Introduction

The Specter of Death

This book is about maternal mortality, or pregnancy-related death, and its impact. My focus is to explore some consequences of how the global community has tried to prevent these deaths from happening. I argue that the global campaign to decrease maternal mortality has actually created barriers to reducing deaths and also threatens to make some of the very communities that it is designed to help even more vulnerable.

In the more than twenty years that pregnancy-related death has been on the international agenda, our understanding of it has become overly circumscribed. Essentially, maternal mortality has been reduced to a medical problem where lack of access to skilled biomedical providers dominates the agenda for making pregnancy safer. The evaluation of our effort has involved ever increasing surveillance of maternal mortality rates and biomedical skills relating to emergency obstetrics. An unspoken effect of reducing maternal mortality to a medical problem is that life and death become the *only* outcomes by which pregnancy and birth are understood. The specter of death looms large and limits our full exploration of either our attempts to curb maternal mortality, or the phenomenon itself.

Certainly women's survival during childbirth is the ultimate measure of success of our efforts. Yet using pregnancy outcomes and biomedical attendance at birth as the primary feedback on global efforts to make pregnancy safer is misguided. First, as I discuss in chapter 3, our measures of maternal deaths are woefully poor indicators of the effects of an intervention. Second, we neglect to monitor the potential impacts of the international Safe Motherhood campaign

as a global blueprint for how to mobilize monetary and human resources, and script local daily interactions concerning pregnancy and birth worldwide. We know that life and death are not the only outcomes that are important to women or their families in relation to pregnancy and birth. The forced biomedicalization of birth and the abuses that poor women like Rosario suffer at the hands of biomedical practitioners during this vulnerable and liminal period are central to women's concerns.[1] Third, we neglect the myriad rich and important other sources of data that might help us mitigate some of these deaths.

In other words, the global campaign to decrease maternal mortality has incredible potential to disrupt women's daily lives, yet little effort has been made to evaluate any dimension of this effort other than its ability to prevent death. The more this campaign has focused on the biomedical management of pregnancy and birth, the more it has advocated standardizing the everyday practices related to the control of these events around the world. But the narrow rhetorical space in which this campaign has taken place has concentrated on international agents engaged in a battle against obstetric pathology, and the question of what actually happens when health systems and development agents try to lower maternal mortality has been invisible. Denise Roth Allen (2002) and Craig R. Janes and Oyuntsetseg Chuluundorj (2004) have recently demonstrated how to move forward by confronting Safe Motherhood as more than a transparent attempt to save the lives of women. My book continues this effort by examining the actual effects of the global campaign and pushing to broaden the conversation about maternal mortality and its causes.

Interrupting a Global Campaign to Help Make Birth Safer

An obvious reason this ethnography is important is to help us better understand why decreasing maternal mortality around the globe is so difficult, but this case study is also critical to helping each of us understand globalization and global citizenship. From my perspective, ethnography has a vital role to play not necessarily in defining "globalization," but rather in interrupting its narrative of inevitable western dominance that exculpates those of us living in the developed world from seeing, acting on, or challenging injustice. Examining a global health project can help each of us, as scholars, teachers, and students, realize what is at stake when we fail to question or

examine attempts to—in John F. Kennedy's terms—"help them help themselves."

So I start with the claim that an ethnography of Safe Motherhood can help us learn about globalization.[2] In its most dominant version, globalization theory accounts for an inevitable, global transformation where a world rich in variety gets squeezed through a bottleneck to produce a more uniform, homogenous world.[3] As Jan Nederveen Pieterse (1995:45) summarizes popular takes on the process of globalization, "the world is becoming more uniform and standardized through a technological, commercial and cultural synchronization emanating from the West." Arjun Appadurai (1990:295) emphasizes the connection between a world looking more "western" and the uniform spread of global capitalism when he claims that globalization frequently contains "an argument about 'commoditization.'"

I am suspicious of globalization theory because it smacks of being a "stor[y] we tell ourselves about ourselves" (Geertz 1973:8). The primary "we" who tell the story of globalization are those who live in the global North. And the storyline itself can be roughly translated into "everyone wants to be (or is inevitably becoming) more like us." Looked at from this perspective, globalization theory sounds remarkably like what Gananath Obeyesekere (1992) refers to as "European myth-making."

Is it true that everyone wants to be like the global North? Is that really where the world is going? Is it inevitable? Anthropologists who have written before me have persuasively provided a counterdiscourse to what Kalman Applbaum (2000:258) aptly describes as the "cheerful version" of an inevitable westernized world. When we look at what happens on the ground we can see that globalization is not a steam roller and people around the world are not passive recipients. Instead of traveling unimpeded into a "cultural void," the processes of globalization are significantly shaped by a diversity of "local" practices and beliefs (Inhorn 2003).[4] Globalization doesn't just happen; rather, individuals in diverse settings from all over the world are implicated in accommodating, negotiating, or resisting change.[5] Empirical accounts have taught us that globalization does not have any one desired effect. Anna Lowenhaupt Tsing (2005) argues that her own empirical accounts contain the details necessary to "fragment" what may at first appear to be a "well-oiled machine," thereby subverting the idea of "smooth global integration."[6] Finally, anthropologists such as Karen Ho (2005:86) have cautioned us to consider globalization "not simply a[s] fact, but a hope, a strategy, and a triumphalist ideology."[7]

