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## Overview

A critical ethnography of global health must attend to the granular ways in which interventions (multiple and fragmentary and tied to neoliberal principles and strategies) become part and parcel of public health landscapes and social relations in resource-poor settings. The chapter by Susan Reynolds Whyte, Michael Whyte, Lotte Meinert, and Jenipher Twebaze focuses on the micropolitics of HIV/AIDS care in Uganda—the ways in which social networks are produced, expanded, and cultivated in efforts to access health programs and the associated benefits they confer—and how the roles of the state and ideas of political belonging are being transformed by global health initiatives.

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

Reynolds Whyte and colleagues describe those who benefit from these health initiatives as “clients,” a felicitous term that can be understood in two contrasting and interestingly supplemental senses. One, which harks

back to Uganda's political past, points to the ways in which these persons, who enjoy little power or resources other than those afforded through social networking, must seek out patrons better positioned within the world of health care in order to gain access for themselves. The other meaning of "client" echoes the voices of neoliberalism, which guide much of global health investment, and refers to persons as clients or consumers of a product (in this case health care), thereby establishing a contractual obligation between them and the providers of the product. Here health is not a "right" available to all, but a service open to those in the know, and health care interventions increasingly become a survival mechanism that extends beyond the medical and includes labor, food, and education.

Moreover, good clients are expected to be faithful to a program and the services it provides and to recruit others into it, contributing to its growth. An economy of loyalties and of financial, institutional, and medical support is thus created. In this "therapeutic clientship" (standing in for citizenship and governance), the HIV-positive Ugandans can, as much as the funding-dependent NGOs that offer them drugs and care, negotiate and establish their positions by cultivating and extending social relations.

If Vincanne Adams's analysis describes a movement toward an epistemology of health that rejects social positionality and institutional and historical context as sources of knowledge, the chapter by Reynolds Whyte and colleagues demonstrates the ways in which national and international political contexts are experienced locally—and how it is precisely from this base of locality that these politics can be realized, by providing an irreducible logic that is more complex, meaningful, and significant extralocally than what is allowed in other epistemic regimes. Their analysis offers a way to approach persons not exclusively as patients, or as outcomes or failures of interventions, but rather as embedded actors, moving within complexly intertwined social networks. It provides a point of entry to assess the micropolitics in which health and health care are brokered, accessed, and transformed—and it also provides hope that a way will be found to include those who have been left out.

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Despite the deluge of monies and organizations flowing into resource-poor settings worldwide, local health systems continue to be woefully inadequate. Many times, donors' myopic insistence on funding vertical

programs and bringing change from the outside comes at the expense of the public sector. In his chapter, James Pfeiffer explores the system of health care that has emerged in postsocialist, democratizing Mozambique after the arrival of the US President's Emergency Plan for AIDS Relief (PEPFAR) aid and looks into the gaps that the Plan's dogged rejection of public-sector expenditures creates for those seeking anti-retroviral treatment. We can locate such rejection of public-sector expenditures within the context of structural adjustment policies and the politics that guide—and gird—the flow of resources from rich to poor countries.

The result of this divestment in the public sector is the creation of a fractured and uneven health system in which state-of-the-art facilities for HIV/AIDS testing and treatment coexist with all-but-dilapidated state hospitals, where wealthy donors create showcase clinics in one region while the clinics in a neighboring region atrophy and their long-term sustainability is always in question. In this makeshift system, the focus is squarely at the level of the clinic, where interventions can be followed and their results measured. Attempts to make assessments at a national level are left by the wayside and the myriad social factors that can contribute to positive health outcomes are by and large ignored (or, if acknowledged, not acted on). Health workers are also in short supply outside the spheres dominated by NGOs, because limits are set on wages at public institutions, and because NGOs can afford to pay them more to provide more specialized services.

The workings of international political economy once again become palpable at the local level, as do the fraught and complicated interactions between international donors and host countries. Global health interventions leave people behind, not only by limiting access to the services provided, but also by producing a parallel system of care and governance that undermines other avenues for care that might take into account broader systemic factors. For example, Pfeiffer shows how a poor national infrastructure and terrible economic hardships intersect with everyday patterns of sociality to hinder HIV/AIDS treatment adherence, especially among pregnant women. Pregnant women are at higher risk of being “lost to follow up” (LTFU) because they must confront a number of unique restrictions and risk-laden choices that make treatment access perilous and adherence highly problematic. Faced with hunger, difficulties in accessing

treatment, the severe side effects of medication, and the stigma associated with AIDS, too many pregnant women drop out of programs.

Pfeiffer's work draws attention to two important facets of a critical ethnography of global health. First, ethnographic accounts allow for a telling juxtaposition of scales (ranging geographically, from a perspective at the level of the patient and the community to a much broader view that reveals the systemic flaws of the international financial impositions in Mozambique; and in time, from the country's socialist past to its market-fundamentalist present). Ethnography lays bare how interventions are woven into larger spheres of political economy and points to the impact of structural and economic factors on treatment and disease.

Second, certain statistical and quantitative data can be productively reconciled with qualitative ethnographic approaches. If "lost to follow up," for example, is viewed not just as a metric for judging the success or failure of a given intervention but is instead used as a starting point for looking beyond the limits such an evaluation imposes and into the confluence of other factors (national economic systems and infrastructure, for instance) on the lives of the HIV-positive, then new ways of looking at care and accountability might result. Ethnographic evidence can thus be put to use in developing different plans of action.

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In her ethnographic work, Julie Livingston documents the emerging epidemic of cancer in Botswana, and the social capillaries and ad hoc forces of improvisation through which oncological medicine is forged and pain is managed in a context of scarcity. This phenomenon today unfolds against the backdrop of the country's much publicized universal HIV/AIDS treatment program funded by the government in partnership with the pharmaceutical giant Merck and the Gates Foundation. Patients are now surviving their HIV disease only to find themselves grappling with viral-associated cancers facilitated by their history of immunosuppression. Challenging the global health imaginations of medical need that channel care resources disproportionately toward infectious disease, Livingston asks, "How and why does biomedicine proceed in Africa with so little palliation and so much compliance?"

Cancer is something that happens between people and amid institutional efforts to treat it or ignore it. In Botswana's lone oncology ward, where most people come in driven by the intensity of their pain, and where efforts are directed primarily toward its relief and not toward its treatment, this means recognizing that the social existence of the disease and the experience of pain are bound to the material, cultural, and biomedical milieu in which they arise. Pain is thus intimately social and socializable: it mediates relationships, scarcities, health policies, and medical protocols, creating spaces for care and palliation as well as disregard.

Despite the fact that pain is central to life on the cancer ward, opiates are rarely given to those who need them. Lack of access to morphine is the central reason for this. Stocks are difficult to maintain and, due to fears of the creation of a black market in highly addictive drugs, their circulation is tightly regulated to the point of making their prescription, even within the hospital, an onerous task. Moreover, African medical culture in general does not put a very high premium on the relief of pain. As an outgrowth of British colonial medicine, and in its current form as a node for vertical international interventions, health care in Botswana has traditionally operated under the assumption that it is a "zero-sum enterprise."

In such a system, patient comfort is not a priority. Efforts are largely directed elsewhere (as Adams, Reynolds Whyte and colleagues, Pfeiffer, and Moran-Thomas also show in their chapters), oriented toward the demonstration of successful delivery of lifesaving drugs and implementations of large-scale programs. Pain management is often outside the metrics of success of such interventions and thus becomes invisible in a system with very specific evidentiary demands. Moreover, doctors and nurses lack the tools to measure and treat pain medically. These are the systemic silences that muffle the social experience of pain in Botswana and through which palliation can appear only as a frill, inaccessible and unworthy of attention from national and international decision-makers.

Seen ethnographically, biomedicine is inherently a midlevel trial-and-error enterprise—as much a global system of thought and technology as it is a localized and improvised practice. Livingston's own work seeks to wield ethnography as a species of salve through which to socialize pain and enact care. Her descriptions—vivid, difficult, and often also funny—dramatize the physical suffering of cancer patients and their caregivers'

efforts to provide relief. They draw the reader into this network of care, demanding our empathy as a prerequisite to analysis. Empathy alone, certainly, offers no guarantee of any improvements, but it is an alternative to raising our hands in defeat, dismissing the pain of others as epistemologically inaccessible and impervious to action. By arguing that pain is itself a social language that must be learned, Livingston emphasizes the very human and humane ways in which people deal with anxiety and duress in the absence of painkillers, while at the same time signaling that the failures of palliation, both interpersonally and institutionally, are also failures in communication, flaws in our ability to see beyond the envelope of our own skin and imagine life in others.

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Even the most magical of bullets can only succeed by taking into account the nuances of micropolitics and of local notions of disease causation. Technology adoption strategies are unruly. Understanding this on-the-ground unruliness requires acknowledging the “others” among and between us, as well as the importance of meaning-making in any intervention take-up. In her chapter, Amy Moran-Thomas takes the program for the eradication of the guinea worm in northern Ghana as a launching point from which to examine the different epistemologies at work in global health initiatives. The ethnographer teases out the ways in which the local landscape of health care is changed and imagined through such initiatives, and the ways in which people actively engage with them, transforming biology and magic into heuristics for one another.

Diseases have stories to tell. In Moran-Thomas’s case, the eradication of guinea worm becomes the stage for the encounter (and confrontation) between multiple histories of medicine and the theories of causality and self, and beliefs in the power of things in which these histories are entrenched. In a social context where many understand themselves as inhabited and inhabitable by other selves, this understanding encompasses the guinea worm as well. Western epidemiology, on the other hand, posits a population as the subject and touchstone of health and views the guinea worm as a parasite that enters an individual body through the consumption of infected crustaceans living in shared bodies of water—that is, as an alien agent and harbinger of disease and economic collapse.

Internationally, the parasite has offered a political rallying point to organizations that seek to make their mark in the world of development. Because of its graphic visibility, the worm can be mustered as a powerful symbol of poverty and decay (even when there are other, far more fatal diseases in the region) and an objectifiable target for interventions. Here we see symptoms of a semiotics of medicine overtaking the pragmatics of care in global health policy: targeted people often do not use water filters, or use them in ways that were not originally intended; filters are introduced in the absence of a longstanding contact between doctors and their patients that could enable an understanding of biomedical explanations for the disease; doctors and campaign workers express their puzzlement at the locals' refusal to comply with their treatment, while the latter are often bewildered by and suspicious of the formers' intentions, their methods, and, certainly, their perplexity.

Here, as elsewhere, the metrics of delivery often eclipse people's own assessments of the value of interventions. As Moran-Thomas shows, the physical objects used in these interventions—these magic bullets—can become integrated into local structures of political and religious power. To possess a guinea worm filter or a malaria bednet is to be aligned with the privilege of the foreigners, a perceived status that can be reinforced and put to use by programs that seek to hire persons well positioned within villages, who often articulate their roles through the language of traditional authority. Thus, not only do such interventions reinforce existing power differences, but they can expand the language in which social distinctions are expressed or contested. Moreover, the requirement that locals comply with a treatment also opens the door for them to voice other needs and desires and to be recognized as other kinds of subjects.

Moran-Thomas's analysis casts a refractive light on the world of Western biomedicine and global health, exploring the myths that orient it and the ways in which local magic can sustain it. As the anthropologist tacks between one person's fictions and the other's realities, she sheds light on the ways in which discourses and actions are produced and transformed in a field that, despite its insistence on vertical approaches, is alive with voices and cosmologies that regularly collide with one another.

—*João Biehl and Adriana Petryna*