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Global Health

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Global health is a field of expertise that has emerged at the turn of the twenty-first century alongside changing disease profiles, health technologies, and governance structures. This entry provides an overview of the historical conditions that have given rise to the field. It illustrates the new political and financial transformations that have made global health 'global', in contrast to earlier work on international, world, or tropical health. It also charts new understandings of wellness and disease, which have been shaped by global pandemics including HIV, the increase in non-communicable illnesses, and the recent concern for planetary sustainability. While anthropologists have played a central role in global health since its inception, the fields of anthropology and global health also operate in an 'awkward relation' (Strathern 1987) with one another. In the second part of the entry, we overview how anthropologists work within, against, and in-between the expertise of other global health practitioners. We suggest that insofar as the field of global health is emergent, so too are the ways that anthropologists engage with it.

Introduction: an awkward relation

Throughout the twentieth century, 'global health' was an uncommon term. The terms 'world health' or 'international health' were commonly used instead to discuss expansive supra-national health concerns, from epidemic diseases to political relations and financing. 'Global health' emerged to draw attention to the *global* connectedness of diseases and of the people and institutions that govern and respond to them, driven by the spread of new technologies that facilitate rapid global transit, exchange, and communication.

Global health has become codified as a field of expertise over the new millennium, and today the term is used widely. Global health centres exist at most major academic and health-focused institutes. The World Health Organization now issues a global health agenda¹ and compiles its health-related statistics in a database called the Global Health Observatory.² Numerous publications advance 'global health science'. For example, the journal *Global Public Health* launched in 2006, and the medical journal *The Lancet* initiated a publication devoted entirely to global health in 2012. International conferences organised around the theme of global health draw thousands of professional and academic participants each year and news outlets commonly have global health sections as part of their broader health reporting.

As global health has exploded onto the scene of health scholarship, the field of anthropology has responded by taking it up as a set of practices within which to engage as well as a concept to study critically and ethnographically. Many anthropology departments now participate in multidisciplinary undergraduate and graduate programs focused on global health, and university partnerships between centres for global health and anthropology departments are common. Academic presses such as Duke University's Critical Global Health series also connect the fields and several anthropologists have published review articles, readers, textbooks, and edited volumes on global health (e.g. Nichter 2008; Janes & Corbett 2009; Singer & Erickson 2013; Biehl & Petryna 2013; Adams & Biehl 2016; Brown & Closser 2018). Moreover, numerous meetings convened in recent years explore the rapidly transforming theories, policies, and practices produced through the intersections of these fields (e.g. de Klerk 2015).

Anthropologists have found diverse ways to engage with global health, and they have witnessed important frictions between the methods, orientations, and interests of different scholars and practitioners in these overlapping fields. In this sense, anthropology and global health are in 'awkward relation' to each other (Strathern 1987). This is to say that tensions arise when two differently-oriented and internally diverse fields meet and occasionally merge, and that the coming together of the fields will not be seamless. This entry will review the alternative orientations and praxes that have emerged in global health and anthropology's intersections, and illustrate how this heterogeneity can be both productive and disruptive to efforts to address health problems around the world.

The entry is divided into two parts. The first shows that global health's formations are both expansive and emergent. Its sprawling systems and organization of stakeholders include an exceedingly complex and dispersed set of interactions between microbes, carcinogens, billionaire donors, government officials, medical and pharmaceutical corporations, NGO workers, health care professionals, and publics. Moreover, the priorities, methods, and impacts of these multiple actors are rapidly transforming. That said, 'rapid transformation' is also a discursive strategy of some powerful players in the field of global health, and attention to the field's historical formation shows that much of what is presented as 'new' echoes colonial-era patterns of consolidating wealth, exacerbating global inequality, and monitoring sickness and health for the sake of empire and/or corporate profit (Packard 2016; Trouillot 2003).

The second part of the entry shows that anthropologists over the past two decades have held a variety of dynamic positions in relation to the field of Global Health. It focuses on three positions, reviewing how anthropologists have worked within, against, and in-between dominant global health interests.

