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THINK PIECES

What is critical global health?

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Abstract

This essay summarizes and responds to the Think Pieces gathered here through the lens of critical global health. I ask: What does global health offer that differs from the international health efforts of the past half-century? What kinds of critical scrutiny do these efforts warrant? How do these disparate efforts represented here coalesce and converge under the gaze of critique, and still offer insights about how to do global health work today?

Keywords

critical global health, metrics, contemporary ethnography

The provocation of this collection of think pieces, and the 'Critical Global Health: Evidence, Efficacy, Ethnography' book series from which it draws, is the question: what is 'critical global health'? To answer, I think one must begin with the prior question: what is 'global health'? Before we turn to the possibility of critical engagement, that is, we might revisit the widely shared sentiment among many medical anthropologists who had devoted years to the work of 'international health' that 'global health' was itself a bit of a thief.

In the halls of anthropology departments and at our professional meetings, there was a palpable feeling of being hijacked. The long-term commitment to whatever it was many of us in anthropology had been doing for many decades (health development, international health, human rights health) was being pulled out from under us, like a rug from under some heavy furniture, as this new thing called 'global health' was rolled out and paraded forward, kind of like an IKEA remodel. Leaner, more cost-effective, and geographically unbounded, this global health was being offered as a corrective to what had come before. Just as with

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IKEA, many of us would embrace this turn toward the global with both alacrity and trepidation. We love the furniture and the price, but wondered: would it really solve many of the old problems that, after all, we in anthropology had helped to point out?

Like IKEA, global health seeks global solutions with an eye to cost-effectiveness, to scaling up practical, technologically sophisticated interventions that are not only affordable but also profitable and that hold some accountability to the masses. Still, just as many find quick solutions to their design challenges in the halls of IKEA only to learn later of the hidden costs of these home furnishings, many anthropologists are also learning to ask questions of global health: Will global health serve as an antidote to the history of failures and perceived failures seen in the era of international health, or will it merely reproduce them? Or worse, will it create new ones? Who, in other words, will count the costs of these design roll-outs in terms of the global uniformities they seek, the built-in obsolescence of their products, and their frequently hidden accumulation of profits?

Such views and sentiments (of simultaneous attraction, suspicion, and betrayal) have called for new kinds of scrutiny. What then is global health, and what insights can a critical medical anthropology bring to bear on it today? We could, for instance, scrutinize the move to conceptualize the 'global' in global health as that beyond the nation state: that is, beyond the notion of inter-national, attentive to a universal humanity, and achieved through objectivist claims. This might be seen as a counterpart to globalization itself in several ways.

First, the 'global' in global health today is frequently premised upon universalist notions of humanity by treating humanity as a given, a process that began during the era of human rights and has persisted in humanitarian-driven global health programs such as Médecins Sans Frontières (Redfield 2013) and the Bill and Melinda Gates Foundation (Rees 2014). To make claims about globality is to engage in an iterative process of creation that must be attained, sustained, and reproduced through many practices of counting, labeling, advertising, and conceptualizing, among other things.

Second, global health arrives (or is delivered) on the well-greased wheels of the political economic institutions that preceded it. That is, global health today mobilizes funding strategies that increasingly rely on private-sector solutions, including those appearing in the institutional forms of the nongovernmental organization, the private wealth philanthropic foundation, the public–private partnership, and the for-profit pharmaceutical/biotech corporation. In this way, global health accompanies globalization's market demands for forms of accountability that make fiscal responsibility a reproducible bottom line (McGoey 2015). In short, what all this means is that we have collectively shifted toward neoliberal solutions, increasingly allowing health economists, as opposed to health care practitioners, to

do more and more of our thinking for us when it comes to planning, implementing, and accounting for global health efforts.

Third, the shift toward global health has entailed a deployment of more rigorous forms of science in the work of intervention. This shift (partly a result of having economists and pharma/biotech scientists in the mix) has been accompanied by a growth in the use of forms of health intervention that are tied to scientific metrics and experimentally produced data (Petryna 2009; Crane 2013). These shifts link bench scientists to zones of critical care, indulging bench-science fantasies of the world as one giant laboratory and imagining that outcomes will be hard, fast, scalable, and reproducible, much as they are in the laboratories of biotech and pharma.