My own attempt to answer questions about inevitable westernization focuses on the translation (Pigg 2001) of a global health campaign in a particular place at a particular historical moment. I want to show how the meanings of the global campaign to lower maternal mortality are mediated by the health workers in Sololá whose job it is to implement global policies. Importantly, what this global campaign comes to represent in Sololá is surely not what was intended in the conference rooms in Geneva or New York, where such policies are hammered out. Rather, front-line health workers interpreted the tools and technologies of the global fight against maternal mortality to fit locally familiar narratives. Health workers in Sololá inextricably linked the fight against maternal mortality with efforts to forge national unity in the chaotic and violent aftermath of an even more vicious civil war. The global campaign piggybacked on a narrative of national progress and modernization that was used to justify rooting out "backwardness" that endangered this progress. For health workers, the global campaign against maternal mortality provided an objective, neutral framework to cloak their own prejudice toward certain types of difference. For example, it problematized obstetric practices preferred by many poor, indigenous Maya, such as birthing at home with a traditional midwife instead of with a biomedical provider in the hospital. It also attempted to subtly erode these practices and the understandings of the world that organized them.

This account of attempts to decrease maternal mortality interrupts the "story" of globalization and the moral cover that it provides for processes that should, in fact, be questioned. When globalization is allowed to remain a metaphorical phone booth that converts all who enter it into Westerners, we lose sight of our own collusion in the process. Only by recognizing that the medication that I buy or the vote that I cast can be intimately connected to exploitation, structural violence, empowerment, and "well-being" on the other side of the globe, can I consciously participate in a construction of the global. Yet I consider the imperative of interrupting what Frederick Cooper (2001) refers to as the global "juggernaut," specifically tied to my responsibilities as a teacher. David L. Blaney (2002) insists that engaging students in a valuable conversation about the global depends on problematizing their own social privilege, and not allowing them to take it for granted.[8] Challenging the inevitabilities of the global conversion to the West is one means of drawing us all into a conversation that recognizes the complexities and specificities of the processes we refer to as globalization.

Biosocial Subjectivities: The Meaning of Making Babies

I contend that one of the significant consequences of the global Safe Motherhood campaign has been to unintentionally encourage a shift in subjectivity among Kaqchikel Maya villagers with whom I lived in Guatemala. While *subjectivity* is a term that has a certain "openness of … meaning today" (Biehl, Good, and Kleinman 2007:15), I simply use it to refer to someone's own understanding of his or her place in the world. Subjectivity is about an individual's internal processes, dispositions, or understandings, as opposed to other people's judgments or attributions about an individual.

Highlighting the biosocial nature of subjectivities helps us understand how global Safe Motherhood might provoke a subjective shift. I use the term *biosocial subjectivities* to emphasize that our own understandings of our place in the world are necessarily mediated by and reflective of our biological processes. In other words, biosocial subjectivity draws our attention to the necessary symmetry between our bodily experiences and how we understand ourselves. Perhaps this relationship has been most evocatively drawn out in bird's-eye-view studies of gender that show how treatments of bodies (Boddy 1989) and understandings of bodies (Delaney 1991; Kaspin 1996) map so well onto more holistic renderings of self and society. My emphasis on biological processes and bodily experiences intentionally shifts our attention away from the body as an object per se and toward an exploration of biological processes and actions.[9]

I use *biosocial* as it is used in a number of disciplines, including anthropology, to signal that a particular phenomenon must be analyzed with reference to both the biological and social. On a lexical level, biosocial shares much with Paul Rabinow's (1996:99) concept of biosociality, which inverts the nature/culture distinction by revealing scientific systems as cultural systems, and thereby recognizing that culture is how we come to know about the world. In my larger analysis, I certainly argue that the global Safe Motherhood campaign is dependent on cultural understandings of birth and birthing-related problems rather than any "natural" understandings that it might claim. Nevertheless, I do not carry Rabinow's thought experiment anywhere near its logical conclusion. Semantically, no overlap is intended here between my use of biosocial and biosociality, and metaphysically my analysis differs from his. By invoking biosocial, I intend to suggest that it is analytically productive to consider the biological and social as two different domains that mutually constitute our world. My analysis assumes that the two

are intertwined, but leaves aside questions of whether or not one is dominant over or constitutive of the other.

Perhaps Brigitte Jordan (1978:1) has most productively used the idea of biosocial in her groundbreaking ethnography to show that pregnancy and birth across the globe must be understood as "biosocial event[s] [that] recognize at the same time the universal biological function and the culture-specific social matrix within which human biology is embedded." It is important to read Jordan's statement in relation to the temporal context in which it was written. For the purposes of using it today, I would gloss references to "universal biological function" as referring to the propensity of women across the world to get pregnant and give birth. We certainly understand that not all women can (Inhorn and Balen 2002) or do birth and that what seems to be universally biological can be as heterogeneous as it assumed to be homogenous (Lock 1993). Nevertheless, by employing a biosocial framework, Jordan was able to instantiate that birth could not be considered as a solely physiological process, but demands a conjoined cultural analysis. The legacy of her insight has organized much subsequent work on birth and reproduction, including my own.

While Jordan employed a biosocial framework to highlight the social and the cultural, my intention in employing the term *biosocial subjectivity* is to emphasize the importance of understanding the relationship between subjectivities and biological processes.[10] Michel Foucault (1978) has drawn our attention the great potential of the biological domain to mediate understandings of self through his concept of biopower. Many of the mechanisms that the State uses to consolidate power over its citizens directly involve propagating discourses about biological processes. His analysis reveals how central our experience and understandings of our own biological processes are to subject-making. By controlling discourses around biological processes the State is able to produce self-disciplining subjects that do not threaten State power. In sum, influencing discourse around biological processes is a mechanism that the State uses to produce particular subjectivities that it is able to subjugate.

I am following Foucault's lead in drawing attention to the privileged position that biological processes hold in subject-making, and I argue that pregnancy and birth are some of the most important sites for shaping our subjectivity. As social beings, humans are seeped in contexts of culture, and ideas of continuity and reproduction (as well as disruption) of culture are central to society. Yet cultures cannot be produced or reproduced without new members. The processes

through which new members are procured are myriad (e.g., marriage, adoption, conversion, etc.), but making new members from one's own body holds a particularly important place. Pregnancy and birth are the physiological processes that create the next generation. They are, accordingly, particularly charged locations from which to define and reproduce the social world. Pregnancy and birth should then serve as comparatively robust sites from which to understand biosocial subjectivities.

Yet, unlike Foucault, my exploration of biosocial subjectivities is not focused on the link between discourses around pregnancy and birth and State (or global Safe Motherhood) power. While this ethnography certainly could be read as a story about State-produced shifts in subjectivities that increase its own power over the indigenous population, I don't find such an orientation analytically productive. That story reads far too much like our current stories about globalization where the outcome—increase of State power and loss of subject autonomy—is foretold. By shifting our analytical lens we can instead focus on parts of this research that remain obscured: What are the empirical ways that pregnancy and birth are linked to wider social life that make them important subject-forming locations? What does this mean, in particular, for public health interventions aimed at those sites? How has global Safe Motherhood worked to alter subjectivities by changing everyday events surrounding these important biological processes? What tangible consequences might such interventions in birth have for communities, such as those in Sololá?

In this ethnography, I argue that global Safe Motherhood's cultural understanding of pregnancy and birth as primarily physiological processes have worked in Guatemala to promote autonomous, as opposed to mutually constituted or connective subjectivities. The cultural understanding of pregnancy and birth are well highlighted by Rosario's birth story. In the version of her story favored by the global campaign, and demonstrated by the health system in Sololá, Rosario's anemia contributed to an acute post-partum hemorrhage. The description of what went wrong was essentially derived from her autopsy, and focused exclusively on the internal factors that caused her difficulties (e.g., failure of her uterus to contract). While the former version of the story may appear to a biomedically oriented reader as neutral, medical anthropologists have persuasively demonstrated that even descriptive work, such as mapping chromosomes (Rapp 1999) or describing reproduction (Martin 1992), is framed culturally. Perhaps most helpfully, Davis-Floyd (1992) de-

constructed hospital birthing events in the US to show how obstetric protocol could be just as much about culture as it was about medicine.

Perhaps the particular, cultural orientation of the Safe Motherhood campaign is more obvious when it is juxtaposed to the version of events that dominated Rosario's village. In this version, a malevolent person induced Rosario to suffer a heart attack with the aid of a witch. Both birth and birthing problems were understood through reference to social relationships in contrast to physiological ones. Village gossip pegged the root of her birthing trouble externally, on a spurned woman—not on the internal physiological mechanism that this woman might have employed to take revenge, i.e., the heart attack. In sum, both models prioritize a certain way of understanding birth. The emphasis on the social aspects of birth prioritized in Rosario's village can be critically applied to the global campaign to reveal how the health system ignores the potential of birth as a site to make meaning about social relationships. What might such a disruption of opportunity to make meaning imply? Is it important, and if so, how?

As Rosario's difficult birth story illustrates, the potential involvement of extensive kin make pregnancy and birth events special locations to (re)define social relationships—particularly kin relations. I follow in the footsteps of anthropologists who have found it instructive to attend to the definitions of kin terms such as "husband" or "daughter" as they are defined processually, rather than focusing on how they are determined by blood.[11] Kaqchikel pregnancy and homebirths are robust sites for studying how relationships are performed, as each can require the participation of husbands, parents, in-laws, grandparents, aunts, uncles, and sometimes even other children. For example, when a husband physically supports his wife so that she can maintain a squatting position during labor, what it means to be a husband or a wife is both enacted and reinstantiated.

The involvement described above where a number of kin participate in the typical homebirth simultaneously reflects and reinstantiates an understanding of one's place in the world as related to and constituted by others. In other words, the homebirth encourages a relational subjectivity. It reinforces the idea that, in Marilyn Strathern's (1988:13) words, "persons are frequently constructed as the … composite site of relationships that produced them."[12] The individual ceases to have any discrete meaning beyond those relationships. In her provocative work on connectivity in brother-sister relationships, Suad Joseph (1994:55) gives us a glimpse of the everyday actions

that illustrate how "connective persons … require the involvement of others in shaping their emotions, desires, attitudes and identities." She details interactions between siblings to demonstrate the "processes by which one person comes to see him/herself as part of another,"[13] further helping us delineate what constitutes a relational subjectivity.

Perhaps the easiest way to understand what it means to say that a particular process of birth reinstantiates subjectivity is to consider the converse: another birth process (e.g., hospital birth) can promote an understanding of individuals as autonomous. Just looking at a snapshot to compare the two events can help us with this conceptualization (see Illustration 1 and Illustration 2).

Illustration 1 depicts a hospital birth in the United States. Illustration 2 is a painting of a homebirth in a Mayan community in Sololá. Regardless of whether or not these illustrations are typical, overlaying a kinship diagram onto these two birthing events certainly helps us understand the relationship between the experience of a biological process and one's understanding of self. While the physiological details of each birth might have significant overlap, the social matrix in which the birthing event is located is profoundly different. One event prioritizes kin connections. In the other, individuals are disconnected.

I argue that the Safe Motherhood campaign encourages a shift in subjectivity by organizing everyday events around birth to em-

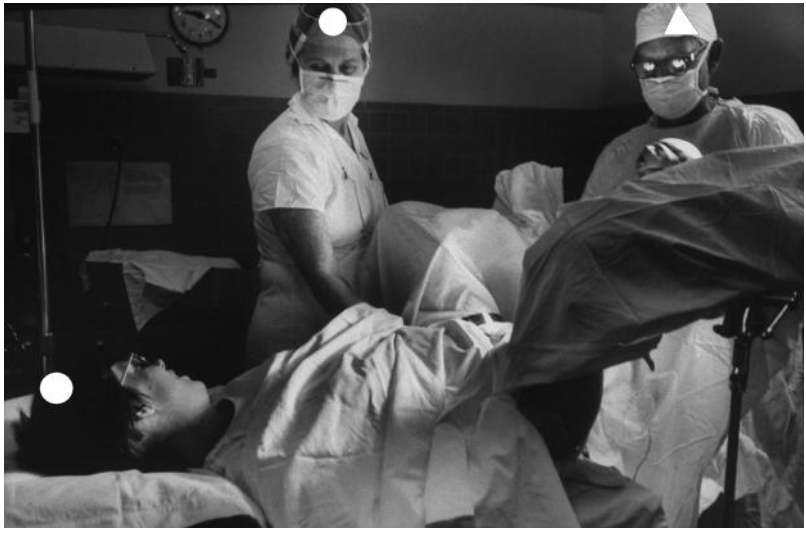


Illustration 1. Hospital birth in New Jersey, USA

ILLUSTRATION 2. Homebirth in Atitlan, Guatemala

phasize birth as a physiological process. In the subsequent chapters I highlight how the Safe Motherhood campaign endorses a biologization of birth. We can easily see this biologization in the definition of the causes of maternal mortality, the organization of resources around skilled attendance, and the inevitable push for more hospital births. Yet, as I argue, shifting Kaqchikel village births from home to hospital necessarily engenders a shift in how both the woman who gives birth and her kin who attend a birth understand their places in the world.

Subjectivity and Globalization

Scholars writing about subjectivity and globalization have used two different lines of inquiry to understand transformations associated with the global. The first approach concentrates on trying to understand how transformations in subjectivities happen. The second attends to the subjective experience of globalization more broadly.

Of course the two lines of inquiry are not mutually exclusive, and I have tried to connect what is happening in Sololá to both.

Despite the fact that globalization is arguably not the homogenous, all-powerful transformative process that some might assume, invoking globalization writ-large still opens a discussion about transformations. How do global processes transform subjectivities? Foucault has contributed generously to this discussion. One of his primary insights has been to illustrate how subjectivities are the products of particular historical moments and are intricately bound to the cultures and institutions in conjunction with which they are formed (1978, 1983). Foucault's insight helps us view subjectivities as part of a specific (social ecological) system. Subjectivities are, therefore, variable across both time and space. Foucault also emphasizes subjectivities' dependence on the larger macro elements of the system for their own definition. He deftly sketches out the terms of this dependence by attending to the intertwining of knowledge and power to produce subjects. His works on prisons, clinics, madhouses, and other institutions help show how experts' beliefs and verbal articulations, or discourses, shape society members' own understandings. The basis of a discourse is not truth, yet these discourses differentiate, for example, sick from well or normal from abnormal. The central point is not just that experts see these divides, but discourses form part of one's own understanding of the world. This produces an effect of self-discipline, where individuals internalize and uphold understandings of the world promulgated by discourses.

Foucault's theories help to elucidate the critical impact that ramping up the dissemination of biomedical discourses about pregnancy and birth in Sololá can have on subject formation. As Foucault helps us understand, these causal explanations of birthing difficulties are not divorced from how we understand the world, or our place in the world. Rather, both our subjectivity and our casual explanations of birthing difficulties are developed with respect to the same institutions and fields of discourse. A biomedical model that emphasizes direct causes, or the primarily physiological pathologies that result in death, has been emphasized by global Safe Motherhood and is easily identified in the Ministry of Health's analysis of Rosario's demise. The individual, Rosario, is taken as the unit of analysis. A physiological failure—that is a lack of contraction of her uterus—is identified as the cause of her death. The inability of her uterus to contract at that crucial moment after birth is regarded as random or inexplicable. From this logic stems the idea that the best interventions

are those that connect failing individual pregnant or birthing bodies with skilled attendants who will know how to treat hypertensive disorder, hemorrhage, infection, obstructed birth, or an unsafe abortion—the most common pregnancy-related pathologies. On a theoretical level, the ability to globalize these interventions depends on reductionist abstractions of the individual as a discrete physiological system: e.g., whoever you are, wherever you are, a shot of Pitocin should make your uterus cramp. In sum, I argue that the discourses of biomedicine upon which the global interventions to decrease maternal mortality are built, propagate a particular western, autonomous subject.[14]

Foucault's work also indexes a tension concerning the power of states and other larger institutions over the daily lives of individuals. Yet many allege that this is where the limits of his theorizing lie (Sangren 1995; Cooper 1994; Sivaramakrishnan 1995). A rich discussion of agency, or the ability of individuals to influence their own lives, is missing from his writings. While Foucault certainly helps us arrive at a better understanding of the role of power in co-opting knowledge production and generating discourses, he leaves us with an underdeveloped sense of the potency of individuals to create and shape those discourses themselves. In other words, many argue that Foucault's emphasis on power and institutions does not prepare us to understand or predict how people work to transform the world they live in, be it through violent or non-violent social movements, or just individual actions.[15] Scholars who work on agency, such as James C. Scott (1985), describe an individual's ability to transform their world because they possess an original subjectivity that enables them to see the travesty of discourses imposed upon them by institutions such as the State. This original subjectivity enables individuals to exercise their own will and resist (and transform) institutions that would attempt to control them.

While both the "power over" the subject (e.g., Foucault) and the "resistance of" the subject (e.g., Scott) sides of the spectrum have their merit, grounding an analysis on one side or the other can be problematic. Arun Agrawal (2005:170) critiques the one end of the spectrum for a "tendency toward the colonization of the imagination by powerful political beliefs … and the other [for] the tendency toward durability of a sovereign consciousness founded on the bedrock of individual or class interest." As he points out, subjectivity must be (re)habilitated by finding a middle ground.

Trying to operate in the middle ground certainly buys some flexibility, yet both of these frameworks have particular weaknesses for

understanding the relationship between globalization and subjectivity. The "power over" version basically articulates all subjectivities in relation to the same set of historically situated power structures. In my discussion above about interpreting birthing problems I certainly agree that subjectivities are formed in relation to wider social institutions. Yet with respect to globalization, however, is there really a commensurability of a global subject across space? For example, in this analysis, I allege that the autonomous subject is being circulated on the back of Safe Motherhood interventions worldwide. Yet, digging deeper into my own analysis, while I can read the autonomous subject into the journals and literature on Safe Motherhood, in Sololá I could only find it interpreted and shaped by local contexts and actors. This layer of shaping by local actors means that understanding the influence of globalization on subjectivities in multiple locales needs to be more nuanced than simply assuming that one global subjectivity is "colonizing … the imagination" (Agrawal 2005). Furthermore, Foucault has given us little material that we could use to theorize relational subjectivities. Rather, the subject is assumed to be, to some extent, the unit upon which discourses act. Social life is triangulated back to the central discourse. So how do we account for or theorize subjects who triangulate upon each other to understand their place in the world? Finally, I find the presupposition of linearity in relation to subject-making in the "resistance of" versions of subjectivity similarly constraining. The "resistance of" model presupposes a point in time where an obdurate consciousness exists, which at a later time hegemonic, global forces attempt to inscribe. Like the "power over" model, the "resistance of" model imposes a focus on questions concerning the relative dominance of one subjectivity over another, or the origin of subjectivities. In my project, these focuses distract my ability to develop a grounded description of the relationship between subjectivities and globalization.

Alternatively, drawing on models that can accommodate multiple subjectivities could help develop our understanding of the relationship between subjectivities and globalization. Facsimiles of the globally promoted subjects, like the autonomous subject who is the assumed client of global Safe Motherhood campaigns, certainly exist in Santa Cruz. But rather than rolling over and replacing the "authentic" relational subject, these subjectivities coexist. Whether one sees one's place in the world as being defined relationally or autonomously is not a question of either/or, but rather more or less. Like bicultural individuals, context and events prime a person to emphasize one mode of understanding over another (Hong et al. 2000). For

example, walking through the city wearing "western" clothes might inspire a different understanding of one's place in the world than assisting one's wife while she gives birth. P. Sean Brotherton's (2008) description of complex subjects simultaneously navigating Cuba's socialists and capitalist-inspired medical systems provides another example of this type of approach. Mikhail Bakhtin's (1981) ideas of how linkages and borrowings that occur during interactions create social meaning provide an alternative "origins story" for subjectivities: temporal linearity is replaced by complex and convoluted constructions of meaning, the origins of which are not only untraceable, but are seemingly less important. The idea that subjectivities are always under construction helps us understand how they could change. Nevertheless, shifts in subjectivity cannot be understood without linking them to shifts of larger institutions.[16]

My approach to helping us understand the relationship between subjectivities and globalization, then, is to provide a detailed ethnography of everyday social interactions. I consider how we understand our own place in the world largely as a collaborative project.[17] Our subjectivities are constructed and reconstructed through daily interactions (Mahmood 2005), and these interactions provide the nexus between how someone understands his or her place in the world, and the everyday events that he or she participates in. By anchoring specific real-time social situations that occur in particular historical moments to wider institutions, such as the Guatemalan State, we are in a position to understand how the larger political-economy serves as a motivator in constructing everyday life. Because of my close attention to everyday interactions, in this ethnography we can only see the global and the State through proxies. These proxies can be, for example, the actions of individuals who imagine the State, or the specific ways that global policies shape daily action. My framework allows for a representation of the real variation in how globalization is operationalized, and a grounded, empirical description of how it might impact or shape subjectivities.

