Chapter 1

Introduction

Lauren J. Wallace, Margaret E. MacDonald, and Katerini T. Storeng

Introduction

This book treats policy as an ethnographic object. Its ten chapters examine global policies for improving maternal and reproductive health, tracking the processes and politics of their making, the mechanisms of their implementation in diverse contexts, and people's intimate encounters with their consequences and effects. Doing so is timely since there is a growing appreciation that the success of health policies and interventions hinges on issues that are at the core of medical anthropological inquiry: the complexities of program implementation, the impact of socio-political contexts, and issues of local agency, equity and accessibility. Indeed, the burgeoning subfield of health policy and systems research views an interpretive and critical inquiry that draws on multiple disciplines, not least anthropology, as essential to understanding and informing effective policy (Gilson et al., 2011; Ghaffar et al., 2016).

The inspiration for this book was a double panel at the American Anthropological Association annual meeting in Washington, DC, in 2017 convened by Lauren

---

L. J. Wallace (✉)

Department of Anthropology, McMaster University, Hamilton, Ontario, Canada

Dodowa Health Research Centre, Research and Development Division,

Ghana Health Service, Accra, Ghana

e-mail: wallalj@mcmaster.ca

M. E. MacDonald

Department of Anthropology, York University, Toronto, Ontario, Canada

e-mail: maggie@yorku.ca

K. T. Storeng

Centre for Development and Environment, University of Oslo, Oslo, Norway

Faculty of Epidemiology and Population Health, London School of Hygiene and Tropical Medicine, London, UK

e-mail: katerini.storeng@sum.uio.no

© The Author(s) 2022

L. J. Wallace et al. (eds.), *Anthropologies of Global Maternal and Reproductive Health*,
Global Maternal and Child Health, https://doi.org/10.1007/978-3-030-84514-8_1

Wallace, entitled 'Ethnographic Examinations of Global Maternal and Child Health Policy and Practice', for which Maggie MacDonald and Katerini Storeng served as discussants. The panel sought to honour recent ground-breaking studies in which anthropologists had exposed the logic, values and practices of global health. As the book took shape, we sought to bring current medical anthropological research on global maternal and reproductive health into more direct conversation with anthropological studies of policy and with health policy and systems research. Our goal was for these conversations to produce more nuanced, more useful accounts of the making and implementation of global health policy than one field alone.

Reproduction is a unique entry point for anthropological analysis and critique of global health policy because it is a key site of social reproduction in every society. By focusing on reproduction, this book raises vital social and cultural concerns relevant to individuals, families, communities and nations: the meaning of life, personhood and death; moral regimes of gender and sexuality; the complexity of kinship and familial relations; and the intersectionality of gender, class and race. Reproduction is also a site of governance of women's bodies and lives (Jordan, 1978; Ginsburg & Rapp, 1995; Locke & Scheper-Hughes, 1987; Morgan & Roberts, 2012). Policies and interventions designed to improve maternal and reproductive health connect intimately with all levels of health system functioning (Storeng & Béhague, 2017) and are entangled with some of the most fundamental and long-standing tensions in global health including how to balance community versus facility-based health services; targeted interventions versus health systems strengthening; selective versus comprehensive primary care; the distribution of scarce resources across competing actors and needs; and contestation over what constitutes evidence (McCoy et al., 2010). Not unlike other global health interventions, maternal and reproductive health policies are also often framed by perceived wisdom and evidence that has been generated by a narrow set of research methods, often making it difficult to derive solutions relevant to the local context (Béhague & Storeng, 2008; Olivier de Sardan, Diarra & Moha, 2017).

As this book goes to press, the global COVID-19 pandemic is in its second year. The pandemic has disrupted routine reproductive, maternal, newborn, and child health (RMNCH) services, especially in low resource settings, threatening hard-won gains in maternal mortality reduction (Robertson et al., 2020). The pandemic has also exacerbated larger social and economic challenges that underlie weak health systems and poor access to quality of care, laying bare the structural violence that creates vast inequities between nations and within nations along intersectional lines of race, class and gender. At the same time, the pandemic has reinforced the need for critical social science research on the workings of health policy and health systems to be part of the evidentiary mix upon which people-centred and equitable

health policy and systems everywhere are built. It is a key moment of reckoning for maternal and reproductive health policy, and for global health more broadly.

