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Protocols and Deviations

Good Enough Care

The Mawingu Regional Hospital, like the Tanzanian Ministry of Health, was influenced by and worked to adhere to national and international sets of guidelines related to providing care for pregnant mothers and newborns. These guidelines for best practice often were derived from internationally sanctioned, World Health Organization recommendations, which the Tanzanian Ministry of Health and Social Welfare (MoHSW) then took up and reviewed. Pending approval by their experts, the MoHSW would reproduce these guidelines in English or Swahili (or sometimes both), affix the seal of the Tanzanian government as official endorsement, and then disseminate these recommendations and protocols throughout the country. This was one avenue by which the state continued to act as a gatekeeper for external interventions and continued to prove its fundamental importance in health care despite a landscape of increased projectification—reliance on shifting donors and policies, and the fragmentation of what should have been health sector–wide reforms into often isolated, singular projects run by nongovernmental organizations and others—and the explosion of NGOs.[1] In one instance, a new poster appeared on the maternity ward bulletin board, illustrating the use of a new device. The poster did not bear this seal from the MoHSW, and one of the nurses immediately became suspicious of those who were sponsoring the device, a conglomeration of NGOs. She picked up her cell phone and called a friend who worked in the ministry to inquire about the legitimacy of the project and ensure that the women of Rukwa would not be guinea pigs for an untested intervention of questionable origins. In the days thereafter, it became clear it was a legitimate project, but her concerns were not unreasonable given a broad history of exploitative scientific and medical experimentation across sub-Saharan African.

NGOs were often involved in suggesting or developing new guidelines or protocols based on evidence from international trials of devices or drugs: for example,

changing guidelines and protocols related to the use of misoprostol,[2] treatment of eclampsia with magnesium sulfate, and the more recent introduction of a device called the NASG (nonpneumatic antishock garment) for the management of postpartum hemorrhage. The MoHSW, together with USAID, Jhpiego, WHO, UNICEF, UNFPA, and other NGOs, developed a set of assessment guidelines related to basic emergency obstetric and neonatal care (BEmONC) entitled *Standards-Based Management and Recognition for Improving Quality in Maternal and Newborn Care* (*SBMR* Tool). This tool included standard protocols for everything from greeting a woman when she arrived at the facility, to managing an emergency situation ("First, shout for help!"), to disposing of the placenta properly. There was a version for use in hospitals and a separate version for the lower-level health centers and village dispensaries. These are most often the standards of care to which I refer. Throughout the chapter, I use the terms *standards, protocols,* and *guidelines.* Protocols and standards are more rigid and are generally a concrete set of steps defining a treatment regimen or procedure. Guidelines are less rigid and include space for assessment and subsequent modification based on patient needs and local contexts. In Swahili, the government uses the word *mwongozo,* which includes the meaning of both guideline and protocol but most often translates to guideline. If I refer to the technical, clinical care that was provided as being of a low quality, it is always as compared to these guidelines or standards that nurses and doctors were using or based on their views of the care they or their institution were able to provide, and not a result of my own personal judgments of the quality of care. I refer to these particular standards of care because the hospital staff members and other health care providers with whom I worked referred to them and aspired to provide care in full compliance with them. Providers and facilities were also measured against the *SBMR* Tool by outsiders and via internal, self-assessment activities. While the maternity ward staff members strove to meet these guidelines, their environment often constrained care, both technical/clinical, and intersubjective emotional care, to be just "good enough"—good enough to keep most women alive and to let providers work another day.

The role and influence of these standards and guidelines shaped health care workers', as well as women's and men's, expectations of clinical, technical care, and patients' roles as biomedical subjects. As part of the global health development complex, these types of protocols, guidelines, and standards for care are the yardstick by which individual providers, facilities, regions, and countries are measured. Their deservingness of aid and investment, and their individual and collective efficacy, are judged by their ability to successfully implement and adhere to these measures despite widely varying access to resources—both human and material—as well as varying infrastructure and differing effects of geographic surroundings. Global health organizations and governing bodies often present these guidelines and protocols as the solutions to improving health care outcomes and reducing morbidity and mortality, including the deaths of pregnant women.

It is clear that, on the ground in Rukwa, these guidelines were nearly impossible to meet.

Against the background of scarcity, it starts to become clear how and when and why nurses and doctors on the Mawingu maternity ward did not or could not comply with all these ideals of best practice. In this chapter, I lay out many of those ideal, standard protocols for each stage of a woman's time on the maternity ward, and I start to show how care in practice deviated from these ideals. In the midst of these deviations it is possible to begin to see the many ways nurses sought to balance their needs with those of their patients—to uphold codified professional ethics, while preserving their own abilities to continue working day after day in an unforgiving system. Sometimes the nurses engaged in emotion work to demonstrate nursing ideals of caring and pleasantness,[3] but other times they did not have the emotional reserves to act out what might have been the desired affective components of caring for their pregnant clients on the ward as they juggled expectations and demands.

THE ADMISSION

Upon finally entering the ward, passing through the doors of the admission room, which bore a sign forbidding admittance to anyone not in labor, each woman handed a nurse her antenatal clinic card. The card included basic health information, a rudimentary obstetric history (number of previous pregnancies, miscarriages, living children), HIV status, and checkboxes about chronic or preexisting health problems, including categories such as heart problems and diabetes. According to guidelines, health care providers at the prenatal clinics were supposed to test every pregnant woman for HIV/AIDS, and while most were tested, sometimes the woman's village dispensary did not have the necessary reagents, test strips, or trained providers for carrying out the rapid tests.

With the antenatal card in hand, the nurse then recorded the woman's demographic information and basic obstetric history in the ward's admission book, a ragged notebook that had pages falling out and was much repaired with medical tape, regular Sellotape, and glue. After this, the nurse instructed the woman to take her things and lie on the examination bed so the nurse could check the woman's vital signs, count her contractions, listen to the fetal heartbeat, conduct a vaginal examination to estimate cervical dilation, and do a general "head to toe" assessment of the woman's overall health. Ideally, the nurse would be conversing with the woman throughout in order to take her history. On the basis of cervical dilation, the nurse then decided where to send the woman to wait out the rest of her labor until it was time to move to the delivery room. While these examinations and measurements were all supposed to make up the initial admission exam, nurses often rushed through them or simply wrote "normal" after looking at a woman.

FIGURE 8. The labor and delivery room. Photo by author, 2014.