Centering my ethnography in everyday interactions has allowed me to describe the relationship between globalization and subjectivity by attending to the lived experience of those with whom I've worked (Biehl, Good, and Kleinman 2007). Like colonialism, globalization is often a violent process, particularly for the poor and disenfranchised. João Biehl, Byron Good, and Arthur Kleinman (2007) critique academics who study subjectivity and globalization but who gloss over the brutality of the experience in favor of enriching theory. They contend that "[t]heories of subjectivity are too often over-

stated, obscure, and even dehumanizing. People who are subject to the most profound human experience—suffering massive violence and incomprehensible cruelty, the routine degradation of poverty and despair, the terrors of madness and life-threatening disease, or even facing the impossible dilemmas of providing care, whether surrounded by the highest technologies or near total absence of resources—have too often been transformed into remote abstractions, discursive forms, or subject positions" (13). By attending to the lived experience of indigenous peoples in Sololá, we can also begin to see why questions about subjectivity and globalization are actually far from academic and actually do matter. On a functional level, in an economically impoverished and often violent setting this relational (rather than autonomous) subjectivity can literally form the barrier between life and death. In a State that suffers from a lack of political, legal, and financial resources for poor Maya, a relational subjectivity translates into obligations that frequently provide the only available (albeit flawed) social safety net. In sum, changing birthing practices do matter—these changes can unintentionally transform Maya subjectivities in a way that contributes to weakening the social safety net upon which poor, disenfranchised Maya rely. Ultimately, the global effort to make birth safer may unwittingly generate conditions that jeopardize a population, creating a greater risk than maternal mortality threatens.

Constructing the Field in Sololá, Guatemala

The seeds of this project were sown in 1999 when I had a conversation with the director of the Ministry of Health (MSPAS)[18] in Sololá about the problem of maternal mortality among Mayan women. Based on his suggestion, I returned in August of 2000 and set up shop in Santa Cruz La Laguna. Santa Cruz is a Kaqchikel village on the shore of Lake Atitlan that had about twelve hundred inhabitants at the time of this study. It is the seat of the municipality of Santa Cruz, one of nineteen municipalities that administratively belong to the *departamento* of Sololá. While technically only about seventy-five kilometers from the capital, Guatemala City, Santa Cruz was distinctive for its relative isolation; it could only be accessed by boat or foot. Perhaps because of this "antiquated" arrangement, *Cruceños,* inhabitants of Santa Cruz, have a reputation among other Mayan groups around the lake for being closed, backward, and traditional.

ILLUSTRATION 3. The village of Santa Cruz

I arrived in Santa Cruz fluent in Spanish and English, but I basically spent my first year in the field studying Kaqchikel. My teacher was a man from Santa Cruz, who was more or less my age, fluent in Spanish, and who had graduated from high school. He was one of the few Cruceños who could write Kaqchikel, which was important to me. Over the year that I studied I made a dictionary and created written dialogues about daily aspects of life (such as going to the market, buying tortillas, greeting people on the path, etc.). As my Kaqchikel advanced I would record my teacher telling stories, and then transcribe these stories. Learning the language really dictated the terms of my entrance into Santa Cruz, as I got to hear many more stories and histories of the village, its geographical surroundings, and its inhabitants than normally would have come up in conversation.

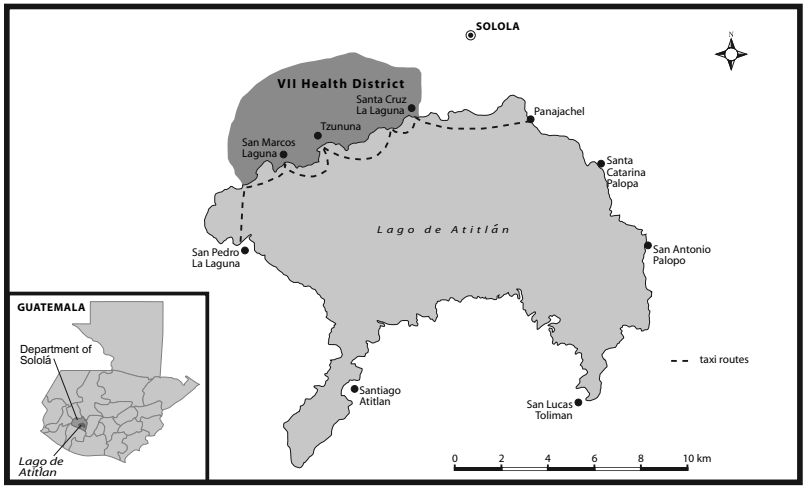
While my language-learning activities oriented me to much of day-to-day life, Cruceños were aware that I was there because of my interest in women's reproductive health. The more I became settled, the more I was sought out to deal with those sorts of matters. Women asked me to accompany them to healthcare providers for any types of "women's problems." I was also frequently recruited to visit women who were sick in their homes or in the hospital. I was sought out to evacuate pregnant women with medical emergencies, like Rosario, to the hospital. Watching women attempt to navigate

public, non-governmental organizations (NGOs) and private healthcare systems and being present when families interpreted illness and negotiated healthcare choices was at many times painful for me to witness, but invaluable as a learning tool.

