worked to cope with a pregnant woman's death. In this context, I repeatedly heard the narrative that the majority of the women who died were coming in "already dead." This discourse included more cases than those in the last chapter, in which the details of women's arrivals and deaths were lost because the women were, literally, dead on arrival or shortly thereafter. Instead, it came to encompass many, many deaths in which the nurses felt they had been unable to save a woman because of her life experiences and decisions preceding her arrival at the hospital. What follows in this chapter is a discussion of this narrative as a coping mechanism for the nurses and a form of care for themselves. Examining these underlying narrative structures can help us see more clearly the underlying "imprint of institutionalized practices and ideologies."¹ "Narratives shape action just as actions shape the stories told about them"; stories also "suggest the course of future actions."² The narratives we construct about maternal deaths operate and perform on a variety of levels, including the interpersonal, the institutional, the regional, the national, and the global. Additionally, the nurses' narratives help to reveal their ethical deliberations and how they engaged with the memories of dead women to guide their ethics of care moving forward.

It was late April 2015, and Nurse Peninah and I sat in the HIV testing and counseling room in the maternity ward, the red light on the voice recorder blinking as Peninah paused for a moment. The recorder started again as she began talking and flatly stated, "Let's say, for this year maybe, since we have started in January, we have had only two deaths. And a lot of them that happen aren't *of here*. You find there are referrals, they come from far away, and they come here and they do what? They die."

Several nurses repeatedly told me they thought the women who died primarily came from far-off villages and arrived in such a poor state that their deaths were attributable, not so much to the hospital or the ward, as to the community or family from which they came. Out of curiosity, in May 2015, after hearing this narrative arise in many of my interviews with nurses, I went back to the records of all the deaths that had occurred in 2014 and 2015 to see from which districts or villages the women had come. The fact of the matter was that the vast majority of the deaths were of women who had listed their home residence as a location within the urban district, immediately surrounding the hospital. Fully half of the deaths, seventeen of thirty-four on which I had data, were of women who came from within the urban district; 23 percent were from Sumbawanga DC (aka Sumbawanga Rural) District, 24 percent from Kalambo District, and just 3 percent, or one woman, from the furthest-away district, Nkasi (map 2). This means that transportation and bad roads, long distances, and poor access to facilities were not

the primary causes of many of these women's deaths. Often other delays slowed a woman's arrival at the regional hospital, but the truth was that these women were not coming from the far reaches of the region; they were from the hospital's own backyard. Likewise, data from their medical records indicate that even the women coming from the urban district did not arrive "already dead." The median length of stay was between one and two days, accounting for about a third of these seventeen women. Four of them were at the hospital for five or more days before they died, and only two were at the hospital for less than four hours before a physician pronounced them dead. Some cases were of women who had traveled long distances to arrive at the hospital, but these were rarer.

There are a number of ways to read the assertion that women came "already dead": (1) the nurses actually believed this to be true; (2) in reframing deaths as women who were unable to be saved by the time they arrived, the nurses effectively divested themselves of responsibility; and (3) the nurses used this discourse as a way to alleviate the personal emotional burden that was the result of being unable to prevent women's deaths because of systemic constraints, lack of resources, and lack of support.

Nurse Rukia went into greater depth than Peninah, insisting that these deaths came from afar, often as referral cases from outlying communities:

The number of pregnant mothers who are dying, it's decreasing. If you compare with the past, it's decreasing. Another time we, we get deaths, patients are brought, they're not from inside here. Eh. She comes that way in critical condition, you'll do top to bottom but you can't do anything. . . . [Deaths] come from the villages, honestly. Those people in the villages, many times they always have the habit of always delivering them there, at the traditional midwives' [*wakunga wa jadi*], they deliver them there, if they deliver they see that they have been defeated. . . . I mean, they are there, it's too late. . . . A lot of times, we get cases like that.