While the hospital continued to increase the number of nurses working on the maternity ward, those assigned to a shift were not necessarily present, and even when they were, the number of women arriving, in labor, waiting for a C-section, or needing other forms of care could easily stretch the nurses thin. This, not infrequently, resulted in the women having only brief, truncated interactions with the nurses in which the nurses did not ask key questions about the woman's previous medical history, problems during the pregnancy, or current health. Certainly, during the busiest times, it was not possible to obtain any kind of social history, which would have improved care by adding context to the woman's pregnancy (Wanted? Unplanned? Supported by her family? In the context of a marriage?), or to ask questions that would have eased the awkward and foreign interactions taking place. More than once, as a nurse expressed dismay and frustration, a woman resisted a vaginal exam. Nurses could certainly have tempered these violations of women's bodies, but the absence of time for these interactions was itself a product of a structurally violent situation for the nurses, in which they lacked the personnel and resources they

needed. In the absence of other information or context, sometimes the nurses and doctors explained away a woman's strange behavior or noncompliance by saying she was out of her mind from the pain of contractions; other times, their inattention to a woman's faint signals for care or help resulted in that woman's death.

If the woman was in early labor, less than three or four centimeters dilated, the nurse would give her a bed in the antenatal room with instructions to come back to the admission room when her contractions got stronger. If she was between four to six or seven centimeters dilated, the woman would generally receive a bed in the admission room, closer to the delivery room. In both the antenatal and admission rooms, the women almost always shared their bed with a second woman and, at particularly busy times, maybe even with two other women. This was due to a lack of beds but, more importantly, to a lack of a place to even put other beds. If the woman had already reached six or seven centimeters, she would go directly into the labor room.

In the labor room (figure 8), women never shared a bed because of the need for enough space to conduct the delivery and the messy nature of giving birth. On busy days there was a rapid turnover in beds. Other times, women quickly progressed through the last few centimeters and gave birth in the beds in the admission room, in close proximity to other women, without privacy, and, many times, without the assistance of a nurse, who would come running just as the woman finished pushing her baby into the world.

LABORING

Once sorted in this way, the women made their way to the appropriate part of the ward to wait for their contractions to increase. Clinically, a woman's labor is divided into three stages. The first stage is further divided into the latent and active phases and, overall, is the entire time from when the cervix is closed until it reaches ten centimeters, considered full or complete dilation, and the woman is nearly ready to start pushing. At this point, from the time the cervix is fully dilated to when the baby is born, the woman is in the second stage of labor. The third and final stage of labor is from when the baby is born until the birth of the placenta.

There are few hard-and-fast rules for the amount of time a woman can or should stay in any stage of labor. However, once the woman is in active labor, in the first stage, her contractions will, ideally, remain regular and increase in strength, duration, and frequency. The general rule of thumb is that the cervix should dilate one centimeter every hour during the active phase of the first stage. Then the woman enters the second stage, which can last from a matter of minutes to a matter of hours depending on many factors including (but certainly not limited to) how many previous pregnancies the woman has had, the angle at which the baby's head entered the pelvis, the position in which the woman is laboring, the size of the baby, and the mother's own mental, emotional, and physical state. For example, a woman may have had a very long first stage of labor during which her contractions

did not allow her to get much sleep. She may not have eaten much throughout her labor, and when it comes time to push she may be very tired.

Women who were feeling tired and unable to push would often say that they did not have strength (*sina nguvu*) or that they were defeated (*nimeshindwa*). The passive construction does not provide any idea of who or what may have defeated the speaker, while still conveying the sense that the speaker has tried and, not because of anything within her power, was unable to do something. Perhaps a reflection of a cultural sense of the locus of control, this phrase is a common one, not just in the hospital but in life more generally. In the case of the women, I suggest a reading of this phrase that takes it also as a sign that the speaker, the woman, was aware of her lack of control and was relinquishing it, turning it over to the nurses and biomedical intervention in all its forms. The passive voice here also acts to revoke agency and, in so doing, contradicts the neoliberal image of the patient as advocate for her own care.

FIERCE CARE AND THE SECOND STAGE

The nurses would often become very concerned about how long the mother was in the second stage of labor because, they said, this was the most precarious time for mother and baby. If a baby spent too long in the birth canal, the umbilical cord might be compressed, cutting off the baby's oxygen supply. Nurses said then that the baby would not "score well," referring to the APGAR score used to assess the baby's appearance and reflexes upon birth. Babies who did not have enough oxygen during birth could develop a number of complications, including twitches, which might be an indication of brain damage, and were at risk for birth asphyxiation, which was a relatively common cause of neonatal deaths while I was at Mawingu. In this second stage of labor, babies were also at risk for getting meconium or other secretions in their mouths, which they could then inhale deeply into their lungs when they were born and first began to cry. This created the possibility of infections, especially pneumonia.

When confronted with a woman who was defeated or was experiencing an extremely difficult second stage of labor, the nurses would frequently resort to hitting the woman's legs or using harsh language. When I asked about these behaviors, Nurse Halima explained this way, and her answer was generally representative:

> If you yell at a person, she will understand you. But if you tell her gently—me, I have tried to admit a woman gently, if I reach labor [room], gently, every area, gently. Until I came to change; it was necessary for me to be severe, why? Because that patient, she comes there, she sees you, that you have your gentleness, and [it shows] she doesn't have to be serious. Therefore, she arrives there, she is strangling the baby, she arrives there, you tell her she should lie on her back and push the baby, [but] she sits, she sits on the baby's head and the baby dies there. Therefore, if you don't use that severity—*that fierceness* helps, at the end of the day, her to get her baby, and at the end of the day that patient, she comes to thank the nurse: "Thank you, there,

> without you doing that to me like that, I wouldn't have given birth." You see? . . . Even if you go wherever, you can't hear a nurse speaking gently to a pregnant woman because the nurse is doing that fierceness to save that baby. But I don't believe that that severity, a person would do it to a person who has, I don't know, maybe I should tell you, maybe like an intestinal obstruction. If [the nurse] does that, we have to ask her, 'You, why are you doing that?' but in things with childbirth, the pregnant mother's mind, it is as though it's not there. Therefore, you have to scare or shock her. You have to yell at her, tell her, "You, you do this and this and this, and here this should be this way and this way. If you don't do these things, you will lose your baby, you will do this!" You tell her even the complete outcome. But a person, if you tell her the truth, a person sees like you are abusing her or you have asked her for bad things, therefore, this is what it's like. Except, the biggest thing is that we always speak in order to protect the baby. At the end of the day, a woman gives birth to a baby who is alive and then she complains about things like those, it's not good. While for her, you are her assistance. (emphasis added)

Halima had first worked on the private ward, and when she'd had reason to pass through maternity, she had often remarked to herself that the nurses were using mean and abusive language with the women. She could not see why and often sympathized with the women—until, she said, she was transferred to the maternity ward and quickly found her gentle demeanor did not help her in extracting the required compliance or outcomes from her new patients. Nurses yelled at or hit the women, yes, to help them find the strength to give birth but also to protect themselves as providers, demonstrating they had done everything possible to ensure a good outcome during the birth. Using a translation of a Swahili word, which Halima drew on in her explanation, I term this "fierce care" in order to draw the discussion of these behaviors into a more local frame and a more nuanced space for analysis.

