Critical Global Health

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A Visit with the Patient

Janira 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 Brazil's universal health system, while the 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 Paula Pinto de Souza, the public defender responsible for her case. "Is it here that I get the medicine?" she asks.

Paula welcomes Carmen "to the juridical hospital," but she explains that getting the medicine will not be so simple. In her role as a legal advocate for the poor and chronically ill, Paula's job is to ameliorate suffering and to restore the rights of her clients. "The person," she explains, "comes here sick. Her right to health has been profoundly injured by public power. Even if the medicine might not bring them life, the claim is also for their dignity." That, at least, is Paula's goal.

Given the severity of Janira's condition, Paula will ask the district judge to issue a court injunction compelling the state to provide Janira's treatment right away. She cautions Carmen not to get her hopes up too high, however, as state attorneys will most likely appeal the lawsuit. "It might take years to reach a verdict," she says. And this is not unusual. It is in fact typical of the right-to-health lawsuits that now inundate the Brazilian judiciary. And the problem does not end there. 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."

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. 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 shack, we noticed an offering to the *orixás* filled with packaged sweets.[1] "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 station. Within days of the public defender's filing, the district judge issues an injunction for the medicine to be delivered to Janira. Two months later it has still not arrived.

At a time of great medical progress, Janira is barely clinging to life. Her family is locked in a daily struggle for survival on several fronts, for in order to preserve Janira's life they must not only battle her disease but also resist political and economic death and social oblivion. Theirs is only one story, but it accurately reflects the way in which broad-based questions of access to technology and social justice are often contested in today's rapidly changing public health context. Anthropological fieldwork or home visits, such as the one we have described, can vividly capture and draw attention to these efforts and to the real persons whose imperiled lives they impact. For anthropologists, these peopled accounts—stories that are so often hidden from view, obscured by more abstract and bureaucratic

considerations of public policy—are the very fabric of alternative social theorizing. By looking closely at life stories and at the ups and downs of individuals and communities as they grapple with inequality, struggle to access technology, and confront novel state-market formations, we begin to apprehend larger systems. We are able to see them in the making or in the process of dissolution, and we understand more intimately the local realities, so often unspoken, that result when people are seen or governed in a particular way, or not at all.

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 other rich countries. Meanwhile, mortality rates remained high and life expectancies short in poor countries (Cutler, Deaton, and Lleras-Muney 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 that has come to be known as 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 engaging in struggles over access to high-quality care and, at a more fundamental level, debating the meaning and implications of health conceived as a right rather than a privilege (Biehl et al. 2012; Fassin 2007).

Magic-bullet approaches—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— have been the norm in international health interventions for decades. 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 they are, is insufficient. Also, unintended consequences may be unleashed by even the most carefully designed interventions (DelVecchio Good, Good, and Grayman 2010; 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 break-

downs 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; Cueto 2007; Farmer 2004; Freedman 2005; Hahn and Inhorn 2008; Singer and Hodge 2010; Utzinger et al. 2002). 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 (Reinhardt, Hussey, and Anderson 2004; Deaton 2008), 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 ill 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 ask: What really happens when new treatments are introduced into epidemiologically diverse and variable social worlds? How is care organized by providers, by state and nonstate institutions? 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?

When People Come First brings together an international group that includes anthropologists, historians, and an epidemiologist and human-rights scholar to produce an ethnographic critique of the contemporary global health enterprise. While global health initiatives and programs are booming in the United States and have begun also to displace earlier framings of the field (such as "tropical medicine" or "international health") in Western Europe and Latin America, critical analyses of the social, political, and economic processes associated with this quickly evolving field are still few and far between. The contributors to this volume are engaged in both empirical and theoretical investigations of global health-related initiatives and epistemologies, and are concerned with the actual impacts of these initiatives on care, health systems, and governance. The book emphasizes ethnography as a crucial methodological tool for achieving better comprehension of health services at all levels of analysis and advocates anthropological case studies and crosscultural analysis as foundational to a much-needed critical global health perspective.

