

Theorizing global health

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Abstract

Reflecting on the recent West African Ebola outbreak, this piece advocates for a critical and people-centered approach both to and within global health. I discuss the current state of the field as well as critical theoretical responses to it, arguing that an ethnographic focus on evidence and efficacy at the local level raises rather than lowers the bar for thoughtful inquiry and action. The current moment calls less for the all-knowing hubris of totalizing analytical schemes than for a human science (and politics) of the uncertain and unknown. It is the immanent negotiations of people, institutions, technologies, evidence, social forms, ecosystems, health, efficacy, and ethics – in their temporary stabilization, production, excess, and creation – that animate the unfinishedness of ethnography and critical global health.

Keywords

theories of global health, ethnographic theorizing, critical global health

We live in interconnected, yet also radically unequal, insecure, and unhealthy worlds: exhausted worlds. The spread of infectious disease across borders, struggles over access to treatments, and the rise in chronic disease pose highly complex and often unpredictable challenges – realities that are, time and again, couched in the vocabulary of emergency, hinging on a temporality that insists on a break with the past, and a rhetoric of compassion and recovery even as conditions stagnate or worsen. Accelerating environmental change, the visible and invisible wounds of ongoing war and mass migration, and the tolls of poverty and discrimination within precarious health systems all create conditions of dire vulnerability. What algorithms generate insight into the medical and political dimensions of present and

coming health challenges, or help navigate questions of accountability and our ethical ‘response-ability’ (Haraway 2007, 89), now and on the horizon?

Reflecting on the recent West African Ebola outbreak, this piece advocates for a critical and people-centered approach both to and within global health. I discuss the current state of the field as well as critical theoretical responses to it, arguing that an ethnographic focus on evidence and efficacy at the local level raises rather than lowers the bar for thoughtful inquiry and action. The current moment calls less for the all-knowing hubris of totalizing analytical schemes than for a human science (and politics) of the uncertain and unknown (Biehl and Locke n.d.; Petryna 2015). Ethnography can serve as an empirical lantern within and beyond the open-source anarchy that global health has become, highlighting how the targets of interventions implode the units through which they are conceptualized, producing contrapuntal knowledge of how things are, what sustains their intractability, and how they might be otherwise. ‘Global’ is here best understood not merely as geographical but as a political work-in-progress that calls on us to remain ever mindful of the ‘imperial durabilities of our time’ (Stoler 2016).

Open-source anarchy

The West African Ebola outbreak was an ‘acute-on-chronic’ event, in the words of physician-anthropologist Paul Farmer (2011): part and parcel of long-smoldering public health crises that humanitarian and global health interventions and politics as usual could not placate (or had even fueled), and with compounding deadly effects that people had to fight, at least initially, by themselves. As Jeremy Farrar, director of the Wellcome Trust, and Peter Piot, who helped to discover the Ebola virus, rightly pointed out, ‘the particularly devastating course of this epidemic’ could not be attributed to the ‘biologic characteristics of the virus’ alone (2014, 1545). It was, rather, the result of the combination of ‘dysfunctional health systems, international indifference, high population mobility, local customs, densely populated capitals, and lack of trust in authorities after years of armed conflict’ (Farrar and Piot 2014, 1545). And, perhaps most importantly: it was ‘a highly inadequate and late global response’ (ibid.). As Ebola kept crossing borders, we also witnessed a grotesque disparity in risk and outcome, reflecting both our technical prowess and the inequalities built into current world orders and value systems.

So, how did we get here?

Displacing earlier framings, such as colonial-era ‘tropical medicine’ and postwar ‘international health’, the contemporary field of ‘global health’ brings together a vastly diverse array of actors and interests in elastic relationships, and it has indeed become a big

business (Brown, Cueto, and Fee 2006). Informed by various agendas, the World Health Organization, the World Bank, the Gates Foundation, pharmaceutical companies, governments, universities, and innumerable nongovernmental organizations are all working to address pressing health issues worldwide with unprecedented financial and technological resources (Biehl and Petryna 2013a). Changes in the material and political capabilities of state and nonstate actors, and changes in the world of ideas, now have more impact on each other than in the closed, state-centric system that prevailed during the Cold War.

