EPILOGUE

I sat in the hall at the hospital where we normally had the morning clinical meeting. It had been transformed into a festive venue for the evening in celebration of International Nurses Day, May 12, Florence Nightingale's birthday. Brightly colored bunting and rows of plastic chairs faced the head table, which was covered with various beverages in glass bottles. In the midst of the din from the enormous speakers, I looked around at the hospital staff members, everyone dressed up in evening finery, patterns and colors filling the room. With less than a month left at Mawingu, I began to feel as if I was disembedding from the maternity ward and the hospital. I looked around at the nurses and doctors, part of the group so often demonized in the popular press in Tanzania or written about as the opposition in women's stories of interactions and experiences during pregnancy and childbirth. Through their stories, and from working alongside them, I had started to think of them more as antiheroes of a sort—unkind at times, yes; selfish, surely, as are we all. But also as possessing the strength, tenacity, resilience, and ingenuity that kept a system moving along.

The hospital staff members were undeniably human, with all the attendant needs, desires, flaws, and aspirations. These needs and desires sometimes came into conflict with their professional mandate to care and their personal aspirations to do so to the very best of their abilities. At those moments of negotiation between their needs and those of the patients, they entered into complicated, but sometimes instantaneous, calculations of care, which constituted a version of the local ethics of care at play in Mawingu and similar hospitals throughout Tanzania and other low-resource settings. A system constrained by political economic processes with deep roots shaped the health care workers' (in)ability to enact change or provide care that fulfilled the technical and emotional needs of their patients, colleagues, and subordinates all at once. Caught in this system, they worked to provide pregnant women with care that was good enough, while also maintaining some semblance of lives for themselves even as they were entangled in a global complex that expected them to continually implement new policies with little commensurate support.

I am finishing writing this book just three days into 2020, the two-hundredth anniversary of Florence Nightingale's birth and the year that the WHO has declared to be the Year of the Nurse and Midwife. In this, their year, I hope we can remember that nurses and midwives are vital for the success of health care systems the world over. But, too, we must remember that they are people who deserve workplaces that facilitate their full (technical and affective) caring potential and treat them with dignity and respect. Beyond needing their care, the world needs their innovation, resilience, tenacity, creativity, and potential for radical change; these will be some of our most necessary inputs for generating and carrying out plans to accomplish sustainable declines in maternal death.

Though the faults in the health care system in Tanzania are much more visible much more frequently than elsewhere, similar weaknesses in maternity care are present in places all over the world. In May 2017, ProPublica and National Public Radio (NPR) in the United States unveiled an investigative journalism project over a year in the making, a series of pieces that over the ensuing months provided a picture of maternal mortality and severe morbidity in the United States that was shocking to many.[1] The first paragraph of this collaborative project's second article states, "When a new or expectant mother dies, her obituary rarely mentions the circumstances. Her identity is shrouded by medical institutions, regulators and state maternal mortality review committees. Her loved ones mourn her loss in private. The lessons to be learned from her death are often lost as well."[2] While the authors are referring to the United States, the high-income country with the highest maternal mortality ratio, these words could just as easily have come from reporting in Tanzania or from this book.[3] The drivers of increasing maternal deaths in the United States certainly have specific roots, some related to stratified reproduction in a country where access to services is often determined by wealth or poverty, and to racism. Another contributor might be the growing fixation on improving neonatal outcomes to the detriment of the mothers themselves.[4] Martin and Montagne found that at the US federally funded Maternal-Fetal Medicine Units Network, the leading obstetrics research collaborative, only four of thirty-four initiatives specifically focused on mothers themselves, while twenty-four specifically focused on babies.[5] Not so different from the 1987 question "Where is the M in MCH?"[6] In the end, many of the problems appear to be the same across institutional settings.

In another point of commonality, records of maternal death and severe morbidity in the US sometimes also blame women. The blame is not necessarily for delays in reaching care during birth but for preexisting conditions or poor prenatal care that hospitals perceive to be contributors to their problems.[7] In an extensive exploration of hospital data related to maternal health outcomes, *USA Today* identified hospitals in various settings throughout the US with worse-than-usual outcomes even when such factors as poverty and the woman's racial identity were

controlled for.[8] Much as in the maternal death audit meetings in Tanzania and on the ward, a lack of transparency and a fixation on locating blame with mothers obstruct improvement. At one hospital in New Orleans profiled in the *USA Today* series, it is clear that though it is located in a high-income, high-resource country, the institution is plagued by issues similar to those prevalent in Tanzania. Slow response times, poor communication with doctors, a lack of adequately skilled and supervised clinicians, and poor attention to the details of women's medical histories all create life-threatening or deadly situations.[9]

These issues are everyday realities in Tanzania, where many more women die each year because the remaining elements of the system (such as supply chains, drug availability, diagnostics, and proximity to higher levels of care) are less robust. But ultimately what I hope these examples demonstrate is that while we may imagine maternal mortality is confined to places like Tanzania, like the Mawingu Regional Hospital, these deaths still occur, and are on the rise, in one of the world's wealthiest nations. And the causes and contributing factors leading to deaths in the hospital setting in the United States are not so very different from those leading to deaths at Mawingu. In the end, it will always be the most marginalized in any society who bear the biggest burden of maternal deaths.

Overall, we must ask ourselves, as anthropologists, health care workers, policy makers, public health practitioners, community members, and humans, a critically important question. How can we appropriate biobureaucracy and technical interventions and use them to repoliticize maternal death instead of allowing current projects and interventions to continue to reduce maternal mortality to causes amenable to technical intervention? Any answer to this question will not be easy. The answers will force us to confront difficult truths about inequities. Those comfortable and enriched by current political economics are sure to meet any proffered answers and solutions with resistance. These difficult answers will be one of the most crucial components of plans for finally eliminating the deaths of pregnant women globally.