Emergent transformations in global health

1. Responding 'globally'

'Global health' has emerged in policy and development spaces that were, until recently, organised around

‘international’, ‘world’, or even ‘tropical’ public health concerns (Brown *et al.* 2006). It operates as both a collection or assemblage of individuals, organizations, and nation-states and as a discourse about health that travels beyond these institutions. The term has become so commonplace in public discourse that it may be easy to overlook that it is an invented, historically specific concept, which organises the world by prioritising some set of values over others (eg. charity over political justice, moral universalism over cultural specificity, global citizenship over Indigenous sovereignty, etc.) (Butt 2002).

Much anthropological work on the topic unpacks how global health has been constituted as a ‘global’ domain. It emphasises that the category ‘global’ is not an objective summation of all places in the world; rather, places and things that are considered to be global are produced out of specific historical and cultural milieus (Law 2004; Tsing 2000). And though ‘global’ purports to represent the entire world, the category often reinforces exclusions and absences. Current anthropological engagement and concern with global health can thus be seen as a continuation of anthropology’s awkward relation with state-making projects; indeed, medical anthropology itself has a root in the enlistment of anthropologists into twentieth century international health development projects (e.g., Foster 1976).

However, as Nolwazi Mkhwanazi (2016) points out, global health does not adhere to a single origin story. Doing global health well, she insists, entails searching out and listening to the stories that are often systematically erased alongside those which are commonplace. For example, the widespread interest in sexually transmitted disease and sexual violence in Africa on the part of global health organizations may foreclose attention to the fact that, for many, sex remains a source of thoroughly healthy pleasure (Hendriks & Spronk 2017). Or, the global health agenda focused on ‘maternal health’ may unfairly burden women with the responsibility for reproduction while silencing the experiences of domestic and caring fathers (Han 2009, Powis 2019). It is important to keep the power of stories in mind when reading the common histories of the field. Whether the explanation offered for the rise of global health focuses on transitioning disease profiles, changing governance structures, or something else entirely, it must be understood in terms of its narrative effect, which creates and reinforces the thing it purports to simply describe (Mattingly & Garro 2001).

One powerful story about the ascendance of global health emphasises the acceleration of contagions and potential pandemics whose vectors of transmission do not adhere to national boundaries (Caduff 2014). These epidemics involve viruses such as the human immunodeficiency virus (HIV), swine flu, or Ebola; bacteria such as tuberculosis or cholera; protozoa like the ones that cause malaria; and agents whose mechanisms of infection are not well understood. Many experts have responded to fears about the spread of illness by linking global health to national security. For example, the U.S.-based Centers for Disease Control (CDC) describes the basis for its commitment to global health as follows:

Disease knows no borders. In today’s interconnected world diseases can spread from an isolated,

rural village to any major city in as little as 36 hours. The U.S. cannot protect its borders and the health of its citizens without addressing diseases elsewhere in the world. (2018)

The case made by the CDC and numerous other health agencies is that ‘local’ health and illness programs must be simultaneously global in outlook, since global monitoring is good for the nation. Of particular concern are countries or regions that health professionals frequently characterise as ‘resource-poor’.¹⁴ Global experts often positioned these countries as the containers of diseases – or people with diseases – which might, potentially, spread beyond their borders (Brada 2011). Experts typically talk about diseases moving from south to north or east to west. It is important to note, however, that many countries deemed ‘poor’ by the global health community are, in fact, resource-abundant and their apparent poverty is the result of Euro-American colonial expansion and extraction (Benton 2014) as well as on-going, deliberate efforts to maintain income and health inequalities on the part of exploitative global elites (Vasquez 2018).