The Anthropology of Global Maternal and Reproductive Health Policy

Policy is a social and political construct. It is a window into larger processes of governance – the mechanisms of power, knowledge, values and vested interests that are used by social actors, including governments, and corporations, to conceptualise, organise and regulate human life and relationships. An anthropological approach to policy contrasts with the instrumental, linear-rational model of the policy process that is often seen in policy analyses rooted in political science. It entails taking on the often complex, ambiguous and messy nature of policy by studying *through* and *across* the multiplicity of actors and interests, locales of power and influence and cycles of policy proposal and revision. The anthropology of policy takes a capacious approach to what counts as policy, including documents and clinical guidelines, laws, position statements, political speeches and declarations. Ethnographic fieldwork is particularly well suited to following policies into their ‘implementation contexts’ where they are interpreted, adapted, worked around or ignored in the context of practical norms and professional cultures (Shore & Wright, 1997; Wedel & Feldman, 2005, p. 2; Olivier de Sardan, Diarra & Moha, 2017; Fassin, 2013).

Anthropological critique often reveals the *local* consequences of global health, countering the ‘master narratives’ and working assumptions of the global health enterprise including the dominance of biomedical approaches to understanding health and illness and technocratic approaches to organising care (Nichter, 2008; Whiteford & Manderson, 2000; Castro, 2004). Working in the political economy of health tradition, critical medical anthropologists have also sought to connect the macro-level politics of structural violence and inequality to the micro-level of embodied experience (Singer & Baer, 1995; Farmer, 2004). Such efforts have shifted anthropologists’ gaze beyond the local setting and its immediate context, towards an appreciation and analysis of the deeper economic, political and historical underpinnings of health and illness. This shift has involved looking directly at the ‘global health enterprise’ itself to unpack the complex assemblages of social networks, power relations, ideologies, funding flows, documents, things, knowledge claims and epistemic discourses that constitute it (Pfeiffer & Nichter, 2008, p. 413; Ong & Collier, 2005; Janes & Corbett, 2009). Most recently, the term ‘critical global health’ has emerged to capture the expansive approach taken by many anthropologists to understanding the ‘policy space’ of global health (Biehl & Petryna, 2013).

Some of the earliest work in the field of critical global health focused squarely on maternal health. Judith Justice’s detailed examination of the planning and implementation of a program to train and disperse Assistant Nurses Midwives throughout

the Nepalese countryside (1989) and Brigitte Jordan's classic critique of training courses for traditional birth attendants in Mexico (1978) both clearly illustrate the lack of consideration of local context in national-level policies meant to improve maternal health care. These studies and a small body of ethnographic work that followed explored the interface between the technical logics of global health policy and programs and the material and sociocultural realities that produce poor maternal health. In so doing, they pointed to stark disjunctures between global 'safe motherhood' policy and the lived experiences of women, health workers and their communities (Pigg, 1997; Allen, 2002; Foley, 2007; Berry, 2010; MacDonald, 2017; Olivier de Sardan, Diarra & Moha, 2017). The interest in policy as a site of ethnographic inquiry within medical anthropology and critical global health studies has expanded greatly over the past decade; attention to metrics and the datafication of global health playing no small part (Storeng & Béhague, 2014; Adams, 2016).

The chapters in this edited book contribute to a growing body of knowledge illuminating global maternal and reproductive health policies through close attention to their formation and implementation in particular contexts. This volume offers ethnographic insights into the mechanisms by which global maternal and reproductive health policies are formed and implemented in diverse locales around the world, from India to Burkina Faso, Tanzania and Uganda, Switzerland and Serbia, the United States and Brazil. They will be of interest to scholars working in the overlapping subject areas of critical global health, medical anthropology, and the anthropology of reproduction and health policy and systems research. It is our intention that these chapters also speak to and inform the work of global public health experts and the development of guidelines and interventions. In short, we hope that these chapters can contribute to improved knowledge as well as actual practice.