I prompted her further: "Okay, even if we say the number is decreasing, why do you think women and babies are still dying here, inside the hospital?" Rukia said, "The reason is just that. People come in late condition. Mhm. That is, pregnant women come in very bad condition. Eh. People die. Maybe another thing, maybe another time she has come with a severe infection, you can use an antibiotic and whatnot, but it's not possible because she is in the severe [stages] of the disease. You see, yes? They die." Throughout the conversation, Rukia resolutely denied the idea that women died because of the care being offered on the maternity ward. Instead, she blamed *wakunga wa jadi*, local midwives with little to no formal training, whom she accused of essentially forcing women to give birth at home. Informally trained women working as midwives have long been scapegoats and the targets of biomedicine's efforts to establish obstetrics as a legitimate realm of practice.³ This was historically the case even in the United States but is an ongoing conflict in many, particularly low-income, settings throughout the world, not just

Tanzania. These generalized women, portrayed as victims of the local midwives' coercion, fit nicely within WHO's messaging and images from the start of the Safe Motherhood Initiative, in which a nonspecific "everywoman," Mrs. X, was already on the "road to death" because of poverty, gender inequality, and dangerous "cultural practices."⁴

There were, without a doubt, times when women arrived in very poor condition due to long delays seeking help, finding transportation, or being referred to the regional hospital. However, many times these deaths were not even counted in the number the hospital recorded, as explained in the previous chapter. Therefore, the nearly thirty deaths I was mentioning to the nurses did not include those of these other women whose deaths had not been recorded at the hospital. Undeniably, the narrative itself of these women coming "already" dead, as well as the almost dead, continued to do cognitive, emotional, and ethical work for the nurses.

Some other nurses, like Nurse Halima, were much quicker to admit to serious delays or a lack of emergency care at the hospital. When I asked nurses in this group what the hospital would need to continue reducing the number of maternal deaths, they focused on concrete suggestions. In their accounts, the locus of control was very much within the hospital itself, though not often actually centered on the staff of the maternity ward. Their responses tended to focus on supplies and medications, or in the case of Halima's response, the need for better triage at the OPD because the hospital lacked an emergency department.

Halima described her process of acclimating to the maternity ward and how she had learned more about how deaths were occurring once she was assigned to work on maternity. Halima said that before she worked on maternity and heard reports of deaths "I was feeling really sad. Fine, after that, I was moved here to maternity. [I] came to see, to discover more. The deaths that happen, here, here at this regional hospital are few, I mean those that are caused [by things] here, and they die here. And those, those that occur, I'm always sad, but many of the deaths, really, they come from the villages. Now, there in the villages, *I don't have the ability to do anything*, to go and do what? I don't have anything I can do" (emphasis added). She remained pragmatic about the situation, framing the deaths of the women coming in poor condition from the village as those over which she had no control and, therefore, she tended to not feel quite as bad when confronted with one of those deaths. Halima's explanation suggests that, in addition to removing the locus of institutional control and responsibility from the regional hospital, the nurses might have been using this narrative of "already dead" women to help lessen the more personal burden of these deaths. The fact that no one at the hospital made data available to the ward staff or reported on the quarterly or yearly number of deaths in a venue that was open to all staff members allowed this narrative to continue in the maternity ward. The narrative made it easier for the maternity ward staff to remove themselves from accountability for the deaths that occurred and simply to continue to hold the districts, or individual women and

their families, responsible for the woman's death. "Almost dead" women were also in this category, their trajectories before reaching the hospital predisposing them to death for which the nurses would not be responsible. While knowing more might have helped the nurses to understand the extent of the problem within their own facility, the lack of knowledge played an incredibly important role that facilitated the nurses' ability to continue working each day without being continually traumatized by these deaths. This complicated everyday ethical trade-off between knowing more to be able to (in theory) improve care and continuing to see deaths as predetermined in order to resist responsibility and lessen emotional burdens should not be underestimated. Deftly avoiding self-blame by not closely examining this narrative was a form of self-care and even care for shift-mates, that helped nurses continue working and providing care to all the women who did not end up dying. At the same time, the narrative perpetuated deaths by creating the cognitive space to not confront individual actions, ward or hospital responsibility. This narrative was yet another way in which the system protected itself and its inertia, resisting efforts at change to improve care.

SELF-REFLECTION AND REMEMBERING

In addition to talking about women as arriving at the hospital already dead, the nurses deployed other coping mechanisms to help themselves deal with the deaths of women under their care. While we were discussing deaths on the ward in the previous year, I asked Nurse Aneth how she felt about them. She explained:

Of course, I can't feel good. It's a death that, okay, she died, and other people, on other wards, they died. Fine. But that death [of a pregnant mother] is one which is somehow exceptional, because if you tell me a man on [male medical] died, a woman on [female medical] died, obviously they came and they were sick, indeed that's the reason they came to the point of being admitted. But pregnancy is not a sickness. Pregnancy is not an illness. We usually depend on the fact that this mother comes when she's pregnant, she gets her baby, and she returns home. . . . Therefore, it's—of course, I always feel bad. It's not nice. . . . You really think about a lot of things. You will think this, you'll think this, you'll think this. But enough, it has happened.