In addition to categorising disease patterns and technologies, the ‘global’ of global health also references new structures of governance. The meteoric rise of global health in the past two decades speaks to the crucial role of non-governmental actors, including corporate and philanthropic foundations, in shaping health services today (McGoey *et al.* 2011; Nguyen 2005; Rottenburg 2009). The World Health Organization, founded in 1948, and the Latin American Health Organization, founded in 1902, once coordinated public and international health concerns among their ‘member states’. Now organizations headquartered in the Global North such as the Bill and Melinda Gates Foundation or Save the Children serve as ‘uneven partners’ of impoverished countries in the project of making health globally accessible (Crane 2010). Yet while the ‘single story’ of global health emphasises the emergence of non-state actors and disappearance of the state, other stories make clear that non-state actors were historical drivers of ‘international’ health, and that the involvement of the state remains central and on-going in global health practices today (Quirke & Gaudillière 2008; Vaughan 2007).

One especially common origin story of global health locates its roots in the strategic responses to the devastating effects of twentieth century HIV. In the US and Western Europe, infected people and their allies and advocates successfully pressured their governments to make therapeutic drugs more widely accessible in the 1980s and 1990s. Meanwhile, antiretroviral drugs (ARVs) and therapies remained prohibitively expensive for many people dying outside these countries, particularly in Sub-Saharan Africa, Brazil, and India. In fact, many health experts even argued against treating AIDS outside of Euro-America, framing prevention and treatment strategies as mutually exclusive, and arguing that AIDS should be prevented but not treated (Moyer 2015).

Grassroots movements connecting diverse global communities were instrumental in challenging the denial of ARVs to people outside the West. Activists demonstrated that successful treatment and high adherence rates were possible in resource-restricted settings and they leveraged pharmaceutical companies to make

generic drugs available worldwide (Avirgan 2005). They also convinced donors to pay for the delivery of treatment and care, bringing foundations and non-governmental entities into the conversation. Bill Clinton, as President of the United States, initially supported Western pharmaceutical companies' attempts to protect their patents on antiretroviral drugs abroad. In 1999, under pressure from global AIDS activists and members of the Congressional Black Caucus, Clinton announced that the United States government would not pressure sub-Saharan African countries to give up their rights to import or produce cheaper, generic ARVs (Messac & Prabhu 2013). In the early 2000s, the newly formed Clinton Foundation brokered a reciprocal investment/production deal between governments and generic drug producers in Africa and India. This was broadly described as a 'win-win', with profits made by drug companies and needy government purchasers securing drastic price reductions (Biehl 2006; see also Allen 2006; Erikson 2016).

The Clinton Foundation's involvement in ARVs set the stage for other philanthropic organizations to join the emergent global health movement. In 2001, Amir Attaran and Jeffrey Sachs published an influential article in *The Lancet*, proposing a new funding structure dedicated to controlling the world's three greatest infectious killers (Attaran & Sachs 2001). Later that year, leaders of the world's eight largest economies launched the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria. While the goal of universalising access to treatment has not been met, the Global Fund helped galvanise a massive increase in health financing that connected diverse non-state actors, including civil society groups, in the project of health governance. Speaking of health as 'global' and not 'international' was, in this sense, a strategic move to bring together actors whose interests extended beyond the wellbeing and security of single nations.

In addition to its unfolding against the backdrop of a worldwide mobilization against HIV, twenty-first century Global Health has also emerged as a response to the devastating global effects of structural adjustment programs, which dominated the international development agenda during the 1980s and 1990s. The World Bank and the International Monetary Fund had offered loans to low-income countries in exchange for various fiscal reforms. Some of the most crippling reforms involved government reductions in health care spending, leading to poorer quality and often non-existent public health care (Pfeiffer & Chapman 2010). During this period, the deregulation of global, transnational corporations led to the accumulation of massive wealth in the hands of the few, while also contributing to large-scale environmental degradation through resource extraction and the promotion of white middle/upper class consumption habits. Much of the work of global health today aims at righting the wrongs done by a previous era of experts who created widespread health inequity and illness in the name of global development. We explore how this is playing out further in the section below.