My life and experiences in Santa Cruz form the basis of this ethnography, yet this is really a far more comprehensive look at efforts to decrease maternal mortality in Sololá. Obtaining a detailed understanding of how this campaign affected people on an everyday level meant that I had to incorporate many sites and many methods into this study.

From the day I arrived I tried to integrate myself as much as possible into the Safe Motherhood campaign. I traveled frequently around the health district to which Santa Cruz belonged. I learned about State-provided prenatal care by observing women who came to health posts for prenatal visits, traveling with Ministry of Health–contracted health workers to neighboring villages that lacked a health post to help with prenatal efforts, and going on house calls to deliver prenatal care to pregnant women who had not come into the clinic on their own. I also participated in the meetings between *iyoma*, as the local midwives were called, and the Ministry of Health throughout the district.[19]

There was always a lot to be done in Sololá to improve Safe Motherhood, and on the departamental level, I stayed abreast of what the Ministry of Health and the NGOs were trying to do. This involved going to a lot of meetings where, in addition to the business of the



MAP 1. Fieldsites in Sololá, Guatemala

day, we always had the opportunity to eat lunch and drink coffee. I very much appreciated and enjoyed forming professional relationships with colleagues, the vast majority of whom had much more expertise in the area of maternal health than I did. I was able to call on these relationships for the help that I needed—from explanations about medical particulars of certain maternal deaths to advice about designing interview protocols.

During my second year of fieldwork attempts to improve the quality of emergency obstetric care at the hospital became much more important to my work. I participated in the doctor training sessions where the latest protocol for obstetric emergencies was introduced and where we practiced manual actions on the torsos of mannequins. I made daily trips to the hospital for two and a half months to see what happened when a woman came to the hospital with an obstetric emergency. I spent many days sitting in the general emergency room (ER) and then the obstetric (OB) section watching interactions between doctors, nurses, patients, and their families. I also followed patients from the ER to the maternity ward and to the operating room. Informally, I interacted with hospital workers at all levels, from the janitorial staff to the social workers and record keepers. Nevertheless, I call my activities in the hospital "observation" because I did not actually participate in providing medical care, nor did I advocate for the patients.

When I originally designed this study I assumed that the primary interactions that I would observe in the obstetric ER would be between the healthcare providers and the women themselves.[20] After observing the ER for one week I realized that this assumption was completely unfounded. There was very little conversation between patients and the medical staff. In fact, constructing the patient as singular denied the social reality of the hospital. The few unaccompanied individuals I saw in any part of the ER were picked up off the street by the firemen and all of these cases attested to some sort of social pathology—men who were drunk and passed out blocking the road and a woman beaten by her husband and then thrown out of the house and into the street. There was no case of anyone in the OB section of the ER ever coming in alone, whether they had a scheduled appointment or were unscheduled. I, therefore, quickly had to amend my research ethics permissions to include family members in the study.

While I ran around Sololá I tried to formally interview as many people as possible. One of my primary focuses concerned what happened in a homebirth when a woman had an obstetric emergency

and, closely related to that, why a woman remained at home instead of seeking biomedical care. To discover women who had remained at home during an emergency, I carried out two courses of "village" interviews in Santa Cruz and two surrounding Kaqchikel Villages. These village interviews consisted of a demographic survey that included a reproductive history, information on the use of different health resources, and educational and household information. I then had a number of open-ended questions that dealt directly with women's feelings about using the hospital for emergency obstetric care, assessments of risk, understandings of biomedical treatments, etc. All of these interviews were completed with the assistance of a trained field assistant. Because most women had no experience with interviews and disliked dry questioning, we tried to make the interviews as conversation-like as possible. The field assistant would ask the questions, which she had largely memorized, and I would take notes on the woman's answer, interjecting if I wanted more information about a situation. The longest interviews took an hour and a half; the shortest, about twenty minutes. All of these interviews were of course completed in Kaqchikel. Most participants were revisited after six months for a follow-up interview. Also, if it seemed after writing up an interview that a relevant detail had been left out, women were revisited. I completed 122 random interviews with women and 13 non-random interviews with men. Unlike the random sample of women, I chose the male participants sheerly because they were loitering in a public space (like outside of the barber's shop, at the dock, or in the center of town). While it would have been nice to add men to my random interview sample in the village, this was impractical as most men work all day Monday through Saturday afternoon. Sunday is their only day off, and those who are not in church are playing basketball or soccer. There was no time except for the evening to find men in their homes (a condition necessary for my random survey), and I could not ask a field assistant to work nights, nor was I comfortable walking around and knocking on strangers' doors at those hours. Thus, the village interviews with men that I did get, I got on weekends. All of the male participants come from Santa Cruz.

To better understand why women did end up in the hospital, I made thirty-three audio recordings of healthcare worker–client interactions in the ER and had a follow-up interview with all but one of the woman recorded.[21] While I was able to communicate with most of them by speaking Kaqchikel or Spanish, either neighboring patients or a midwife helped me conduct the interviews with mono-

lingual speakers of K'iche' and Tz'utujil. While I administered the same demographic survey that I used in the village, the follow-up questions concerned the decision-making process to send the patient to the hospital and her experience once she arrived. In addition to interviewing the recorded patients, I interviewed ten husbands, four midwives, three family groups, two mothers, one father-in-law, and one brother who accompanied the patients. Again, I concentrated on understanding the decision-making process that led up to their presence in the hospital, as well as their perception and understanding of what had occurred since they arrived. As families always bring at least one Spanish speaker with them to the hospital, communication was never an issue in these interviews. In many instances I ran into and chatted with family members over several days.

The multiple sites and diverse research methodologies have been crucial to this work. I have been able to present a far more holistic understanding of why maternal mortality was not decreasing in Sololá than I would have had I restricted myself to a "village study" or decided to just concentrate on the Safe Motherhood campaign itself. This work also intends to take the discussion of why women are reluctant to use the state-provided healthcare to another level by presenting data that could not be gathered through interviews or surveys. My use of audio recordings has allowed me to enrich our understanding of how structural issues, such as race, ethnicity, and multilingualism, are enacted in the delivery of healthcare, making it profoundly uncomfortable for disenfranchised Maya. I use this rich data to construct a detailed picture of how women, families, and *iyoma* are motivated to seek out certain types of care and why health workers are motivated to shape the care they offer in particular ways. As I describe in the following chapters, the Safe Motherhood campaign in Sololá rests on top of this maneuvering, sometimes intersecting with the needs and desires of the involved parties, yet at other times remaining completely disconnected.

Outline of Chapters

This book is divided into six different chapters. Chapters 1 and 2 examine the two settings for birth: the home and the hospital. I begin chapter 1 by exploring village life in the Guatemalan highlands where I lived. With that context in hand, I focus on the everyday practices surrounding pregnancy and childbirth in Santa Cruz. I analyze these practices to show how childbirth is an important local site

where kin ties are formed, which creates and reinstantiates mutually constituted, relational subjectivities. This chapter highlights the costs of policies that seek to move birth out of the home and into the hospital. Chapter 2 takes us directly to the obstetric emergency room, where we follow the admission of one woman whose family brings her to the hospital with an obstetric complication. A micro-level analysis of the interaction between the family and the nurse in the obstetric ER helps reveal the everyday terms upon which Safe Motherhood's message of "skilled care" is propagated. The micro-analysis provides a link between the global Safe Motherhood campaign and how health workers use policy to reorganize daily practices related to childbirth in order to promote particular "modern" subjectivities that can remake Guatemala. Ultimately the chapter poignantly illustrates why seeking care can be profoundly uncomfortable for poor, indigenous Maya.

Chapters 3 and 4 take a closer looks at the impact of policy in helping to prevent maternal mortality. Chapter 3 puts the Guatemalan Safe Motherhood efforts in conversation with the global initiative, by outlining how the Safe Motherhood campaign in Guatemala has followed the contours of larger, global Safe Motherhood. It enriches our understanding of how the design of the local Sololá campaign is linked to a global initiative, and how both assume a western, autonomous subject as the client of the campaign. In this chapter I use the notion of spin to illustrate how the terms upon which the global campaign has been waged have actually impeded our ability to decrease maternal mortality. Chapter 4 focuses on the rejection of particular Mayan subjects by the Guatemalan healthcare system. I trace how this rejection occurs at all levels: in health worker–client interactions, in hospital policy, and in mandated policy from the Ministry of Health. This chapter helps highlight the local narratives available in post–civil war Guatemala into which the discourses of the global Safe Motherhood campaign ultimately were incorporated.

Chapter 5 explores the everyday lives of the Kaqchikel men and women who live in places that suffer such high rates of maternal mortality. The theme of violence frames this chapter and I argue that violence is paramount both to understanding the history and ongoing daily experiences in Guatemala. I use violence as an entrée into my field site, showing how social organization and economic resources available to villagers have been shaped, at least in part, by the violence. In my view this legacy of violence is critical to the prejudice and rejection certain Mayan subjects/citizens experience in Guatemala. Many particularly middle and upper class Guatema-

lans see the ethnic divisions of the past as a motivator for continued violence. They conceptualize the way forward as a "modern," democratic, uniform Guatemala where the populace shares important values (education, health, hard work, small families, etc.). I tie the positive reception of global Safe Motherhood within the national health systems to the fact that it both represents and embodies this new, "modern" Guatemala.

Chapter 6 looks at how the Safe Motherhood campaign gets translated at the village level, and what this means to the practices outlined in chapter 1. This discussion brings to the fore different ways of viewing problems in pregnancy and childbirth. The local Safe Motherhood campaign betrays the bias of the global campaign and views maternal mortality as a biomedical problem, while in Santa Cruz, physical problems during pregnancy and birth are generally considered manifestations of underlying social problems, such as a poor relationship with God resulting from sin. These differing etiologies lead to different means of addressing problems: while health workers want women to receive biomedical attention, villagers place a premium on dealing with and resolving social ills.

As my Kaqchikel informants pointed out time and time again, for the woman who is pregnant, birth is what Victor Turner (1957) would call a *liminal* state. "Täq xatel libre," they say—literally meaning "maybe you will leave free," and figuratively meaning "maybe you will get out alive, but maybe not." Birth is also one of the few areas where ethnographers have achieved a deep intimacy with their subjects. That same intimacy is present in the ethnographer's experience of studying death during birthing. This ethnography firmly places us in the difficult, intimate spaces where mothers who should have lived die.