When I had first arrived on the maternity ward in February 2014, there was a spate of deaths that month. I felt as though I could barely process one death before another woman died. I was still trying to gather the information to reconstruct the trajectory of the first woman's demise when another woman would arrive and subsequently die. It seemed like a flood. However, the nurses only once ever publicly showed that they too were moved by the number of deaths on the ward and in fact sometimes deeply so. From my outsider's perspective, it more often appeared as though the nurses were barely touched by the deaths of women and even less so by the daily deaths of neonates. Aneth's description of the thoughts that would swirl

around in her mind after a death proved otherwise and also came to be representative of one of the main coping mechanisms the nurses described to me.

But, before talking about coping, in interviews, the nurses and I discussed why it might look as if, from the outside, the nurses were unaffected by these deaths when, in actuality, they told me they were all pained by the deaths of women on the ward, as well as the deaths of the babies. Nurse Sokota, who always had a no-nonsense demeanor, told me, "A nurse shouldn't, you know, shouldn't be really sad, to the point that . . . it's not that . . . maybe you're not hurt. Really, you're hurting. I don't show a lot . . . [because] the women will say the nurse has started to cry tears on the ward, now you, you're not a nurse. You see?" While several of the nurses told me that sympathy and empathy were important, they emphasized how letting the women see them struggling with the pain of a death could undermine their professionalism and be demoralizing to the women.

Crying in front of patients could also close the distance between the women and their providers, an undesirable outcome that could, in future encounters, undermine the nurse's authority in the ward setting. While it may have appeared that the nurses were not compassionate, their accounts reveal that they were, in fact, engaging in difficult emotion work to suppress their sadness or personal distress in order to inspire patients' confidence in their technical nursing care by appearing stoic and businesslike; emotion work itself became an act of affective caring.

In thinking about care, if we separate technical care from the affective care work done by nurses and other health care providers, we do a disservice to them. Likewise, this separation collapses some of the complexity of working in a busy, underresourced maternity ward. The interconnectedness of these two elements profoundly challenges providers' decision-making when they encounter ethically difficult or morally uncertain situations. Overlooking this interconnection reduces our understanding of how they arrive in the domain of everyday ethics. In the aftermath of deaths, the nurses may not have adopted the affect some patients or onlookers would have expected or desired. But they were engaged in a different, locally and professionally appropriate form of affective care work shaped by their everyday ethics.

Nurse Peninah confirmed Sokota's thoughts about a nurse's appropriate emotional expression, elaborating:

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

Instead, the nurses saved the outward manifestations of their inner distress for other venues and more domestic, as opposed to professional, spaces.

Just as Aneth mentioned, many of the other nurses explained that the deaths of women on the maternity ward were especially painful because pregnancy was not an illness that ought to lead to death; these deaths were more exceptional and less anticipated. Nurse Happy explained the effect of this on nurses' emotions, as well as how news of these deaths found its way into nurses' domestic spaces, where they might more openly mourn:

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

The deaths also took nurses by surprise because of the sometimes-sudden onset of complications and the woman's rapid demise, which differed from the chronic or slowly progressing conditions of patients on other wards.

While they clearly were affected personally by the deaths of women on the ward, the nurses found it important to maintain their professional comportment in front of the patient or, in the case of her death, in front of her family. The nurses saw their stoicism in the face of a tragedy as part of demonstrating to the patients that they were in control of the situation and that they could be relied on for continuing care. The good nurse suppressed her own feelings and any outward show of them until a more appropriate, private time. Still, Nurse Peninah explained how lingering thoughts about a death could impinge on daily activities, escaping from the neatly stacked mental boxes: "People have become used to it because every day—let's say, what have people gotten used to? That every day you encounter deaths? You see people have died, babies have died, but . . . [when] [the nurses] are sitting . . . alone, for example, there in the tea room, they start, 'Why did this baby die? This baby, why did he die?'" Nurses mentioned that this type of reflection on prior deaths most often occurred as they went about their daily activities. Likewise, it could follow them home as they continued to think on the events that had transpired and what they might have done differently. Through conversations, it slowly emerged that this type of reflection was the primary coping mechanism for many of the nurses.