2. Transitions in 'health'

Just as the 'global' in global health is emergent and under negotiation, so too is 'health'. In the current era, it is often difficult to tease apart health as a biological condition of well-being from health as a risk factor,

indicator, or proxy for development (Adams & Pigg 2005; Harper 2014). Global health professionals routinely use ‘health’ strategically, to reference both an immediate physiological state *and* a value-laden future aspiration. The following example of how health and health policy professionals are re-purposing the term ‘health’ illustrates the conceptual fluidity of the term.

“‘Health’ has had its day’, Julio Frenk – then Dean of Public Health at Harvard University – declared at a 2013 conference held at the Institute of Health Metrics and Evaluation (IHME), an institute endowed by the Bill and Melinda Gates Foundation which has carried out much of its work under the banner of global health. Frenk was describing what he saw as a decline in the previous era of biomedicine, which had oriented public health toward body-focused and individual indicators for health such as maternal mortality, child morbidity, or average life expectancy. In its place was growing health-related interest in global development.

For Frenk, and many others at the IHME conference, this transition was linked to the Millennium Development Goals (MDGs). As Frenk explained, the assembly of these first UN development goals (in effect from 2000-2015) had been a small affair. Over three days, a relatively small number of politicians and policy experts had come up with eight global goals, giving themselves a 15-year window to meet them.

Three MDGs (Goals 4, 5 & 6)⁽⁴⁾ were unquestionably related to biomedicine, seeking to reduce disease and mortality and to enhance health. Yet the goals also promoted a framework for thinking of health as a matter of global economic progress and planning. ‘No one expected the MDGs to be such a success’, Frenk told his audience. Crucially, the ‘success’ he referred to came about not because the MDG targets were achieved (most countries’ attempts to meet them fell far short) but because they significantly changed the conversation and influenced health funding allocations by channelling funding toward the elimination of specific, targeted diseases such as HIV and malaria (see also Hardon & Blume 2005). The merging of health and economic development can be seen clearly in MGD Goal 1, which coupled the eradication of extreme poverty and the eradication of hunger, bringing the experience of bodily suffering squarely into dialogue with economic concerns.

As the UN committee settled on ‘sustainability’ as the theme for their second set of development goals (named the Sustainable Development Goals or SDGs), health further shifted from being primarily a human body-based quality (i.e. the experience of wellness) to being a proxy for economic growth and development. While body-based health concerns such as morbidity and mortality remain key aspects of the SDGs, these operate alongside ‘health’ concerns of gross domestic product, human capital, and environmental sustainability. This result was not the contraction or disappearance of ‘health’ as Frenk had originally declared but rather its expansion: linking health tightly to global development makes health relevant far beyond biomedicine’s traditional focus on the individual body.

Changing disease pathways and illness profiles also fuel transformations in the conceptual underpinnings

of twenty-first century health. New antibiotic technologies and the development of the field of nutrition in the early twentieth century ushered in major demographic population shifts. Today, people around the world are living longer and dying more commonly of non-infectious, chronic, and comorbid illnesses than in the past. Complementing conversations that aim to control contagion and limit the spread of illness vectors are conversations about 'lifespan' concerns, including metabolic disorders, tobacco prevention, mental health, and cognitive decline (Cousins 2015; Kalofonos 2010; Solomon 2016; Reubi 2012; Davis 2018). Aging, once a given part of life, is becoming a medical condition that is financially lucrative for the health industry precisely because it is *not* curable (Manderson & Smith-Morris 2010; Danely 2019).

Rising temperatures and sea levels also shape the manifestation of afflictions such as diabetes and kidney disease (Nading 2016; Moran-Thomas 2019). Hygiene has likewise extended beyond the discourse of personal medicine, which often exacerbates racism and sexism by blaming and shaming individuals for system-wide failures (Briggs & Mantini-Briggs 2003; Saldaña-Tejada 2017). It now encompasses 'dirty' atmospheric airstreams and construction technologies and their related - and still racially and gender-stratified - afflictions (Kenner 2013; Whitmarsh 2008). Concern about the immediate effects of microbial infection broadens to slower disasters, such as absorption of carcinogens or heavy metals. Illness, once defined as a feeling of being sick and suffering, has come to encompass that which accumulates in the body all but unnoticed, as in the case where the victim of a heart attack 'suffers' without longterm awareness of the disease. In many conditions of chronic illness, health may not pertain to patient perception but to diagnostic capacity and the anticipation of a future manifestation of illness yet to come (Lynch & Cohn 2016; Weaver & Mendenhall 2014). At the inception of the SDGs, *The Lancet* released a report on planetary health which expanded the concept of illness even further by drawing climate change, microbial environments, water security, and ecosystem diversity into global health's terrain (Horton & Lo 2015).

