

Peopling Global Health

A Saúde Global centrada nas pessoas

João Biehl

PhD in Anthropology. Susan Dod Brown Professor of Anthropology and Co-director of the Global Health Program at Princeton University.

Address: 128 Aaron Burr Hall, Department of Anthropology, Princeton University, 08544, Princeton, NJ, USA.

E-mail: jbiehl@princeton.edu

Adriana Petryna

PhD in Anthropology. Edmund J. and Louise W. Kahn Term Professor of Anthropology at the University of Pennsylvania.

Address: 3260 South Street, Department of Anthropology, University of Pennsylvania School of Arts and Sciences, 19104-6398, Philadelphia, PA, USA.

E-mail: petryna@sas.upenn.edu

Abstract

The field of Global Health brings together a vastly diverse array of actors working to address pressing health issues worldwide with unprecedented financial and technological resources and informed by various agendas. While Global Health initiatives are booming and displacing earlier framings of the field (such as tropical medicine or international health), critical analyses of the social, political, and economic processes associated with this expanding field – an “open source anarchy” on the ground – are still few and far between. In this essay, we contend that, among the powerful players of Global Health, the supposed beneficiaries of interventions are generally lost from view and appear as having little to say or nothing to contribute. We make the case for a more comprehensive and people-centered approach and demonstrate the crucial role of ethnography as an empirical lantern in Global Health. By shifting the emphasis from diseases to people and environments, and from trickle-down access to equality, we have the opportunity to set a humane agenda that both realistically confronts challenges and expands our vision of the future of global communities.

Keywords: Global Health; Political Economy; Evidence Making; Pharmaceuticalization; Social Change; Human Values; Fieldwork; Medical Anthropology.

Resumo

O campo da saúde global articula um diversificado leque de atores que trabalham para resolver problemas prementes de saúde em todo o mundo, com recursos financeiros e tecnológicos sem precedentes e munidos de agendas das mais variadas. Apesar das iniciativas em saúde global estarem crescendo de forma expressiva e deslocando enquadramentos anteriores do campo (como a medicina tropical ou saúde internacional), as análises críticas dos processos sociais, políticos e econômicos associados a essa expansão ainda são escassas. Neste artigo sustentamos, a partir de uma perspectiva que leva em conta os sujeitos, que o campo da saúde global é uma “anarquia de código aberto”. Em geral, perdem-se de vista os supostos beneficiários das intervenções, que aparecem como tendo pouco a dizer e nada a contribuir. Argumentamos por uma abordagem mais abrangente e centrada nas pessoas, demonstrando o papel crucial da etnografia como lanterna empírica na saúde global. Ao mudar a ênfase das doenças às pessoas e seus contextos e do acesso de cima para baixo para a equidade, temos a oportunidade de definir uma agenda humana que simultaneamente confronta realisticamente os desafios que enfrentamos e expande nossa visão sobre o futuro das comunidades globais.

Palavras-chave: Saúde Global; Economia Política; Produção de Evidências; Farmaceuticalização; Mudança Social; Valores Humanos; Trabalho de Campo; Antropologia Médica.

Introduction

The field of “Global Health” brings together a vastly diverse array of actors and interests and it has become, in the words of economist Angus Deaton, “a big business” (Deaton, 2013; Brown, et al., 2006; Cohen, 2006; Fassin, 2012). 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 and informed by various agendas. While Global Health initiatives are booming and displacing earlier framings of the field (such as “tropical medicine” or “international health”), critical analyses of the social, political, and economic processes associated with this quickly evolving field – an “open source anarchy on the ground” – are still few and far between.

In this essay we contend that, among the powerful interests of Global Health, the supposed beneficiaries of interventions are generally lost from view and appear as having little to say or nothing to contribute. While there have been efforts to engage civil society and activists, especially in the response to HIV/AIDS, there continues to be a strong biomedical orientation which sees civil society engagement as politically necessary but “scientifically” irrelevant. In other words, with the hope of a biomedical magic bullet reigning, the power of “data” defined in biomedical terms, the vision of technocrats tends to outweigh other forms of data and evidence. We make the case for a more comprehensive and people-centered approach and demonstrate the crucial role of ethnography as an empirical lantern in Global Health.