Implementation Disconnects and Policy Rhetoric

The disjuncture between policy ideals and their implementation in practice – a long-standing concern of anthropological critiques of global health – is taken up by several authors in this volume. The notion of a 'travelling model' whereby an intervention developed by international experts is introduced in a standardised format in many settings, without consideration for specific, local, implementation contexts, analytically captures this situation. Travelling models have long been taken to be intrinsically effective, and therefore universally applicable; yet in reality, they ignore or underestimate the particularities of social and cultural context, resulting in disconnect on the ground (Olivier de Sardan, Diarra & Moha, 2017; see also MacDonald, 2017).

The trouble with travelling models is illustrated in **Ljiljana Pantović's** chapter on the implementation of the international Baby Friendly Hospital Initiative (BFHI) in a Serbian hospital. Pantovic shows how the social, political and economic conditions in Serbia – namely the devastating effects of the civil war, international

sanctions in the 1990s and the deleterious effects of IMF policies on the Serbian healthcare system since the 2000s – have severely hindered the uptake of the BFHI by frontline health workers. The ten steps meant to foster the uptake of breastfeeding by new mothers, she observes, are both thinly learned and thinly applied by healthcare workers struggling to manage high workloads in understaffed hospitals, in combination with unsustainable national funds for implementation.

Bonnie Ruder and Alice Emasu's chapter on the global push to bring surgical repair to obstetric fistula similarly reveals the failure of a travelling model to solve a complex problem. Their ethnography examines a donor-funded treatment model in Uganda that focusses on surgical camps but without follow-up or patient tracking. While the majority of women who receive the surgery experience its life-changing benefits, a sizeable minority experience residual incontinence and complications – something that the surgical camp model does not fund or even measure. Poor outcomes are underreported and thus women suffering from residual incontinence fade from view in the story of a global health intervention defined by its success. Consequently, limited attention and resources are dedicated to residual incontinence, leaving many women without alternative treatment options.

New drugs and devices are key features of health policies and projects as they circulate around the world. Getting them to have the effect that policymakers intended, however, is a process often met with roadblocks, gaps and diversions (Russel, Sobo & Thompson, 2000; Suh, 2015). This is starkly relayed in **Seydou Drabo's** ethnographic fieldwork on access to a drug, misoprostol, for medical abortion in Ouagadougou, Burkina Faso, where abortion is illegal in most circumstances. Growing evidence for the safety and effectiveness of misoprostol for use in the prevention and treatment of postpartum haemorrhage and unsafe abortion – two major causes of maternal death worldwide – have persuaded global and national level institutions to recommend its use. As Drabo explains, women seeking abortions in Ouagadougou are able to access misoprostol through unofficial channels, including intermediaries such as health workers and drug sellers, sex workers and friends. However, he describes a landscape of deeply unequal and frequently unsafe access to the drug depending on one's social position. Drabo concludes that even as global policy hails misoprostol as a revolution in terms of its safe and effective biochemical effects on the body and simple and low cost features, the matter of safe access to safe abortion for all women in settings like Burkina Faso has not been addressed.

Like travelling models, the 'key social representations' and 'master narratives' in global health that surround them often frame problems in ways that limit thinking about potential solutions, leading to implementation gaps and distortions, unintended consequences and failed projects (Nichter, 2008; Inhorn, 2006). **Meredith Marten's** chapter examines the impact of the circulation of buzzwords, master narratives and policy rhetoric – in her case the push amongst global donors to implement 'sustainable' maternal health programs and projects in Tanzania. By describing programmes focused on prevention of mother-to-child transmission of HIV, (PMTCT), Basic Emergency Obstetric and Newborn Care (BEmONC) and Respectful Maternity Care (RMC), she reveals how donors' unrealistic yet

frequently replicated ‘doctrine of sustainability’ paradoxically seems to undermine the strength of the health systems that donors claim to support. Marten argues that the sustainability doctrine fails to challenge neoliberal and philanthrocapitalist models of health care, advancing funding and implementation models more accountable to donors than to the public health systems providing care.