Ultimately, the nurses viewed behaviors such as yelling at the women, telling them they were killing their baby, or hitting them as a form of care that they undertook to help the woman give birth. Hannah Brown cites similar behaviors in a maternity ward in Kenya, where nurses suggested that letting women relax during labor was disadvantageous and did not result in good outcomes for mothers and babies.[4] Similarly, Josien de Klerk troubles Western conceptions of care practices, demonstrating how the "toughening" of those who have lost relatives, and the concealment of dying patients' HIV status are, in fact, locally valued forms of care, though cultural outsiders might not view them as such.[5]

In my own, later work in the Kigoma region, to the north of Rukwa, I found strong community consensus around the value of strategic hitting or yelling for helping a woman to give birth. In general, community members of all ages, both male and female, agreed that a pregnant woman should never be hit. However, when my research team presented them with specific instances in which a woman might have difficulty in the second stage of labor, community members condoned hitting, usually the woman's legs, and/or yelling. These specific cases included when a woman was tensing up or closing her legs; when her fear prevented her

from pushing; when she was making a lot of noise (using her strength to make noise instead of pushing); and if she was not pushing strongly enough. Community members explained their endorsement of hitting or yelling in these instances by saying things like, "It is necessary for nurses to hit the pregnant woman if she is afraid or not a brave person." A second woman explained, "A pregnant woman shouldn't be hit if she doesn't have any problem. [But if there is a problem] you hit her to ensure that other people won't say you have killed the baby. You hit her to save yourself." This particular sentiment not only describes the broader social milieu from which nurses, too, came but also combines with the hospital protocols related to the documentation and review of neonatal deaths, for which individual providers might be held accountable.

Another woman in the community, when asked if it was accurate that nurses yelled at women in order to save the baby, stated, "You can't know, even the nurse, if the baby will be alive or not. It is an outcome, not an expectation," so even the nurses had to do everything that might possibly help ensure the birth of a healthy baby. These descriptions of locally valued care practices lead to a more nuanced reading of these behaviors in which the nurses engaged, recasting them as forms of care suitable to the environment in which the nurses found themselves, not just deviations from ideal care protocols designed in other settings. Riskiness and the uncertainty inherent in reproductive outcomes in Tanzania have led to the development of expressions of fierce care, which in other circumstances—for example, Halima's mention of a patient suffering from an intestinal obstruction—would be abusive, according to community members and many nurses.

Though Halima said women often thanked the nurses for hitting them to help them give birth, the women and their relatives could just as easily report the nurse for abuse and a violation of the official, codified ethics of the Tanzania Nurse Midwives Council. Often, during the second stage of labor, the woman's fleeting pain, shame, or violated privacy were generally agreed to be elements that could be sacrificed if the baby's life was in danger; fierce care became the most suitable care. In these instances, nurses, women, and community members collectively redefined and reshaped care, entering into tacit mutual agreements about which outcome was the most important in their constrained setting. Along the way, because of persistent resource scarcity, lack of mentoring, and few alternatives, this fierce care, though not necessarily desirable, became normal both for women and for their nurse-midwives. Possibilities for other forms of care during this crucial moment in the second stage receded, fading from view and imagination.

Many of the nurses described women in labor, with no access to pain medications, as "out of their minds" or unable to listen and follow directions, as Halima also mentioned. While some women, especially young women experiencing their first pregnancy, were clearly distraught because of the pain and fear of being in labor, many others labored quietly and compliantly followed all the nurses' instructions. Occasionally, we received women who stood out as atypical

examples of noncompliance, and their memory has stayed with me. One woman refused to do anything other than sit on the dirty tile floor. Every time a nurse and I helped her up onto the bed, we would turn around moments later to find her back, squatting on the floor. The doctor kept walking through the labor room that day and repeatedly berated the nurses for "letting" the woman remain on the floor because he had not seen our struggles to move her up onto the bed time and again.

Another woman's relatives told us she seemed to have experienced a significant shift in her personality with the onset of labor. She spoke of seeing spirits around her and she was extremely agitated. Because of her prolonged labor, the nurses started her on IV fluids, but the woman repeatedly pulled the cannula out of her arm and quickly made her way out into the courtyard of the ward. More than once we went to check on her and found a trail of blood from where she'd pulled out the IV, leading us to the flowerbed where she was squatting and bearing down with contractions while muttering incomprehensibly, covered in dirt.

Truly, in cases such as these, it was possible to understand how the nurses came to view hitting, slapping, or yelling as the appropriate, and needed, tools. There was nothing much else they could do with women such as these, particularly as they repeatedly defied efforts to entice them into staying put on their assigned bed, threatening to give birth in an unsanitary location with no assistance, as could have been the case in the flowerbed. These were full-grown women, with pregnant bellies, whom the nurses could not easily physically remove to their beds or elsewhere, who refused reasoning and for whom the nurses had no other technical or medical options. Understaffing and no relatives on the ward meant there was no one to continuously stay with these women. Lacking other possibilities, nurses resorted to this fierce care that contravened formal nursing ethics but made profound ethical sense in this everyday setting.

