MAT Medicine Anthropology Theory

INTERVENTIONS

Critical convergences

Social science research as global health technology?

Ramah McKay

Abstract

Thinking through two objects – a focus group and a photograph – this essay suggests that ethnographic critique is not separate from but constitutive of global health. Social science representations, from data and focus groups to ethnographic descriptions and clinical snapshots, not only analyze, unpack, or depict global health; they also constitute it as a field of intervention and define certain spaces, particularly clinical ones, as exemplary global health sites. This co-constitutive role complicates ethnographic critiques that see their role as primarily destabilizing global health facts. Rather, by drawing on feminist approaches to ethnography and critique, I suggest that convergences between ethnographic and global health knowledge stem from historical alignments through which anthropology and global health alike emerged and have come to circulate. These convergences point to the need for a 'non-innocent' critique of global health that centers the disciplinary complicity between, and methodological adjacency of, social science and global health.

Keywords

ethnography, global health, feminist theory, materialism, embodiment

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Ethnographic reflections

One long weekend, early in my fieldwork in Mozambique, I traveled from Maputo, the capital city, to the city of Beira, halfway up the coast in Sofala Province. While there, I visited a Brazilian friend who worked with a health nongovernmental organization (NGO) based in the city. On the day I arrived, she was scheduled to conduct a 'site visit' at a couple of rural health centers with the aim of picking up data on clinic attendance. She suggested I come along to see what her work was like, to see the green and expansive countryside, and to hang out.

That afternoon, we arrived at a small but newly renovated health center. My friend introduced me to the head nurse, mentioning that I was an anthropologist interested in health in Mozambique and that I was accompanying her. After chatting with the head nurse for a while, I suggested that I could sit in the waiting room while the nurse got back to work. Instead, the nurse politely asked me to wait a moment. Five minutes later, she ushered me into a breezy, shady, open-air meeting space at the side of the health center. There, a group of six community health workers were sitting on chairs in a circle, with a space open for me. 'We are ready for the focus group', they told me. I received this news with alarm. I had not intended to conduct a focus group and, in fact, rarely used that technique in my research. I knew very little about the health center. As a result, I felt a sense of embarrassed disavowal, not unlike the awkward moment when, passing a store window, you mentally judge the reflection even as you are starting to realize it is your own.

What can this impromptu focus group tell us about the entanglements of global health, social science, and health labor in Mozambique? Was it a mirror, reflecting what I, as a white American researcher and a friend of the doctor, was presumed to want or expect? Was it, as my friend later suggested, better considered as a gift, an act of generosity within the economies of data and exchange (Biruk 2018) that entangle global health, anthropology, and health work in transnationally funded clinics? Or perhaps to see it as a mirror or a gift, even to see it as spontaneous or inadvertent, overlooks a more prosaic but important aspect of the focus group: perhaps for many health workers participating in ethnographic research in scripted and deeply familiar ways was as prosaic as me checking my email or preparing for class. For the participants, the focus group was just part of their job.

In this essay, I consider two modes of generating and circulating global health knowledge and images – the focus group and a photograph – to ask how certain kinds of work become visible, even hypervisible, and others invisible in the relationship between ethnography and global health. Far from being outside health work, these objects suggest, social science research and the economies of representation that accompany it have been integral to the job of making and doing global health. Highlighting the material entanglements of research

and representation, then, the first part of this essay asks how ethnographic fieldwork becomes visible to others, such that participating in research engagements may become a routine part of the work of health in Mozambique. How, in this process, might anthropological research and ethnographic representation help to stabilize 'global health' as a field?

In the second part, I ask what roles are available for ethnographers and for ethnographic critique when anthropological research is not just entangled with but constitutive of the object of critical analysis. As Jonathan Rosa and Yarimar Bonilla (2017, 203) note, scholars such as Michel-Rolph Trouillot, Faye V. Harrison, and others 'long ago demonstrated that anthropology is co-constitutive of the very hierarchies that are positioned as somehow outside it'. From this vantage point, convergences between global health and ethnographic methods speak not only to global health practice but also to broader formations of imagining and managing the world (Trouillot 2003, 221). In such a context, what is the role of critique? And what possibilities for ethnographic engagement does global health critique enable or foreclose?

I explore these questions by drawing from two strands of anthropological theory. The first comprises accounts of care as a material practice and of the relationship between care and critique. Michelle Murphy (2015, 719), for instance, argues for the central role of critique in developing a 'non-innocent' politics of care, one that attends 'to the complexities and complicities in recent histories of care within feminist and postcolonial circuits'. This view understands care not as a product of feminist analysis 'but rather as an already circulating, hegemonic force in our worlds' and one in need of 'unsettling' (Murphy 2015, 731). The second addresses ethnography as an embodied practice that shapes and is shaped by the gendered and racialized presence of the ethnographer (Berry et al. 2017; Navarro, Williams, and Ahmad 2013); these accounts have underscored the inseparability of anthropology and anthropological research methods from the making of racialized colonial distinctions (Rosa and Bonilla 2017). Together, these approaches suggest that critical convergences of ethnographic and global health practice are structured not only by the forces that produce health inequities but also by embodied relations of work, care, and knowledge production on which global health and ethnography alike depend. Taking inspiration from Murphy (2015) and Rosa and Bonilla (2017), then, I ask: might ethnographers of global health develop a 'non-innocent' politics of critique, one that recognizes critique as 'an already circulating, hegemonic force' rooted at once in the discipline's colonial histories and the embodied politics of ethnographic practice?

The focus group as method and object

The focus group offered just one example of what I came to see as a taken-for-granted quality of ethnographic research in global health spaces. During the time I conducted research in Mozambique, the presence of student researchers often seemed an anticipated, if not always welcomed, dimension of transnational medical practice. NGO staff frequently responded to my requests for interviews, for instance, with immediate suggestions of how I might help them to generate data. As I note elsewhere (McKay 2018), for some, my role as ethnographer offered the promise of making visible a 'real world' outside the clinic in ways that could inform or refine programmatic notions of success or failure. At other times, my overtures were ignored, rebuffed, or met with suspicion. And in some instances, as with the focus group, the generation of data and the performance of research participation were immediate. In almost all cases, however, the presence of social science research appeared a common dimension of professional life in donor-funded clinics.

That ethnographic research frequently appeared to be not separate from my objects of study but bundled with them is also suggested by the flood of nongovernmental, biomedical, and pedagogical interest in HIV in Mozambique. High levels of donor funding for health in Mozambique came with a deluge of consultants, reports, social science analyses, and case studies, all driven as much by the imperatives of funding as by biomedical need or specific concerns (Matsinhe 2008). In Mozambique and in the United States, this expansion of global health social science has provided anthropologists with new professional opportunities, including opportunities for consulting and research as well as for teaching and pedagogy (Gonçalves 2019). For instance, ethnographic and anthropological accounts have been incorporated into global health training of university and medical students (see, for example, Farmer et al. 2013). As a result, the arrival of an ethnographer in a clinical space was part of a larger set of relations between knowledge producers and the patients and medical staff – like the ones who formed the focus group – through whom knowledge was generated, as well as with the health practitioners, policy makers, researchers, academics, and students who consume such information.

This was initially surprising to me, since I understood my project not so much as participating in as analyzing this mode of biomedical practice. Indeed, despite the centrality of social science to global health practice, ethnographies of global health have often taken a critical stance towards the projects they analyze. Describing how NGOs have become key actors in managing population health and providing medical services, for instance, ethnographers have shown not only how health disparities result from global economic forces but also how the humanitarian logics and practices that emerge in response may intensify these political economic regimes (Braga 2017).

Despite what I understood to be my critical orientation, however, my fieldwork – like many ethnographic research projects on global health – was also embedded in and dependent on the projects I studied. Sometimes these entanglements were formalized, as when I was offered 'consultancies' or given assignments interviewing patients, analyzing clinic practices, or writing reports. More often, they were ad hoc, for instance, as I helped guide patients through clinic spaces or assisted clinicians by delivering files or information across the clinic. My ethnographic methods thus involved an ambivalent relation to the extension of care, sometimes working at cross-purposes to my critical analysis.

Ethnography in the critical cave

Not only was my ethnography dependent on my object of study, but I also frequently found that the critical apparatus I brought with me to the field was widely circulating and well known to my interlocutors. NGO directors, clinic managers, and patients were well versed in anthropological critiques of NGOs. Some reflected with me on their own anthropological educations and enthusiasms. Far from remaining the purview of the ethnographer, then, the ambivalences of nongovernmental assistance, the indeterminacy of intervention, and the instability and even inadequacy of medical knowledge were widely shared concerns. They became grounds not only for suspicion or mistrust of ethnographic research but also for shared enthusiasm and commiseration. Even as distinctions between applied and critical scholarship have been central to the history of medical anthropology (Sobo 2004), they still do not always describe the ethnographic landscape of global health. Not only do ethnographers participate in global health pedagogy and practice but practitioners are often powerful critics of global health. Anthropologists and practitioners alike have articulated critiques of the political-economic conditions through which such interventions become necessary, as well as of the magic bullets, privatizing practices, and brain drain that are often enacted by NGOs (see, for example, Pfeiffer and Chapman 2015).

Critical entanglements of ethnography and global health have long been the object of anthropological reflection. Addressing the relationship between ethnography and global health, for instance, Didier Fassin (2012) draws on the analogy of Plato's cave to suggest that anthropologists might productively take up a liminal stance that is both internal to (engaged with) and external to (critical of) the field of global health (see also Latour 2004). This position makes clear that critique is not only the purview of anthropologists but of humanitarian actors themselves, often expressed through repertoires of cynicism, sarcasm, irony, and humor. Confronted with the unequal social relations (and uncomfortable political implications) of aid work, humanitarian and medical actors may draw on a cynical or ironic repertoire of jokes, parodies, and satires of the aid world, sometimes in ways that mirror anthropological analysis (Redfield 2013).

Critique, these accounts show, is a part of the everyday work of humanitarian and global health practice. Yet when ethnographic critiques are taught in global health training courses, or when critical ethnographic stances are articulated by key global health actors, it points to deep methodological and analytical complicities between ethnographers and ethnographic objects (Mkhwanazi 2016). For the participants in the focus group, for instance, the work of global health included not only the professional work of medical caregiving but also rendering that work visible for broader audiences by way of participating in social science research. To extend the metaphor of the cave, ethnographers are not only located inside the cave (as in 'engaged' or 'applied' research), outside the cave (as 'mere' critics), or at the threshold, but they also help to build it.

Matters of critique

In her book *Matters of Care: Speculative Ethics in More Than Human Worlds*, Maria Puig de la Bellacasa (2017) suggests a path through the oppositions of engagement and critique (see Latour 2004). Describing an approach to the instability of scientific knowledge characterized by both care and critique, she argues for a materialist approach concerned with 'intervention and involvement, and let's say ethico-political commitment and obligations, as an essential part of the politics of knowledge production' (Puig de la Bellacasa 2017, 40). While feminist theorists have described care as entailing efforts 'to maintain, continue, and repair our "world" so that we can live in it as well as possible', both feminist and medical anthropological work has shown how this work is inequitably distributed, falling disproportionately to women of color (Tronto 2013, 19). For Puig de la Bellacasa (2017, 50), focusing on matters of care – the technologies, practices, and materialities through which care is made – enables us to ask not just what worlds are maintained, but how, and by whom, and at what expense.

This view opens possibilities for centering the role of critique in the making and maintaining of global health worlds. In July 2015, for instance, I stopped by a Maputo clinic where I had conducted research some years earlier. It was late morning, a time of day when the early rush of patients was likely to have eased but before lunch breaks, competing obligations, and last-minute tasks began to eat up the afternoon. The hallway was quiet as I entered, and I was uncertain whether I would find any familiar faces. Yet when I asked for Nurse Elsa, the receptionist waved me through to the back office where I saw her familiar tall, gray-haired figure, as she stood with a younger colleague in front of a storage closet. Their heads were bent over a photograph, and they looked up as I knocked on the open door. As the clinic's head nurse, Nurse Elsa was often busy and rushed, but she had also long been a key mediator in my encounters with other clinic staff. Today, she waved me in and we chatted for a moment, and then she turned the photo toward me. A large, professional photo, the

image showed the visit of then US First Lady Laura Bush and her daughter, Jenna, who had briefly visited the clinic during a visit to Mozambique. Assembled around them were patients and family members, smiling and carefully staged.

At the time, the Bushes' visit (and the photos that memorialized it) seemed distasteful to me, evidence of the many ways that global health spaces were made at once exemplary and 'unreal' through selectively delivered and bounded resources (Herrick 2017). The patients, I knew, had been selected to produce a vision of healthfulness and project success, and the clinic had painstakingly prepared for the visit. The staged photos seemed to epitomize a mode of gendered and racialized representation that has been both ubiquitous and the target of much satire and critique. A rich realm of satire – epitomized by the *Onion* article '6-Day Visit to Rural African Village Completely Changes Woman's Facebook Profile Picture' and the Instagram account @barbiesavior – shows how images like the one used in the clinic at once center and disavow the racialized geopolitical inequities on which global health also depends (Benton 2016). Both online images and the photo make clear how global health spaces not only have become sites for intervention but also the staging ground for representations of care in ways that are overdetermined by relations of race, national origin, and gender, and by economic and epidemiological difference. This representational work is also integral to the possibilities and impossibilities for health that inhere in such projects (Bailey and Peoples 2017; Prince 2016).

Given my reaction to the photo, then, I was struck by the intent concern with which Nurse Elsa and her younger colleague regarded it. I soon understood that, to them, the celebrity visitors were hardly relevant. Rather, they were using the photo to reflect on patients who had survived over the decade since the image was taken, and on those who had not. The celebrity snapshot, captured on glossy A4 paper, thus provided a moment of pause, an object of memorialization, and a means of reflection on their patients and their work before they returned to the cases at hand. As a material object of care, the photograph made clear how Nurse Elsa's everyday professional labor was at once entangled with and rendered invisible by the performative staging of care that produced the photograph.

So too were the politics of the photograph's production both constitutive of and excluded from the image. Reflecting on the photograph of Jenna and Laura Bush, now many years after it was taken, I recall not only the memory of Elsa and Nilza but an adjacent memory as well – of walking down Kenneth Kaunda Avenue, a wide leafy boulevard on which the American Embassy in Maputo was located at the time of the presidential visit. Suddenly, amid a cacophony of sirens, a convoy of black armored SUVs passes. It is not the usual parade of luxury cars with flags aflutter that accompanies diplomatic delegations around the city. It is Laura and Jenna Bush on their visit. Shielded from exposure by tinted windows,

they were not visible. What I saw instead were the American soldiers, in fatigues and dark sunglasses, hanging out the back of the last vehicle, automatic weapons at the ready.

Anthropologist Jemima Pierre (2013), describing 'spaces of whiteness … hidden in plain sight within depressed neocolonial contexts' (3), argues that they must be analyzed in light of the racialized political economies that enable 'ongoing neocolonial politics of both benevolence and malevolence' (5). This observation expands the arena of global health critique to encompass the racialized political formations through which global health interventions are enabled. Here, for instance, the photographic image pointed to the performance of racialized benevolence (the snapshot) and to the political economy and violence (the convoy) that formed the conditions of its staging. Rendered visible in the celebrity snapshot, such inequities of power and knowledge also inhere in the production of social science data more broadly, as when my presence signaled the need for a focus group and when anthropological knowledge production follows the routes of the PEPFAR interventions enabled by these political forms (Crane 2018). At the same time, attention to how the photograph circulates back into practices of care makes clear how the politics of the photograph's production shaped but did not fully determine the forms of work that it enabled for Nurse Elsa and her colleagues.

Care, research, and pedagogy as embodied and material practices

Neither abandoning critique, nor restricting scholarship to it, attending to matters of care involves asking: what needs to be in place for global health matters – including the focus group and the photograph, as well as biomedical goods and techno-scientific knowledges – to unfold? As a matter of care, what worlds do global health practices maintain, how and by whom, and at what expense? And what is the role of the ethnographer, and the ethnography, in performing that maintenance and calculating or adjudicating that expense? This approach is helpful for querying the worlds that global health makes and unmakes, and that ethnographers traverse, analyze, and participate in. Indeed, as Puig de la Bellacasa (2017, 87) notes, accounts of care as something that happens 'out there', for instance in the clinic or the field, disconnect it from the scholarly and disciplinary work that also serves to constitute it.

At the same time, ethnographic research is not only a material practice but also an embodied one that is both constitutive of and constituted by the centrality of 'the field' in practices of knowledge production. As Berry and colleagues (2017, 537) recently argued, the field is a political and imperial space, as well as an epistemological one, and it plays a central role in constituting not only ethnographic data but ethnographers themselves. Because of this constitutive role, 'centering the [ethnographer's] body in the stakes of . . . research advances the path towards decolonizing anthropology' (Berry et al. 2017, 558). Just as attending to

material practice raises questions of how global health and ethnographic worlds are made and maintained, attending to the embodiment of research and the disciplinary legacies that produce the field highlights the central role of critique in entangling global health, social scientific, and ethnographic knowledge. Ethnographic critiques of global health, for instance, may draw attention to suffering in the face of political-economic neglect, but these representations may also reinscribe gendered, racialized, and classed understandings of who generates knowledge or performs caring labor, of how these efforts are valued, in what ways, and towards the maintenance of which worlds.

Attention to ethnography as embodied as well as material thus opens consideration of which forms of global health knowledge are made visible or obscured in ethnographic rendering. It also highlights how this knowledge is reproduced in the classroom. Teaching courses on care, for instance, I find the students in my classrooms to be predominantly women, often white women, their numbers reflecting but also exceeding their proportion of the student body at a predominantly white institution (see also Brodkin, Morgen, and Hutchinson 2011). From this classroom as well as the field, then, I observe how critical accounts of global health also serve as technologies of subjectification, not only analyzing relations of care but also inscribing racialized and gendered visions of the primacy of care and caring to the audiences who read them. As a result, attending to the presence of the ethnographer in global health's clinical and pedagogical spaces as well as to the material practices through which global health is made highlights the disciplinary formations through which care and critique are coproduced and come to circulate as ethnographic objects.

Conclusion: A non-innocent global health critique?

What does it 'mean … for a project of critique to be complicit with its object' (Ahmed 2007, 149)? Social science representations, from numbers and focus groups to ethnographic descriptions and clinic snapshots, have not only analyzed or depicted global health but also served to constitute it as a field of intervention, including defining certain spaces, particularly clinical and pedagogical ones, as global health sites (Sangaramoorthy and Benton 2012). These convergences speak to the recursive or 'looping' nature of anthropological knowledge practices (Fortun 2012). Here, I suggest that the co-constitution of critique as both a global health and an ethnographic practice also speaks to anthropology's disciplinary foundations and the regimes of race, power, and political economy that they enable (Trouillot 2003).

As critical objects, the focus group and the photograph are materials through which medical care operates; they also materialize the politics that enable it. Objects like the photograph enable multiple and surprising economies of work and care, as when Elsa and her colleague found in the photograph a referent for and reflection of their work. These imbrications

show how global health images enter into local moral economies and social worlds, and suggest ethnographic avenues for understanding how such objects may provide the basis for medical work in ways that exceed critiques of humanitarian imagery. At the same time, as the focus group shows, health workers not only make use of the materials of global health in order to provide care for patients. They also work to become visible to global health in contexts in which such visibility is professionally valuable, unevenly distributed along lines of race and national origin, and mediated by social science research and researchers, including ethnographers.

Together, then, the focus group and the photograph speak to the non-innocent conditions of global health and ethnographic critique and practice, conditions rooted at once in colonial and neocolonial political economies and in efforts to repair and maintain relational worlds. From this vantage point, critical approaches to global health might best be served not by seeking and teaching the innocence of critique but through attention to the non-innocent conditions of both ethnographic and global health knowledge production; in other words, by attending to the disciplinary complicity, as well as the critical distance, between social science and global health.

About the author

Ramah McKay is an assistant professor in the Department of History and Sociology of Science at the University of Pennsylvania. Her book *Medicine in the Meantime: The Work of Care in Mozambique* (Duke University Press, 2018) examines the critical and temporal politics of development and global health projects in Mozambique. Her ongoing work focuses on for-profit medical care and the construction of transnational medical marketplaces that link patients and providers in Africa, India, and the United States, and on the role of social science and ethnography in global health and development.

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