The question of which - or whose - health is targeted by global health institutions has been a central concern for anthropologists (see Yates-Doerr 2018). As discussed further below, global health institutions have been widely critiqued for transforming culturally sensitive and locally attuned responses to complex diseases into 'magic bullet', short-term solutions. The field of global health has frequently ignored or devalued structural underpinnings of health and disease including access to food, employment, and high-quality primary health care (Closser 2010; Maes & Kalofonos 2013; Maes 2017). Yet in some important ways, the emergent focus on sustainable development among many key actors in global health may be helping to link health to structures of poverty, the violence of colonialism and deregulated capitalism, and climate vulnerabilities. Some suggest that on-going shifts in global health resonate with the social justice spirit of the Alma Ata Declaration of 1978, in which societal concerns for primary care were strengthened (Fee & Brown 2015). Exemplifying these shifts are movements to expand universal health care and ensure basic income. However, anthropologists caution that optimism about how these movements are unfolding should be tempered (Prince 2017; Berliner & Kenworthy 2017). There is clear empirical support for

concern, for instance, that the cash transfer programs championed by behavioural economists and the World Bank may unfairly burden marginalised women's lives or that turning health into a measure of poverty may have a dangerous 'hidden cost', by upholding gendered and racist inequalities (Cookson 2018).

The Global Burden of Disease (GBD) study, commissioned by the World Bank in 1990, did much to make global health a household term by quantifying the economic cost of more than 100 diseases across eight world regions. This study gave diverse and previously incommensurate illnesses a measurable standard through which they could be compared. *The Lancet* editor Richard Horton noted at a conference at the IHME celebrating the twenty-year anniversary of the study that 'before the GBD there was not a science of health metrics'. Today, econometrics is central to global health, which makes use of disability adjusted life-years (DALYs), quality adjusted life-years (QALYs), and inequality measures called Gini Coefficients to transform diverse kinds of health into a single health metric to be defined by big data computing technologies. 'Big data' has brought health to policies previously focused on development while giving global health a decidedly economic flavour (Adams 2016; Yates-Doerr 2014).

At the GBD retrospective there was widespread celebration of the large number of lives saved by statistical analysis and its related 'evidence-based policy' (Adams 2013; Fan & Uretsky 2017). Several in attendance argued that the GBD study was a clarion call for investing more in health information systems. A speaker on an all-male panel noted that if the global community really 'wanted nurses to save lives, we'd arm them with data collection tools'. This sentiment that data collection is more important than on-the-ground care is popular in many global health circles, whose participants seek distance from intimate patient-centred care practices and strive to improve health through the aggregation and analysis of (presumably neutral) data. A book celebrating one of the GBD's founders is titled *Epic measures: one doctor: seven billion patients*, implying that better health data will have universal, global benefits. But data are not value-free, as those who study their assembly have shown (Geissler *et al.* 2016; Beisel & Schneider 2012; Sanabria 2016; Kelly 2012; Biruk 2018). Cultural and political orientations shape which questions are asked and how they are investigated. Framing health problems in some ways over others, in turn, shapes their solutions. For example, if the global increase in diabetes is framed as a biomedical problem, treatment strategies will address medication and diets; if it is framed as a problem of unjust food systems, responses may seek to bolster community-based food sovereignty and hold predatory food corporations to account (Carney *et al.* 2019).