The stories and ideas we present come from close readings of the Global Health literature and our teaching of Medical Anthropology and Global Health courses. We also learn a great deal from the archival work of medical historians and the field studies of anthropologists seeking to understand the impact of Global Health interventions on health systems, governance, and citizenship. Our independent research projects with marginalized communities dealing with treatment access for HIV/AIDS and psychiatric care (Biehl, 2005, 2007) and on the globalization of

clinical trials (Petryna, 2009; Petryna et al., 2006) have been critical to our understanding of social and political determinants of disease and health. We draw lessons from our co-edited book, *When People Come First: Critical Studies in Global Health*, which gathers vivid case studies focusing on the themes of evidence, interventions and markets in Global Health (Biehl and Petryna 2013).

When using the term “critical” we have in mind Michel Foucault’s essay “What Is Critique?” Critique, he wrote, is a certain way of thinking, speaking and acting: “a certain relationship to what exists, to what one knows, a relationship to society, to culture, and also a relationship to others” (Foucault, 1997, p. 42). As such critique is “the art of not being governed quite so much” (p. 45). But critical thinking also entails imagining and desiring that things might be otherwise: “Critique only exists in relation to something other than itself [...] it is an instrument, a means for a future or a truth that it will not know nor happen to be” (p. 42).

Critical thinking seeks epistemological breakthroughs. Such breakthroughs however do not belong to experts and analysts alone. The unpredictable and cumulative experiences of people navigating Global Health and humanitarian interventions and their aftermaths, we argue, can also produce breakthroughs that demand recognition. People’s practical knowledge compels us to leave comfortable disciplinary silos and to think of them not just as problems or victims, or patients or, worse, as vectors or disease carriers, but as complex agents with sometimes competing interests about the value of health and the meaning of wellbeing. That knowledge can also help us to better understand how larger systems and policies shape life chances locally, while at the same time keeping our attention to panoramas in flux. People on the ground recognize what is troubling them and it is somewhere in the middle of social lives that the work of critique always begins. As ethnographers, we are uniquely positioned to see what more categorically minded experts may overlook: namely, the empirical evidence that emerges when people express their most pressing and ordinary concerns, which then open up to complex human stories in time and space and that must become the center of public reflection and action.

Changing public health contexts

In the course of the twentieth century, innovations in public health and medicine helped to increase life expectancy at birth by almost thirty years in the United States and in other developed countries. Meanwhile, mortality rates remained high and life expectancies short in poor countries (Cutler et al., 2006). Advances in medical technology continue to give cause for hope, as does the substantial increase in financial resources now available to address some of the world’s most pressing health challenges. New state policies, public-private partnerships, and multidisciplinary research collaborations are reshaping the field of Global Health and, in the process, putting older paradigms into question and transforming realities on the ground. In key developing democracies – such as Brazil, India, and South Africa – we see activists and patients engaged in struggles over access to high-quality care and, at a more fundamental level, debating the meaning, object and implications of health conceived as a right rather than a privilege or commodity (Biehl et al., 2012; Fassin, 2007).

Consider the story of Janira who lies in bed at home while her mother, Carmen, visits the public defender’s office in Porto Alegre, Brazil. Carmen is filing a lawsuit to obtain the medicine that her daughter urgently needs to treat severe pulmonary hypertension. A heart attack the year before led to a loss of mobility, and Janira has not been able to resume work. Her doctor has prescribed six medicines; five are provided through Brazilian Unified Health System (SUS), while the Brazilian sixth, a high-cost vasodilator, is not. The doctor advised the low income family to seek free legal assistance at the public defender’s office.

Carmen hands the doctor’s prescription to the attorney Paula Pinto de Souza responsible for her case. *Is it here that I get the medicine?* she asks.

Souza welcomes Carmen *to the juridical hospital*, but she explains that getting the medicine will not be so simple. As a legal advocate for the poor and chronically ill, Souza’s job is to ameliorate suffering and to restore the rights of her clients. *The person*, she explains, *comes here sick and wronged by the failure of public policies. We are beyond preventive medicine here and the concept of health as physical, mental and social wellbeing is no more. When*

this infirmed person comes to me, the cure is most likely no longer possible. Her right to health has been profoundly injured by public power. Given the severity of Janira's condition, Souza will ask the district judge to issue a court injunction compelling the state to provide Janira's treatment right away.

Carmen, whose husband died of cancer, is retired and lives on a small pension. Her home is a one-room shack on the outskirts of the city, which she shares with her daughter and two granddaughters. A monthly course of the vasodilator Janira needs costs about US\$1,000. Carmen has been purchasing the medicine in small amounts with borrowed cash, indebting herself to members of her extended family. At the same time, Carmen complains that she has already gone to the state pharmacy several times to obtain the five other medicines that Janira needs, and that should be publicly available, *but they are always out of stock.* She makes a little extra money performing Afro-Brazilian rituals in her home and occasionally receives a food basket from her religious organization. When we visited the family, we noticed an offering to the *orixás* filled with packaged sweets. *I do this so that all patients who need medicines win their lawsuits,* Carmen explains.

What Janira really needs is a heart transplant, and all the medicines she takes are meant to keep her healthy enough to undergo the surgery. Janira's brother, who lives in another shack on the same lot with his own family, routinely checks the status of her case at a nearby Internet cafe. Within days of the public defender's filing, the district judge issued an injunction for the medicine to be delivered to Janira. Two months later it still had not arrived.

When we returned a year later, Janira said that she was receiving the medication as a result of the injunction. The year before she could hardly get up by herself to go to the bathroom, and now she could help with house chores. She began to cry when she said that she could now take her daughters to school, which gave her immense pleasure.

At a time of great medical progress and amid Brazil's economic boom, Janira is barely clinging to life. As she waited for her condition to improve to be able to qualify for a possible heart transplant, the

family went into debt and *judicialization* became a last resort. The public health system was now finally working for Janira, but could it work fast enough to save her?

Attorney Paula Pinto de Souza considers the costs of lawsuits for treatment to the state to be negligible when compared to the scope of unrecognized patients' needs, but critics allege the *judicialization of health* makes the health system less efficient and more unequal overall (Ferraz, 2009; Yamin and Gloppen, 2011). Janira and Carmen do not invoke rights and for them it does not matter if the life-extending medicine comes from the medical or the juridical hospital, as long as it comes. They are desperate but also resourceful and determined in their efforts. In their fight for life, they attempt to maintain healthy bodies but also healthy relationships and households.

Indeed, the story of Janira and her family efforts is not unique. It reflects how broader questions of access to technology and social justice are playing out in today's rapidly changing public health contexts. Fieldwork or home visits such as the one we have described can vividly capture these realities in flux. Accounts based on the experiences of real people – stories that are often obscured by abstract and bureaucratic considerations of public policy – are essential to comprehending the collision of a crushing burden of disease with emerging audit cultures and the new therapeutic regimes in which life chances unfold. Such accounts also point to the need for comprehensive care in Global Health and how it can be crafted.

In what follows, we explore the concrete and unexpected effects of Global Health interventions, taking as case studies the magic bullet attempt to eradicate malaria in Mexico, the public-private treatment rollouts in Uganda and Mozambique, and the impact of evidence-based medicine in the design and implementation of public health interventions in Nepal and post-Katrina New Orleans. We argue that ethnographic evidence is essential for re-envisioning care and implementing different plans of action. The very concept of failure and of what counts as meaningful evidence of a successful intervention must also be scrutinized.

Through and beyond the magic bullet approach

When we look at international health interventions historically, it becomes clear that the political and economic requirements of the day and the ideological whims of the elites in charge determine how priorities are set and why they are abandoned. As social scientists unearth the recent history that explains how people become target populations in Global Health, unanticipated anthropological terrains come into view: we find ourselves face-to-face with profound disconnections between campaign designs and intentions and the complex ways in which those campaigns are actually received and critiqued. The counter-knowledge of the people who are at the center of interventions is thus integral to assessing their actual impacts and to mitigating against blind spots and repetitions of history.

In his book *Cold War, Deadly Fevers*, historian Marcos Cueto (Cueto, 2007) documents the story behind the Malaria Eradication Program that played a crucial role in Mexico's public health policy during the politically charged years of the Cold War era. While constantly keeping in view the campaign's international political implications, Cueto's detailed account of the way the eradication campaign unfolded in different locales leads him to document how the Rockefeller Foundation and elite national health experts campaign designs clashed with indigenous understandings. For example, many families living in rural Mexican communities simply refused to let the DDT sprayers into their homes. Cueto found cases of spontaneous protest escalating to armed conflict. After the first several years, even people who had complied with earlier rounds of DDT spraying angrily noted that it worked less effectively every time, and that many insects seemed to be developing resistance and growing bigger instead of dying off.