Partly because of my own efforts to process the maternal and perinatal deaths all around me for over a year, in interviews I pointedly asked the nurses how they coped with seeing deaths on their ward or of the women under their care. I asked

them what they did in order to not lose heart, so that they might continue to work with other women in the days, months, and years to come. I also wanted to learn if their experiences with a relatively high number of deaths caused them to ever question their line of work or their desire to continue working in maternity care. Nearly every nurse related at least one instance of a woman for whom she had been caring who had died and whose death had stayed with her.

As we sat together in overstuffed armchairs in her sitting room, while other women quietly passed through the room on bare feet, going into the kitchen or fetching Faraja's daughter, a young and perpetually cheerful Nurse Faraja became thoughtful and began to tell me in vivid detail, "I feel really bad, you can even cry." She said a woman could arrive on the ward in good condition, engaging and talkative, and then "She dies because she doesn't get blood, postpartum hemorrhage [PPH], or her condition just changes, it really hurts a lot." I gently murmured, encouraging Faraja to continue. "I remember there is one day when all the nurses that were on shift, we cried. One mother came, she was in the second stage. She was a grown woman, healthy. So, anyway, she was delivered, she pushed out the baby. I mean, in the act of just pushing the baby, she straightened out right there and died. And she had come talking a lot and, really, we remained there asking ourselves, 'What was this thing?'"

As we continued to talk, Faraja told me of a second woman whose death was not easy to forget. Faraja had herself given birth to her daughter around Easter in 2014. Faraja recounted the case of another mother whose child was nearly the same age now as her own: "It was her first pregnancy, she had come and stayed two days on the ward. The third day her contractions increased, and she gave birth to a baby girl who weighed 3.5 kilograms. After that, we were talking with her like normal. Now she got PPH, yeah, and there was no blood in the blood bank, no relatives [to donate]. Well, we were talking with her, and then she said, 'Nurse, I'm feeling tired.' She had been sitting drinking tea, so I told her to lie down. I say! That lying down, it was silence right away." Faraja paused to shake her head and, looking into the distance, past the softly waving curtain at the open front door, finished with "It hurt us so much and her baby was crying so much, like she knew her mother had died. So that was last year in March. Her baby is still there, she's called Enjoy and now she's learning how to walk." Unlike the deaths of women after a slower decline or after showing outward signs of chronic conditions, such as advanced AIDS, these deaths that stuck with Faraja were of women who had suddenly collapsed and rapidly descended into death, without time to help them.

In response to my question about how the nurses were able to return to work day after day when they faced these deaths, Nurse Rachel described how she had been the only experienced maternity nurse, assigned to night duty with several new graduates who had not yet learned to deal with obstetric complications. After stating that she always felt bad when she heard of a maternal death on the ward because of her own experience failing to save a woman, she began to tell me what

had happened. She described the never-ending night shift, saying, “Honestly, I struggled with that mother from admission until she passed away, and it was during my shift [that she died]. Honestly, I lost the desire to work. I felt totally like I couldn’t do work after that mother died. Then she died around the time of midnight, so I felt the work was really hard until it came to be 6:30 a.m. [end of night shift].” Sometimes even a nurse’s commitment to professional comportment was barely enough to carry her through a shift; the case would follow her home, with the details swirling in her head as she second-guessed herself and all others involved. Nurse Rachel suggested that she might lose the motivation to work because she was preoccupied with the details of what had gone wrong, emotionally frustrated by the lack of information she had and the lack of ability to more effectively aid the woman and to save her life.

In their explanations, it is clear that these cases often stayed with the nurses and caused them to ruminate on the details of the woman’s care and illness or the events leading up to her death. Many nurses explained that this was their coping mechanism for coming to terms with the deaths of women. The nurses consistently worked in this same environment that hobbled along as best it could. Most women, who did not have any complications, were able to give birth and leave the hospital without any adverse events; they received care that was *good enough*, and the system operated similarly. However, the cases of complex problems or emergencies exposed the ever-present fault lines and weaknesses of the maternity ward and resulted in deaths.

