What Can Critical Medical Anthropology Contribute to Global Health?
A Health Systems Perspective

The flow of international aid from wealthier to poorer countries has increased dramatically over the last decade. This is attributable in part to the efforts of health activists, including medical anthropologists, who have rendered bare the realities of health disparities and human suffering. We are now facing an unprecedented moment in the history of global health, in which infectious diseases such as HIV/AIDS, malaria, and tuberculosis are no longer peripheral concerns but primary targets of bilateral aid programs, philanthropy, and research. Emergent health problems range from antibiotic resistance to tobacco use to SARS and avian flu to the flow of health professionals from developing to developed countries. These problems demand global solutions, challenge the internal sovereignty of nation states, and involve new sets of actors, networks, partnerships, and transnational health initiatives.

There have been dramatic increases in funding from the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR); the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Gates Foundation; the Doris Duke Charitable Foundation; the Clinton Foundation; and myriad other philanthropies dedicated to health problems in the developing world, transforming the way in which high-priority health problems are being addressed, in what has been termed the politics of the possible. As engaged medical anthropologists, we have fought to keep the health and health care problems of the world’s poor on the radar screen of wealthier nations by calling attention to issues involving both social justice and enlightened self-interest in the face of these mounting crises. We celebrate the recent emphasis on funding global health initiatives, yet at the same time we remain alert to major concerns related to governance, oversight, and the impact of high-profile public health efforts on state health care systems.

As social scientists, we are sensitive to deepening divisions in the global health community over the way forward, in addition to the manner in which injecting massive resources into vertical health interventions deflects attention away from the management of other health problems. We are also sensitive to recent trends that threaten to undermine the remarkable potential of this historic moment. We are concerned by reports of wasteful spending, poor planning, and uncoordinated
project development, which suggest a growing anarchy on the ground in global health efforts. This state of anarchy is fueled by an avalanche of resources landing on neglected health systems facing workforce shortages and crumbling infrastructure, unprepared to manage this largesse, having been weakened by two decades of macroeconomic reforms (known as structural adjustment programs or SAPs) promoted by the World Bank and International Monetary Fund (IMF), and sometimes referred to as the “Washington Consensus.” SAPs, recently repackaged euphemistically as “Poverty Reduction Strategy Papers” or PRSPs, have emphasized major cutbacks in public sector spending, including health and education, while promoting economic privatization to stimulate economic growth and repay debt.

This promotion of the private sector while, public services atrophied from underinvestment, left many national health systems in a shambles, especially in Africa but also in other resource-poor countries. Training institutions have been starved, health workforces cut back, salaries reduced, management systems undermined, and some specific services either scaled back or eliminated. NGOs, often cast as private sector substitutes for public services, have proliferated as global aid flows expand. All too often, national health systems have been overcome by new NGO and donor pet projects, growing donor demands, and heightened expectations. As private health services and NGOs have multiplied, they have often contributed to the “brain drain” of health workers from public systems. Beyond the health sector, the push for privatization and free market reforms has in some cases stimulated economic growth but has also deepened social inequality and insecurity. The removal of price controls, food subsidies, and other safety nets has had important effects on health that extend beyond the health sector itself.

There is growing recognition of the urgent need to build or rebuild health systems, yet the increasing flow of aid from donors continues to promote narrow interventions and specific projects. This “stove-piping” of projects creates additional stress on government health infrastructures while providing little in the way of institution building. The debate continues over the best role for the private sector and NGOs in providing health services in poor countries, amid signs that the Washington Consensus is in retreat. As aid flows increase dramatically each year, there are questions about whether these funds should be channeled predominantly to public-sector systems, with the private sector playing a supporting role, or diverted to myriad NGO, donor, and philanthropic projects. These levels of aid may not last and this window of opportunity may close soon, making such concerns all the more urgent. One positive development is the move, mainly by non-U.S. aid agencies, to pool funds and provide directly to the public sector (Ministries of Health) to support the development of a country’s health system infrastructure. This is the case with Canadian and Swedish bilateral development agencies in Zambia and Mozambique, for example. The problem is trying to move USAID, PEPFAR, the Gates Foundation, and other donor agenda setters in similar directions.

The question of governance is also important. A central concern is finding the best public–private sector balance in bringing quality services equitably and universally to poor populations. Some contend that new resources can most effectively be spent by avoiding inefficient government bureaucracies and channeled instead to NGOs or private practitioners. Others see a strong, adequately funded, national public
sector health system as the only way to guarantee delivery of basic primary health care services to the poor. Some argue that vertical funding for specific diseases and health problems can be most effective when it is spent on basic health system strengthening, while others maintain that progress on specific diseases will only be made if they are tackled through special efforts, often led by NGOs, universities, and other international actors. And who should coordinate the activities of this amalgam of agencies in individual countries: the public sector, donors, or new coordinating bodies? The perennial debates over user fees, "cost effectiveness," and sustainability are a backdrop to these fundamental dilemmas.