In this charged historical moment, medical anthropology emerged as an applied social science. Anthropologist Isabel Kelly, a former student of George Foster at Berkeley, began collaborating with Héctor García Manzanedo and the Mexican Health Secretariat on rural projects in 1953. As the pair began researching how the malaria eradication program was being received by indigenous communities,

they conceived their roles to be those of listeners and cultural brokers. Beyond the underestimated language barrier, their report noted many complications with respect to the program and why it was not achieving its anticipated success. For example, the medical anthropologists explored complex rotational housing patterns linked to seasonality, which meant families abandoned houses that had been sprayed or preferred to simply sleep outside in the heat of the summer. More fundamentally, indigenous communities often employed their own healing systems and understandings of fever that co-existed uneasily with the public health information that government agents circulated about malaria. And, as the medical anthropologists would point out, underpinning this environment of suspicion were fundamental differences in health priorities. In many communities, malaria was not conceived of as a major health problem or even as a single disease, and many people in rural areas wondered why it was being singled out when other more pressing health concerns were being ignored.

This collision between local values and international public health agendas was hardly just a fluke or footnote in the history of malaria eradication: Cueto's complex portrait captures the fact that it was a key reason for the campaign's ultimate failure. Without paying attention to how this intervention became embedded in local economies and politics, national health officials often treated social resistance as a "communications problem" in a population in need of education rather than as a problem of the design of the intervention itself.

The implications of these realities run deep for our health policies today. In 2007, the Gates Foundation revived the failed malaria campaign, pledging to eradicate the disease from the world (Cueto, 2013). A year earlier, the World Health Organization once again approved the spraying of houses as an appropriate part of malaria eradication. As Cueto notes, pyrethroid-soaked bednets and pharmaceuticals have become the technical fixes of a supposedly "new era" of magic-bullet approaches. Four decades after its original failure was declared in 1969, the goal of malaria eradication is now resurrected.

The fact is that the magic-bullet approach – the delivery of health technologies (usually new drugs

or devices) that target one specific disease without regard to the myriad societal, political, and economic factors that influence outcomes – has been the norm in international health interventions for decades (Birn, 2005; Enserink, 2010; Stepan, 2011). There are, however, significant practical and epistemological downsides to this approach, which is now being challenged. Social scientists and health policy advocates caution that a narrow focus on the triad of technology delivery, patient compliance, and the basic science of disease, as important as these are, is insufficient. Also, unintended consequences may be unleashed by even the most carefully designed interventions (Larson, 2011).

The Global Health community has overemphasized individual risk factors that ignore how health risks are shaped by law, politics, and practices ranging from industrial and agricultural policies to discrimination, violence, and lack of access to justice. We need to better attend to breakdowns in public health systems and to the many political and social determinants of health (such as education, water, sanitation, vector control, air pollution, and accident prevention) that make people vulnerable to disease and injury in the first place (Amon and Kasambala, 2009; Farmer, 2004; Freedman, 2005). Given the extreme inequalities that are so intricately woven into the current international order as well as into the social and political fabrics of countries and regions (Deaton, 2013), we need integrated approaches that recognize the profound interdependence of health, economic development, good governance, and human rights. Any sustainable development has to reach and improve the conditions of the poorest and most vulnerable groups carrying the highest burdens of compromised health. Moreover, as is evident in Janira's case, disease is never just one thing, technology delivery does not translate into patient care, and biology and technology interact in ways we cannot always predict.

So, we must ask: What *really* happens when new treatments are introduced into epidemiologically diverse and variable social worlds? How is care organized by providers, and by state and nongovernmental organizations? By what trajectories and means do the people who desperately need care access it (or fail to access it)? And how can the stories

of real people dealing with insecurities of all kinds find their way into and improve current practices in Global Health?

Projectified landscapes of care

In the twentieth century, international health initiatives were by and large implemented by states, subject to the coordination of specialized bodies such as the World Health Organization (WHO). In this paradigm, the main source of authority was the state, which took the lead in setting priorities and allocating resources. The politics of international health care were, as a result, subject to the usual constraints of diplomacy (Fidler, 2007), while the WHO and related bodies played a coordinating role, often using the discourse of human rights to orient and instigate efforts. These dynamics would be somewhat altered in the context of the United Nations Millennium Development Goals (MDGs), which recognized health as an essential value and as a key pillar of development (United Nations, 2000). New forms of cooperation and intervention were established to reach the targets of reducing maternal and child mortality and expanding access to treatment for infectious diseases, for example. In the process, the interests and practices of the private sector began to play a larger role in global public health. Humanitarian schemes and health system building have made common cause with the technical and financial know-how of the private sector.