Sometimes anthropologists and global health practitioners may agree on how health problems and their solutions are constructed, finding each other at points of convergence and adding synergistically to the others' perspectives. However, the person-centred, participant-observation, and ethnographic methods of much anthropological research are frequently at odds with the metric-centred methods of global health. Anthropologists and global health professionals may additionally take different positions with regard to

their critique of colonialism or their embrace (or not) of capitalism, and they very often have differently imagined end-goals when carrying out research and subsequent interventions. The result is an awkward relation between the fields. In the next section, we address the different and dynamic positions that anthropologists hold in relation to the field of global health.

Anthropological engagements with global health

Anthropological engagement with global health can be characterised more by its diversity than by any uniform mode of relating. However, three broad positions of anthropologists with regard to global health can be identified: working within, in-between, and against other global health professionals. Additionally, the idea of an ‘awkward relation’ between anthropology and global health emphasises that different positions can be held by the same actor even while positions are in tension (see also Vernooij 2017).

1. Working within

While the field of medicine pre-dates anthropology by millennia, anthropologists have been centrally engaged in global health for as long as ‘global health’ has been recognised as a field. Some key anthropologists are well-known public health figures, such as the World Bank’s former Director Jim Yong Kim and his long-time collaborator Paul Farmer, co-founders of the NGO Partners in Health, which seeks to simultaneously treat individual illness *and* address the structural violence that devastates poor communities (2004). Kim and Farmer have been among several prominent anthropologists involved in the formulation and execution of health policies and intervention projects. As such, they are positioned to make a powerful case to the global health community to target the cultures of elite privilege that enable systemic health inequities in addition to – or even instead of – the cultures and behaviours of impoverished people when designing health projects (but see Shaffer 2018).

Other global health anthropologists hold valuable positions on the ground – often with little public visibility – where they work to improve local acceptability of global interventions or ensure projects are run in ways that matter to the people whose lives they are intended to shape (de Klerk 2013; Pell *et al.* 2019). Anthropological methods are embraced by several global health projects, which have found ethnography, and qualitative research more generally, crucial to their long-term success (Campbell 2011).

This work can be perspective-driven, addressing questions such as: what are local beliefs about vaccinations (Larson *et al.* 2016; Closser *et al.* 2016), food supplementations (Trapp 2016), microbiocides used in STD prevention (Pool *et al.* 2010), or regionally specific understandings of health, wellness, illness, or dying more generally? Their work can also be practice-driven, with anthropologists seeking to learn about how people receive vaccinations so as to make vaccination campaigns more effective (Sullivan 2017), to help experts design dietary interventions to better respond to people’s needs (Warin & Zivkovic 2019), or to impact midwifery policy to bring locally-accepted techniques for childbirth into public health

systems (Kennedy *et al.* 2018; Berry 2010).

The anthropological project of ‘working within’ global health can entail the work of transforming how both experimental trials and their resultant interventions are carried out. Hardon and Pool, for example, call for ‘strategic collaboration’, in which anthropologists team up with biomedical allies to break the hegemony of many existing global health technologies (2016). One strategic collaboration entails multi-authored research projects drawing together experts from a range of regions and disciplines. For example, the book *Second chances: surviving AIDS in Uganda*, was based on collaborative writing between African and Western scholars to encourage global health’s polyvocality (Whyte 2014). Another example is the Ebola Response Anthropology Network, which formed in response to the 2013-2015 Ebola pandemic, and which aims to enable social scientists and outbreak control teams working for NGOs and governmental and international agencies to interact and engage in more appropriate and effective practices of containment of the epidemic and care for those affected.¹⁴

Anthropologists have also noted that for all the talk of its global reach, ‘global health’ remains an English word with British colonial histories – as seen clearly in the outsized presence of global health institutions in former British colonies (and a less active presence in Latin America and China) and in the absence or looseness of regulations that exist for clinical trials and medical experimentation outside of Euro-America (Petryna 2009; Cerón 2011), clinical medical-tourism (Wendland 2012), and family planning policies that continue colonial-era practices of population control (Kuumba 2001).