Much global health scholarship is invested in developing models – more or less hypothetical – of optimal interventions and in identifying and evaluating programs that supposedly ‘work’ and that might therefore be replicated or scaled up across a range of often widely divergent contexts. Global health players can become impervious to critique as they identify crises, cite dire statistics, and act on their essential duty to promote health in the name of ‘humanitarian reason’ – as Didier Fassin (2011) would call it – or as an instrument of economic development, diplomacy, national security, or market expansion. Meanwhile, ‘evidence-based medicine’ has become the default language for both public- and private-sector actors concerned with identifying problems and measuring outcomes (Adams 2013a; Lemieux-Charles and Champagne 2004; Timmermans and Mauck 2005). This new landscape of evaluation is displacing the previous goals of interventions, making the provision of actual health services secondary to the development of reliable methodologies and the generation of comparable data. Metrics are presented as objective, value-free, and abstracted from social and political contexts. Yet, in reality, as Vincanne Adams and colleagues (2016) have noted, they operate as administrative apparatuses that shape health futures by reducing the noise of context and enabling business management rationalizations and decision making.

Treatment access has been one of the central tenets of global health activism and a professed goal of interventions since the mid-1990s (Nguyen 2010). Public–private partnerships are booming and pharmaceutical companies have rebranded themselves as ‘global health companies’, making older treatments available and expediting access to newer ones (Biehl and Petryna 2013b). We now see a multiplicity of actors, all vying for resources and influence while setting new norms for institutional response, sometimes providing the public health resources that states and markets have failed to furnish. In practice, the concerns of donors, not recipients, tend to predominate. Often, donors insist on funding disease-specific and technologically oriented vertical programs at the expense of the public sector. Thus, in settings ranging from neoliberal Mozambique to urban North America, state-of-the-art facilities for HIV/AIDS coexist with dilapidated public hospitals (Pfeiffer 2013). Coinfections are yet another indication that narrowly targeted interventions can miss the mark. Such is the case with malaria. No one contracts it or recovers from it in a vacuum, and its biological and immunological uncertainties beg for a more nuanced science. In fact, the

narrow focus on Ebola during the recent outbreak overlooked other diseases such as malaria or tuberculosis, causing them to spread relatively unchecked.

Such multiple and fragmentary global health interventions also consolidate what anthropologist Susan Reynolds Whyte and her colleagues (2014) working in Uganda call ‘projectified’ landscapes of care. While enabling much-needed access to AIDS treatment, for example, the amalgamation of public–private interventions can endow states with new (sometimes abusive) powers while also diversifying claims to citizenship. We are left with what legal scholar David Fidler (2007) would call an ‘open-source anarchy’ around global health problems – a policy space in which new medical technologies, ideas, strategies, rules, distributive schemes, and the practical ethics of health care are being assembled, experimented with, and improvised by a wide array of deeply unequal stakeholders within and across countries.

Within this increasingly crowded landscape, the supposed beneficiaries of interventions are too often hidden from view, and appear either as having nothing to contribute or as unabashedly, uncritically receptive. While there have been some efforts to engage civil society and activists, a strong biomedical orientation remains pervasive, casting community engagement as politically necessary but ‘scientifically’ irrelevant (Biehl 2007). As hopes for a magic bullet reign and the power of ‘data’ is ever more fetishized, the visions of technocrats tend to outweigh other forms of practical and meaningful evidence, as even Angus Deaton (2012), the latest Nobel laureate economist, has emphasized: ‘Randomized control trials have been given a free pass in the name of rigor. But there are no magic bullets and there are no gold standards’.

At the core of the Ebola crisis were social and political determinants that defied technical and theoretical quick fixes (Amon 2014). Intended to minimize disease transmission, for example, curfews and quarantines failed to take into account historical and contemporary tensions between peoples and governments in Guinea, Sierra Leone, and Liberia, backfiring so spectacularly that in August 2015, Liberian troops ended up shooting at people protesting such draconian and ill-conceived measures. To unpack nonmedical determinants – a lack of emergency preparedness, the capacity of frail or nonexistent health systems, myopic funding mechanisms, and slow-coming political action – we need to move out of our comfortable disciplinary silos and produce empirically rich, comprehensive, historically deep, and geographically broad analyses of the power constellations, institutions, processes, and ideologies that impact the form and scope of disease and health processes.

The human populations that constitute the subjects of health and development plans are not flat and homogenous, and they are not just the source of problems or so-called cultural obstacles. Epistemological breakthroughs do not belong to experts and analysts alone;

people's practical knowledge can help break open and transform paradigms, and may well provide the keys to an otherwise (Biehl and Petryna 2014; Deaton 2013). In the Ebola outbreak, sociocultural knowledge proved crucial to understanding the epidemic and enacting containment efforts. Social scientists on the ground have shown why curfews and quarantines were received so poorly, even violently; why rumors about Ebola needed to be taken seriously rather than dismissed as illogical or paranoid; and why bereaved families hid bodies, rather than surrendering them for sanctioned burial (Frankfurter 2014). The recognition of history, politics, and culture productively liberate people from the decontextualized, faceless, and pliable role of 'victim' (Edelstein, Angelides, and Heymann 2015; Global Citizen 2015). Moreover, a focus on the institutional cultures of various organizations themselves highlights how much of the responsibility for the epidemic lay not with culture itself – as if culture were something bounded, inherently irrational, or dangerous – but with particular decisions and disagreements within and among a global class of supposed saviors.

At stake is not just technopolitical preparedness but also social scientific preparedness and the embrace of 'radical changes in behavior' in governance at the global scale, as Richard Horton (2014, 2015), editor-in-chief of *The Lancet*, has called for – that is, the development of human and institutional capacities that go beyond the repetition of history and that can help to defend, in a spirit of radical political openness, what Albert Hirschman (1971, 37) calls 'the right to a nonprojected future as one of the truly inalienable rights of every person and nation'.

Scrutinizing global health

If global health has emerged as a prominent sphere of action and intervention, its consolidation as a field has called for new kinds of scrutiny (Janes and Corbett 2009). A number of important critiques have emerged, destabilizing assumed global health architectures and imperatives, and challenging our sense of what counts as 'global'. While unearthing the dominant epistemic and political modes that enable global health operations, social theorists have also thought critically about what kinds of interventions are actually workable, desirable, or ethical in the face of widespread disease, new vectors and disasters, toxic environments, and deadly health disparities. Attending to these inquiries helps us to better grasp what is at work and at stake in contemporary global health, and to push our methods and analytics to better account for life on the ground (Biehl and Petryna 2014; Das 2015).

A first body of critique understands global health as a neocolonial or postcolonial imperial project. Historian of medicine Warwick Anderson (2014), for example, not only argues that

biomedicine is ‘constitutively colonial’ but also questions how too-easy binaries of domination and submission miss the complex postcolonial ‘contact zones’ in which relations of power unfold in multiple, shifting, and contested ways. Against the linear march of a triumphant narrative of globalization, he attends to how global health both perpetuates and obscures colonial dynamics and to how global ‘flows’ rarely circulate smoothly. Such critiques resonate with the recent Ebola epidemic. Long before the outbreak erupted, the colonial legacy of the ‘rubber plantation model of international health’ shaped dramatic inequality in access to knowledge as well as resources (Dahn, Mussa, and Nutt 2015). As early as 1982, scientific research warned of Ebola risk in the region, yet these findings – based on research carried out on the bodies of Liberian rubber workers by German scientists and published in a European journal – were never brought back to Liberia. The ‘flows’ of research were less ‘flows’ than lopsided allocations.

Where Anderson productively argues for a more multifaceted view of colonialism and postcolonialism, Jean and John Comaroff (2012), too, work to decenter global sovereignty, rejecting the conflation of ‘the global’ with the ‘Euro-American’. ‘Theory from the south’, in the Comaroffs’ telling, not only flips the West/non-West binary but destabilizes it, casting the global South as ‘a harbinger of history-in-the-making’ (2012, 13). And indeed, countries in the global South are actively altering global health agendas for their own ends, through South–South partnerships, the circulation of generic pharmaceuticals, the contestation of trade and patent agreements, and the opening up of new markets (Cassier and Correa 2008; Hayden 2007; Rajan 2012). As in the case of Brazil (Biehl 2007, 2013; Biehl and Petryna 2013b), these countries are at once implicated in the broader landscapes of global health, and are forging novel dynamics for health care between markets, states, and citizens.

A second line of critique explores how global health reflects and shores up a capitalist neoliberal world order. Anne-Emanuelle Birn, for example, highlights how global health concerns merge with geoeconomic interests, increasingly under the purview of private-sector actors (Birn 2014; Birn and Dmitrienko 2005). The capacities and interests of public multilateral health agencies give way to an ‘asymmetry of power’ between private-sector actors and public interests, and philanthropic efforts to improve health and quality of life may in fact reinforce the very inequities they seek to overcome (Birn 2014). Such arguments also dovetail with what Naomi Klein (2007) has called ‘disaster capitalism’, when, in moments of health emergency, the chaos of crisis is harnessed to implement controversial neoliberal policies while ‘shock’ prevents citizens from mobilizing resistance. As both Klein and anthropologists Anne Lovell (2011) and Vincanne Adams (2013b) observed in the aftermath of Hurricane Katrina, the less obvious effects of disaster capitalism include the creation (and destruction) of infrastructures and mechanisms of social displacement and eviction, which get prolonged as a way of life while bureaucratic processes reproduce (rather than dismantle) conditions of vulnerability.

Anthropologist-physician Paul Farmer is one of the most vocal critics of the structural violence wrought by neoliberalism, taking on poverty and disease through a community-based approach that blends technological intervention with a focus on making health systems work. Farmer and Partners In Health, the organization he cofounded, understand diseases as loci where biology, environment, and medicine have gone awry, and their notion of intervention accordingly tackles the structural conditions that perpetuate disease (Keshavjee 2014). During the recent Ebola outbreak in Sierra Leone, they challenged foreign interventionist approaches to the epidemic, hiring approximately one hundred Sierra Leoneans, including Ebola survivors, as community health-care workers and contact tracers for every one foreign medical professional shipped out to the country. Such hiring practices facilitated local trust and helped build up a more sustainable, equitable, and accessible community health-care network that has persisted after Ebola quieted down and foreign/silo interventions ended. Farmer's work serves as a kind of critique in action, rejecting economic orthodoxies and taking a social justice approach to patient care.

A third critique of global health takes a more Foucauldian approach, focusing on the new regimes of governmentality and biosecurity reconfiguring discourse and practice around health and risk. As scholars like Andrew Lakoff and Stephen Collier (2008, 16) have argued, biosecurity in the realm of global health troubles traditional regulatory boundaries, as biological threats move without regard to borders, and globalization becomes as 'a key source of pathogenicity'. In this 'emergency modality of intervention', approaches shift from prevention to preparedness, creating new modes of surveillance and intervention, and encouraging technical responses without much concern for ongoing living conditions (Lakoff, Collier, and Kelty 2015). While these are compelling and important arguments on the level of institutional biosecuritization, this body of work largely ignores local perspectives. These critiques leave little space for asking how people exist amidst – and also lodge their own lived critiques of – such regimes of biosecuritization. Furthermore, the trope of 'security' functions through a largely Westernized notion of governmental operants and biopower. What other forms of securitization exist elsewhere, and what clashes occur when they come into contact via global health interventions?

Public intellectuals in the global South, such as the Brazilian public health and legal scholar Deisy Ventura (2016), offer an important swerve here, hinting at how critiques of governmentality might more fully account for the social and political. As we see currently in Brazil, where 'the securitization of the response to Zika turned the *Aedes aegypti* mosquito into public enemy number one' (Ventura 2016, 3), the depiction of disease as a 'security threat' can also have other effects, including panic, haste, suspicion, and discrimination, as certain populations are labeled as vectors or 'at risk'. Such securitization, Ventura argues, fosters a proliferation of surveillance techniques to prevent the spread of disease, exerting

control not only over contagions themselves but the myriad vectors that carry them (in other words, people and goods). Moreover, the ‘risk’ Ventura foresees in her analysis dooms global health to ongoing periods of ‘war’ and ‘truce’ as opposed to a systematic practice addressing the infrastructural roots of socially determined health outcomes.

A final sphere of critique has approached global health as a form of transnational humanitarianism. Perhaps best exemplified by the work of Fassin (2011), these critiques see global health as an extension of a broader form of humanitarian reason, which has become a dominant form of moral thinking in the West. Fassin (2012) cautions against taking the ‘idea’ of global health for granted, interrogating the assumptions of both ‘global’ – ultimately neither universal nor ever truly worldwide – and ‘health’ – where the politics of life are never a given. Attentive to how compassion in the face of suffering can be depoliticizing, and to the ways humanitarian intervention has become an increasingly important form of global governance, Fassin and others rightly trouble our complacency about acting ‘in the name of humanity’, and highlight the inequality and violence that accompanies care (Redfield 2013; Ticktin and Feldman 2010; Han 2012; Stevenson 2014).

Yet, while critiques of global health as humanitarianism can nuance our thinking about rationality, interventionism, and morality, in certain forms, their uptake can also elide the very possibility of engagement itself. Grossly oversimplifying the anthropological engagements with suffering, poverty, violence, and affliction as akin to acritical and heroic impulses towards universal humanity and salvation (Robbins 2013; Ticktin 2014), such approaches can themselves produce a kind of myopia, missing ethnographic ambiguities and the complexities of how projects are actually conceptualized, implemented, and worked out, or desired by people themselves. Scholars like Farmer, engaged in the practical work of delivering care on the ground, highlight the deep ambiguities that coexist with new potentials and impasses, while also refusing to disengage from action in the face of radical injustice, despite inevitable double-binds and ethical gray zones. Analytical distance too easily becomes a sanctioned form of moral detachment that dooms people differently than humanitarian reason – but dooms them nonetheless. The challenge here is to restore to the social sciences a sense of moral purpose and practical solidarity that might animate both critical thought and social action (Wilkinson and Kleinman 2015; Briggs and Mantini-Briggs 2016).

Peopling global health and multiplying theory

While all of these spheres of critique point to the uneasy stakes of global health and its agendas, forms of practice, and consequences, none can fully account for the highly complex and uneven ways they unfold on the ground, nor the difficulties of engaging at all. In *When People Come First* (2013), Adriana Petryna and I make the case for an ethnographic empirical

lantern in the critical studies of global health. That is, we advocate for charting the lives of individuals and institutions over time, chronicling people's varied interpretations of their conditions, all the while denaturalizing operational categories and illuminating the concrete ways meso- and macro-level actors impinge on local worlds and become part of global orders. Close attention to particular realities and to the various technologies and metrics in which they are cast highlights the productive and fraught coexistence between the design of global health systems and the alternative models people craft for 'engaging the real . . . [and for] worlding the world', as Clifford Geertz put it (2007, 222). They attune us to the places where global inequities and ideologies – neocolonialism, neoliberalism, governmentality, humanitarian reason – are reified, and also to the limits of those categories.

Ethnography can thus capture the active embroilment of reason, life, and ethics, offering entry points into the plasticity of systems, theorizers, and norm-makers themselves and leaving space for pursuing new forms of socially meaningful anthropological work in global health. Instead of withdrawing to a dispassionate 'armchair' position and easy cynical dismissal, this kind of work inhabits the tension between a critique of and a critique in global health, sustaining a space for critical inquiry and action, understanding and doing.

People and the worlds they navigate and the outlooks they articulate are more confounding, incomplete, and multiple than dominant analytical schemes tend to account for. Drawn to the unsettling of rationalities and ingrained commonsense, critical global health eschews a sense of theory as a totalizing enterprise or as the privileged domain of elite knowledge-makers self-appointed to speak on behalf of benighted populations. Rejecting the division between those who know the world and those who must simply struggle to survive it, and upholding an equality of intelligences, our ethnographic forays can chronicle lived tensions between theory and practice and invoke both alternative conceptual frameworks and new kinds of imagination.

The 'people' of global health tinker with alternative spaces of the 'global' in the pursuit of 'health' – troubling the inequalities of geopolitics and the hollow conceptions of truth and justice in preposterous social orders. Current emergencies in global health, from the Zika virus to the water contamination in Flint, Michigan, speak to how bodies, infrastructures, technologies, and evidence are unequally shared and lived. No longer a mere backdrop, materials and infrastructures (from water management and sewage and road systems to birth control methods and pesticides) actually assume a central, often agentive role, interacting with communities in ways unaccounted for, and many times harmful (Barreto et al. 2016; Bellinger 2016). Epidemiological uncertainty unleashes new forms of evidence making and surveillance, expanding to the policing of women's reproductive practices or standing-water tanks in favelas, for example. Only by insisting upon a space where precarity is actually a

mobilizing force and where ‘those of no account are counted’ (Rancière 2001) might we restore the place of the poor in political and scientific community.

Ethnographic theory emerges from and in conversation with people and world-making practices, with various ways of knowing and relating. It is a way of staying connected to open-ended social processes and unknowns – a way of counterbalancing the generation of certainties and foreclosures by other disciplines. Keeping interrelatedness, precariousness, uncertainty, and curiosity in focus, our theorizing is never detached from praxis, but directly shapes and channels anthropology’s entanglements in processes of transformation. In this way, theory is multiple and multiplies, a ‘tool box’ that can be actionable, in the world and in our writing: ‘it has to be used, it has to work’ (Deleuze 2004, 210). It is these immanent negotiations (of people, institutions, technologies, evidence, social forms, ecosystems, health, efficacy, and ethics) – in their temporary stabilization, production, excess, and creation – that animate the unfinishedness of ethnography and critical global health.

Acknowledgments

This essay builds on a paper presented at the session ‘Critical Global Health’ of the annual meetings of the American Anthropological Association, in Denver, November 2015, and on a lecture delivered at the Cermes 3 international colloquium ‘Savoirs, Pratiques, Politiques: Les Sciences Sociales et les Transformations Contemporaines des Mondes de la Santé’, in Paris, May 2016. I want to express my deepest gratitude to Vincanne Adams, Jean-Paul Gaudillière, Peter Locke, and Adriana Petryna for their generous and very helpful comments and to Elizabeth Durham, Alexandra Middleton, and Naomi Zucker for their critical engagement and wonderful editorial help.

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