We now see a multiplicity of actors, all vying for resources and influence in the political field of Global Health, each seeking to remain a relevant and powerful player. Ranging from the Gates Foundation to pharmaceutical company drug donation programs and PEPFAR (the [US] President's Emergency Plan for AIDS Relief), to research initiatives, South-South cooperation and myriad rights-based pilot projects, these diverse interests are setting new norms for institutional response, sometimes providing the public health resources that states and markets cannot or have failed to furnish. Locally, such multiple and fragmentary Global Health interventions consolidate what anthropologist Susan Reynolds Whyte and colleagues (Whyte et al., 2013) in Denmark and Uganda call "projectified" landscapes of care.

The Ugandan health system, at least as it relates to HIV/AIDS, is almost exclusively dependent on international aid projects. After the civil war, Uganda's government seized on health interventions to bolster its legitimacy abroad and at home. This welcoming attitude wins the Ugandan government a place in the world of international politics, as it demonstrates at once a willingness to lift itself from its ruinous recent history and, perhaps more importantly, to comply with neoliberal norms of state intervention. At home, the introduction of international actors provides much-needed relief to people living with HIV/AIDS and their families, and enables the government to present itself as at least partially providing health care to its populace.

In their longitudinal fieldwork with the first generation of AIDS patients who has had access to antiretroviral therapies and thus to a second chance at life, Reynolds Whyte and colleagues describe those who benefit from these health initiatives as "clients," a felicitous term that can be understood in both contrasting and complementary senses. One, which harks back to Uganda's political past, points to the ways in which these persons, who enjoy little power or resources other than those afforded through social networking, must seek out patrons better positioned within the world of health care in order to gain access for themselves. The other meaning of "client" echoes neoliberal trends which inform much of Global Health investment, and refers to persons as clients or consumers of a product (in this case health care), thereby establishing a contractual obligation between them and the providers of the product.

Here health is not a "right" available to all citizens, but a service or thing available to those in the know and well-connected. "Good" clients are expected to be faithful to their programs and to help foster their growth. This "therapeutic clientship" becomes a support mechanism that extends well-beyond the medical including possible employment, food access, and educational demands. An economy of loyalties and of financial, institutional, and medical sustenance is thus created. This "therapeutic clientship" stands in for citizenship and governance. The ethnographic analysis of Reynolds Whyte and colleagues offers a way to approach persons not

exclusively as patients or as outcomes or failures of interventions, but rather as embedded actors moving within complicated social networks. This analysis provides a point of entry to assess the micropolitics in which health and health care are brokered, accessed, and transformed – and it gives us openings to think of ways to include those who have been left out.

Global Health as open-source anarchy

There is considerable confusion about how old and new players and initiatives fit together in a Global Health architecture, and how they inform the ongoing debate about whether such architecture can and should be constructed and, if so, by whom and in whose interest (Cohen, 2006; Frenk, 2010; Keusch et al., 2010). In practice the concerns of donors, not recipients, tend to predominate (Easterly, 2006; Epstein, 2007; Ramiah and Reich, 2005; Farmer, 2011). Often, donors insist on funding disease-specific and technologically oriented vertical programs at the expense of the public sector. And, whatever differences in interest and ideology may divide corporate, activist, and state public health agendas, the imperatives of "saving lives" and "increasing access" seem to reconcile these differences and fold them into an ethos of collective responsibility in the face of "crisis." Global Health players can become impervious to critique as they identify emergencies, cite dire statistics, and act on their essential duty of promoting health in the name of "humanitarian reason" or as an instrument of economic development, diplomacy, or national security (Fassin, 2011; Adams et al., 2008; Buss and Ferreira, 2010; Lakoff and Collier, 2008; Ventura, 2013).

Despite the deluge of monies and organizations flowing into resource poor settings worldwide, local health systems continue to be woefully inadequate. We are also left with an "open-source anarchy" (Fidler, 2007) around Global Health problems – a policy space in which new 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.

The anthropologist James Pfeiffer (Pfeiffer, 2013)

cuts an ethnographic path through the system of health care that has emerged in postsocialist, democratizing Mozambique and after the arrival of the US President's Emergency Plan for AIDS Relief (PEPFAR) aid. The result of the divestment in the public sector is the creation of a fractured and uneven health system; state-of-the-art facilities for HIV/AIDS testing and treatment now coexist with all-but-dilapidated state hospitals where wealthy donors create showcase clinics in one region while the clinics in a neighboring region atrophy and their long-term sustainability is always in question. In this makeshift system, the Global Health focus is always at the level of the clinic, where interventions can be followed and their results measured. Attempts to make assessments at a national level are left by the wayside and the myriad social factors that can contribute to positive health outcomes are by and large ignored (or, if acknowledged, not acted on). Moreover, health workers are also in short supply outside spheres dominated by NGOs as limits are set on wages at public institutions and because NGOs can afford to pay more for specialized services.