Finally, it is increasingly clear that global health is deeply intertwined with matters of international relations. No longer can we focus only on the health sector, expecting that the basic tenets of public health action—advocacy and collaboration—will have an impact when it is the broader, political-economic self-interests of powerful nation-states, especially around such issues as trade and security, that often have the most pernicious effects. Practicing global health will increasingly demand some political sophistication, particularly in terms of arguing the health implications of trade policies, the role of health in human security, and the importance of health as a human right. As anthropologist Susan Erikson (2008) points out in the Lancet, global health realities are at odds with the prevailing international public health paradigm. International public health professionals compound this problem if they have too little understanding of the mindsets, histories, and concomitant power structures behind foreign policy and international affairs. Effective global health action thus means getting political.

As a special interest group of the Society for Medical Anthropology (SMA), we are committed to bringing a critical perspective to global health that encompasses factors that contribute to the maldistribution of disease, health care inequities, and problems in health care management, within a biopolitical environment where hard choices have to be made. In the anthropologists' traditional roles as culture brokers, we are often better positioned, as both health workers and observers, than other public health professionals to document and contextualize the effectiveness of health services as they impact people’s lives. Policymakers from Washington, DC, to Seattle rarely have experience with health systems and services delivery in real-world settings in poor countries. Wide-reaching policy decisions, such as the promotion of private health care, are often made on the basis of personal or institutional ideology, abstracted data, and conventional wisdom or bias. Community-based and health system-based ethnographies of health care and health services can act as powerful antidotes or corrective to this conventional wisdom and can help shift how we might evaluate the effectiveness of competing strategies. They can also provide insights into how NGO willingness to engage in the critique of transnational programs is being influenced by administrative procedures and audits that foster compliance and dependency.

Our research can provide vital information on environments of risk that contribute to individual diseases as well as syndemics (sets of interactive problems). We can provide insight into lines of communication and trust that mobilize networks of people during health crises and disasters, and into how health care systems work when subject to the exigencies of local power relations. Central to the mission of anthropology is the study of social organization and the distribution of resources.
Medical anthropologists can provide insights into the impact of poverty and economic insecurity on patterns of social support and mutual assistance; we can provide insights into how health policy governing medical assistance impacts social relations and health citizenship. Anthropologists are in a good position to document the impact of short-term but severe and extended periods of illness on households as well as individuals, providing an understanding of the burden of illness beyond body counts of the afflicted or DALYs.

A major challenge that we envisage for anthropologists is how to best present our findings to key stakeholders in the global health arena such that our arguments are viewed as compelling, timely, and well balanced. Becoming more effective will require translational research attentive to the audiences we are trying to reach. It will also mean becoming increasingly political in our advocacy. We will also need to become more sophisticated when “studying up” and carrying out multisite ethnographies of multiple stakeholders in health systems, donor communities, and emerging global health networks. By illuminating the social processes, power relations, development culture, and discourses that drive the global health enterprise, medical anthropologists can contribute in valuable ways to health diplomacy and advocacy efforts, as well as on-the-ground transdisciplinary problem solving. We can help ensure that the evidence base that frames global health debates is inclusive and represents multiple dimensions of the human experience, including the voices of those whose lives are affected by global processes. We can take a stand that “speaks truth to power” in the sense written about by the Quakers in the 18th century. They rightly recognized that three sets of stakeholders and centers of power needed to be addressed simultaneously: those who hold high places in our national life and bear the terrible responsibility of making decisions for war or peace, care providers, and the populace who are the final reservoir of power in any country and whose values and expectations set the limits for those who exercise authority.

Note

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Recommended Reading

Benatar, Solomon R.

Brown, Theodor M., Marcos Cueto, and Elizabeth Fee

Buse, Kent, and Kelley Lee
2005 Business and Global Health Governance. Discussion Paper No. 5. London: London School of Hygiene and Tropical Medicine, Centre on Global Change and Health.
Chikanda, Abel

Cooper, Richard A., and Linda H. Aiken

Erikson, Susan L.

Farmer, Paul


Fidler, David


Garrett, Laurie

Gloyd, S.

Hein, Wolfgang, and Lars Kohlmark

Kamat, Sanjeeta


Kickbusch, Ilona

Kim, Jim Yong, Joyce V. Mullen, Alec Irwin, and John Gershman, eds.

Kirigia, Joses Muthuri, Akpa Raphael Ghary, Lenity Kainyu Muthuri, Jennifer Nyoni, and Anthony Seddoh

Lee, Kelley
McCoy, David, Sara Bennett, Sophie Witter, Bob Pond, Brook Baker, Jeff Gow, Sudeep Chand, Tim Ensor, and Barbara McPake
McCoy, David, Mickey Chopra, Rene Loewenson, Jean-Marion Aitken, Thabale Ngulube, Adamson Muula, Sunanda Ray, Tendai Kureyi, Petrida Ijumba, and Mike Roswon
Nichter, Mark
Ooms, Gorik, Wim Van Damme, and Marleen Temmerman
Ottaway, Marina
Pfeiffer, James
Schieber, George J., Pablo Gottret, Lisa K. Fleisher, and Adam A. Lei
Shiffman, Jeremy
Singer, Merill, and Scott Clair
Swidler, