PROLOGUE

Paulina was in her late twenties, and as she sat on the chair opposite the doctor, I took in her shining skin, nice clothes, and plump figure. She looked to be the picture of health now, in her third pregnancy. Dr. Deo was meeting with her because she had already had two Cesarean sections and knew from her last birth that she should report to the hospital early to plan the surgery before her contractions began. In addition to looking in excellent health, Paulina was also what a Tanzanian nurse or doctor might consider to be the ideal patient. She had around her feet all the items health care providers told women to bring with them when they came to the hospital to give birth. In the absence of disposable bed coverings or sheets for the beds in the labor room, women brought brightly colored *vitenge* or *khanga* fabric to lay over the cracked or worn foam mattresses encased in vinyl on the metal frame beds. Paulina's all-purpose plastic basin was also there next to her feet, brightly colored and waiting to function as bed pan, emesis basin, trash can, and dirty laundry basket. Peeking out of her purse were pairs of sterile surgical gloves in the paper packaging; deeper in the bulging bag were neatly folded clothes for the baby. Paulina and Dr. Deo discussed some of the particulars of her present pregnancy and the reasons she had had C-sections previously. They agreed that she would stay overnight and Dr. Deo would perform the operation the first thing the next morning.

I passed by Paulina and Nurse Lucy around 8:30 a.m. the next day as they were on the way to the operating theater for the scheduled C-section. Paulina looked calm, a veteran of the C-section, as Lucy and the ward cleaner wheeled her across the bumpy concrete path between the maternity ward and the operating room on the other side of the hospital. By 1:30 p.m., back on the maternity ward, the

nurses and I were still waiting for Paulina's return from the theater. Normally, an uncomplicated C-section would last only a little over one hour, the surgeons working to extract the baby before it was exposed to too much of the mother's general anesthesia. The fact that Paulina had been in the theater for more than five hours suggested something had gone incredibly wrong. Lucy came back to the ward finally, around 1:45 p.m. and reported that Paulina had just died. After Dr. Deo initially finished the operation, Paulina had begun to bleed again and bleed excessively. Staff quickly took her back into the operating room to see what had transpired, only to find that the hospital and Red Cross blood banks had just one unit of O negative blood, a very rare type that would be the only option for Paulina. But as she continued to hemorrhage, the one unit was not enough to begin replacing her lost blood volume, and she descended into hypovolemic shock from which they were unable to save her. Her baby daughter survived and weighed in at an impressive 3.5 kilograms. She lay in the infant warmer, blissfully unaware that her mother had just lost her life as she was only beginning hers.

After Nurse Lucy came back to the ward to tell us that Paulina had died, I witnessed the only time in nearly two years that the nurses would openly discuss their feelings about the deaths of the pregnant women on their ward. Nurse Rukia said to the cluster of gathered nurses that Paulina's death was particularly painful because Paulina was so healthy, so beautiful. She was so unlike some other women whom the nurses might expect to develop complications because of an appearance of poor nutrition, or signs of HIV infection. Rukia also lamented the fact that Paulina had already agreed to have a bilateral tubal ligation, a permanent form of birth control; this was to have been her last pregnancy. Instead of joining her happy, healthy family, Paulina was leaving behind three children, including her newborn daughter left alone in the ward. Later in the afternoon, as the nurses dealt with complication after complication on that particularly busy day, Nurse Peninah said that every time a woman died the way Paulina did it hurt a lot, *inaumia sana.* Peninah told us that some people said, "Pregnancy is not a sickness" (*ujauzito si ugonjwa*), to which Rukia immediately retorted bitterly, "Who says that? Pregnancy is poison!" (*Nani anasema hivi? Mimba ni sumu!*) Peninah admitted that Rukia was right and added that many of the women were so young at the time of their deaths. Paulina was so unlike so many other women whose poverty brought them to the hospital with faded, torn and restitched *khangas,* one rumpled, dirty package of gloves, and a barely legible antenatal card, either snacked on by mice or dirtied by life in a one-room home. Their deaths, too, pained the nurses but were somewhat less unexpected than those of women like Paulina. The nurses clearly recognized that a hard life wore down women. For a pregnant woman, poverty, low levels of education, or being an ethnic minority could mean she was one step closer to death even before any physical obstetric crisis began. Though Paulina was visibly of a slightly higher socioeconomic status, every death was painful for the

nurses; young or old, poor or wealthy, unknown to the nurses or a member of their community, every death was an unwelcome event, the afterlife of which trailed along behind those involved in the woman's care for months and years afterward.

Though I was not involved in the clinical care of any of the women who died while I was at Mawingu, their deaths and the countless stillbirths and neonatal deaths affected me as well. Like the feelings of the nurses whose stories I convey here, my own emotions related to witnessing and grappling with maternal and neonatal death are not often visible in the text that follows; they were, nonetheless, a constant companion during the fieldwork. On some days the emotions refused to stay in the background and I had to remove myself from my research setting, leaving the hospital to spend a day doing other things, lest an outburst of feelings, a bubbling over, impinged on the professional setting of the maternity ward. In the local setting of this hospital, the nurses and doctors would have seen such an open demonstration of emotions as unprofessional and inappropriate; such a display would have undermined my credibility and acceptability in their eyes. In light of these norms of professional conduct and the hospital staff members' expectations of me, managing my feelings and engaging in emotion work became important elements of my ethnographer's tool kit during my research. Faced with the events I relate here, I was often deeply saddened, as well as frustrated and enraged. The deaths of pregnant women and their babies *should* provoke these feelings. However, the work of close, nuanced, and full analysis to try to uncover the reasons *why* these deaths continue to occur in health facilities required that I put my feelings (temporarily) on a shelf. While conducting fieldwork, I came back to them in quiet moments at home. Now, five years later, I still return to these emotions. They connect me as an ethnographer, a scholar, and a person not only to the research presented here but also to the first time I witnessed the death of a pregnant woman, when I was just nineteen years old, on my second trip to Tanzania. The emotions evoked by the injustice of these deaths and their profoundly inequitable distribution drive all of my work, even if they do not appear on every page of this text. I invite you to sit with the feelings that might arise for you as you encounter tragic stories of too-short lives and lives not lived. Some of the events and details recounted here will be disturbing. Some of the terms the health care workers use may seem cold or distant, but they offer us clues about the kinds of strategies necessary to cope with work in such a profoundly challenging environment.

Paulina's death illustrates so many of the precarious moments that can arise when a woman is pregnant or in labor and giving birth. In this instance, it was nearly impossible for the hospital staff members to blame Paulina for the events leading to her death. She was a model patient, well-disciplined to arrive early, before the onset of labor, to schedule her Cesarean section. She arrived well dressed and clean, a signal to the nurses and doctors that she was probably of higher socioeconomic status and that either she or her husband probably had attained more than

the average level of primary school education. There were no apparent delays in scheduling her surgery, but from there her health and care began to unravel. Structural problems, such as the lack of sufficient blood supplies or cauterizing equipment, contributed to her prolonged hemorrhaging. A small number of present, skilled doctors, and the complete absence of a physician with specialized, advanced training in obstetrics, who might have been equipped with additional knowledge to identify and solve Paulina's complications, also contributed to her death. Poor communication and procedures that had broken down within the hospital because of understaffing meant that the nurses had not sent Paulina's blood samples to the laboratory or received the results before she went to surgery, even though Paulina had been admitted to the ward for nearly twenty-four hours and had a nonemergent C-section.

Paulina's case is but one of thirty-four maternal deaths that transpired in 2014 and 2015 at the Mawingu Regional Referral Hospital in Tanzania. These deaths highlight the need for ethnographic inquiry into hospitals and the lives of health care providers in lower-resource settings to better understand the complicated phenomenon that is maternal death. How is it that skilled (biomedical) assistance during childbirth is the unquestioned hegemonic solution to reducing maternal deaths worldwide, yet the institutions in which these skilled attendants work often operate in ways that not only fail to prevent deaths but can sometimes speed women's decline? From this attempt to understand these facilities and their health care providers' social maneuvers of caretaking, forgetting, and denial as necessitated by their work environments, it becomes clearer that health care workers' strategies ultimately fail to counter the structural conditions, in hospitals, countries, or globally, that lead to pregnant women's deaths.