Our case studies explore the agonistic relationships among people, medical technologies, markets, and public institutions and reflect on the limits of the evidence-making practices, models of care delivery, and moral calculus that underpin large-scale health interventions. Contributors attend to the variable intended and unintended effects of these interventions on those in need, and they challenge the certainties of planners and implementers while probing the limits and possibilities of the social theories informing their works. Cases draw from fieldnotes, interviews, life histories, and database and document analyses, and they are constructed in dialogue with rich bodies of applied and theoretical work carried out in specific countries and regions. While each case has something important and original to say about a particular facet of global health today, the cases also play off each other to produce a critical cumulative effect that is greater than the sum of its parts.

When People Come First offers innovative ways of thinking about older debates in light of emerging realities, and it sets a new agenda for research in global health, one aimed at a more comprehensive framework for understanding the human, technical, and political issues involved. The title of the book expresses our shared respect for the dignity and singularity of the people with whom we work, and our close attention to the ways in which their own struggles and visions of themselves and others create holes in dominant theories and interventions. People constantly exceed the projections of experts. The medicoscientific, political, and humanitarian frameworks in which they are temporarily cast cannot contain them. Their plights and travails demand intense listening and continuous attention. We must hold social theory accountable for the full range of human conditions, for all the polyvocal and contradictory realities that we encounter in the field, and that are too often obscured by the lens of established thought. *When People Come First* is thus as much a critical study of global health as it is a field guide for a global health humanities that can challenge perceptual deficits of all kinds, open new avenues of thought, and inform the continuous efforts of multiple stakeholders to create a health sufficient to liberate human potentials and futures, wherever they are thwarted.

The Field of Global Health

In the twentieth century, international health initiatives were by and large implemented by states, subject to the coordination of specialized bod-

ies 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; Brown, Cueto, and Fee 2006), 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 (Cueto, this volume). A complex mix of partnerships linking state and nonstate actors—the latter including philanthropic agencies, nongovernmental organizations (NGOs), and the pharmaceutical industries—has arisen and is shaping health interventions worldwide under the rubrics of humanitarianism, development, and security (Fassin 2012; Lakoff and Collier 2008; Birn 2005b).

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 Susan Reynolds Whyte and her colleagues call, in this volume, "projectified" landscapes of care (see also DelVecchio Good, Good, and Grayman 2010). While enabling much-needed access to AIDS treatment, for example, the amalgamation of public-private interventions can also endow states with new (and sometimes abusive) powers. The "projectification of care" is thus a key venue in which the scope and roles of government are redefined, micropolitics

diversified, and entrepreneurial prospects of all kinds explored (Ecks and Harper, this volume).

There is considerable confusion about how these 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; Garrett 2007; Frenk 2010; Keusch et al. 2010). In practice the concerns of donors, not recipients, tend to predominate (Schieber et al. 2007; Easterly 2006; Epstein 2007; Ferguson 2006; 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 (Pfeiffer, this volume). Thus, in settings as diverse as neoliberal Mozambique and urban America, state-of-the art facilities for HIV/AIDS testing, treatment, and clinical research coexist with dilapidated public hospitals. Coinfections, which are not built into the calculus of disability-adjusted life years (DALYs), are yet another indication that global health interventions that limit their target to one disease can miss the mark. Such is the case with malaria. No one contracts it or recovers from it in a vacuum, and its biological and immunological uncertainties beg for a more nuanced science (Packard 2007).

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, Novotny, and Leslie 2008; Buss and Ferreira 2010). We are left, however, with an "open-source anarchy" 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 (Fidler 2008:410; Pogge 2010).

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 Hansen 1997; Duflo and Kremer 2008; Imbens 2010). In this dominant regime of veridiction and falsification (Foucault 2008), 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).

Indeed, "RCTs have been given a free pass in the name of rigor," development economist Angus Deaton argues. "But there are no magic bullets and there are no gold standards" (2012).[2] With the hegemony of this theoretical and technical fix, 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, this volume; see Krieger 2011).

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.

Needless to say, such approaches perpetuate a limited understanding 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 (Amon, this volume). This preoccupation with scientific and economic issues results in less attention to on-the-ground social dynamics of programs and in assumptions that a particular model will work in an array of countries and situations, despite the fact that each is home to distinct institutions, practices, and rationalities, not to mention persistent inequalities and stubborn deficits in local infrastructures (Moran-Thomas, this volume).