We believe these shifts call for anthropological scrutiny of at least three things: evidence, efficacy, and ethnography. Specifically, what kinds of evidence are recruited to make what kinds of claims about efficacy? How might ethnography shed critical light on these efforts? How might ethnographic practices be granted recognition for their own kinds of efficacy? Is it possible to not just counter but also engage in global health practice by interrogating other ways of envisioning what we are supposed to be doing in this work? To further the rather clunky metaphor, I would argue that critical global health asks: How comfortable is ethnography in the new IKEA remodel? How large a space will it fill? And, more important, how long will the furniture last under global health's new forms of evidence? Can critical global health offer some sort of engagement with this remodel, our own alternative to IKEA that holds fast to the sense of limitless possibilities for improvement that both global health and IKEA boldly offer?

This provocation leads us to ask what we mean by 'critical'. First and foremost, the authors of these think pieces call attention to the problem of accountability: whose notions of evidence and whose notions of efficacy will be used in global health? Already, asking the question in this way reveals a critical stance. None of these phenomena are given, sui generis; the critical global health anthropologist is poised to study them as they are contested, effaced, and made to speak.

Metrics

As part of the Critical Global Health: Evidence, Efficacy, Ethnography book series, the book *Metrics: What Counts in Global Health* seeks to answer this question about accountability (Adams 2016). The contributors to this book argue that as forms of accountability in global health advance and promote the use of quantitative metrics – starting with statistical efforts to measure 'global burdens of disease' (GBD) and ending in efforts to make randomized

controlled trial (RCT) methodologies the gold standard – they simultaneously displace other kinds of evidence, even while leaving unanswered questions about efficacy.

Critical medical anthropologists and sociologists have, for instance, shown us that RCTs in US and British hospitals and health care systems have promoted hard and fast notions of evidence in evidence-based medicine, but they have also raised serious concerns over the funding, priorities, and health outcomes that get attached to these forms of evidence. As we roll out and export RCT methods to other places, global health becomes increasingly attached to the idea of generating reliable evidence that is accepted as globally universal, apolitical, and postnational. The RCT is imagined to solve old problems of accountability and to transcend old problems of political fallibility. As we move away from GBDs and toward RCTs, practices of counting, estimating, randomizing, controlling, chi-squaring, and linear regressioning, in a word, quantifying – even the most unquantifiable social experiences – often work as a team, a sort of an IKEA A-Team to produce global health here, there, and everywhere. But what happens when these projects succeed?

In *Metrics*, we argue that rather than solving old problems of accountability in health, quantification metrics often create new problems – not just as side effects, but as planned outcomes of letting the numbers do our thinking for us. When health workers are tasked with wrangling qualitative realities into quantitative policy platforms, concerns with fidelity of method often become substitutes for, even while erasing, the evidence of what patients actually need. Efforts to produce reliable numbers often require forms of estimation that deliberately erase important specificities about morbidities and mortalities that are crucial for intervention. Practices of hiding death can become political tools that are necessary for receipt of global health aid, masking deaths where they are politically inconvenient. The production of evidence-based data as routine demands of global health programs can lead to displacements of health but also of political claims to sovereignty. As political efforts become increasingly dependent upon optics attesting to good measurable outcomes, health workers learn to use quantitative data as a political tool. Even the survivability of NGOs can be put at risk, and missions overhauled, because of the need for producing metrics that can be counted. Displacing healthcare interventions with countable routines that can be packaged as 'widgets', metrics work can displace perfectly good and effective health efforts.

We are also interested in how the use of specific kinds of metrics enables and prolongs dangerous neoliberal arrangements that are of questionable value when it comes to health. Organizations like the Bill and Melinda Gates Foundation and the Global Fund are now able to engineer profit making as a global health tactic by using RCT metrics, envisioning it as a win-win scenario. But it is only through the use of quantitative metrics that such interventions can be counted as win-win. The metrics, in other words, tether neoliberal

forms of profit seeking to global health by making 'scalability' the primary measure of efficacy.

The think pieces in this Special Section question whether the forms of quantitative evidence making and scalable versions of efficacy that are prioritized in global health today, even when they are successful, shift our understanding of which outcomes matter most, and for whom. Metrics may, directly or indirectly, return us to possibilities of health governance that recall an era of empire (following Birn 2014) suggesting a neofeudalism by way of the private wealth enterprise and its tyrannical forms of reason. We need to ask not only what happens to health when metrics are produced in these ways, but also what new demands are placed on those laboring in the world of global health, that is, not just those laboring under the burdens of disease and morbidity but also under the burdens of data production. Do these processes of making evidence actually produce the kinds of efficacy we can live with?