TO FOLLOW UP

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

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

One important linguistic note: in many of the original transcripts the nurses used the word *imeshindikana*, which I have translated as “it was not possible.” However, this translation does not effectively capture the nuance and the sense

of the original Swahili. In the original Swahili construction, the sentence does not indicate a subject or responsible entity. This is perhaps indicative of another move on the nurses' part to remove the locus of control from themselves and onto some external entity, be it chance, bad luck, the will of God, or some other force. I prefer to think that this turn of phrase reflects the general state of the system. In some of these narratives, it was not something such as luck that prevented the woman's life from being saved but instead the broken health care system itself that impeded her treatment and possible recovery, together with the bureaucratic, underresourced environment of the hospital. Rachel specifically mentioned that the poor availability of supplies had caused her to be unable to resuscitate the woman on her deathbed.⁵

Nurse Aneth, when talking about the deaths of babies, started by saying, "Mm, well here, really the thing to do is—you know, a lot of people, these questions that you're asking me, I don't think that my colleagues, how they answered you but I think a lot maybe have answered you theoretically. She just thinks, 'I can do—I can do—' but that thing, has she ever done it even once? The thing that you do, first, you follow up." She went on to give me an example of what she would do to try to make sure a woman got some answers about why her baby had died in utero, including suggesting testing for the woman and her partner. This explanation about following up was nearly universal for the nurses with whom I discussed this topic. Problematically, because most of the nurses were not included in the maternal death audit meetings, most often they did not even have the opportunity to go over the case of a woman's death with the physicians or their fellow nurses to compare their interpretations of the problems.

ACCESS TO INFORMATION

While the nurses were left ruminating on the deaths to which they may or may not have contributed, the physicians and administrators were holding maternal death audits every seven or eight months, including only a couple of nurses from the ward, and not returning a report of the results of the audit to the full ward staff. In the absence of answers or other mechanisms for discussing or debriefing cases of deaths, the nurses almost universally told me that their coping strategy was to go over the details of the cases alone, in their heads. In this context of little to no information about the details of women's cases or the results of the maternal audit meetings' analysis of these cases, it is easy to imagine how nurses could become demoralized and lose motivation as they continued to encounter the deaths of women and babies on a regular basis. Without the necessary information to confirm the ideas they had worked out in their mental walkthroughs of the cases, they were less able to act on their ideas for improving outcomes in similar cases, even if they had come up with practical and concrete ways to do so. Alternatively, without confirmation of their own culpability that might have been a result of the maternal

death audit meeting discussions, the nurses may also have personally benefited from their lack of inclusion and information.

The poor communication back to the rank and file on the maternity ward after these audit meetings was another way in which the institutional environment of the hospital inhibited efforts to improve care and prevent maternal deaths. Nurses did not change their behaviors because the administration did not empower them with the necessary information to affirm their individual analyses of the problems that led to women's deaths, nor did the institution support single-handed efforts to change routinized practices, even those the hospital identified as inhibiting better care. The lack of communication in these cases also supports the idea that the hospital and regional health leaders were primarily using the maternal death audit meetings to fulfill biobureaucratic requirements and that they considered the purpose fulfilled when the paperwork was complete. This perspective created no expectation for actions beyond the bounds of the paperwork, which was why the information stopped at the administrative level. These results of the audit meetings were yet another example of how top-down, technical approaches to solving complex health service challenges were ineffective in this setting. Overall, the nurses expressed frustration with their lack of information, not just about maternal deaths, but also about institutional goals and policies of the hospital.

CARING FOR THE CARERS

In a meeting on respectful maternity care held in Dar es Salaam in July 2015, one of the presenters, Dr. Brenda D'Mello, talked about "caring for the carer." In a large hospital in Dar es Salaam, on the other side of the country from Mawingu Regional Hospital, she had been working to implement a program for the nurses on maternity to be able to discuss cases and express concerns, frustrations, and challenges within their environment, emphasizing "no shame, no blame, no name." Giving the nurses a formal mechanism for voicing their struggles with grief due to encountering deaths or due to working in high-pressure/high-volume work environments was one way in which Dr. D'Mello and her teams had been trying to grow hospital staff support programs. At Mawingu, as of the end of 2015, there were no such support mechanisms for the nurses and physicians working on the maternity ward. In the absence of formal avenues for coping with the stress of seeing women and babies die on a regular basis, combined with the under-resourced work environment and an overall poorly functioning health care system, the nurses often comforted themselves through narratives of hopeless cases, women arriving "already dead" from far-off villages. They comforted themselves by repeatedly examining the trajectory of a woman's care and subsequent death in the hospital, turning to narrative as a way of creating order and understanding around these tragic experiences.