Pfeiffer also shows how a poor national infrastructure and terrible economic hardships intersect with everyday patterns of sociality to hinder HIV/AIDS treatment adherence, especially among pregnant women. Pregnant women are at higher risk of being "lost to follow up" (LTFU) because they must confront a number of unique restrictions and risk-laden choices that make treatment access perilous and adherence highly problematic. Faced with hunger, difficulties in accessing treatment, the severe side effects of medication, and the stigma associated with AIDS, too many pregnant women drop out of programs.

Pfeiffer's work draws attention to two important facets of a critical ethnography of Global Health. First, ethnographic accounts allow for a telling juxtaposition of scales (ranging spatially, from the perspective of the patient and the community, to a much broader view that reveals the systemic flaws of the international financial impositions in Mozambique; and temporally, from the country's socialist past to its market-fundamentalist present). Ethnography lays bare how interventions are woven into larger spheres of political economy and points

to the impact of structural and economic factors on treatment and disease. Second, certain statistical and quantitative data can be productively reconciled with qualitative ethnographic approaches. "Lost to follow up," for example, is not just a metric for judging the success or failure of a given intervention. Instead it is a starting point for looking beyond the limits such an evaluation imposes and into the reality of other factors (national economic systems and infrastructure, for instance) on the lives of the HIV-positive. Ethnographic evidence can provide new ways of looking at care and accountability; it can be put to use in developing different plans of action such as those carried out by Pfeiffer and Health Alliance International on the strengthening of primary care in Mozambique's health care system.

Metrics and values

Treatment access is one of the central tenets of Global Health activism and a professed goal of interventions. Biological and medical sciences have greatly contributed to today's therapeutic armamentarium, and the metrics of epidemiology and pharmacology have productively shaped the design and implementation of interventions. Amid fluctuations in funding, the field of Global Health has been consistently driven by scientifically based schemes of evaluation revolving around natural experiments, randomized controlled trials (RCTs), and statistical significance (Hammer and Berman, 1995; Anand and Hanson, 1997; Duflo and Kremer, 2008). In this dominant regime of veridiction, evidence-based medicine has migrated to the realm of health interventions and has quickly positioned itself as the default language for both public and private-sector actors concerned with identifying problems and measuring outcomes (Deaton, 2010; Cartwright, 2011).

Anthropologist Vincanne Adams (Adams, 2013) studied a resiliency-training program for school-age children in New Orleans and a safe-motherhood training program for Tibetan health workers. Both programs required health workers to participate in the new and unfamiliar economy of information on which the legitimacy of the programs rested. And, in both cases, the demands imposed by the now-predominant evidence-based medicine approach trans-

formed not only the evaluation of the interventions, but also their methodologies, goals, and subjects. The New Orleans program could only be deemed reliable, credible and ultimately fundable through the acquisition of privately produced and internationally standardized assessment tools. In Tibet, the original project had to be radically altered on statistical grounds: it was not possible to determine whether the intervention was more effective than chance because “not enough women” died. Following the advice of a Maryland research consortium, the program – now upgraded to a “study” – was made “more scientific” and more globally comparable by abandoning training in safe motherhood and focusing instead on infant mortality for which “better numbers” were available.

The advent of for-profit institutions as purveyors of services (be it the fulfillment of specialized functions or an entire intervention) has demanded the incorporation of systematic economic assessment techniques, of which the cost-benefit analysis and the audit are the most salient. In this new landscape of Global Health saturated with NGOs and special-interest groups, there is a movement toward making interventions cost-effective and scalable. Thus, interventions themselves become producers and consumers of marketable and comparable information. Entrepreneurship over capitalizable data has taken hold.

As Adams’s study shows, this new landscape of evaluation is displacing the previous goals of interventions, making the purveyance of actual health services secondary to the development of reliable methodologies, the generation of comparable data, and the training of a workforce capable of deploying interventions with similar results at a later date. Abandoned in this move are the experiences of the nominal targets of interventions. The focus is no longer on the sick and their caregivers, nor is much consideration given to the long-standing effects of programs on the lives of people and on public institutions.