We might think of *Metrics* and the essays here as effecting a reverse hijacking – a critical exploration of why some remodeling methods might land us right back in the store, looking for a better model, a better design, a couch that will last a little longer. By exploring the accountabilities that different kinds of evidence demand, and tracing these accountabilities to their ethnographic endpoints, we may be able to argue for an invigorated and concrete critique of the forms of making evidence now in play in global health.

The global

If we now have some insight into what we mean by 'critical' in critical global health, we still might ask what 'global' means in this method. What do pregnant, addicted poor women in San Francisco, the unlimited technologies of ordinary medicine in America, or injured US war vets have to do with global health? Why are these sites, people, and problems now also concerns of global health and what kind of critical global health will enable us to recognize and scrutinize the rationales that have brought them together?

In the introduction to this set of essays, João Biehl and I argue that critical global health displaces our attention from the geographic markers of global health and returns us to questions of world making and critical social theory. In the halls of global health programs across the country, the 'global' of global health has been invoked to talk about vectors of disease transmission (that cross borders), about distributions of scientific and technological resources (that account or fail to account for the zero-sum games of inequity), and about health opportunities (that must be able to transcend national political obstacles). If we take the use of 'global' on its own terms, then a critical global health might scrutinize how evidence and efficacy work hand in hand to create but also sometimes efface health in places

both near and far as equally global phenomena. Using the notion of 'global' to talk about methods, in other words, gets us beyond problems of geography and on to questions of how and when different kinds of evidence get produced and to what ends. We believe that ethnography is a method that can highlight these processes better than any other.

From the bedside of injured US war veterans to the feet of overweight South Asian Indians, from the daily-rent hotels of San Francisco to the laboratory reports authorizing defibrillators for centenarians, and from the scale-up metrics of the Global Fund to the media collusions in genocide authorized by public health narratives in Venezuela, we witness the opportunities afforded by our ethnographic method, revealing it to be a globally useful instrument. Our method can shed critical insight on not only what but also how we are doing in the projects of global health. This is, in many ways, our critical interrogation of globality as both a geographic and methodological reference.

What continues to make anthropology relevant is our ability to document what gets hidden by, or what remains invisible to, other disciplinary practices. Our method, in other words, is the basis for our claims to be doing critical thinking in our forays into global health. 'Global' here is thus as much a kind of methodological tool as it is a reference to moving beyond geographic boundaries. Ethnography offers a means of getting to the core issues of how evidence is produced, and for whom, and what claims about efficacy it serves. These are concerns that have geographic specificity and global relevance simultaneously. By making visible the kinds of evidence that matter in out-of-the-way places that have often been made invisible, we make critical and compelling contributions.

However, the idea that 'evidence that matters' resides in out-of-the-way places is not simply a return call for an anthropology of the abandoned or forgotten, nor is it by any means a call for an anthropology of the so-called suffering stranger (Butt 2002) or the 'suffering slot' (Robbins 2013). The fact that evidence that matters can be found in out-of-the-way places does not limit our engagement to the most vulnerable who are frequently hidden from view, but it also does not overlook these forms of invisibility. Indeed, sometimes these 'hidden spaces' are inhabited by those who are socially invisible or neglected, marginalized or silenced. However, at other times, these hidden spaces point to evidence that matters in different ways, as in the conceptual linkages of different phenomena, the idea of seeing something for the first time because we see it in a new way. How we trace knowledge, money, disease, homelessness, metrics, metabolism, or even soldiers' bodies, as if these were a whole new country, is what is important here. Often, what is sitting right in front of us is not seen until the ethnographic lens sheds light upon it. In this sense, critical global health focuses not just on people, but on the institutions, objects, and materialities that fuel visibility and invisibility. This effort returns us to what João Biehl calls for in his think piece:

a way of 'peopling' global health through methods that multiply our gaze and enable us to see micro, meso, and macro spheres of action at once. The effort to resist forms of 'open-source anarchy' that pervade global health today should not simultaneously obviate a persistent need for openness and multiplicity in our methods.

Critical global health in this sense points to our engagement with and critical exploration of anthropology at a turning point, where 'the social' is not so much defined by particular narratives or even solely by the people we study, but by the objects, conceptual sites, and on-the-ground entanglements we are following. There is a push to go beyond the mandatory use of the patient narrative as the primary focus of health ethnography. Taking a cue from Charles Briggs's (this issue) gripping account of the rabies outbreak in Venezuela, there is good reason for this. In his full book on the topic, co-authored with Clara Mantini-Briggs (*Tell Me Why My Children Died*), we learn that a lack of narratives of patient experiences could not be blamed for the extraordinary violence of this outbreak. Rather, it was the hypercirculation of narratives (in the media, in government health offices, in clinical spaces, and in the public) that impeded diagnosis and the collaboration that could have brought the outbreak to an end. This work reminds us that we might usefully focus on the communicative labor that objects do as they are set into motion and as they produce certain possibilities and limit others, exacerbating health disasters before they ameliorate them.

A focus on evidence beyond the personal narrative is, in other words, warranted, and we might even talk about the ethnographic tracing of objects' and institutions' own narratives: what stories do our technologies, our bodies, or our metrics tell us? I am talking here about methodological shifts to ontologies over sociologies as sites for critical global health, shifts that displace debates over anthropologies of suffering vs. anthropologies of the good, over concerns that by studying objects we somehow lose our ability to talk about people. I am thinking here of looking at ecosystems as having narratives that do not necessarily privilege human voices but must also include them, at viral pathogens that narrate relations with humans and nonhumans by way of languages that we are only beginning to understand, forests that speak a language humans can only imagine they understand but that nevertheless are heard, microbes that govern our guts and our neurons and teach us about survival in the anthropocene. These are more than efforts to privilege scientific or biological forms of narration, more than efforts to substitute laboratory, environmental, or experimental sciences for those of the irreducibly social human. These are efforts to understand the languages by which humans are implicitly and explicitly already made to live.

In this sense, we resist the tendency to exclude narratives that keep us close to first-person experiences. The effort to make sure that we are 'peopling' our global health work, as João Biehl notes, is more important than ever. It is important not only because these stories matter as forms of evidence, but because they render visible the messy practicalities of our

ethical commitments, the hidden architectures of our desire for engagement, and the effects both of these have in global health. How might this expanded attempt to think through narration and ontological possibility work as a method in critical global health?

In 'After War', Zoe Wool's beautifully crafted account of injured and recovering soldiers at the Walter Reed Memorial Hospital, the cultural and ontological logics at play illustrate how the demands of war do not end for these soldiers as they get rebuilt, convalesce, and make new lives in the hospital. These men are unrelentingly asked to perform American masculine heroism in and through a shattered body that is required to be made whole, ultimately an impossibility as a return to the 'ordinary' is forever pushed beyond reach, always only emergent. Her project foregrounds these intimately and resolutely human exchanges, showing how they are mediated by technological objects and promises of masculine cyborgian futures and vice versa (technologies as bodies and bodies as technologies). In the end, her work sheds harsh light on the unrelenting psychopathy of our gendered industries of war (Wool 2015).

In Harris Solomon's account of diabetes in India, metabolism is the key narrator. Metabolism tells a story of global health, and we are taken on its journeys through its acts of consumption, of intestinal absorptions and excretions, of food potencies and dangers, and the all-too-common endpoints of diabetes. We are taught how to read the maps of specific kinds of health experiences and social possibility in and through the gut. Caste, gender, poverty, diabetes, obesity, social mobility, and religious sensibilities are, in Harris's work, not interchangeable, but similar in that they are simultaneously physiological disorders and public health problems. In the clinic, these metabolic lives are pushed through other kinds of narrative templates. Death itself becomes a living ontology that creeps into bodies and portends the end, the life of dying. Death has its own story to tell here, as a part of the metabolic life that has gone terribly awry in a place of both food excess and food scarcity. Harris's stories are not guides to the morbidities of the gut; rather, the gut and its metabolic journeys are a guide to India's contemporary morbidities (Solomon 2016).

Sharon Kaufman, who might once have been identified as one of our discipline's key champions of the patient narrative, offers compelling evidence that we have come a long way from treating the patient as the only centerpiece of our inquiries. As she tracks the formation of elite, expensive, and extreme medicine as it becomes 'ordinary', it is precisely the stakes for the patient (and his or her family) that matter even while US medical evidence-producing institutions are ultimately the subject of her study. Countering old worn narratives of iatrogenesis in relation to cost cutting in US health care, she shows us how ordinary medicine is, in fact, extraordinary in its fiscal excesses that push accountability always beyond

our grasp while leaving unanswered the question of efficacy as measured in improvements to quality of life (Kaufman 2015).