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 2010; Porter 2009; Porter and Teisberg 2006). 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 goal shift away from increasing access to treatments and toward delivering value for patients (Kim et al. 2010; Denzter 2009).[3] 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 called for, and diverse disciplines (including anthropology) must be engaged as we seek to understand the complexities of the context and content of interventions as well as the trial and error, the endless tinkering, of real people in specific circumstances trying to figure out what works for them (Cartwright and Hardie 2012). Such multiscale empirical knowledge 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 (Epstein 2007; Stepan 2011; Feierman et al. 2010).

Anthropologist-physician Paul Farmer is one of the most prominent proponents of a community-based approach that blends technological intervention with a focus on making health systems work (2004, 2011). Farmer and Partners In Health, the organization he cofounded, understand diseases as loci where biology, environment, and medicine have gone awry, and their notion of intervention accordingly tackles the structural conditions that perpetuate disease at the local level.[4] 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; Bourdieu 1998; Pfeiffer and Chapman 2010). In Partners In Health's social justice approach, accounting for individual patient trajectories and staying with patients throughout the progression of their disease and rehabilitation (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, alongside other initiatives of this kind, created dents in the prevailing rationalities that guide global health interventions, and has redefined the perceived boundaries of feasibility.

Indeed, multiple approaches, moral principles, methodological techniques, and epistemologies cohabit within the broad framework of global health. Many would agree that global health "is more a bunch of problems than a discipline" (Kleinman 2010:1518). While the field still debates fundamental questions of self-definition and values, it has nonetheless become a significant political, economic, technological, and social nexus for a variety of actors and interests that engender projects that "are complex, diverse, temporally unstable, contingent, and often contested or resisted at different social scales" (Janes and Corbett 2009:169; Nichter 2008; Rylko-Bauer, Whiteford, and Farmer 2009). So far few, if any, institutions have been put in place to conceptualize, evaluate, or monitor the immediate and broader impact of this expanding field.

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 that are routinely facing multiple morbidities and economic insecurity (Han, this volume; Livingston 2012; Manderson and Smith-Morris 2010). So, how are we to measure the value that interventions have for people, their health, and their subjective well-being, 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?

When People Come First grapples with the transnational and local realities that are emerging through and in the shadow of large-scale health and development interventions that come and go in a climate 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 are real, impacting institutional capacities and social relations—a multivalent impact that people trying to escape grim medical destinies are left to reckon with, and that has to be addressed on its own terms.

Epistemological breakthroughs do not belong to experts and analysts alone. The unpredictable and cumulative experiences of people navigating health and humanitarian interventions and their aftermaths can also produce breakthroughs that demand recognition. This practical knowledge compels us to think of people not just as problems or victims, but also as agents of health. It can also help us to better understand the larger systems and policies in which lives actually unfold. A life is lived out and endured regardless of whether it is written off, ostracized, or degraded in the technocratic discourses of the status quo.

When People Comes First emerges from the lessons its authors have learned through sustained engagement with the altered human, institutional, and technological landscapes of disease and health in poor settings today. The book's case studies attend to people's struggles for survival and a future, and also to the larger discourses, structures, and economies that shape life chances—that is, to the ways in which politics matter. As we know from our various experiences in the field, unexpected events happen all the time, and different relations of causality are created as people mobilize, seek resources, and confront the vagaries of the market. Thinking through lives and social fields in transit and the categories that are important in human experience can contribute to making global health sciences more realistic and, we hope, more relevant and accountable to those in need.

An Empirical Lantern

This book is the result of a workshop exploring the entanglements of people, disease, health policies, and market dynamics in the present day. The workshop was held at Princeton University in the spring of 2010, and conversations about the chapters have continued online and in face-to-face discussions. The book's contributors work in a variety of academic, activist, and nongovernmental organizations, and the chapters draw from

archival, multisited, and long-term field research, and from professional and consultancy work in the fields of development, international health, and human rights.

We all share an intellectual curiosity and sensibility that privileges ethnographic approaches: charting the lives of individuals and institutions over time and chronicling people's points of view and their varied interpretations of their conditions, all the while denaturalizing operational categories and illuminating the concrete ways in which meso- and macro-level actors impinge on local worlds and become part of global orders, if only transiently. Attending to the omnipresence of social relations and humbly aware of our own situatedness as researchers, we strive to produce nuanced portraits of people, experts, institutions, and situations. This approach also entails comparing phenomena across regions and different analytical points of view; historicizing social processes and recognizing that they are embodied and marked by time; and probing established social theory and striving to create alternative figures of thought. While we value multidisciplinary collaboration in the production of knowledge relevant for public debate and policy, we acknowledge unknowns, the limitations of expert knowledge-making, and an inexhaustible richness at the core of the people we learn from.

Several of us teach courses in global health, medical anthropology, research methods, and the social studies of science and technology. We are all committed to addressing, in our teaching, pressing sociomedical realities. Some of us are helping to launch global health programs and to internationalize education in our universities. As we reflect on the gaps between technical know-how and health outcomes, we are also creating pedagogical pathways through which this generation's overwhelming interest and on-the-ground involvement in global health can be harnessed toward a deepened understanding and meaningful action. We share a healthy skepticism of established hierarchies of knowledge-making, recognizing that innovation can come from surprising places.

We advocate "thinking-in-cases" (Geertz 2007:214). Much global health scholarship is invested in developing models—more or less hypothetical—of optimal interventions, and in identifying and evaluating programs that supposedly "work," and that might therefore be replicated or scaled up across a range of often widely divergent social contexts and geographic locations (Biehl 2007; Cueto 2007; Stepan 2011). Against

the dominant epistemic and political modes that enable these operations, *When People Come First* offers ethnographic case studies as an alternative heuristic. The form of the case brings granular ethnographic evidence to the forefront of analysis and enables analogical thinking. Close attention to particular realities on the ground and to the metrics in which they are cast highlights the productive and uneasy coexistence between global health systems design and the alternative models people craft for "engaging the real . . . worlding the world" (Geertz 2007:222).

Each contributor has chosen a specific problem in global heath as his or her focus of inquiry. And each case is representative of a broader phenomenon or a slice of reality that can, in being studied and described, provide a ground for social critique. The case becomes a means whereby both the researcher and the reader gain a sharpened understanding of why particular outcomes emerge or what determines the plasticity of a given reality. This in turn allows problems and questions to be reframed in concrete terms, illuminating the entanglements between systems and human experiences. The written case—a condensed ethnography of sorts—is a way of interrogating evidentiary practices with an eye to what is at stake, not just for patients and other kinds of beneficiaries, but for all the actors involved in the enterprise of health and care.

The book's case studies are drawn from field research involving state and nongovernmental agencies, public-private partnerships, and clinics and communities in Brazil, Chile, the Caribbean, South Africa, Botswana, Ghana, Mozambique, Uganda, and India. Cases are indices of key problematics in global health, but they by no means exhaust the field. They tackle issues such as the possibilities and limits of technology-centered approaches to disease control and eradication, the migration of evidence-based medicine into cost-effective global health policy, the moral economy of vulnerability, and the politics of global health knowledge. Cases also examine how massive treatment rollouts, specifically in response to HIV/AIDS, impact care, health systems, and well-being in resource-poor contexts; the work of nongovernmental organizations on neglected tropical diseases; and the lack of systematic attention to noncommunicable and chronic conditions, such as cancer and mental illness. A final set of cases considers market-based solutions to tuberculosis treatment; the emerging science of global chronic disease care; and how the demand for pharmaceuticals as a human right, as in Janira's case, blurs the border between the

clinic and the court, forcing us to consider the limits of reigning concepts of health and quality of care.

If this book has a bias, it is against a too uniform and unilateral diagnosis. As we chronicle in our works, disease is multilayered and multiply determined, people are plural beings and not reducible to populations, and local realities still very much frame, constrain, and orient interventions, be they vertical or diagonal. The agency of local actors is not limited to their blind acceptance or refusal of whatever form of knowledge, technology, or care is provided by extralocal interests. 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.

We identify with the humanism and critique of economist Albert O. Hirschman, who wrote: "I have always had a certain dislike for general principles and abstract prescriptions. I think it is necessary to have an 'empirical lantern' or a 'visit with the patient' before being able to understand what is wrong with him. I know well that the social world is most variable, in continuous change, that there are no permanent laws" (1998:88). Our goal is to advance methodological and analytical frameworks that focus on people and the dynamism of social fields. We explore on-the-ground involvements that address the successes and failures of health efforts, the politics of control *and* nonintervention, the effects of heterogeneity, the primacy of the personal and the role of the interpersonal, and, finally, human inventiveness in the face of impossible choices and even untreated pain.

The human populations that constitute the subjects of health and development plans are not just the source of problems or so-called cultural obstacles. Their experiential and practical knowledge, all too readily dismissed by the champions of quick technical fixes and measurable, generalizable results, can transform paradigms and may well provide the keys to effective solutions. At stake is the development of institutional capacities that go beyond the repetition of history and help to defend, in Hirschman's words, "the right to a nonprojected future as one of the truly inalienable rights of every person and nation" (1971:37).

We have organized the essays in the book under three general headings: *Evidence*, *Interventions*, and *Markets*. The first set of essays (by Cueto, Adams, Amon, and Fassin) traces specific global health institutions, epistemes, and programs to their historical, political, economic, and disciplinary

roots. The second set (by Reynolds Whyte and colleagues, Pfeiffer, Livingston, and Moran-Thomas) examines how global health interventions (various and piecemeal and often tied to neoliberal principles and strategies) become part and parcel of public health landscapes and life chances in resource-poor settings. Finally, a third set of essays (by Ecks and Harper, Han, Whitmarsh, and Biehl and Petryna) explores the legal, political, social, and medical realities that accompany the expansion of therapeutic markets and their encroachment in public health.

At the opening of each section, we provide an overview, reflecting on the central themes of each contribution and how it fits into the broader scheme of emerging global health regimes. We also highlight the conceptual importance of each case study and the insight that emerges through its interplay with other cases in the section and in the book as a whole. The afterword (by Fischer) brings the book's main findings to bear on new frontiers in the life sciences.

In attending to the implementation of policies and their embodied responses, the book examines the value systems undergirding incentives, expertise, technologies, measurements, and outcomes. In the process, models of causality and claims of success are scrutinized, and new possibilities for research, policy, and care are brought into view. What or who must be valued in order for knowledge to count as global health science, and what or who remains subjacent or unaddressed? What forms of patienthood and political belonging take shape when new medical technologies are deployed via global health interventions? How can donors and governments be held accountable in the long run, especially in financially volatile times? How can human rights and equity concerns be integrated into global health research and policy? These unanticipated problems and questions have to be addressed now, as lifesaving imperatives are being converted into pharmaceutical and geopolitical capital.

People's everyday struggles and interpersonal dynamics have a way of eluding expert projections and short-lived experimental approaches. The task of the social sciences and humanities in the field of global health is to break through these projections (Whitmarsh, this volume) and to produce different kinds of evidence as we approach bold challenges such as 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 (Biehl and Petryna, this volume).

A historical and critical assessment of global health knowledge and tools combined with dedicated ethnographic research is a vital antidote to the quick theoretical fix that has taken its place in our culture alongside the quick technical fix. For the contributors to this book, people come first. Upholding the right to microanalysis, our chapters bring into view the fields and ideas that people invent and live by: call it contrapuntal knowledge. This respect for people, their travails and aspirations—combined with attention to how health policies are put together, take institutional hold, and function in the messiness of idiosyncratic human milieus—makes a great deal of difference in the kind of knowledge we produce.

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

In making these peopled fields—always on the verge of disappearing from view—public, the authors of *When People Come First* want to elicit a different sense of what might be possible. As Hirschman writes, "In all these matters I would suggest a little more reverence for life, a little less straitjacketing of the future, a little more allowance for the unexpected—and a little less wishful thinking" (1970:338).

Ethnography in Global Health

Ethnographic evidence consistently *dies* within the dominant conceptual paradigms of global health. The multiplicity of problems ethnography uncovers has nowhere to live in the numerical counting of drugs delivered, in the recording of dire (and often faulty) mortality statistics, and in the biased selectivity of randomized experiments. In an atmosphere that gives its first allegiance to quantifiable, volume-based audits or replicable sci-

entific knowledge, ethnographic evidence is readily seen as anecdotal and exceptional, unreliable on account of its granularity or the wiliness of its subjects.

Yet, to make the case, we need a human story. To draw public attention, to politicize a cause, to enlist donors, to name and shame, to justify sweeping ideas and large-scale interventions, nothing seems to work better than a compelling story of crisis. The call to intervene is strongest when it evokes empathy for a particular human need. As anthropologists have painstakingly noted, this humanitarian storytelling is quite selective. An unattended-to inequality of lives is at the core of a Western moral economy in which an ethics of suffering and compassion freeze-frames people and compromises a politics of rights and social justice (Fassin 2011; Redfield 2005; Bornstein and Redfield 2011; Feldman and Ticktin 2010; James 2010; Nguyen 2010).

With our empirical lanterns, we see people refusing to be stratified out of existence and trying to be singularized out of the molds of abandonment, salvation, or rescue into which they are cast. The fine-grained ethnographic excesses of lives and stories are often smoothed over or averaged out by coarse-grained statistics and plans. Ethnographic granularity impedes generalizable knowledge, so the official story line goes. Our view, to the contrary, is that ethnography often debunks generalized knowledge, if only retrospectively or too late. The ethnographic, we argue, offers a sharper resolution of how things are, what sustains their intractability, and how they might be otherwise. People's practices of survival and inquiry challenge the analytical forms we bring to the field, forcing us to articulate more experience-near and immediately relevant conceptual work. How to operationalize ethnographic knowledge, and whether this move compromises what can and cannot be asked in the field, is a crucial and enduring question.

Consider the widely cited study by economists Edward Miguel and Michael Kremer (2004) 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 commenta-

tors suspected that families who had not benefited from treatment during the study would very happily adopt this new technology.

But Kremer and Miguel observed a puzzling turn of events after the trial ended and when they followed a group of families outside the original cohort (2007). 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 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 their strict methodological imperatives, global health experts often sacrifice 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. How to account for persons in the context of their homes and relationships, and how to involve local communities in the very design and implementation of feasible (rather than technology-enamored) interventions, are 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 of present pragmatics?

In this book we think of ethnography as an early warning system. People on the ground recognize what's troubling them. And it is somewhere in the middle of their social lives that ethnographic work always

begins. Ethnographers 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. Life stories do not simply begin and end. They are stories of transformation, linking the present to the past and to a possible future.

The argument that ethnography is not replicable tends to solidify a technocratic monopoly on truth and, really, misses the point of what ethnographers can convey. The simple fact that we are interested in particularities, contexts, awkward scales, and even the virtual, does not make the work of ethnographers any less rigorous. On the contrary, it raises the bar. The complex social realities of "target populations" and the midlevel actors on whom the burden of implementation lies beg for analytic frameworks that weave them together, and for innovative genres that will allow people-centered evidence to add up, to travel, and to *matter* publicly and comparatively.

When People Come First provides a place where ethnographic evidence can live and expand without the demands and constraints of hegemonic modes of truth-making and evaluation. Against the taken-for-granted and obvious, the book's case studies problematize the ways in which global health initiatives work or fall short. They attend to the altered landscapes left behind after programs scale up or down or move on and elicit how people go on with their lives and imagine alternatives. Ethnographic cases untangle people from their shadow realities and representations, capturing, for a moment and over time, institutional designs, diseases-in-motion, and survival, implicated as these are in scarcity, politics, technology, and money. Taken together, these accounts affirm the urgency of a crosscutting framework that integrates health, development, and social justice. 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 the deep challenges the world faces and expands our vision of the future of global communities.

There is no universal formula for relevance, and ethnographic research should not be valued or discarded solely on the basis of its immediate utility. The realities social scientists unearth are often urgent, but they are also historically deep and carry the potential of discernment that is so critical for movement forward. In our work, we must continue to chal-

lenge orthodoxies of all kinds and seek original ways to communicate the categories that are significant in human experience, even when the powers that be dismiss this as anecdotal, nongeneralizable, and inherently impractical—and we must seek ways of translating and communicating that experience so as to compel the worlds of science, policy, and human rights to reckon with it. If this kind of engagement leads to the subtraction of quick-fix theories and policies, and to the advent of new ways of theorizing and reconstructing worlds, so much the better.

Notes

1. Orixás are spirits or deities, manifestations of God in the Yoruba religious system, which appear in Afro-Brazilian religions such as Candomblé and Umbanda.

2. See http://nyudri.org/initiatives/deaton-v-banerjee/.

3. See http://www.hbs.edu/rhc/global_health.html.

4. See http://www.pih.org/pages/who-we-are/.