As described in the Introduction, in analyzing the nurses' actions in this context, it is critically important to remain open to care's local meanings and practices, paying particular attention to uncovering, in actions, decisions, and interactions, "what is sought, fostered, or hoped for, then and there: what is performed as good . . . [and what] is avoided, resolved, or excluded: what is performed as bad" care.[6] The ethical norms of care practices also shift depending upon the actors involved, as well as the constraints in play. Occasionally, the good and bad forms of care are obvious or straightforward, but more frequently they are complex and ambivalent: "If one looks hard enough any particular 'good' practice may hold something 'bad' inside of it (and vice versa)."[7] Sometimes, the expected care relationship produces violence, as when nurses hit, slap, or verbally abuse laboring women. When we examine these events in light of more *unexpected* or capacious care relationships, we come to understand that these actions are a different sort of care practice. Sometimes nurses used these methods not simply to vent frustration but to care for a woman's larger kinship network and her as she worked to give birth to a living baby who would solidify her place in her marital family, win her respect,

demonstrate her valor as a woman, and relieve any fears of a cursed mother or baby or wronged social relations. These fierce care practices might appear ambiguous, with mixed positive and negative, kind and violent elements, because the care recipient is sometimes beyond our expected scope of perception. Western-derived approaches and perspectives miss how the individual care recipient is embedded in a broader social network, which is also receiving care in a less direct manner. While I personally do not condone hitting or yelling at women and believe women have a right to a birth free of abuse and mistreatment, viewing these actions as broadly directed care would challenge many policy makers and public health practitioners to rethink relatively straightforward, one-size-fits-all, rights-based policies for respectful maternity care in places where local forms of respectful care may look unrecognizably different depending on resources and on care priorities and practices. In the very particular instance of the second stage of labor, these explanations do not mean that hitting or verbal manipulation is acceptable but simply that we must engage with these practices on their own terms in each setting in order to understand what motivates them.

BIRTH

After the birth of the baby, the nurses would quickly cut the umbilical cord, and they had all learned active management of the third stage of labor (AMTSL or, alternatively, AMSTL), in which the nurse would first palpate the uterus for the presence of another baby and administer an injection of a uterotonic, usually oxytocin, to help the uterus to contract.[8] Then, using forceps, the provider would clamp the umbilical cord close to the mother's perineum and pull with slow, steady pressure in a downward motion until the placenta fully detached from the uterus and was delivered. The nurse then checked the placenta to make sure it was complete and thoroughly massaged the uterus to ensure that it expelled any blood clots and to verify that it was contracting, a key sign that bleeding would stop.[9] Ideally, the health care provider would explain to the mother how to check and periodically massage her uterus, as well as give her information about danger signs in the immediate postpartum period. Only rarely did I ever hear the nurses in the labor and delivery room give the woman any advice that went beyond how to check if her uterus was still contracted and telling her to void her bladder.

Most often, the nurses at the Mawingu Regional Hospital were able to let the women continue to rest in the labor room after delivery so they could monitor their conditions. This was supposed to include vital signs monitoring, though this particular aspect hardly ever happened—sometimes because other women needed assistance, others times because the blood pressure cuff was missing or broken, or no one could find a functioning stethoscope. In lieu of the more technological monitoring specified in care guidelines, the nurses who were more experienced

would visually assess the mother and deem her condition "normal." Sometimes, depending on how busy the ward was, the nurses had to almost immediately move new mothers to the postnatal room because incoming women were ready to give birth and needed a bed in the labor room. These sometimes-hasty transitions were not ideal and more than once led to incoming mothers giving birth on the floor near a bed, or immediately after reaching a bed. The outgoing mothers were forced to carry all of their belongings to the other side of the ward within minutes of giving birth. When this happened, the mothers hobbled slowly along, sometimes with blood dripping on the floor from between their legs, balancing on their heads plastic basins overflowing with soiled clothes, while any free staff member carried their newborn.

Once a woman had given birth, she moved to the postnatal room across the ward, near the entrance, where she typically spent twenty-four hours, give or take, depending on her health and whether she had experienced any complications. Once she was in the postnatal room, the postnatal nurses took over her care and were responsible for ensuring she had any necessary medications or monitoring. The postnatal nurses were also responsible for providing health education related to family planning, breastfeeding, personal hygiene, and basic nutrition and baby care information. On this part of the ward, the nurses also filled out another set of documents, completing documentation started by the labor room nurses in the delivery book in which all the births were recorded, as well as filling out the birth announcement form that families took to their district administrative offices if they wanted to get a birth certificate for their child. If any of the women had not already previously been tested for HIV, the postnatal nurses counseled and tested them, providing those who tested positive with medications for the baby and further instructions for follow-up testing. The women also received a mild painkiller and an iron and/or folic acid supplement, as well as vitamin A, which they received when other nurses or auxiliary staff members arrived on the ward to vaccinate the newborns.

SURGICAL BIRTH

If a woman needed a C-section, either planned or emergency, her flow through the ward differed somewhat from the norm. If the nurses identified a possible complication or previous history that suggested the woman might need a surgical birth, they would call the doctor to alert him of a patient for review. When the doctor confirmed the need for a C-section, the nurses prepared the woman for surgery by having her sign a consent form; taking blood samples for laboratory tests (blood grouping, cross-matching, and hemoglobin levels), in case she should need a blood transfusion and to rule out anemia that might be life-threatening during the surgery; administering preoperative antibiotics and IV fluids; and inserting a catheter to drain the woman's bladder during the surgery and her recovery.

FIGURE 9. Maternity ward operating theater. Photo by author, 2014.

Once the mother was in the operating theater (figure 9), which, as of December 2014, was located within the maternity ward itself, a nurse from the labor room accompanied her to receive the baby. This nurse often had to resuscitate the baby (with greater or lesser degrees of intervention depending on a number of factors, including the type of anesthesia used) and then was responsible for weighing the baby, recording its APGAR score, sex, and time of birth, and then carrying the baby back to the labor room, where the baby would wait in a warmer until its mother awoke from the general anesthesia and was able to care for the baby.

At this point, the postnatal nurses took over the care of the mother and were responsible for collecting her from the operating theater after the surgical team was finished. The postnatal nurses transferred the unconscious and/or immobilized woman to a bed in the post-Cesarean room (figure 10), changed her perineal pad, and ensured that she was warm, clean, and secure. The postnatal nurses then were also responsible for the follow-up care of these patients, which included administering pain medication and antibiotics on a schedule and dispensing advice related to food and fluid intake, breastfeeding, urination, care of the incision site, and general information about recovery. The nurses, and often the doctor too, would try to impress upon the post-C-section mothers the necessity of using a form of birth control to prevent pregnancy for two to three years so their bodies would have enough time to heal and not predispose them to possible future complications, such as a ruptured uterus.

FIGURE 10. View of the post–Cesarean section room on the maternity ward. Photo by author, 2014.