In Kelly Knight's compelling and moving essay, 'addicted.pregnant.poor', we are quickly dissuaded of the pretense that patient experiences alone will guide us to solutions for the predicament of homelessness and precarity in San Francisco (Knight 2016). The ethnography on which the essay is based takes us on a journey through the epidemiological labor of neurocrats, the ethical conundrums of social workers, the ambivalences and greed of landlords of single-room-occupancy buildings, the hopeful friendship of a diligent anthropologist, and the attachments of women to their hopes for permanence in and through reproduction, treating us to a tapestry of narration. Just as these women hold onto memory objects that disrupt the burdens of living always 'temporarily', we are shown how homeless, drug-using, and pregnant women become a mere conduit – a passage point – in search of permanent solutions to their problems. By looking at these discursive spaces together, and tracing their contradictory goals, we are offered an understanding of their best-intentioned but ill-conceived efforts, not much more than a means by which to hold aspirations for a kind of efficacy permanence, or even evidentiary stability.

Finally, returning to Charles Briggs's essay, we are offered a strong case for the limitations and necessity of keeping humans at the center of our critical engagement. By tracing the multiple discourses about the rabies epidemic through its public health, ministerial, and media campaigns, this work sheds light on the processes by which something as infinitely preventable as rabies could have come about. The multiple narratives constructed around this episode created erasures and misrepresentations, but it is the powerful insights of village women who have lost children to rabies, who demand to know why their children died, that form the basis for a new exploration of the communicative labor involved in health inequality.

In all this work we see a shift to a critical global health that follows people (and what they say) as well as the objects of knowledge and ontological framings that are produced, that circulate, and that generate human consequences by way of their own narratives. Anthropologists are uniquely poised to hear these narratives and provide us with a sense of their accountabilities. The critical method here is one that aims to capture them as problems of evidence and efficacy but also, finally, as ethical problems. In some sense, anthropological critique has always been aimed not just at the world out there but at how we study the world out there. Often this means we argue with one another about 'how' we should do not just critical anthropology, but anthropology at all. This is where, and how, the consideration of evidence in relation to efficacy creeps back into our method and enables us to claim, in the end, critical global health as an ethical possibility.

IKEA as the future

I want to return to my metaphor of the IKEA remodel here to make this point clear. If global health is like an IKEA remodel, we might say that the jury is still out on how well it will work for us. Many will point to problems of the longevity of its products, the profit orientation of built-in obsolescence, the underpaid labor involved in production, and the homogenization of design for the masses. But others will argue that its affordable, functional, and design-conscious furniture is produced for the masses who must conceptualize living in smaller, more affordable, and frequently shared spaces. A politics of IKEA and a politics about IKEA are ambiguous, just like the politics of and about global health. But these politics involve not just stories of furniture; they also involve stories of global capitalism, neoliberalism, planetary accountabilities, ontologies, and people.

Returning to my opening question, 'what is critical global health?', I thus want to offer several answers. First, the possibility of globality is both embraced and interrogated by our commitment to interstitial spaces that are often hidden or overlooked in other disciplines but that become quite visible when looked at through long-term ethnographic engagement or with a trained ethnographic eye. Critical global health in this sense remains resolutely local, even while being able to capture phenomena that have a very large footprint. This means refusing to treat global health as if it were not always also and simultaneously in our own backyards, and taking the conceit of globality seriously by locating its practices in specific times and places and then tracing its successes and failures as contingencies of differently situated (and often globally located) concerns with evidence and efficacy.

Second, critical global health remains committed to ethnography, even when this means thoughtfully interrogating who the speaking subject or object is. Following actors who are ontologically divergent is part of our commitment to a critical stance. Ethnography pushes us to persistently interrupt and question what we take to be our method. It offers hope that even as we acknowledge the need for tools to interrogate the ontological possibilities of our ethics, we can also remain committed to global health efforts that are impactful. Sometimes impact has to be calibrated in relation to not just humans but also the human condition in which humans are a mere partial fragment in a larger scheme of things.

To end once again with the clunky metaphor, perhaps the IKEA remodel of global health will, in fact, have room for us – and possibly more room than our old apartment did – but that does not mean that we don't have much to think critically about as we try to assemble the furniture. At a minimum, we may at least come up with some better instructions for doing so.

About the author

Vincanne Adams, PhD, is Professor and Vice Chair in the Department of Anthropology, History and Social Medicine at the University of California, San Francisco. She is coeditor of the Duke University Press book series entitled Critical Global Health: Evidence, Efficacy, Ethnography. She is also the editor of *Metrics: What Counts in Global Health* (Duke University Press, 2016) and author of *Markets of Sorrow, Labors of Faith* (Duke University Press, 2013) as well as other ethnographies. She is currently working on several other projects, including one on pesticides and pediatric health in the United States and another on Tibet and science.

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