Introduction

My journey to studying maternal mortality started when I was an undergraduate visiting Tanzania for the second time in the summer of 2008. I was based at a regional referral hospital and one of the doctors invited us to witness an autopsy. The two other American students and I followed the doctor into the small morgue and peered at the woman’s body lying on the table. As the doctor began the procedure, he explained she had died during labor and, while he wanted to try to identify her cause of death, he also needed to extract her full-term infant who had also died. Locally, people did not bury pregnant women who died with the baby still inside; they must be buried separately. I was just 19 years old at the time and, as the doctor worked, I was struck by the fact that the incision he made was the same as would have been made at the start of a cesarean section, which might have saved this woman’s life and that of her baby. Standing there, I began wondering why it was that women still die due to pregnancy-related causes. In a world with the clinical knowledge to identify and prevent many of the complications that most frequently cause the death of a pregnant woman, I was deeply disturbed by the global inequities that meant women in places like sub-Saharan Africa had vastly greater chances of dying due to pregnancy than women in any other geographic region of the world.

Maternal death is a culmination of structural (financing, infrastructure, human, and material resources) and social issues and, as such, it is a sensitive measure of the value societies place on women’s lives, as well as an indicator of the overall functioning of health systems. The vast majority of maternal deaths continue to occur in low-income countries. However, some high-income countries, the United States in particular, are experiencing a surge in maternal deaths related to persistent social inequities. Anthropological investigations of maternal mortality have spanned geographic contexts, focusing on structural and political-economic forces, as well as locally specific notions of maternal risk and locally valued care during pregnancy, birth, and postpartum. Most frequently, these investigations have centered on the voices of women and their community members, as well as indigenous practitioners of midwifery or other forms of childbirth support and assistance. Some of this work parallels shifts within the Safe Motherhood Initiative, an effort led by the World Health Organization, which at its 1987 founding emphasized prenatal care, then shifted focus to training “traditional” birth attendants, then to training in biomedical emergency obstetric care. More recently, in light of the growing emphasis on...
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biomedical birth in global policy, anthropologists have turned to investigations of biomedical care, facilities, and practitioners to further understand maternal death.

This chapter highlights work in the anthropology of reproduction related to understanding pathways to maternal death. I first define maternal mortality and provide an anthropological overview of this phenomenon, followed by a review of main themes in the literature. I then describe my own ongoing work on maternal mortality in Tanzania. Finally, I suggest pathways for how anthropologists can continue to contribute both to public health and policy discussions of this issue, as well as how we might use maternal mortality as a topic to continue pushing anthropological theory forward more generally. Anthropological investigations of maternal mortality uniquely interrogate seemingly routine and minor incidents, both in healthcare settings and in communities, revealing them to have sometimes calamitous effects for pregnant women, as well as deep roots in systems of power and inequity. Attending to these deaths from this anthropological perspective shows us where we need to do better and cautions us all against taking the deaths of pregnant women for granted as expected or natural.

Studying maternal mortality: Definitions and challenges

Due to the critically important role of reproduction for societies and nation-states, the management of birth has long been a site for state control and intervention. Globally colonialism, post-colonial trajectories, neoliberal economic policies, and more recently the forces of late capitalism have influenced patterns of intervention and population management via maternity. Despite the long history of these efforts, far too many women continue to die during pregnancy, childbirth, and the postpartum period. In the 1970s and 1980s, second-wave feminism helped draw attention to neglected women’s health issues, which generated increased research and jump-started efforts to elucidate the global burden of maternal deaths; the extent of the problem revealed in the 1980s was a shock to many (Rosenfield and Maine 1985). We continue to seek more and better ways to prevent pregnancy-related deaths. The World Health Organization (WHO) (2016) defines maternal mortality as:

The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. To facilitate the identification of maternal deaths in circumstances in which cause of death attribution is inadequate, a new category has been introduced: Pregnancy-related death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death.

The WHO further breaks down these deaths into direct and indirect causes. Direct causes are clinical conditions responsible for a majority of maternal deaths globally and include complications such as hemorrhage, complications from abortion (or attempted abortion), hypertensive diseases (including eclampsia and pre-eclampsia), sepsis/infection, and obstructed labor (Maine and Rosenfield 1999; Ronsmans and Graham 2006). Pregnancy itself can worsen several pre-existing health conditions such as diabetes, HIV, malaria, obesity, or heart problems, which, together, can result in indirect maternal deaths (WHO 2015a).

In low-resource settings across the world, maternal mortality continues to be a real and present threat for women of reproductive age; in places such as sub-Saharan Africa, women face a one in 45 lifetime chance of dying due to pregnancy-related problems (WHO 2015). For women in high-resource, high-income settings, the chance of death is far less overall, but the
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most disadvantaged and marginalized groups bear an outsize portion of the maternal mortality burden. For example, in the United States, there have been several important anthropological investigations of the impact of racism and structural violence on the reproductive health experiences of women of color (e.g., Bridges 2011; Davis 2019). These works show how intersecting factors contribute to the disproportionately higher rates of maternal death for Black women, nearly 2.5 times greater than the rate for non-Hispanic White women and 3.1 times greater than for Hispanic women, as reported by the US Centers for Disease Control and Prevention (CDC) (Hoyert et al. 2020).

From an ethnographic standpoint, maternal deaths can be nearly impossible to witness in real time due to their relative infrequency in many settings, even where they are more common. Additionally, cultural norms or bureaucratic biomedical systems can limit discussions of these particular deaths. There are few book-length anthropological investigations specifically of maternal death (Allen 2004; Berry 2010; Strong 2020; Wendland n.d.), but many monographs on pregnancy and reproduction include some consideration or mention of the death of pregnant women (e.g., Chapman 2010; Cosminksy 2016; Lukere and Jolly 2002; Maraesa 2018; Sargent 1982; van Hollen 2003). There are, of course, many more articles on the topic. However, the relative infrequency with which maternal death occurs can make it an extremely difficult phenomenon to study. For instance, in the entire United States in 2018, only a total of 658 women were identified through medical records and vital statistics registries to have died due to “maternal” causes and another 277 “late maternal deaths” occurring between 43 days and one year postpartum (Hoyert et al. 2020). The total number of births reported in the United States in 2018 was approximately 3,788,235 (Hamilton et al. 2020), meaning that maternal deaths occurred in just 0.025% of births. In my own field setting of Tanzania, out of a population of more than 56 million people, between 8,000 and 13,000 women die each year in the country due to pregnancy-related causes (Shoo et al. 2017). Although this represents a much higher mortality rate, it is still difficult to carry out anthropological research on a relatively rare phenomenon because of the need to be in the right place at exactly the right time. Additionally, these are traumatic events that are difficult for people to process and discuss, including for healthcare workers, community members, and researchers themselves.

In other countries around the world still struggling with much, much higher numbers of maternal deaths, it would be, in theory, more possible to study this problem due to the greater frequency with which these deaths occur. However, there are numerous additional barriers to studying maternal mortality, beyond the small absolute number of women dying in any one place, such as cultural norms prohibiting speaking of these deaths or fears of blame. In some cases, anthropologists are accidental witnesses of maternal death; Cameron Hay’s (1999) work in Indonesia, for instance, recounts two maternal deaths for which she was present in one small community. Similarly, Marta Rohatynskij (2001) writes about the death of her friend, Amsatou, a Fulbe woman in Burkina Faso, who died shortly after giving birth. In contrast, some anthropologists explicitly aim to study maternal mortality. Claire Wendland, for instance, has long been committed to studying maternal mortality. Rooted in ethnography in Malawi but following the connections between individual maternal deaths and metrics, politics, and meaning, Wendland (n.d.) writes of the partial stories and multiple perspectives involved in every maternal death. My own work, which I discuss further at the end of the chapter, specifically focuses on maternal mortality in health facilities (Strong 2020). Wendland’s research and my own have specifically incorporated the perspectives of biomedical personnel charged with caring for pregnant women and averting their deaths. Others who have focused on maternal mortality in their ethnographic monographs, notably Denise Roth Allen (2004) and Nicole Berry (2010), have tended to draw on the perspectives of women and local midwives or traditional birth attendants, as well as the
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local effects of global policies. These approaches complement one other and both are crucial for understanding maternal mortality.

Because maternal mortality ratios (MMRs) have become a metric closely tied to international development goals, good governance, and the smooth functioning of states and health systems (Wendland 2016a), proposing to explicitly focus on maternal death is often met with reluctance and skepticism. People involved, including healthcare workers and administrators, policy makers, and individual families or communities, often fear they will be blamed for the deaths of pregnant women. Many countries suffering from the highest burdens of maternal mortality also lack a robust civil registry or vital statistics systems that can track deaths and their causes. Without this capability, it is difficult to ascertain the extent of the problem or other relevant information. When available at national levels, maternal mortality ratio data are often not disaggregated by region or smaller units, further complicating attempts to understand where maternal deaths are most common and why. Data produced at local, district, or even regional levels can be plagued by uncertainty and inaccuracies due to the same infrastructure constraints affecting data collection at all levels. The possible reasons for data that do not reflect the actual number of deaths are many. It may be hard for healthcare workers to report data to higher levels; women may be giving birth at home, never intersecting with systems that would track them; healthcare administrators may be loath to increase the deaths attributed to their facility or region. Additionally, people most immediately affected by the death of a woman who was pregnant or during the immediate postpartum period may not wish to discuss such deaths. Carolyn Sargent’s (1982) early work in Benin neatly lays out these challenges. She writes:

Because of the absence of birth and death registrations it is difficult to estimate mortality rates. Information on maternal mortality proved impossible to obtain on a systematic basis due to the prevalent Bariba attitudes toward maternal deaths. Although some attempt was made at interviewing matrones regarding maternal deaths which they had encountered or remembered, this questioning was dropped due to distaste and outright refusal to answer the question among all the matrones. Information on maternal mortality was therefore acquired by hearsay.

(Sargent 1982: 147)

Themes in the anthropology of maternal mortality

At the start of my investigations into maternal death in Tanzania, I was, like many anthropologists before me, most interested in the experiences of women themselves. It quickly became apparent that both anthropological and public health studies had already covered much ground in explorations of women’s access to, and use of, life-saving obstetric care. The answers seemed clear: Contributors to a lack of access involved far distances to healthcare facilities, lack of transportation, inequitable opportunities for education, and, perhaps most importantly, poverty and structural violence. Years of public health and advocacy efforts meant that women in Tanzania had taken to heart messages about how biomedical health facilities could help them and their babies during labor and while giving birth. Fewer and fewer women over the years have expressed a desire to give birth outside of biomedical facilities. Public health messages driving women to biomedical care derive from research that shows it is incredibly difficult to predict which women will develop life-threatening complications while giving birth (Yuster 1995). It is often difficult to clinically identify women most at risk for pregnancy-related complications; health systems must be ready at any moment in order to prevent these deaths. As a result, policy in many places globally has shifted to emphasize biomedical healthcare as the
answer to eliminating maternal deaths. Despite these important efforts and research, hundreds of thousands of women globally continue to die of pregnancy-related causes each year. These ongoing deaths suggest that the public health and clinical insights into causes of maternal death are insufficient for fully explaining the stubbornness of these deaths. It is at this point that much of the anthropological research on maternal mortality takes up the thread and extends lines of inquiry into some of the complicated aspects of the lives of women and communities, as well as global structures, that might be sustaining high rates of maternal death.

There are several main strands of anthropological research on maternal mortality seeking to address this complicated phenomenon more holistically. Here, I concentrate on four trends: 1) Concepts and management of risk; 2) interactions with biomedicine; 3) global health policy related to Safe Motherhood; and 4) metrics and data collection. I have artificially separated out these four areas here, but, in truth, they are all intimately connected and co-constitutive. For instance, notions of risk in the community might structure women’s decisions of where to seek care during pregnancy or when giving birth (Allen 2004; Chapman 2010; Sargent 1982), while biomedical notions of risk inform global policy development (the Safe Motherhood Initiative) and its foci for intervention, and metrics play a vital role in establishing authority and efficacy.

Anthropologists have rarely engaged with these topics in isolation; instead, they have pursued these issues as they are in real life—entangled, diffuse, and very real in the lives of pregnant people and those who care about them.

Risk

The advent of the Safe Motherhood Initiative in the mid-1980s articulated a host of contributors to maternal death and, in turn, generated campaigns that sought to convey to women, healthcare workers, and policy makers the risks women had to overcome on the way to a healthy pregnancy and birth. Public health research on the contributors to maternal mortality exploded during this period and continues unabated to the present (e.g., see the maternal health series from the Lancet in 2016 and a similar series in 2006). One of anthropology’s major contributions to this research was an elucidation of just how drastically biomedical or public health concepts of risk can differ from how women and community members understand risks or threats to pregnancy and successful reproduction. Additionally, the risks to many women globally may still be directly related to structural vulnerabilities, including poverty, often produced by economic reforms (Janes and Chuluundorj 2004; Pfeiffer and Chapman 2010).

Biomedical risk includes problems such as anemia, high blood pressure, pre-existing medical conditions, or high parity. However, for many women, these risks rooted in biomedical notions of physiology may not take precedence over risks from other sources. Witchcraft or other social and supernatural threats continue to be a relevant concern both for a woman’s health and that of her child (Allen 2004; Berry 2010; Chapman 2010; Jambai and MacCormack 1996; Obermeyer 2000; Sargent 1989: 1178; van der Sijpt 2010). Biomedical providers are not the appropriate people to untangle these social problems. For instance, in my work in Tanzania, men and women have explained how they were careful to not talk about a pregnancy until the woman absolutely could not hide it any longer. People said they did not tell others when the woman was in labor out of concern that if news traveled someone who did not wish the woman well could use this particularly vulnerable time to send witchcraft to the woman and cause a difficult labor or even the death of the baby or the pregnant woman herself. Mitigating these more diffuse risks includes complicated management of information, bodily presentation, and social relations. For instance, Chapman (2010: 58) describes how women in Mozambique often are reluctant to even say aloud that they are pregnant for fear that these words could be considered bragging or
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that the information could be then used by those who might wish the woman ill; “silence and secrecy are the first forms of prenatal care” (Chapman 2010: 30).

Supernatural, social and physical risks during pregnancy and birth are important to women and their communities. Yet in its effort to solely address the physical dimensions of risk, biomedicine itself may become a source of risk for the community. In her 2004 work, Denise Roth Allen argues that beyond creating inadequate solutions for reducing maternal mortality in Tanzania, reliance on official—that is, clinical or public health—definitions of risk “are, in turn, perceived as risks themselves by local community members” (Allen 2004: 9). Biomedicine and public health interventions become not only the “answers” to solving the problem of maternal death but, simultaneously, the progenitors of new risk landscapes women and their families must navigate.

Interactions with biomedicine

A desire to reduce maternal morbidity and mortality has been one of the key drivers of the medicalization of pregnancy and birth. However, the push to bring pregnant women into contact with biomedical healthcare services has come with reduced options for more holistic care, including home-based care, for parturient women. Sheila Cosminsky’s (2016) work with indigenous midwives in Guatemala highlights how these important members of Indigenous communities have seen the available space for their practice and care shrink as other policies encourage emergency obstetric care in biomedical facilities.

In researching women’s perspectives, and those of their community-based, non-biomedical providers, scholars of the anthropology of pregnancy and birth have sought to bring to light why it is that women do not give birth more frequently in biomedical facilities despite increasing attention to emergency obstetric care at all levels. Several authors have explored women’s decision-making and care-seeking behaviors, describing how their social needs, goals, and risks sometimes lead fewer women to give birth in biomedical facilities than might be expected or than policy makers desire (Berry 2010; Brunson 2010; Chapman 2010; Jeffery and Jeffery 2010; Sargent 1982; Spangler 2011). Reports of discrimination and obstetric violence (see Oluoch et al. this volume) might dissuade some women, while others are unable to access transportation or acquire necessary financial resources. In some instances, delays in reaching biomedical care can result in a woman’s death but in many others, the woman is able to give birth without complications and in a known or socially important setting, such as at home (see Berry 2010). In other cases, restrictive sociocultural practices might limit options for assistance during pregnancy and childbirth, sometimes leading to high rates of death (e.g., Wall 1998).

Anthropologists have documented profound distrust in biomedical institutions and their ability to help pregnant women survive. In many areas of the world, systemic resource scarcity continues to contribute to poor outcomes for women who need assistance during obstetric emergencies. For example, a lack of basic medications, poor sanitation, or other supplies can cause infections contracted in the facility setting (to which women would not likely have been exposed at home) or result in an inability to save women from hypovolemic shock brought on from hemorrhage. Accounts, such as Hay’s (1999), of women’s deaths in health facilities contribute to deep distrust of these spaces.

Additionally, hospital-acquired problems highlight the iatrogenic effects of biomedicine. Emma Varley (2019) documented the routinization of dangerous off-label uses of oxytocin—a drug routinely used in labor and delivery for a number of purposes, including to induce labor and prevent postpartum hemorrhage—that came to threaten the lives of both women and babies. In a unique study conducted on four different hospitals’ maternity services, Yannick Jaffré
Adrienne Strong (2012) argues that, instead of being small, issues such as lost medical files, failing to acknowledge women upon entry to the ward, and conflicting constraints and understandings of responsibility between departments can cumulatively lead to maternal deaths. It might not be that biomedicine itself is harmful but that the institutions in which it is practiced are. This is particularly the case when those involved in clinical care are unable to reflexively analyze the care they provide or what went wrong when someone dies (Jaffré 2012; Strong 2020).

Several anthropologists have documented the tragic negotiations families undertake when trying to help a pregnant woman survive (e.g., Jeffery and Jeffery 2010; Hay 1999). Poor interactions with healthcare workers or previous experiences of corruption or neglect in biomedical settings erode the trust women and their families have in these institutions (e.g., Berry 2010; Jeffery and Jeffery 2010). Such interactions are common contributors to low quality of care in health facilities globally. For other women and their families, economic precarity and lack of financial resources may dissuade them from seeking biomedical care during obstetric emergencies. Women might worry that healthcare workers will turn them away or neglect them because, as poor women, they present limited prospects for providing incentives or bribes to garner better care. Likewise, providers may assume them to be lazy, dirty, or uneducated and neglect them out of distaste or apathy (Jaffré 2012). As Oluoch et al. discuss in this volume, obstetric violence also contributes to low quality of care and women’s choices to pursue care elsewhere during subsequent pregnancies.

**Global health policy and Safe Motherhood**

Egyptian medical anthropologist Soheir Morsy wrote scathingly of how the global agenda to reduce maternal mortality facilitated population control plans and sanitized the population control agenda under the guise of reducing deaths (Morsy 1995: 163). She called for an analysis of maternal mortality and Safe Motherhood Initiative projects informed by historical and political-economic contexts. She further accused biomedically informed policies of “fail[ing] to account for how enhanced risk is both socially produced and historically specific” (Morsy 1995: 166). Following her work, other anthropologists of reproduction have sought to shed light on exactly these socially and historically produced risks to pregnant women and how these articulate with national and global health policies. For example, Rosalynn Vega (2018: 188) criticizes policies that originate in the Global North meant to reduce maternal and infant mortality for, instead, “inadvertently reproducing processes of gendered racialization and reinscribing inequality between global ‘whites’ and indigenous people.” Vega’s focus on global maternal health policy draws attention to the unintended effects of policy plans and reversals that reverberate in local communities.

Storeng and Béhague have written about the development of policies and priorities stemming from the beginning of the Safe Motherhood Initiative in the mid-1980s (e.g., Storeng and Béhague 2016). One of the most significant findings from their work with actors involved in this movement is a description of the fragmentation within the movement and how “the cost of operating within an extremely competitive policy arena has involved a partial renunciation of ambitions to broader social transformations in favor of narrower, but feasible and ‘sellable’ interventions” (Storeng and Béhague 2016: 992). Others have written about how the Safe Motherhood Initiative originally came into being (see AbouZahr 2003 and Starrs 2006). The need to carve out these “sellable” interventions in lieu of more systemic change seems clear. The early 2000s brought with it the Millennium Development Goals (MDGs), one of which was to reduce maternal mortality by three-quarters from the 1990 levels by the end of 2015. Without comprehensive changes, this MDG represents one of the great unfinished agendas of this era.
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Anthropologist Margaret MacDonald’s (2019) analysis of the visual world of the Safe Motherhood movement and contemporary humanitarian efforts to reduce maternal mortality convincingly demonstrates how these campaigns have left behind images of suffering in favor of images of women’s empowerment and hope. MacDonald argues, “The images suggest we can do something, but at the same time mask the social and political forces that perpetuate suffering and lack” (MacDonald 2019: 280). MacDonald (2019: 279–280) argues that newly “hopeful and aspiring subjects” affectively tie viewers to these images while hiding deeper inequality. Despite these critiques, attempts to reduce maternal mortality continue to replicate the same approach: Unable or unwilling to address the deep roots of this global problem, they instead favor more readily available, feasible, technical interventions. Data and metrics feed into these technical solutions, enabling them to continue and helping to cloak complex underlying drivers of maternal mortality at play.

Metrics and data collection

Health statistics have long been a way to measure, track, and control populations. Policy shifts in the global health and Safe Motherhood spaces over the last 40 years have resulted in a heightened emphasis on data collection and reliance on metrics and indicators. Donor countries in the Global North take demonstrated declines in indicators such as maternal mortality to signify other countries’ seriousness in efforts to “develop” or achieve progress (Merry 2011). Maternal mortality ratios are political (Oni-Orisan 2016; Wendland 2016a, 2017). However, inasmuch as these numbers are political, they are also often deeply flawed estimates (Erikson 2012; Wendland 2016a). With a focus on enumerating maternal mortality since the 1980s, there has been a global push, supported by the WHO and the World Bank, for countries to implement maternal death reviews or audits as a way to track deaths, find common areas for improvement, and prevent similar deaths in the future (Mills 2011). Anthropological analyses of maternal death reviews reveal challenges to utilizing these meetings effectively including ambiguity and omission, failures of accountability, and attempts to decenter blame (de Kok et al. 2017; Gutschow 2016; Strong 2020). In my own work, I analyze how metrics, data collection, and audit meetings work to “render technical” (Li 2007) the extremely complicated problem of maternal mortality (Strong 2020). Building on significant work within anthropology on metrics and indicators, I view this push for data collection as a form of reproductive governance (Morgan and Roberts 2012) exerted not necessarily, or only, on women but on healthcare workers and administrators. The global system now functions in a way that prioritizes data collection over care practices for pregnant women on the ground.

Anthropologists are not often present in places that collect pregnant women, concentrating them so that many deaths and births occur all in one place. Claire Wendland’s work at the Queen Elizabeth Central Hospital in Blantyre, Malawi, which she references in a chapter on maternal mortality metrics in an edited volume (Wendland 2016a: 59), is among the first anthropological works examining maternal mortality explicitly in a biomedical space, in an enormous hospital in an urban center with thousands of births per year. Pairing community-based work with ethnography from biomedical facilities brings valuable new insights into the global struggle to continue reducing maternal deaths, as well as how they come to take place and the meanings of these deaths to all parties involved.

Case study: Maternal mortality in Tanzanian health facilities

Inspired by the work of Claire Wendland in hospitals and prompted by the stories of nurses and doctors working on busy labor wards in Tanzania, I eventually came to study maternal
death in the biomedical setting. In this location, community, structural, and personal factors in women’s lives condensed into risk and combined with the global policies pushing for facility-based deliveries and numbers to support public health interventions. With growing emphasis on biomedical assistance at birth, it seemed to me that the actors missing were those meant to provide this care, the interactions with whom most anthropologists render from the point of view of women. I was motivated to begin providing the other side of the equation, the perspectives of those working hard to provide maternal healthcare under difficult conditions in facilities. In the early part of my fieldwork at Mawingu Regional Referral Hospital in Rukwa, far to the west in Tanzania, it became apparent that the doctors and nurses had a great deal to say about their struggle to reduce maternal mortality. I became most interested in what happened when pregnant women managed to arrive at this relatively well-equipped regional referral hospital and then still lost their lives. Over nearly two years at this hospital in 2014 and 2015, I specifically investigated this issue. Maternal deaths have a tendency to impose themselves, demanding attention even when not my specific topic of inquiry. These deaths have occurred while I was conducting research in at least three different facilities in various regions of Tanzania. During my time in the Kigoma region, to the north of Rukwa, from January to December 2018, I spent several months at a busy health center outside of Kigoma Town.

Deaths at this health center were infrequent and so, when a woman named Husna Husain¹ died there in August 2018, it was remarkable and deeply affected the staff members. In a scene forever inscribed on my memory, her relatives prepared her body for burial, even bringing the caskets for her and the deceased baby into the fully occupied ward. Due to various bureaucratic problems and delays, Husna’s body had been lying in one of the ward’s delivery rooms (see Figure 32.1) for almost 24 hours, waiting for a doctor to certify her death before her relatives could claim her body and prepare it for burial. As Muslims, the family wanted to be able to bury her as soon as possible and the long delay was causing them distress. The following is excerpted from my field notes as I pieced together the story of Husna’s death the next day.

From the moment I pulled up in the car this morning it was clear something had happened. I didn’t immediately assume someone had died but it seemed like that could be the case because there were two big groups of relatives out where I usually park my car, one of women and another of men. The general air of the health center was different as well, uneasy. I walked past four of the nurses huddled in a tight cluster in the hallway and nobody greeted me back.

I started asking and they told me there had been a maternal death. I thought it must have happened overnight, but they said no, the woman had died yesterday afternoon, just after 3pm. Up until now, at 12:45pm on Monday, the body is still here in one of the labor rooms, waiting to be taken away by her relatives. Everyone was upset because her death still had not been certified, and the health center In Charge [Chief Medical Officer] was not around, and they had not done anything to separate the baby from the mother.

Moody, the newer male registered nurse, was on the morning shift alone yesterday. When Husna arrived, Nurse Moody did a pelvic exam and found blood clots. Soon after she started hemorrhaging. He started two IVs and only 8 minutes later he started calling on the phone to find a doctor … In the end, no doctor showed up until 3:30 pm. Husna had died at 3:10pm, just 10 minutes after Nurse Edward had arrived for the evening shift. In that nearly two hours alone Moody did what he could to try to stabilize her.
The issue was the delay on the part of the doctors, each one saying they weren’t on duty and to call someone else … When the nurse manager of the ward, Nurse Mary, arrived, she told us that the death of a pregnant mother hurts more than any other kind of death. I think it sounds like they have had very few maternal deaths overall at the health center so it’s not at all a normal occurrence and they all, on the whole, were very upset about it. There was supposed to be another nurse on duty yesterday in the morning, too, according to the roster so I’m not sure why Moody was the only one present. He surely would have benefited from assistance.

Finally, one of the doctors came to the ward and certified Husna’s death, only then was she “officially” dead. Dr. M decided to do the separation of the baby from the mother because the relatives had agreed, even though the district official was saying that medically they don’t do it, that this procedure is “just tradition” and the family had wanted them separated. Dr. M decided to do it right there in the delivery room instead of taking the body to the mortuary or the operating theater. The procedure was messy and unsightly, but I don’t really know how they would have managed to move the body … In this procedure, Dr. M said it was a case of placenta previa, when the placenta sits low in the uterus and either partly or entirely occludes the cervix, a common cause of antepartum hemorrhage.

Figure 32.1 View of the room in which Husna died.
After they removed the baby, sewed her back up, and cleaned up Husna’s body, they called the relatives to let them know they could take her. The floor in the labor room was really a terrible mess and it took a while to mop everything up. It was really grim looking and the blood, mixed with the cleaner, turned all the water a terrible greyish green color. They wanted to clean it all up before the relatives came in, so the relatives wouldn’t see any of that mess. The relatives came into the delivery room and asked permission to be able to wrap her in the off-white cloth used to wrap corpses. The female relatives folded the cloth and wrapped it around Husna’s body, pulling tight so the hospital sheet didn’t show. They tore strips off to tie it around the body. They asked the sex of the baby and I told them male. They called male relatives to do the same to prepare the baby’s body.

Another maternity ward employee arrived, Mama Asha, she was there too yesterday and saw everything that happened. She said it was Husna’s sixth pregnancy. Husna had said her contractions were strange, rising up into her chest and pulling at the back of her neck. Mama Asha said Husna had told her she felt this pregnancy was not the same. Husna had said, “This trip, I don’t know if I will recover.” One of the other nurses saw where Husna had come from on her death certificate, a village hours away, and said, “Poor thing, she knew that she had already arrived into safety.” And yet, in the end, the facility in which Husna had placed her trust and which she had travelled far to reach, failed to save her. Six pregnancies and only 31-years-old. Dead.

I don’t include all the details here to be graphic or disrespectful to Husna, her relatives, or the nurses and doctors involved in her care. In fact, my intention is quite the opposite. So often the reality of these deaths, how they occur, the fight to save the woman, the people left behind and impacted by her death, do not make it through the forest of statistics and the details of high-level policy. Anthropologists often receive explanations of maternal deaths second-hand. Intellectually, we might be able to read the numbers and think we know what they mean, but every death is different and significant. In Husna’s story, the full version of my notes includes an account of how the family brought coffins into the ward and much more detail about the delays in reaching a doctor and convincing him to come to the facility, as well as the other delays resulting in Husna’s death. Staffing problems, in this case possibly related to Nurse Edward’s chronic tardiness and routine requests to swap shifts with others, left Nurse Moody alone on the ward with an emergency that required more hands. Moody had also only been working at the health center for less than a month when this happened, making him less equipped than others to tap into alternative methods for finding a doctor or inducing him to arrive quickly. Quickly, and yet so slowly, Husna’s life slipped away. Global health policy and national efforts to implement Safe Motherhood Initiatives have, over the last almost 40 years, pushed more and more women to give birth in biomedical facilities. Like Husna, these women have been led to believe that they have already arrived at safety when they reach these facilities, overcoming sometimes generations of mistrust in biomedical care. But systemic problems related to poor communication, staffing shortages, and lack of resources mean women continue to die even when they reach these facilities.

**Setting the agenda for the anthropology of maternal death**

Yannick Jaffré writes: “Anthropological research enlightens us and applies a principle of equivalence in the study of factors responsible for deaths and thus underscores how the most modest and distant of technical links can be the breaking point of a life” (2012: 11). This perspective and
attention to detail, the anthropological ability to perceive these distant links that often manifest as normal, routine events, is the great power of anthropological investigations of maternal mortality. The unanswered questions in this area include the profoundly challenging problem of the tenacity of these deaths. Ethnography of biomedical spaces, especially in maternity care, provides vital perspectives and can help to not only expand the theoretical contributions of the anthropology of reproduction to anthropology more broadly, but also suggest additional points of intervention that might help lead to improved care for women. Work in this area has contributed to conversations about the importance of metrics in global health, to understandings of the social and cultural importance of biological reproduction and its precarity, and to theories about care, local forms of medical ethics, and inequities in society revealed through interactions with biomedicine and, ultimately, deaths themselves. Finally, research on maternal mortality provides another window onto the lasting effects of colonialism and biomedical expansion globally as systems of power and inequity are reproduced and sustained in the present day.

Note

1 All names are pseudonyms.

References


Adrienne Strong


Maternal mortality