Policy Ambivalence

Global health has been characterised by several enduring debates about how best to deliver health care and improve health outcomes in low resource settings – comprehensive versus selective primary health care, community versus facility-based health, targeted interventions versus health systems strengthening (McCoy et al., 2010). Several authors in this book trace the arc of interventions intended to address major maternal and reproductive health challenges back to the 1970s, showing how they have played out against this backdrop over time. These authors reflect upon and illuminate the retreat, ambivalence, and in some cases, return, of previously contested policy approaches.

The theme of policy ambivalence surrounding community and facility-based approaches to care is taken up in **Maggie MacDonald’s** chapter, which follows the story of the traditional birth attendant (TBA) in global maternal health from the launch of the Safe Motherhood Initiative (SMI) in 1987 to the present. MacDonald argues that the original shift away from training TBAs within safe motherhood programs and their subsequent loss of legitimacy in global health was influenced by weak and inconclusive evidence, flawed conceptualizations of TBAs and the lack of consideration for the role of the larger political and economic context in which they worked – all of which was shaped by the re-organisation of the safe motherhood movement at the global level. MacDonald discusses how the recent repositioning of TBAs in maternal health policies and guidelines as potentially useful providers has been informed by a growing evidence base pointing to the effectiveness of TBAs, as well as the advent of high tech, cost effective, point of use technologies, which have led to the decentering of health facilities and professional health providers as the sole locus of clinical care.

Policy ambivalence is also illustrated in **Maya Unnithan’s** account of the conflicting approaches to reproductive health that have played out in India since the 1990s. On the surface, India’s family planning program seems to have undergone radical shifts from a population control model implemented through ‘targets’, to the abolition of targets and an integrated reproductive and child health model that upholds the rights of women to contraceptive choice. Yet, looking deeper, policy documents themselves offer clear indications of a return to state-promoted sterilisation, including cash incentives to clients to enhance contraceptive uptake and the introduction of new metrics to evaluate health worker performance. Unnithan shows how on the ground, these metrics are still perceived by Auxiliary Nurse Midwives as ‘targets’. Pressure on these community-level health workers from state directives

to fulfil targets, and their experiences and perceptions of the lack of safety of reversible forms of contraception, combine to create a contraceptive bias towards sterilisation, even as Indian family planning takes on a new rights-based discourse.

Contesting Authoritative Knowledge and Practice

An enduring theme in critical anthropological studies of global health policy and implementation has been how the dominance of biomedicine tends to discredit local health knowledge and practitioners (Davis-Floyd & Sargent, 1997). In maternal and reproductive healthcare, this trend has been characterised by the consolidation of power away from traditional birth attendants and other lay healers and towards biomedical health facilities as the only safe place to give birth. Contestations around the professionalisation of maternity care are contests about authoritative knowledge and practice; that is, whose knowledge and authority counts and what counts as care. Global health interventions into maternal and reproductive health care are typically accompanied by the medicalisation and technocratic management of birth, with myriad and complex consequences for quality of care in underfunded, under-resourced healthcare systems.

Extending the discussion of the role of community-level birth attendants, **Priscilla Magrath** analyses Indonesia's national policy to improve maternal health by promoting an official partnership between 'skilled birth attendants' (SBAs) and 'traditional birth attendants'. In West Java, where she conducted ethnographic fieldwork, the local district health office engaged in 'policy entrepreneurship' to resolve enduring contests over the professionalisation of maternity care and promoted the partnership regulation throughout the region. Taking the local district as her starting point, Magrath maps the dense networks of national and global policies and pressures that exert themselves in local health governance and clinical practice: global policies promoting SBAs and sidelining TBAs; pressure on individual nations to reach the Millennium Development Goal on reducing maternal mortality; and the limited financial power and decision space afforded to districts under decentralisation in Indonesia. She concludes that by spotlighting the relationship between SBAs and TBAs as a key strategy to improve maternal health, attention was diverted from other health system challenges including under-resourced medical facilities and a weak referral system.

The Rise of Evidence and Its Uses

An empirical focus on reproductive and maternal health also provides a lens through which to see transformations in the global governance of health through the rise of metrics and the epistemic communities who uphold evidence-based policymaking as evidence of success and impact. Anthropologists have highlighted how the

‘fetishization’ of indicators such as the maternal mortality ratio (MMR) within global efforts to improve maternal health, while conveying accountability, may actually serve to regulate reproductive health behaviour in limiting ways, casting aside certain types of reproductive bodies as unworthy of protection, damaging health systems and deflecting attention away from the realities of mothers and health workers (Storeng & Béhague, 2017; Adams, 2016; Brunson & Suh, 2020; de Kok, 2019).

Christopher Colvin’s chapter provides insights into why it is important to challenge narrowly defined standards of what constitutes evidence and describes the partial moves underway to incorporate social scientific evidence in a research tradition traditionally dominated by positivist methodologies. He provides an auto-ethnographic account of an effort to integrate qualitative evidence synthesis (QES) into the World Health Organization’s global OptimizeMNH guidelines for task shifting in maternal and newborn health (MNH). Colvin describes the delicate balance between adopting quantitatively inspired methods for evidence synthesis and innovating new methods that would both suit the project needs and be seen as legitimate by qualitative researchers, such as recognition of the critical role of local context in explaining the findings from individual studies. Colvin concludes that the rise of QES indicates growing room for the inclusion of potentially transgressive forms of knowledge within the often conservative world of health policy.

Robbie Davis Floyd’s chapter offers another insider perspective on the uses of evidence in advocacy coalitions in global health. An applied anthropologist, Davis-Floyd recounts how, as a member of an activist organisation with a critical stance towards the mainstream biomedicalisation of pregnancy and birth, she came together with the International Federation of Gynecology and Obstetrics (FIGO) to develop a set of global guidelines for improving the quality of maternity care. This process brought to the fore many of the core debates in the history of global maternal health, notably what to do about traditional birth attendants and what counts as quality of care. She argues that the coalition found agreement on these issues through a commitment to the key values of the women’s health and midwifery movements: a process which seems to have brought ethnographic knowledge, activist commitments and mainstream biomedical authority into productive conversation with each other.

Finally, **Lucy Irvine’s** research from Brazil explores how natural birth activists are trying to get women-centred evidence to successfully inform policies at the national level. She provides a local-level analysis of ‘evidence-based advocacy’ by the movement for humanised care in childbirth in São Paulo. Scientific evidence is used strategically in developing specific policy programmes to optimise the use of medical interventions in childbirth and to lend authority in clinical encounters alongside rights-based language such as ‘obstetric violence’. However, when faced with resistance from pro-C-section doctors, movement members make use of other strategies to improve access to quality care, such as stimulating demand for humanised birth in the private health sector, which can serve to reinforce existing inequalities in access to high-quality maternity care.

Conclusion

The ten chapters in this book explore the making and doing of global health policy in a range of geographical settings, cutting across global, national and local levels, and in doing so, they make evident four key ways in which anthropological knowledge contributes meaningfully to the analysis of global health policy. First, ethnography is unique amongst qualitative methods in terms of its long duration and depth of engagement; triangulation and data saturation are inherent features of the method and are highly effective at yielding detailed insights into people's actions, interactions, moral dilemmas, and beliefs, as well as the sights and sounds of the locations they inhabit. Second, these authors show that knowledge generated at the level of the particular – while not necessarily replicable – can nonetheless provide insights that can contribute to national and global level health policy and practice beyond a given location.

Third, the authors tend to analyse policy development and its unfolding within a holistic 'health systems' framework that considers health policies in terms of their impacts on the entire health system. This involves the capture and critical interrogation of multiple scales and their interconnections at once (Feierman et al., 2010; see also Lee, Buse & Fustukian, 2002). Such an approach endeavours to include the global flows of financial and political arrangements, rationalities, technologies and regimes of actors and agendas that configure health practices and inequalities rather than imagine phenomena as confined by spatial and geographic boundaries.

