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Special Issue: Behind the Measures of Maternal Health

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By Eliza Williamson

[Social Science & Medicine](#) has published a special issue called “Behind the Measures of Maternal Health, Ethnographic Accounts of Inventory and Intervention,” edited by Jan Brunson and Siri Suh. These articles offer “an ethnographic interrogation of contemporary metrics and ontologies of intervention enacted in the global South, investigates ‘behind the measures’ of maternal and reproductive health: the imperfect but pragmatic processes of quantification, inventory, and recording; how metrics are imbued with meaning, morality, and power; and how targets and indicators shape or drive individual and institutional behavior, as well as policy and program creation.”

[Behind the measures of maternal and reproductive health: Ethnographic accounts of inventory and intervention](#)

Jan Brunson, Siri Suh

Ontologies of intervention in global health involve a voracious appetite for data – collection of data as evidence of what is intervention is needed, the establishment of metrics to organize and make sense of that data, further surveillance and measures to determine whether interventions were successful and targets were met, and, increasingly, predictions that determine whether interventions will provide good returns on investments. This part-special issue, an ethnographic interrogation of contemporary metrics and ontologies of intervention enacted in the global South, investigates “behind the measures” of maternal and reproductive health: the imperfect but pragmatic processes of quantification, inventory, and recording; how metrics are imbued with meaning, morality, and power; and how targets and indicators shape or drive individual and institutional behavior, as well as policy and program creation.

[Homebirth fines and health cards in rural Tanzania: On the push for numbers in maternal health](#)

Megan D. Cogburn

Over the last two decades, there has been a global push to improve maternal health by increasing numbers of facility births in low- and

middle-income countries like Tanzania. While recent scholarship has interrogated the increasing hegemony of numbers and metrics in global health, few have ethnographically explored how this push for numbers and its accompanying technologies affect the lived experiences of parturients and those who care for them during pregnancy and childbirth in rural communities. Based on seven months of multi-sited ethnographic research conducted in three different rural communities in Mpwapwa District in 2016, this article explores how mothers and nurses in Tanzania experienced the push for numbers in maternal health, particularly as that push is enacted through homebirth fines and health cards. Intended to reduce maternal mortality, policies meant to increase facility births in rural Tanzania can inadvertently decrease access to care for the most marginalized community members, while simultaneously enticing under-resourced and over-burdened health workers to sanction non-compliant women while doing nothing to improve the wider health systems in which they work. Ethnographic interviews with mothers, nurses, and government leaders show how homebirth fines exacerbate structural inequalities in healthcare access, excluding some of the poorest women from the healthcare services they desire. Additionally, weekly participant-observation conducted at each of the community health dispensaries highlights the way female nurses engage in improvised and often punitive tactics with health cards, key documents for women to be able to access free national healthcare services. While the new sanctions can help lessen the heavy workloads of healthcare workers at rural dispensaries, they also lead to worsening relationships between nurses and the communities they serve. By prioritizing the perceptions and negotiations surrounding homebirth fines and health cards, this paper shows the unintended consequences of indicator-driven care, which most negatively affect the poor.

[Narratives of responsibility: Maternal mortality, reproductive governance, and midwifery in Mexico](#)

Sarah A. Williams

This research highlights the malleability of Maternal Mortality Ratios (MMR) and the ways in which they accommodate a variety of narratives via their claims about women's access to [reproductive health](#) services. MMR plays an important role in determining fiscal and legislative priorities for [women's health](#) in Mexico and in the discursive practices that shape societal beliefs about appropriate birthing practices and birth attendants. This paper is based on ethnographic fieldwork conducted in Yucatán and Quintana Roo between 2009 and 2017 during Ministry of Health midwifery workshops and approximately fifty interviews with [midwives](#), doctors, public health officials, and parents. It explores the mutability of MMR within the context of political struggles for midwifery in Mexico—both for and against its legality and existence. In Mexico, MMR is often used by

bureaucrats and public health workers to reinforce the importance of biomedical [obstetric](#) services over midwifery. However, the same metrics are also employed by midwives in critiques of underfunded and often structurally-violent maternal health care services. While doctors attempt to use MMR to prove that birth is inherently dangerous and must take place in hospitals with access to obstetric technologies and interventions, midwives use MMR to demonstrate that birth in hospitals is risky precisely because of those technologies and their inappropriate use, and to draw international attention and funding in support of midwifery. In addition to examining the strategic use of MMR in health-related discourses, this paper interrogates techniques employed by the state to limit midwives' access to births in the name of monitoring and improving MMR. I contend that while discursive uses of MMR to advance professional and political goals are common in both midwifery and [biomedicine](#), the asymmetric power relations of biomedicine vis-à-vis the Mexican state privilege interpretations of MMR that justify and legitimate enhanced bureaucratic surveillance of midwives.

[What post-abortion care indicators don't measure: Global abortion politics and obstetric practice in Senegal](#)

Siri Suh

Since the early 1990s, [post-abortion care](#) (PAC) has been advocated as a harm reduction approach to maternal mortality and [morbidity](#) in countries with restrictive abortion laws. PAC indicators demonstrate that the intervention integrates safer uterine aspiration technology such as the Manual [Vacuum Aspiration](#) (MVA) syringe into [obstetric](#) practice and facilitates task-shifting from physicians to [midwives](#). In other words, PAC not only saves women's lives, but more generally enhances the organization, quality, and cost-effectiveness of obstetric care. This article draws on my [ethnography](#) of Senegal's PAC program, conducted between 2010 and 2011, to illustrate how PAC indicators obscure the professional and technological complexities of treating abortion complications in contexts where abortion is illegal. [Data collection methods](#) include observation of PAC services and records at three hospitals; 66 in-depth interviews with health workers, government health officials, and NGO personnel; and a review of national and global PAC data. I show how anxieties about the capacity of the MVA syringe to induce abortion have engendered practices and policies that compromise the quality and availability of care throughout the health system. I explore the multivalent power of MVA statistics in strategically conveying commitments to national and global maternal mortality reduction agendas while eliding profound gaps in access to and quality of care for low-income and rural women. I argue that PAC strategies, technologies, and indicators must be situated within a global framework of reproductive governance, in which safe abortion has been omitted from maternal and [reproductive](#)

[health](#) care associated with [reproductive rights](#). Ethnographic attention to daily obstetric practices challenges globally circulating narratives about PAC as an apolitical intervention, revealing not only how anxieties about abortion ironically suppress the very rates of MVA utilization that purportedly convey PAC quality, but also how they simultaneously give rise to and obscure obstetric violence against women.

[Incorporating mammography into an overseas referral metric: Tongan doctors' assessments of patient eligibility for medical travel](#)

Zakea Boeger

Tonga's largest public hospital received its second—although its first fully functioning—mammogram machine in 2016. If diagnosed with breast cancer, Tongan women must travel to New Zealand or Australia to access biomedical treatment (e.g. chemotherapy), but many can only do so with financial support from the Tongan government. Given limited funding, strict referral guidelines require doctors to quantify patients into calculations of risk. According to these guidelines, which I argue serve as an overseas referral metric, only “low-risk” patients—as determined by prognosis and treatment cost—are supposed to be funded. At present, doctors can sometimes draw on qualitative knowledge, such as long-term clinical experience, to circumvent referral guidelines. However, as mammography touts new epidemiological capabilities, it also has the potential to reinforce emphases on quantifiable evaluations of referral eligibility, which are often preferred by program funders. This could potentially exclude some women from treatment, as already-limited funding is increasingly reserved for those deemed “low-risk” according to numerical assessments. Based on recent ethnographic fieldwork (2016-2017) in Nuku'alofa, Tonga, I draw on in-depth interviews and conversations with local doctors to elucidate the interplay between mammography access and practitioners' processes of cancer diagnosis, patient risk assessment, and overseas referral. In following doctors' efforts to maximize accountability and risk management in referrals, I show how broader emphases on quantification and efficiency in global-health practice can generate intense moral dilemmas for those who must grapple with their implementation in the day-to-day. Significantly, these experiences demonstrate how numerical trends in global health not only permeate local health-care practices but also impact transnational health-care seeking, shaping a political economy of medical travel that structures opportunities for some women (and not others) to access biomedical treatment abroad.

[Tool of economic development, metric of global health: Promoting planned families and economized life in Nepal](#)

Jan Brunson

In contemporary global health and development discourses, contraception

is cast in multiple roles: an antipoverty tool at the household level, a tool of economic development at the national level, a smart investment with net gains, a means of empowering women, a way of lowering maternal mortality ratios. In order to examine such discursive uses of contraception – and their implications for women – in a concrete way, I use a compelling case of the history of the promotion of planned families in Nepal and a recent social and behavior change communication contraception campaign designed in the US. Using social text analysis to examine this multi-year, multi-platform campaign in Nepal, I found that the advertisements present idealized images of “smart couples:” progressive, middle-class families engaged in rationalistic family planning to delay and space their offspring. A major theme identified, aspirations to be middle class, links these specific family planning behaviors to upward economic mobility. The small-family ideal previously promoted in the global South had outlived its relevance as Nepal and other countries reached near replacement-level fertility rates. The gradual historical refashioning in Nepal of a discourse that promotes the “small family” to one that promotes the modern “smart couple” is an illustrative example of the global trend in which a message of replacement-level fertility is repackaged as a message of delaying and spacing births under the guise of health, as funding agencies promote contraceptive adoption as a women’s health issue. Underlying this discursive repackaging, however, is a continued economization of life and health.

[Numbering others: Religious demography, identity, and fertility management experiences in contemporary India](#)

Holly Donahue Singh

Demographers have carefully analyzed intersecting aspects of identity beyond religious category that influence fertility patterns in India, such as region, access to wealth, sex ratios, and gender dynamics (Padmanabhan, 2015). Drawing on interviews and participant-observation conducted during 15 months of field research on infertility in Lucknow, Uttar Pradesh, north India, between 2005-07 and 2016-17, this study shows how nuances of demographic change categorized by religion, such as changes in fertility and mortality rates, ripple through public discourse and imagination less powerfully than overall shifts in population percentages. This paper connects media and political discourse about religion, demography, and fertility in large-scale reports, such as the 2011 Census of India and the Sachar Committee Report on status of Muslims in India (Sachar et al., 2006), to the health care services and advice provided to Muslim women and children. While the Sachar Report drew attention to economic and social disadvantage among Muslims, political discourse in response to the 2011 Census continues a trend of labeling disparities in fertility rates across religious categories as a social problem. Such discourse renders individual fertility and infertility experiences invisible and

reinforces longstanding negative representations of Muslims' fertility, with important implications for health, identity, and ultimately, governance (Sangamoorthy and Benton, 2012). Ethnographic data from health outreach efforts led by and serving Muslim women in Lucknow demonstrate the diversity of Muslim women's positions relative to health and fertility services as well as the intersections of various aspects of identity with fertility management experiences. By bringing these perspectives together, the paper shows how ethnographic work matters for making sense of quantitative population data. The political uses of large-scale quantitative data demonstrate how social science analysis can be used both to create "Others" and argue for neo-eugenics, and to bolster arguments for resources and reform that benefit the disadvantaged.

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