UCHACHE AS EXCUSE AND IDIOM

All of the above tasks that went into women's care at each step of their time on the maternity were in addition to administrative and documentation tasks that consumed even more of the nurses' and doctors' time. The standard guidelines, like the *SBMR* Tool, did not appear to consider provider shortages, such as those the patron mentioned in chapter 1. When I interviewed the patron and the assistant matron, we talked about these tools. Patron told me, "I have looked at this tool because we have been in this program, but we are improving by only a very small percentage. . . . Once you miss resources, you will score zero; therefore this tool needs to be improved." The matron nodded her head in agreement, and I encouraged him to continue. He went on, "But the second reason for our low scores is even employees too, by which I mean the fewness (*uchache*) of employees there . . . also causes the employees to have so much work so that they lose their focus on those standards." The matron added, "It is very difficult in a setting in which there is this *uchache* of employees and so many clients, to follow those guidelines point by point while you have a queue of one hundred patients. And because they don't use these guidelines, they can't remember all of them. So the day someone comes to review them, they will find many deficiencies."

In addition to the material scarcity produced by stock-outs, hospital staffing levels were a source of frustration and great concern, preventing adherence

to guidelines for care. Nurses expressed their belief that there were simply not enough of them to conduct all of the necessary patient care and documentation activities that a ward as large as maternity required, substantiated by the patron's report that the hospital was not meeting the WHO's suggested patient-to-nurse ratio. Budget constraints and unmet requests for more providers from the central government affected the hospital administration's ability to hire new staff members or promote those who had been working at the facility for many years. The hospital administration sought ways to deal with these constraints as the nurses and doctors continued to provide care to the best of their abilities.

The nurses and doctors often referred to *uchache,* or "state of fewness," specifically of providers, as a key barrier to improving maternal health outcomes at the hospital, though the medical officer in charge did not feel this was an appropriate excuse for not exerting maximum effort with every individual patient. At a maternal death audit meeting in July 2014, Dr. Joseph, the medical officer in charge, said, "I know we can't avoid death, but you get a death like this and see there were gaps." Nurse Mary suggested maybe the problem was documentation; maybe things were done but the documentation was bad. Dr. Joseph rejoined, "If you say the problem is documentation, you're doing a lot of things, then you should say the problem is that there aren't enough people, '*uchache,*' just say that, because that is the issue!" The conversation about staff levels, documentation, and care continued. Dr. Joseph told the group, "Even if you are few, I expect you to give 100 percent to the patient you are with." The RMO jumped in to ask, "Right now, where we are, it still happens that women are giving birth unassisted?" The assembled group collectively and vociferously asserted that it was still occurring. Becoming exasperated, Dr. Joseph effectively ended the discussion by saying, "It's not *uchache,* the issue is that we are not prepared when we see the patient. We are not prepared with the equipment and documentation."

In light of the fact that the maternity ward received at least eight new nurses during the duration of my fieldwork, it would appear as though the number of people was not so much a cause of poor care as continuing to invoke *uchache* was a way to locate the source of the problem of ongoing substandard care or deaths in something outside the direct control of those on the ward. Maintaining this discourse of *uchache* accomplished a status quo that served the nurses by not requiring, as Dr. Joseph asserted, higher levels of preparedness or commitment. Even as the hospital and regional health administrators sought to continue hiring greater numbers of qualified providers, the problems of miscommunication and delays in care that staff members had been attributing to their low numbers did not disappear. The nurses' continued use of *uchache* can be read as an idiom, coded from an earlier era, for a more general lack of workplace empowerment and professional efficacy, in their "under-resourced work environment that prevented them from realizing improvements in care."[10]

Uchache *and the Night Shift*

Despite a near tripling of the nurses assigned to the maternity ward during my time at Mawingu, there were persistent staff shortages on the night shift. On the nights in May 2015 when I spent several hours at the hospital conducting interviews with nurses on the night shift, I usually was on the ward with two nurses in the labor and delivery room and one nurse assigned to the postnatal portion of the ward. I repeatedly heard that the night shift needed more nurses. One day, I asked Nurse Mpili about it. "I keep hearing that there are not enough nurses on the night shift. But we've gotten so many new people. Why not just assign more people to each shift?" Mpili looked at me and explained, "Even just a few years ago, you would be so exhausted from working here in maternity. You know, you can't sleep on the night shift like on other wards. Because we were so few, we had the night shift maybe even three times per week. You never had time to rest or do anything for your family. Now? Now, we have so many people, you can even do only one night shift each week." Presented with the choice to either improve their own quality of life or assign more nurses to the night shift, the maternity ward had decided to maintain the low staffing levels so that everyone had fewer night shifts, thus preventing more disruptions to family life and sleep schedules. In this instance, the nurses and patients were more subtly on opposite sides of an issue. It was not that nurses actively wanted women to receive worse care at night, but nurses wanted to be able to ensure they could take care of their own families too.

The nursing profession in Tanzania still draws on the idea of Florence Nightingale as the paragon of nursing care. The image of Florence Nightingale often comes with ideas about selflessness and sacrifice in the service of providing care for patients. What is not included in this nursing imaginary is where nurses themselves are meant to find their endless reserves of compassion, patience, and energy. The nurses on the maternity ward at Mawingu strategically continued to utilize *uchache* while actively avoiding assigning more nurses to night shifts in order to preserve a modicum of quality of life for themselves and their colleagues.

MOTIVATION AND THE IMPOSSIBLE DEMANDS OF WORK

Nurses had to contend with the increasing scarcity of supplies while also handling new guidelines and procedures, as well as higher patient loads than ever before. This led to incredible stress that caused many of the nurses to tell me that they were often demoralized by their work environment. As a result, many of the nurses told me it appeared that their superiors, the hospital administrators, did not care about them. Feeling a lack of care, in the form of a work environment that did not enable them to perform to the highest levels of their knowledge and abilities,

demoralized nurses. The type of care they wanted from the hospital administration, on an interpersonal level and also via the procurement of supplies and equipment, did not necessarily fall into either technical or affective care. I sometimes refer to this as institutional care to incorporate the structural, financial, resource, and affective elements necessary to realize a more caring work environment.

In my interview with Dr. Joseph in May 2015, I told him that since I had started coming to the Rukwa region in 2012 people had been telling me that the hospital staff members were not motivated. Sometimes this charge was leveled by community members; other times it was the doctors talking about the nurses. I asked Dr. Joseph what he thought he, as the medical officer in charge, or the hospital administration, could do to improve the level of motivation and morale among his employees. He said:

> I would say, number one [is] to increase the level of supplies—that will boost the morale. Because you are not being motivated if you don't have something to use, you don't have medicines for patients, the infrastructure is poor, you don't have supplies, you get demotivated. Then, from there, we may think of . . . like some competition . . . which departments works better, then we may recognize it by a letter or by certificate. . . . Probably that one would also boost the morale. But we cannot think about that sometimes because there are these problems with supplies so your head gets congested [you are overwhelmed]. I think I have to manage first these.