Fourth, the authors advance a much-needed critical perspective to the study of global health policy. They turn their gaze beyond the cultural beliefs of lay communities to examine how health, illness and healing systems are socially, culturally, historically and politically situated. In unpacking the complex 'how' of policy, including the workings of policy communities, governance processes and the social lives of policies, authors in this volume take note of both the weaknesses of policy processes and their accomplishments. A critical approach is also about the kinds of questions that are posed and the analytical work undertaken to make sense of the data. Critical investigations of global health policy are carried out from the premise that there are important things happening in the spaces rendered invisible by medical and public health frameworks or off to the side of the main social arenas created by global health activities (Pigg, 2013, p. 128, 133). Ultimately, a critical perspective can serve as a powerful corrective to the tendency within global health scholarship to displace policy debates from the political realm and recast them as technical debates about healthcare delivery (Mishra & Storeng, 2014; see also Li, 2007).

An Agenda for Future Research on Global Maternal and Reproductive Health Policy

Medical anthropologists' research on global health has much to contribute to the emerging interdisciplinary field of health policy and systems research (HPSR), defined by Sheikh and colleagues (2011) in terms of its attention to wider influences and micro-processes that shape the multiple levels of policy decisions and practices (see also Gilson et al., 2011). A key insight that anthropological research brings to this field is that techno-scientific solutions alone will not improve health and health care and that critical attention to the making and practice of policy should inform the policymaking process itself. Indeed, HPSR views an interpretive and critical inquiry that draws on multiple disciplines, not least anthropology, as essential to understanding and informing effective policy.

In order to refine useful conceptual and empirical insights about policymaking in global health, anthropologists must be prepared to work more judiciously at the juncture between medical anthropology and anthropology of policy, and in closer partnership with local policymakers and experts. Even as anthropologists tend to see themselves as already allied with local players and therefore critical of the global health enterprise writ large, entrenched power asymmetries in global health whereby funded researchers in higher resource settings partner with those in lower resource settings, often set the research agenda. As Jean-Pierre Olivier de Sardan has observed (2021), weak understandings of specific and varied implementation settings lead to the 'revenges of the context', an idea not confined to local sociocultural context but to the politics of knowledge production in global health more seriously. Relative to anthropology, more has been done within the field of HPSR to go beyond critique and imagine how to build the capacities and collaborative possibilities of researchers and policymakers in lower resource contexts for generating, and using, relevant evidence (Bennett, Frenk & Mills, 2018; Agyepong et al., 2021).

We hope that this book sheds new light on old problems in global health policy through ethnographic attention to both policy spaces and sites of practice. The success of health policies and interventions meant to improve reproductive health and reduce maternal suffering and death, we believe, will be aided by greater and more direct engagement between the often separate worlds of policymaking and the practices of interpretive and critical inquiry. Critical, collaborative, multi-disciplinary engagement is the future of global health policy.

References

- Adams, V. (2016). *Metrics: What counts in global health*. Duke University Press.
- Agyepong, I. A., Godt, S., Sombie, I., Binka, C., Okine, V., & Ingabire, M.-G. (2021). Strengthening capacities and resource allocation for co-production of health research in low and middle income countries. *British Medical Journal*, 372. <https://doi.org/10.1136/bmj.n166>