RCTs have been given a free pass in the name of rigor, economist Angus Deaton argues. *But there are no magic bullets and there are no gold standards* (Deaton, 2012). With the hegemony of theoretical and technical fixes, the kinds of data we collect and

our capacity to apprehend heterogeneity are compromised. Moreover, biosocial approaches to disease and health that could help to specify dynamic causal connections and local politics are relegated to the low-authority category of “soft science” (Adams, 2013; Krieger, 2011).

Consider the widely cited study by economists Kremer and Miguel (2007) on curing worm infections in rural Kenya. Kremer and Miguel found that treating Kenyan schoolchildren with extremely cheap deworming medication increased their school attendance by roughly 10 percent. A *New York Times* op-ed piece heralded the study as “landmark” (Kristof, 2007): with just a bit of cheap medication, poor countries could increase school attendance by leaps and bounds. Given the affordability and stunning success of the treatment, many commentators suspected that families who had not benefited from treatment during the study would very happily adopt this new technology.

But Kremer and Miguel (2007) observed a puzzling turn of events after the trial ended and when they followed a group of families outside the original cohort. Families who were friendly with families in the deworming treatment group were *less* likely to treat their children than those who were friendly with families in the control group. They were also less likely to deem the medication effective at improving health. If deworming medicine is the panacea for anemia and school truancy, then why were better informed families not treating their children?

Miguel and Kremer (2008) do not pinpoint the reason for the negative effect of this word-of-mouth. But they conjecture that the power of communication networks and people’s own understanding of worms as a social disease (not predicted in the study design) might have been at play. We have once again a case in which interpersonal relations and the needs and concerns of people on the ground, as well as their own sense of the complex ecology of disease, health, and medical technology, elude controlled studies. With its strict methodological imperatives, Global Health expertise often sacrifices the ethnographic evidence or counter-knowledge that is available as experiments and interventions (ever more closely linked) unfold – at the expense of better understanding and, ultimately, more meaningful and long-lasting outcomes.

The *unpredictable social* is not just an obstacle to or a means for perfecting theoretical tools and experimental strategies. Questions of how to account for persons in the context of their homes and relationships, and of how to involve local communities in the very design and implementation of feasible (rather than technology-enamored) interventions, pose continuous political, medical, and ethical challenges. With international and national health policy's success largely framed in terms of providing and tallying the best medicines and newest technology delivered, what space remains for the development of low-tech or non-tech solutions (such as the provision of clean water) and the strengthening of local health systems and prevention efforts that could prove more sustainable than high-tech solutions alone? How can we escape the dystopic futures that are inscribed in present pragmatics?

Care

Technocratic approaches (many times beholden to evidence-based medicine) can perpetuate limited understandings of narrowly conceptualized problems and support a rhetoric that offers only temporary control over isolated aspects of a given disease – a rhetoric that is aligned with the demands of funding organizations for immediate technical solutions. The obsession with scientific and economic pragmatism results in less attention to the social dynamics of programs and can lead to erroneous assumptions about generalizability, i.e. that particular interventions will work across countries and situations despite the fact that each will have distinct institutions, practices, and rationalities, stubborn deficits, and persistent inequalities that will undercut the powers of overvalued magic bullets.

Global Health, according to business scholar Michael E. Porter, mirrors the limitations of health care delivery in the United States and “is stuck in an access and volume mindset, rather than focusing on the value delivered to patients” (Porter, 2009, 2010). That is, narrow measurements of efficacy concentrate exclusively on the vertical intervention level and can assess only discrete preventative steps, drugs, or services. Porter and his colleagues call for a shifting of the goal posts, away from increasing

access to treatments and toward delivering value for patients (Kim et al., 2010). The former goal assumes a consumer-patient capable of seeking out and paying for appropriate treatment as long as it is available; the latter puts greater responsibility on health systems and providers for actively reaching the patient in need and attending to the full cycle of care and health outcomes for his or her medical condition. The focus must be on the results obtained by the patients (measured in survival rates and in the degree and sustainability of recovery) and *not* on a program's success (measured, for example, by its compliance with standardized guidelines or by the number of drugs distributed).

A more holistic understanding of health is indeed needed and diverse disciplines (including anthropology) must be engaged as we seek to understand the complexities of the context and content of health interventions as well as the trials and errors of real people in specific circumstances trying to figure out what works for them. Multi-scale empirical knowledge of their efforts is crucial to the development of a patient-centered care delivery framework. This alternative knowledge can and should challenge the reductionist epistemic frameworks that tend to inform donors' priorities and funding decisions as well as Global Health evaluation schemes. Moreover, a people-centered science of care delivery cannot fully flourish without it being grounded in a respect for human rights and structures of accountability and government obligation.