It was not as though the hospital had to choose between either fulfilling bureaucratic reporting requirements *or* providing information to and supporting its nurses. But in the hospital-as-institution's everyday ethical calculations, as engaged in by its administrators, there were greater incentives for filling out the paperwork, or rather, there were greater disincentives for *not* fulfilling those duties. Consequently, the nurses' needs dropped out of sight. The hospital missed an opportunity to care for its employees as they continued to confront the deaths of both women and babies. The administrators could have improved communication to provide the nurses with reassurance that a death was not a direct result of their care or confirmed the nurses' individual assessments and responsibility regarding what had gone wrong. While the nurses sought to do what they could in the event of an obstetric emergency, the institutional forms of care—supplies, supportive supervision and mentoring, protective equipment, timely and responsive communication—all continued to be lacking, further demoralizing and demotivating the nurses, who were left with narrative as their primary coping mechanism.

BEYOND THE HOSPITAL WALLS

If the nurses had little control over what happened within their own ward and hospital, then what transpired in women's lives outside the hospital was entirely outside their sphere of influence. Yet, it always affected the nurses' work. When I made my first visit to Mawingu in 2012, it had not been my intention to study maternal mortality, and it had certainly not been the focus of my early pilot study the following year. However, in 2013 I came to fully realize it was the nurses and doctors who seemed to have stories they wanted and needed to tell. These stories were largely about their work environment, about the difficulties of working in a forgotten and long-ignored region, and about the inequities their patients struggled against on a daily basis. The stories were also about their own professional goals, aspirations, and ethical commitments. I was fortunate to find open-minded doctors and administrators who, instead of being threatened by my subsequent suggestions to research maternal death in their setting, saw in this research an opportunity to learn more about their own practices and improve care. The nurses, lower down the hierarchy, had had no similar say in granting me permission to conduct research on their ward and in their working lives. Instead, they initially accepted, in some cases begrudgingly, my presence as an imposition placed on them from the top.

My first days back on the ward in early 2014 included many conversations in which I tried to introduce my research while maintaining a neutral tone, emphasizing that I was not there to blame people or attempt to hold them in some way accountable for the deaths that continued to occur. I repeatedly told anyone who would listen that I was going to spend time at the hospital but also planned to go

to villages to speak to women, community leaders, and rural health care workers. Some nurses gave satisfied nods upon hearing this part of the explanation, convinced that that was where I would find my answers. I still, more than five years later, distinctly remember Nurse Peninah bristling as I scuttled behind her on the ward, answering her demanding questions while she went about her work. She grumpily said, “You know, most of the problems are because those mothers, they stay there with the *mkunga wa jadi* [traditional birth attendant] there at home for a long time. They delay there at home until there is a big problem, and then, then they come here. They come with impending rupture of the uterus. You see, a large number of them, they die because of ruptured uterus.” I nodded, not wanting to disagree but also not knowing if what she said was accurate, new as I was. She continued in the same accusatory tone, “If you say that it’s mismanagement that is causing maternal deaths, *siwezi kukubali*, I can’t agree!” I hurriedly spluttered, “No, no! That’s why I am also going to villages, to talk to those *wakunga wa jadi* and to those working in the dispensaries and health centers, because they first see those women who are coming from home with problems!” Somewhat placated, she said, “Okay, then you will get good data.”

Similarly, when I was applying for grants to fund this research, some reviewers and granting agencies suggested I needed to do more work in the community, focusing less on hospitals because these institutions were unlikely to be the main contributors to these maternal deaths. Truly, women’s lives beyond the hospital walls deeply and indelibly influence their likelihood of survival during an obstetric emergency.⁶ But it is also true that these same obstetric emergencies revealed the always-and-already present weaknesses in a biomedical system of care that was continually a bricolage. The ragged edges were hidden from sight for most women and their families because most births went smoothly. However, when a problem arose, it was easy to see the many pitfalls in the path to good health that threatened to swallow a woman whole.

Women’s lives outside the hospital could either help them bridge the threatening gaps in the system or work synergistically with systemic scarcity to hasten their descent into death once they had arrived at the hospital. Early in my fieldwork, my good friend Japhet and I sat on the tiled steps of my newly rented little house in Sumbawanga Town. He charged me with an important task: “You will have to look, I know it will be the poor women and the ones from the village who will be dying the most. I’m sure of it,” he said. A month or so later, I held a group discussion with women who attended the church Japhet and his family also frequented. I had only a few questions, and as the rain pelted down on the metal roof, threatening to drown out the voices of the women huddled together in the narrow seats of children’s school benches, I listened to what they thought could cause a woman to die. I asked the women to each make a list, and one of the most commonly cited causes was “*Manesi kuangalia hali ya mtu mwenye pesa*,” the nurses look at the condition of people with money. Time and again, women were convinced that if they did not

look as if they had money or did not know someone who worked at the hospital, the nurses would ignore them or forget them, a situation possibly leading to their death. In 2019 interviews with two of my longtime friends, both told of how they would have received worse treatment, or none at all, had they not had connections to hospital staff members.

In pointing to nurses' evaluations of patients based on perceived wealth or personal connections, the women were invoking the concept of stratified reproduction. Shellee Colen defines this concept: "Physical and social reproductive tasks are accomplished differentially according to inequalities that are based on hierarchies of class, race, ethnicity, gender, place in a global economy, and migration status and that are structured by social, economic, and political forces."⁷ Colen goes on to say that stratified reproduction itself reproduces inequalities and differential access to material and social resources. For women giving birth at Mawingu, their lives before the hospital established these inequalities and converged with the nurses' treatment of them.⁸ Nurses' calculated disbursement of care along perceived class or ethnic group lines, or on the basis of their judgments of who ought to be reproducing (often related to age and/or marital status and number of previous pregnancies), undeniably colored women's experiences of care, even when this differential treatment did not result in death or severe morbidity. Nurses themselves saw their employment status at the health facility as an important source of capital that, while not monetary, nevertheless enriched their kin and strengthened the nurse's position in her family and community. Surely, the nurses would argue that they did not favor some patients over others, but I saw this differential treatment many times, including abrupt changes in behavior as nurses finished with a woman who had arrived from a village and turned to assist a fellow nurse's relative. The difference in expressed compassion and level of cordiality was like night and day.

In the end, my research assistant, Rebeca, and I spent three months traveling to eleven different, randomly selected communities throughout the region in order to hear from women, their husbands, their community leaders, and their village health care workers. From nearly one hundred hours of conversations with hundreds of participants, the road to death for pregnant women in Rukwa began to become clear. To be sure, some women faced nearly insurmountable difficulties in obtaining transportation to health facilities or faced other delays in reaching care, so that they indeed arrived nearly dead. Others arrived early but uncertainly, scarred by previous bad interactions with the biomedical system and lacking the confidence to speak up about their needs.

Clearly, women did not arrive at Mawingu in a vacuum. Instead, before their arrival, they might have already been subjected to a number of factors that could predispose them to poor health and biomedical risk during pregnancy and the postpartum. Starting from a young age, girls might not have had equal access to education, might be married or might have gotten pregnant at a young age in

order to meet the financial needs of their families (through bridewealth payments) or because they lacked other activities to fill their time, bore the largest burden of work in the family, and might not be involved in family decision making, in addition to sometimes being victims of intimate partner violence. The next chapter follows women's journeys in their communities as they grow, enter into marriage, become pregnant, and navigate their options for care. Their logics of risk and care drew on an ethics of interdependence and reciprocal care often unfulfilled in biomedical spaces.

The public health literature often attributes indirect causes of maternal death, as one article from 1985 states, "to the patient, the environment, cultural beliefs or to defects in the health services."^{9,10} Within public health, the three-delays model continues to structure analyses of maternal death. This model cites three types of potential delays for receiving care during an obstetric emergency: (1) delay in deciding to seek appropriate medical help for an obstetric emergency; (2) delay in reaching an appropriate obstetric facility; and (3) delay in receiving adequate care once at a facility.¹¹ This model provided an underlying logic for clinicians, policy makers, and public health practitioners and continued to influence discussions of maternal mortality in Rukwa. Its pervasive influence was particularly apparent in discussions during maternal death audit meetings when providers had to decide when delays had occurred, with blanks on the form for each of Thaddeus and Maine's three delays. Both the broader public health literature and the health care workers with whom I worked often blamed women's decisions to seek care from a local midwife or other indigenous healing expert for delays in reaching biomedical health care services when an obstetric emergency was underway.

But the three-delays model significantly flattens women's experiences, disallowing many other variations and all the intermediate steps at which delays often occur, as well as nearly all the socioeconomic and structural factors that have shaped her life before and during her pregnancy. The model also does not incorporate any discussion of when or why a woman might *choose* to avoid a biomedical facility, assuming only that every woman would be best served if she could make it to a facility soon enough. While the regional hospital employees and administrators often appeared keen to concentrate on improving those items over which they had immediate control, they did acknowledge that many circumstances of a woman's life could predispose her to delays in seeking care or even reduce the likelihood that her body would be able to hold out against an obstetric emergency long enough for her to get effective treatment and recover. If a woman did not choose to immediately report to a biomedical facility, the health care providers and administrators often attributed this to ignorance, backward beliefs, or some other failing on the part of the woman and/or her family. What the audit meetings rarely discussed were women's previous interactions with biomedical care and how these might have convinced them to avoid their local facilities.

When women were able to access care in biomedical facilities, there was the potential for numerous other conflicts between local and global maternal health logics. Understaffed dispensaries, with providers concerned with sustaining their own families on low salaries and working in remote areas with little support, often led to poor quality of care and interactions in the care setting that left much to be desired. It is no surprise, then, that many women with economic means and the money for transportation sought to bypass their village facilities, or even the district hospitals, in favor of Mawingu Regional Hospital. In other cases, repeated encounters with poorly stocked facilities led women and their family members to suspect providers of corruption and extortion.

Against a background of complicated care pathways, poor infrastructure, lack of transparency, and corruption or negligence, which I discuss further in the next chapter, it may seem harder, at first glance, to discredit the nurses' narratives of women arriving at the regional hospital on the verge of death. However, the story is not this straightforward. This line of thinking has led to an anthropological research focus on communities and women's experiences in order to understand maternal death. In contrast, the nurses themselves, in their accounts of how they went over the details of cases in which a mother died on their shift, described how the hospital environment, interactions with other providers, and their own actions could contribute to a woman's death. Even in cases in which they were uncertain about the ultimate cause of a death, the nurses repeatedly searched for points of weakness, breakdowns in care within their own environment, not out in remote villages. However, when confronted with official prompts for auditing and accountability, the nurses and doctors preferred to fulfill bureaucratic requirements without drawing too much attention to their own culpability. In this way, they quietly resisted the new subject formation and self-disciplining that these global systems of auditing would require. In the more informal, private spaces of hospital break rooms, homes, or the corners of their own minds, the nurses and doctors searched, combing through their own (in)actions in search of causes of death.

Engaged in a personal ethic of care that accorded the nurse-patient relationship a quasi-sacred status, many of the nurses found it deeply disturbing when those in their care died. They held themselves accountable through their ruminations and lingering doubts about causes of death. The health care workers created yet another informal system of accountability that adhered to their morals and personal ethics of care and demanded answers about the deaths they witnessed. But when presented with formal modes of accountability, the health care workers often protected their own instead of "telling the truth" to its full extent on forms. These actions too were part of this local ethic of care, deeply shaped and patterned on existing social norms in Rukwa, and in Tanzania more generally. In the absence of other information, nurses formed and re-formed hypotheses and trajectories, hoping to create a better outcome in the future. Ultimately, self-preservation and

the need to work another day to provide for themselves and care for their families, as well as for future pregnant women, led many of the nurses to quietly avoid engagement in meetings or audits that would name themselves or their colleagues as responsible parties in a woman's death. Instead, they bore these deaths as integral, but concealed, parts of their nursing identity. The official records kept at the hospital for years or sent on to the regional and national level condensed the high-stakes events upon which the nurses ruminated long after the fact. Incapable of containing and accurately representing the unknowns, uncertainty, messiness, concealments, fears, and hopes of a woman's care trajectory, the simplified story documented on forms and in files turned truncated representations of life into objective facts.¹² In the process, other true causes and contributors to maternal death in the hospital were allowed to remain hidden, just out of sight, beyond the bounds of official knowledge and fact.