- Allen, D. R. (2002). *Managing motherhood, managing risk: Fertility and danger in West Central Tanzania*. University of Michigan Press.
- Béhague, D. P., & Storeng, K. T. (2008). Collapsing the vertical–horizontal divide: An ethnographic study of evidence-based policymaking in maternal health. *American Journal of Public Health*, 98(4), 644–649. <https://doi.org/10.2105/AJPH.2007.123117>
- Bennett, S., Frenk, J., & Mills, A. (2018). The evolution of the field of health policy and systems research and outstanding challenges. *Health Research Policy and Systems*, 16, 43. <https://doi.org/10.1186/s12961-018-0317-x>
- Berry, N. (2010). *Unsafe motherhood: Mayan maternal mortality and subjectivity in post-war Guatemala*. Berghahn Books.
- Biehler, J., & Petryna, A. (2013). *When people come first: Critical studies in global health*. Princeton University Press.
- Brunson, J., & Suh, S. (2020). Behind the measures of maternal and reproductive health: Ethnographic accounts of inventory and intervention. *Social Science and Medicine*, 254. <https://doi.org/10.1016/j.socscimed.2019.112730>
- Castro, A. (2004). Contracepting at childbirth: The integration of reproductive health and population policies in Mexico. In A. Castro & M. Singer (Eds.), *Unhealthy health policy: A critical anthropological examination* (pp. 133–134). Altamira Press.
- Davis-Floyd, R. E., & Sargent, C. (Eds.). (1997). *Childbirth and authoritative knowledge: Cross-cultural perspectives*. University of California Press.
- de Kok, B. C. (2019). Between orchestrated and organic: Accountability for loss and the moral landscape of childbearing in Malawi. *Social Science and Medicine*, 220, 441–449. <https://doi.org/10.1016/j.socscimed.2018.09.036>
- Farmer, P. (2004). An anthropology of structural violence. *Current Anthropology*, 45(3), 305–325. <https://doi.org/10.1086/382250>
- Fassin, D. (2013). A case for critical ethnography: Rethinking the early years of the AIDS epidemic in South Africa. *Social Science & Medicine*, 99, 119–126. <https://doi.org/10.1016/j.socscimed.2013.04.034>
- Feierman, S., Kleinman, A., Stewart, K., Farmer, D., & Das, V. (2010). Anthropology, knowledge- flows and global health. *Global Public Health*, 5(2), 122–128. <https://doi.org/10.1080/17441690903401338>
- Foley, E. (2007). Overlaps and disconnects in reproductive health care: Global policies, national programs, and the micropolitics of reproduction in northern Senegal. *Medical Anthropology*, 26(4), 323–354. <https://doi.org/10.1080/01459740701619830>
- Ghaffar, A., Gilson, L., Tomson, G., Viergever, R., & Rottingen, J.-A. (2016). Where is the policy in health policy and systems research agenda? *Bulletin of the World Health Organisation*, 94(4), 306–308. <http://dx.doi.org/10.2471/BLT.15.156281>
- Gilson, L., Hanson, K., Sheikh, K., Agyepong, I. A., Ssengooba, F., & Bennett, S. (2011). Building the field of health policy and systems research: Social science matters. *PLoS Medicine*, 8(8), e100179. <https://doi.org/10.1371/journal.pmed.10001079>
- Ginsburg, F., & Rapp, R. (Eds.). (1995). *Conceiving the new world order: The global politics of reproduction*. University of California Press.
- Inhorn, M. C. (2006). Defining women's health: A dozen messages from more than 150 ethnographies. *Medical Anthropology Quarterly*, 20(3), 345–378.
- Janes, C. R., & Corbett, K. K. (2009). Anthropology and global health. *Annual Review of Anthropology*, 38, 167–183. <https://doi.org/10.1146/annurev-anthro-091908-164314>
- Jordan, B. (1978). Revised and updated by Robbie Davis-Floyd in 1993 for the 4th edition. *Birth in four cultures: A cross-cultural investigation of childbirth in Mexico, Holland, Sweden, and the U.S.* Waveland Press.
- Justice, J. (1989). *Policies, plans and people: Culture and health development in Nepal*. University of California Press.
- Lee, K., Buse, K., & Fustukian, S. (Eds.). (2002). *Health policy in a globalising world*. Cambridge University Press.