He also told me in the same conversation that even if the nurses and doctors said they would like recognition for their work in the form of verbal praise or certificates, what they *really* wanted was money, and the hospital simply could not incorporate higher wages or a system of monetary incentives given the already extremely difficult financial state of the institution.

I also asked the RMO about this issue of motivation and what he thought could help regional hospital staff members to be more motivated in their work. First, he asserted, "Ah, all these things we've done, honestly, if a person still isn't doing work with great effort, well this person, that is just how they are—they won't do it." This was primarily in reference to all the ways in which the hospital and regional health administration had tried in the previous three years to ensure that staff members received all the workers' benefits to which they were entitled as government employees, including payment for hospital treatment, paid vacation every other year, promotions every three years, and any back pay they were owed, as well as housing allowances for the physicians. However, the RMO went on to say,

> Also, to really ensure that the environment [at work] is better than where they are [home]. That is, infrastructure. . . . The work environment should be nicer than there at her home, where she is coming from, so she is pulled to stay at work more than staying at home. This is the secret. . . . She enters, she comes to work, she finds that she gets tea there close by, if she turns around there's lunch [nearby], yeah, she finds that everything is there. There is nice furniture. If it's a computer for doing work, it's

> there. Equipment is there. If she turns around there is a blood pressure [cuff] right here, glucose test here, stethoscope here, yeah? Nice things. She likes to stay at work. It's things like that.

One aspect of this overall environment that surfaced multiple times throughout my stay was the availability of tea, electric kettles, and sugar on the wards. The nurses on the maternity ward, and throughout the hospital, considered this to be a crucial part of making their working environment a livable place. They variably justified it to me as making it easier to have a bite to eat without wasting time leaving their workstation or being due this small comfort because of the hard work they did, or because, particularly on the night shift, no other food was readily available inside or outside the hospital grounds. In nearly every all-staff meeting the nurses requested the hospital also start providing bread on the wards, impossible because of the institution's financial state.

It may seem like a small demand, but I read these repeated requests for bread or other snacks as a bid for care. The hospital staff members viewed the provision of bread as a demonstration that the hospital administration had validated their presence and acknowledged their hard work and humanity. In many instances, issues of motivation seemed to center on the point that the nurses felt they were unseen and unheard. Very often, they were simply looking for some form of recognition from their superiors on their ward and within the hospital more generally.

While the administration was often concerned that the actual infrastructure of the hospital contributed to staff members' feeling unmotivated, this was not something that came up in the discussions of motivation and the work environment I had with nurses and physicians. Most commonly, the nurses were concerned with the availability of supplies and—another important factor—with the quality of leadership and mentorship that the hospital management displayed at both ward and hospital levels.

Nurse Anna started speaking about the hospital's infrastructure and the availability of up-to-date technology and quickly moved into a discussion of money as a motivator: "But also let's improve the environment, meaning that motivation, they should give us [to show] *they care for us,* the maternity ward, that's to say, we swim in blood and you know in the blood there is HIV and hepatitis. Therefore, even if they said 10,000 [TZS] every month for each provider on maternity, it would be motivation because of the type of environment in which we work!"

The lack of adequate personal protective equipment exacerbated the risk involved in providing care to pregnant women at Mawingu. Nurses expressed concerns about their abilities to protect themselves from the possible infectious agents present in women's blood and other bodily fluids.[11] These anxieties could color nurses' interactions with patients and even persuade some nurses to lash out against patients or avoid providing care at all, as the work environment was once again asking the nurses to provide care for patients while simultaneously

jeopardizing their own well-being. In some cases, the nurses' concern for their own health and safety prevailed, but in other situations the nurses simply did what was necessary to save a woman's life or that of her baby. Nurse Gire told me that she would improvise protective equipment as best she could but that "no matter what, I don't remove [it]. I care only about saving the patient." She believed in the power of God to protect her in the absence of other, material protections.

Many of the nurses who had been working at the hospital for more than three or four years had mentioned to me, in other contexts, that the maternity ward staff members had formerly received an additional amount of money each month that was classified as a "risk allowance." They had received this money to compensate for the extra work they did in the absence of additional nurses but also to acknowledge the particular difficulties and dangers of maternity care work, especially the exposure to potentially hazardous bodily fluids. Now there were more providers and therefore no need to pay each person more for what was a more reasonable amount of work. Many of the more recently employed maternity ward nurses simply did not know that this money had ever existed and did not bring it up as something they would like to have to help them feel more motivated. Instead, they were more likely to talk about generally improving the work environment or, if discussing money as a motivator, referred to the extraduty and on-call allowances that the hospital had recently reduced.

MATERIAL AND STRUCTURAL REASONS FOR ABUSIVE CARE

Nurses did not engage in actions such as hitting and emotional manipulation only during the second stage of labor. I differentiate between the second stage and all other times in order to nuance the discussion of what different actors call disrespect and abuse (D&A), or obstetric violence. The term *D&A* appears commonly in the public health literature and in research on Africa, whereas the term *obstetric violence* has its roots in activism and legal reforms in Latin America, drawing attention to abuse of pregnant women as a form of gender-based violence.[12] The two terms share much overlap in the behaviors to which they refer; because of the slow spread of the term *obstetric violence* in my contexts in Tanzania, I often use the term *D&A* or abusive care. In a detailed review, Bohren et al. classify the most common instances of mistreatment of parturient women in the existing literature into seven broad categories: (1) physical abuse; (2) sexual abuse; (3) verbal abuse; (4) stigma and discrimination; (5) failure to meet professional standards of (technical) care; (6) poor rapport between women and providers; and (7) health system conditions and constraints.[13] Clearly, women's perceptions of their care may differ drastically from the views of their providers. Likewise, the category "poor rapport" includes a knotty combination of topics ranging from poor communication to denial of birth companions (often limited by infrastructure) and

lack of "supportive care" from health workers. However, researchers and policy makers recognize, and many have adopted, this typology, so I present it here to help define abusive care. Outside the period of the second stage of labor, almost always the period for which nurses justified their fierce care, I approach most of the other occurrences of these behaviors as abusive. Abusive care was violent for women, but structurally violent working conditions for the nurses and doctors often contributed to these seemingly individually violent acts.