At the same time, to foreclose global health as an inevitably colonialist project risks another erasure given that scholars located in the so-called Global South have been busy using – while simultaneously remaking – global health’s infrastructures in powerful ways (Brijnath and Antoniadis 2018; Lasco & Curato 2019; de-Graft Aikins *et al.* 2010; Mishra 2013). Anthropologists Michael Tan¹⁵ and Gideon Lasco¹⁶, for example, each write a popular editorial column for the Philippines Daily Inquirer, amplifying while also repositioning the sciences of global health. Much like medical anthropologists today operate in the shadow of colonial history while also marking a departure from this history through their critiques of colonialism, so too might anthropologists work from within the apparatus of global health to initiate decolonial transformations in how global health work unfolds today (see Benton, Sangaramoorthy & Kalofonos 2017).

2. Working against

Anthropologists also hold themselves at a distance from global health, critiquing its frequently reductive myopic strategies for ‘doing good’. Rather than leverage capitalist-bound structures that often dominate global health care delivery systems, these anthropologists seek to refuse – or at least destabilise – these pathways for action. This emergent domain of ‘Critical Global Health’ (Adams & Biehl 2016) or ‘Critical Health Ethnography’ (Storeng & Mishra 2014) has vocalised a powerful challenge to how the activities of

global health exacerbate deeply entrenched social and political-economic hierarchies. For example, in different ways, Liisa Maalki (2015), Miriam Ticktin (2011), and Elizabeth Dunn (2012) demonstrate how humanitarian calls for charity and compassion individualise suffering and occlude the political and structural determinants of suffering, undermining substantive challenges to capitalism and biomedicine. Numerous anthropologists similarly draw attention to how global health locks its participants into cycles of emergency and crisis which ignore – and thereby perpetuate – deep structural violences and their inequities (Benton 2015; Redfield 2013).

The global health inclination to ‘scale up’ treatment interventions has also received sustained anthropological criticism. Anthropologists showed how the scale up of ARVs in sub-Saharan Africa (Pfeiffer & Chapman 2010) and the response to Haiti’s 2010 earthquake (Schuller 2012) undermined public healthcare systems, contributing to the rise of NGOs and privatised care and leading to immiseration and intensified suffering. Yates-Doerr has critiqued the movement to ‘scale up nutrition’, pointing out that pathways that shape eating and satiety differ from those shaping pathogenic or viral infection, which tend to dominate global health frameworks of biosecurity. This work argues against the common global health paradigm of ‘one health’, which treats health as a singular global entity, by highlighting the diversity in forms of health and forms of health-care that matter in people’s lives (Yates-Doerr 2015a; Yates-Doerr 2015b).

Many involved in Critical Global Health see informed critique as a means of improving the lives of people throughout the globe, yet their critiques also unsettle the very language of ‘improvement’ (Li 2017; Wendland, Erikson & Sullivan 2016). Global health is frequently driven by a call for immediate response to urgent or imminent health crises. By contrast, a critical global health anthropology is likely to frame this as a discursive tactic that too often privileges the scalable, magic-bullet solutions that consistently fail as they move from theory to practice (Erikson 2012; Storeng & Béhague 2017). Here, anthropologists refuse global health’s logics by asking for patience, locality, and slowness (Adams, Burke & Whitmarsh 2014), and even radical inaction. These are posed as difficult but necessary tactics for refusing the capitalist logic of relentless innovation that drives many global health projects, and as a way to transform deep historical inequalities.

3. Working in-between

A final mode of relating involves the work of moving in-between different communities of practice. Anthropologists who study the unfolding of global health programs frequently serve as cultural brokers who mediate between experts and the people affected by experts’ visions for global health. Taking a biographical approach that tracks how health technologies transform as they are implemented, these anthropologists foreground that health practices have ‘social lives’ (Whyte, Geest & Hardon 2002), or what Ramah McKay (2018a) has called ‘afterlives’ in reference to how medical projects live on after official

experts withdraw.