Anthropologist-physician Paul Farmer (Farmer, 2004, 2011) is one of the most prominent proponents of a community-based equity approach that blends technological intervention with a focus on making health systems work. Farmer and Partners In Health (PIH), the organization he cofounded, understand diseases as loci where biology, environment, and medicine have gone awry; their concept of accountability and intervention accordingly tackles the structural conditions that perpetuate disease at the local level. In the interest of making the best care available to the poorest, Farmer and his colleagues reject economic orthodoxies such as demands for structural adjustments to eliminate health and education expenditures in the name of development, cost-effective benchmarks that limit the provision of

wraparound services, and human rights discourses that privilege political over socioeconomic rights (Farmer, 2008; Pfeiffer and Chapman, 2010).

In Partners In Health's social justice approach, accounting for individual patient trajectories and staying with patients throughout the course of their disease and rehabilitation (through the work of local *accompagnateurs*) is as important as tackling the economic and social factors that impact families and mitigating the decay of clinical infrastructures. In this vision, the health care system is seen no longer as a drain on the economy, but as an enabler of social and economic development. While Farmer's project is by no means accepted as a gold standard it has, along with other initiatives of this kind, made significant cracks in the prevailing rationalities that guide Global Health interventions and, above all, it has redefined the perceived boundaries of feasibility.

Conclusion

There are profound discrepancies between how Global Health policies and campaigns are envisaged to work and the concrete ways in which they are actually implemented or received by target populations routinely facing multiple morbidities and economic insecurity (Han, 2013). So, how are we to measure the value of interventions for people, their health, and their subjective wellbeing, and how do interventions affect health systems over time? And how can people and their advocates resocialize ill health and mobilize for a comprehensive right to health?

This essay calls for new and collaborative ways to understand and act on the transnational and local realities that are emerging in the shadow of large-scale health and development interventions and in an era of ever-expanding global medicine. Amid broken public institutions and deepening rifts, the targets of Global Health interventions often implode the units through which they are conceptualized. In the meantime, the externalities created by interventions that come and go are real – leaving multivalent impacts on institutions and social relations that have to be addressed on their own terms and that people escaping grim medical destinies are left to reckon with.

As showed in the field examples from Brazil, Mexico, Uganda and Mozambique, disease is multi-layered and multiply determined, people are plural beings and not reducible to populations, and local realities still very much frame, constrain, and orient interventions. The agency of local actors is not limited to their blind acceptance or refusal of whatever form of knowledge, technology, or care is provided extralocally. Rather, people's agency is bound to preexisting forms of exchange, politics, and desires as they find expressions, both new and old, in the changing landscape created by Global Health initiatives. Their everyday struggles and interpersonal dynamics have a way of eluding expert behavioral modeling and short-lived experimental approaches. The task of the social sciences in the field of Global Health is to break through these models, experiments, and projections and to produce different kinds of evidence as we reckon with historical health disparities and the "pharmaceuticalization" of health care. We must also engage crucial questions about the role of the state and the market in Global Health design and delivery and investigate what happens to citizenship when politics is reduced to survival – all while maintaining a deep and dynamic sense of people in local worlds.

Engaging with the intricacies of people's lives – their constraints, resources, subjectivities, projects in unfixed social worlds – requires us to constantly reset our conceptual compasses and standards of evidence-making. What would it mean for our research methodologies and ways of writing to embrace this unfinishedness, to seek ways to analyze the general, the structural, and the processual while maintaining an acute awareness of the inevitable incompleteness of our own accounts?

People know what is troubling them. And it is somewhere in the thickness of social life that critical work always begins. Fieldworkers are uniquely positioned to see what more categorically minded experts may overlook: namely, the empirical evidence that emerges when people express their most pressing and ordinary concerns which can open up to complex human stories in time and space. The social realities of "target populations" and the midlevel actors on whom the burden of implementation lies beg for analytic frameworks that weave intentions

together and for innovative genres that will allow people-centered evidence to add up, travel, and *matter* publicly and comparatively. By shifting the emphasis from disease to people and environments and from trickle-down access to equality, we have the opportunity to set a humane agenda that confronts the deep challenges the world faces and expands our vision of the future of global communities.

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