Nurse Martha, one of the past in charges of the ward, looked for deeper reasons for abusive behaviors and responded to my question about their causes in light of her own fraught interactions with the hospital administration, which had eventually caused her transfer to a different ward. She told me that a nurse's financial concerns could cause her to worry, causing conflict at home so that she was unable to concentrate and causing her home frustrations to bleed into her work with patients. Martha continued, "There are a lot of things that cause that state. The first thing entirely is the frustration that she has, the employee. . . . Another thing is the harassment that she has gotten coming from the administration: maybe a person has a problem, she has gone there and encountered bad language and she has transferred it to the patient." Her personal experience, as well as the insights she had gained from managing the maternity ward, allowed Martha to explain how poor living conditions, often a result of low wages, in addition to tense or abusive exchanges with the hospital administrators, could influence a nurse's interactions with the women for whom she was meant to be caring. In light of these other stresses, it could be impossible for the nurse to continue to engage in costly emotional labor with patients while her personal precarity weighed on her.

Everything Martha mentioned is an example of a failure of care from the nurses' employer, of institutional care, beginning at the level of the central government, which failed to adequately increase wages in the health sector, leading many nurses to remain preoccupied with the state of their home long after they had walked out the door. Nurses' private lives continued to permeate the boundaries of the hospital, blurring the lines between domestic and professional spaces. At the hospital, the patron was known for his harsh language. His forthrightness, in a culture that valued a certain degree of circumspection and tact, rubbed many nurses the wrong way, often offending them outright if he used language that was profane, or otherwise inappropriate for the workplace, in their interactions. Combined with their superior's attitude toward them, the difficulties of maintaining a good home life, and growing demands to meet guidelines and protocols, all as they worked without many necessary resources, it is not hard to understand why nurses might become abusive toward their patients.

In the nurses' difficult work environment, at one moment biomedicine held the ultimate authority, rendering facts about the body's unseen insides via ultrasound or lab tests and conferring status on those who knew how to interpret the

images or numbers produced. In the next moment, this highly technical environment began to erode, undermined by broken equipment or a lack of supplies. In these instances, breakdown and dysfunction ate away at the social distance between patients and their health care providers. To instantiate their superiority in the midst of breakdown, nurses might flex their social status and the unrelenting authority of their system in other ways. Nurses might label a woman as being "from the village," emphasizing her lack of belonging when she didn't know how to navigate the hospital. For a woman who looked poor or uneducated, the nurses might use derogatory language as a way of reminding her of the distance in their social positions and their resultant access to authority and power. Poor women were often easy targets, as were those from minority ethnic groups who spoke Swahili less fluently and whom the nurses often simply addressed by their group name, such as "the Sukuma." On hectic days, I often heard Nurse Peninah, who was from a different ethnic group, saying to anyone within earshot, "You Fipa women, you just want to have babies until you die! Why don't you use birth control, eh?" Dehumanizing women in these ways may have been a result of stress, as well as a way for nurses to maintain the little power they had within their work environment. One result, however, was that women in these groups might have been more afraid to speak up and, subsequently, less likely to receive the help they needed during emergencies.

Lived realities such as these are extremely difficult to incorporate into, and are therefore entirely lost in the design of, many public health interventions meant to improve care, decrease disrespect and abuse, and empower women in the health care setting. When the nurses themselves felt uncared for, were struggling in their private lives, or encountered stubborn and noncompliant patients in the absence of manpower and sophisticated technology, sometimes they resorted to hitting and yelling. While violating many official guidelines, these interactions had internally consistent logics, making them more understandable, even if never ideal, in this setting.

DIFFERENT SUBJECTIVITIES, DIFFERENT MOTIVATIONS

Different parties throughout the hospital had, unsurprisingly, different ideas of what it meant to be a motivated health care provider and why their fellow providers were not more motivated. Administrators often placed the onus of responsibility on the individual. Even if the nurses received all of their rights as government employees, even if the hospital infrastructure improved, and even if the nurses' employer cared for them, the bottom line was that motivation came from the inside. The administrators felt that they could do as much as was within their power but that providers would still exist who were not invested in their work and did not *kujituma,* or put in an effort. This difference of opinion was not unique to the Mawingu Regional Hospital. Daniel Chambliss explains the conflict

between nurses, in particular, and administrators as a conflict of perceived priorities and as centering on how administrators are removed from "life in the trenches";[14] this distance, physically and in terms of goals, caused administrators to fail to demonstrate the level of appreciation and recognition for which the nurses were looking.

While it was easy to see the differences in perspective between administrators and nurses, a divide that I had not anticipated appeared between the older nurses and their younger counterparts. While the younger nurses never said the older nurses were unmotivated, every older nurse pointedly said the newer graduates did not have the same level of expertise, experience, and training they had had upon graduating. Additionally, the older nurses did not mince words when asked why the hospital staff did not seem motivated and why this accusation of low motivation surfaced time and again at Mawingu. When I asked her how nursing had changed since the time she entered the profession in the 1970s, Neema told me, "Those from the past, that is us, we did work by referring to the past behind us. You provide care that you know, the basics, and a person is happy. But the nurses of today, really nursing is finished! Well, let's say that health care services are coming to an end . . . [now] that health generally is like a job, like any other job. They have removed everything that was called *wito* [a calling]. Now, if there is no calling [to nursing], when you play with a person [i.e., merely go through the motions of providing care] it is like you don't reach the goal."

The term *wito* in this context means to be called to a profession, a vocation, in a way that indicates a deep personal meaning to the work. The older health care providers all lamented that nowadays the people who entered the nursing profession did so as a result of family pressure or a lack of other options as dictated by secondary school test scores. Even community members suggested that health care providers were not invested in their profession, which was one requiring deep caring—affective, not just technical—and compassion, and instead were merely looking for money and stable employment. In her explanation, Neema went on to describe how the previous generation of nurses had started their shifts in the morning by ensuring that patients had everything they needed—medications, fresh air, a haircut, even clipped fingernails. She said that now the nurses did not work this way and had forgotten some of the very principles of nursing care. She went on to tell me about how nursing care of the past emphasized close contact with the patient, including hands-on bodily care and even washing soiled linens. Nowadays, these tasks were left to the patient's relatives, shifting certain forms of care practices that required less technical expertise but also greater emotional proximity into the domestic sphere and out of nursing.

The Rukwa regional reproductive and child health coordinator (RRCHCO) was also a very experienced nurse and had practiced for many years. She echoed Neema's observations about the current generation of nurses and added an example of how these newer nurses sought to remove themselves from direct patient care:

> Me, I see that they don't have a calling [*wito*]. . . . These days, I tell you, we that studied a long time ago, we're different from those who have studied in these recent years. . . . A [nurse] can stay on the labor ward, she is using her phone, she is chatting while a mother is in pain over there. Then this same nurse will claim, "My rights have been violated!" What rights?! Those that studied recently, so often they have gone into this profession of nursing as if they lacked another place to put themselves. . . . A lot of them, their minds are thinking, "If I go to study more, I will arrive, I should be at a high level. This patient, let me not touch her." . . . These trained personnel should be very close to the patient . . . but she who has studied a lot is far from the patient [these days], and it's not right!

The RRCHCO's comments show how she perceived the younger nurses to be selfish but also how she thought these nurses sought to escape the more emotionally laden work of intimate care in close proximity to patients by increasing their technical care abilities. The older nurses all remarked upon the growing reliance on technology as a replacement for other forms of caring, which were more about the humanity of patients and their needs as fellow humans, as in hair care, instead of simply passive subjects, receivers of care, in the form of more technically skilled expertise.

All the other experienced nurses with whom I spoke independently told the same narrative of the decline of nursing care and such practices that were in place to ensure good patient outcomes through close attention to detail: care with less distance. Gregory Mhamela's *A History of Nursing in Tanzania* refers to this type of methodical nursing as process nursing, which has its origins in the nursing methods Florence Nightingale herself started.[15] However, as time has passed, and the length of training programs has decreased and the demand for more health care personnel has continued to rise, nursing education and, in turn, practice have evolved. The younger nurses did not often speak to me about nursing more generally as a profession, though some would talk about it in terms of how their current work environments did not allow them to use all the book knowledge they had acquired in the classroom. Care in nursing education may now focus more on technical expertise, but nursing students still learned the ideals of Florence Nightingale, as well as up-to-date codes of ethics from the Tanzania Nurses and Midwives Council.[16] Their care practices began to change as soon as they stepped into the wards and sought to emulate the experienced, embodied practices of the older, more skilled nurses. Sometimes these older nurses demonstrated a true calling for nursing and a commitment to close patient care. Other times, the chaotic and underresourced environment of the hospital, combined with nurses' own personalities, home situations, and persistent feelings of lacking care from the institution employing them, led nurses to hastily breeze through interactions with patients with limited emotional engagement, producing a type of caring that appeared, from the outside, to be emotionally distant or that resulted in abuse. Yet

these behaviors were the product of an environment with very little room for other options. Younger nurses began to mirror these behaviors too.

I have gone into such detail related to the workings of the maternity ward and the hospital more generally in order to paint a picture of the flow of patients through the hospital and the stages of care on the ward. The tour of the maternity ward outlines the sheer amount of work for which the nurses were responsible on a daily basis. In addition to the tasks I have enumerated, the nurses fetched supplies, attended meetings, rotated onto the HIV testing and counseling service, the family planning service, and the cervical cancer screening clinic, and were responsible for an ever-increasing amount of documentation. In the absence of medical attendants or auxiliary staff members, as on the night shift, the nurses would also mop floors, wipe down beds, wash equipment, and fold gauze for use in delivery kits.

The multiple professional demands on nurses' time occurred against the background of their home lives and domestic needs and responsibilities. More than one nurse on the maternity ward bore the primary responsibility for paying their children's school fees or those of a younger sibling, supporting aging parents, and supplementing the income of their spouse, who often was not employed in the formal sector. All of these competing demands, in addition to low wages, a lack of resources, and unsupportive interactions with hospital administrators, sometimes resulted in care for pregnant mothers that did not meet the guidelines of best practice. The global health community has deemed these guidelines *the* route to reducing inequalities, improving access, increasing the number of births attended by skilled personnel, and, ultimately, reducing deaths. Instead, the care that nurses and doctors were able to cobble together in this environment worked in most instances, keeping most women alive, sometimes with unclear reasons as to why. This care was, for most women, good enough. At times, "'good enough' care may be a wiser goal than care that is 'ever better.'"[17] Just as some ethical negotiations resulted in everyday ethics that deviated from codified professional ethics, sometimes "good enough" care that deviated from guidelines might be all that was possible.

Combined with women who entered the hospital with uncertain knowledge of the institution's procedures, which often undermined their confidence in what they knew about their own bodies, the personal burdens on nurses, and the high demand for their services, culminated in an environment that allowed some women to slip through the gaps. On the night shift, as the one nurse on the postnatal ward sought a few minutes of rest, a woman silently "changed condition and died," as the reports the nurses read the next morning often stated. During the day, the routine hustle and bustle of the ward, combined with a difficult home life or conflict with administrators, could result in nurses abusing or selectively neglecting a particularly difficult patient. That difficult patient might be the one who later died of cardiac failure after overexerting herself in the second stage, while

the nurses yelled at her to push, not knowing (because they had not been able to spend more time on the initial intake and patient history) or not remembering that she had a history of chronic anemia that had contributed to heart problems while she was pregnant.[18]

There was a tension between creating good emergency care and what happened in practice. The maternity ward sought to structure the flows of women through the ward partially in an effort to deal with being overburdened with patients. This highly structured flow, as described in the beginning of this chapter and in chapter 1, was itself a form of bureaucracy within the ward. If a woman did not fit the prescribed structure because of having an unpredictable body—complications, or faster-than-normal labor—she often did not receive the care she needed. This lack of appropriate or needed care could take the form of giving birth on the examination bed or without a nurse, in the admission room, or it could take the form of delayed surgeries, lack of medicine, or neglect during a severe emergency, sometimes resulting in her death.

The biomedical institution is part and parcel of a global biobureaucratic complex while also being a fully functioning biobureaucracy in its own right. Here the boundaries of inside and out, local and global, are no longer useful. Biobureaucratic policies and protocols, as well as institutional goals, order expectations of both technical and affective care. Along with influencing expectations of care, the broader biobureaucracy of global health and safe motherhood has brought with it quality improvement guidelines aimed at improving technical care through increasing surveillance, documentation, and metrics. In actuality, some of these guidelines and technocratic approaches disallow forms of affective care or impose new tasks on nurses and doctors that then reduce workers' satisfaction with their jobs. This reduced satisfaction can result in fraught interactions between patients and providers, further decreasing the quality of care, both technical and affective.

Nurses on the maternity ward repeatedly told me that they perceived the hospital nursing administration to be uncaring, unresponsive, and out of touch with the needs of the ward staff and their very difficult working conditions. However, these same administrators were often severely constrained by the bureaucratic protocols handed down from NGOs and from national and international policies that were often out of date or impractical in their setting. This conflict, for all the providers and administrators, between guidelines or protocols and everyday lived reality contributed to deep-seated feelings of resentment and demotivation and shifted ethics toward providing "good enough" care in their setting and devising inventive ways of concealing their deviations from best practice.