Anthropologists who move in between ‘everyday’ and ‘expert’ sites might find themselves translating information held by global health experts into an idiom understood by those whom experts hope to reach. They might also work in the other direction to bring knowledge gained through long-term, grounded engagement with everyday life to spaces of global expertise so as to improve health experts’ practices of design and dissemination. They might also do both (Vernooij *et al.* 2016; Manderson 1998; Hardin 2018). Moving in-between registers of practice can help to illuminate the expertise that lies in the so-called every day – for example, in the every day practices of community health workers who often refashion projects as they roll them out (Nading 2013; Maes 2014; Kalofonos 2014; Swartz & Colvin 2014) – while also showing how policy spaces are guided by their own cultures (Napier *et al.* 2017; Taylor 2003; Yates-Doerr 2018).

Global health anthropologists frequently find (or place) themselves amid controversies and disjunctures: spaces where conflicting normativities arise. One technique entails the explicit study of ethical disjuncture. For example, Jenna Grant unpacks the presumed universality of experimental research ethics by illustrating how different logics of ‘the good’ compete in an HIV pre-exposure prophylaxis trial (2016). Anthropologists who work with policy makers even as they study policy-making practices routinely draw attention to the frictions and even failures that happen when policy agendas are taken up in everyday life. In doing so, anthropologists do not simply emphasise the need to adjust interventions and pedagogies to be site-specific, but urge policy makers to learn to account for this adaptiveness in the design of their policies. The goal here is not to further Global Health in its own terms, but to illuminate the shortcomings or successes of its strategies.

Conclusion

At a 2009 Yale-based conference organised to celebrate fifty years of medical anthropology, Didier Fassin noted in a keynote lecture that ‘the obscure object of global health’ had rarely been problematised (2013: 96). Anthropologists would soon redress this. In fact, that very year an annual review on ‘Anthropology and global health’ (Janes & Corbett 2009) overviewed the work of more than 100 anthropologists engaged in a critical analysis of the globalization of bioscience. His lecture has served as a call for anthropology to critically unpack globality (asking, for whom is global health global?) as well as the need to open up the black box of ‘health’. Farmer, Kleinman, and Kim, in a similar vein, have pointed to how global health has existed as a collection of problems rather than a discipline (2013: xiii). And McKay (2018b) describes teaching global health as a ‘critical entanglement’, in the sense that anthropologists frequently critique global health interventions even as they use anthropological methods to participate in the work of global health.

This entry has suggested that global health and anthropology connect through an awkward relation. If

global health is an 'obscure object' (Fassin 2013), so too is its anthropology. Indeed, one of the methodological approaches taken by anthropologists is to explicitly *not know* with confidence what is meant by global health but to instead follow, empirically, how global health is brought about in practices. As we've shown above, these practices include those of the anthropologists who work to shape, even as they might oppose, the terrain of the field.

While many economists and statisticians make use of the supposed objectivity of big data econometrics to make a strong claim to global health, Stacy Pigg (2013) notes that anthropologists might make a claim to global health themselves. That anthropologists use data that are typically not easily quantified - that anthropologists' metrics are often lively and social (Verran 2001) - is, in fact, taken by many global health practitioners as a strength. The widespread failure of many global health projects has resulted in an appreciation and uptake of anthropological techniques in and beyond the centres of the field. The 'awkward relations' that are therein produced remain emergent and dynamic.

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[1] Available on-line: https://www.who.int/about/vision/global_health_agenda/en/

[2] Available on-line: <https://www.who.int/gho/en/>

[3] The terms 'resource poor' or 'Global South' have begun to take the place of earlier framings of 'developing' or 'third world'. Each of these terms has problems (Fernholz 2016), reflecting the inherent difficulty of categorising diverse world regions through a shared 'global' agenda.

[4] Available on-line: <https://www.un.org/millenniumgoals/bkgd.shtml>

[5] Information can be found at <http://www.ebola-anthropology.net/about-the-network/>.

[6] <https://opinion.inquirer.net/column/pinoy-kasi>

[7] <https://opinion.inquirer.net/byline/gideon-lasco>