- Li, T. (2007). *The will to improve. Governmentality, development and the practice of politics*. Duke University Press.
- Locke, M. M., & Schepher-Hughes, N. (1987). The Mindful Body: A prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly*, 1(1), 6–41.
- MacDonald, M. (2017). Why ethnography matters in global health. *Journal of Global Health*, 7(2), 020302. <https://doi.org/10.7189/jogh.07.020302>
- McCoy, D., et al. (2010). Maternal, neonatal and child health interventions and services: Moving from knowledge of what works to systems that deliver. *International Health*, 2(2), 87–98. <https://doi.org/10.1016/j.inhe.2010.03.005>
- Mishra, A., & Storeng, K. (2014). Politics and practices of global health: Critical ethnographies of health systems. *Global Public Health*, 9(8), 858–864. <https://doi.org/10.1080/17441692.2014.941901>
- Morgan, L. M., & Roberts, E. F. S. (2012). Reproductive governance in Latin America. *Anthropology & Medicine*, 19(2), 241–254. <https://doi.org/10.1080/13648470.2012.675046>
- Nichter, M. (2008). *Global health: Why cultural perceptions, social representations, and biopolitics matter*. University of Arizona Press.
- Olivier de Sardan, J.-P. (2021). *La revanche des contextes: Des mésaventures de l'ingénierie sociale, en Afrique et au-delà*. Katharla.
- Olivier de Sardan, J. P., Diarra, A., & Moha, M. (2017). Travelling models and the challenge of pragmatic contexts and practical norms: The case of maternal health. *Health Research Policy and Systems*, 15(Suppl 1), 60. <https://doi.org/10.1186/s12961-017-0213-9>
- Ong, A., & Collier, S. J. (Eds.). (2005). *Global assemblages: Technology, politics, and ethics as anthropological problems*. Blackwell.
- Pfeiffer, J., & Nichter, N. (2008). What can critical medical anthropology contribute to global health? A health systems perspective. *Medical Anthropology Quarterly*, 22, 410–415. <https://doi.org/10.1111/j.1548-1387.2008.00041.x>
- Pigg, S. L. (1997). Authority in translation: Finding, knowing, naming and training “traditional birth attendants” in Nepal. In R. Davis-Floyd & C. Sargent (Eds.), *Childbirth and authoritative knowledge: Cross-cultural perspectives* (pp. 233–263). University of California Press.
- Pigg, S. L. (2013). On sitting and doing: Ethnography as action in global health. *Social Science & Medicine*, 99, 127–134. <https://doi.org/10.1016/j.socscimed.2013.07.018>
- Robertson, T., et al. (2020). Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: A modelling study. *Lancet Global Health*. [https://doi.org/10.1016/S2214-109X\(20\)30229-1](https://doi.org/10.1016/S2214-109X(20)30229-1)
- Russel, A., Sobo, E. J., & Thompson, M. S. (2000). *Contraception across cultures: Technologies, Choices, Constraints*. Routledge.
- Sheikh, K., Gilson, L., Agyepong, I. A., Hanson, K., Ssengooba, F., & Bennett, S. (2011). Building the field of health policy and systems research: Framing the questions. *PLoS Medicine*, 8(8), e100179. <https://doi.org/10.1371/journal.pmed.1000179>
- Shore, C., & Wright, S. (1997). Policy: A new field of anthropology. In *Anthropology of policy: Critical perspectives on governance and power* (pp. 3–39). Routledge.
- Singer, M., & Baer, H. (1995). *Critical medical anthropology*. Baywood Publishing.
- Storeng, K. T., & Béhague, D. P. (2017). “Guilty until proven innocent”: The contested use of maternal mortality indicators in global health. *Critical Public Health*, 27(2), 163–176. <https://doi.org/10.1080/09581596.2016.1259459>
- Storeng, K. T., & Béhague, D. P. (2014). ‘Playing the numbers game’: Evidence-based advocacy and the technocratic narrowing of the safe motherhood initiative. *Medical Anthropology Quarterly*, 28, 260–279. <https://doi.org/10.1111/maq.12072>

- Suh, S. (2015). 'Right tool,' wrong 'job': Manual vacuum aspiration, post-abortion care and transnational population politics in Senegal. *Social Science and Medicine*, 135, 55e66. <https://doi.org/10.1016/j.socscimed.2015.04.030>
- Wedel, J. R., & Feldman, G. (2005). Why an anthropology of public policy? *Anthropology Today*, 21(1), 1–2.
- Whiteford, L. M., & Manderson, L. (Eds.). (2000). *Global health policy, local realities: The fallacy of the level playing field*. Lynne Rienner.

Open Access This chapter is licensed under the terms of the Creative Commons Attribution 4.0 International License (<http://creativecommons.org/licenses/by/4.0/>), which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license and indicate if changes were made.

The images or other third party material in this chapter are included in the chapter's Creative Commons license, unless indicated otherwise in a credit line to the material. If material is not included in the chapter's Creative Commons license and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder.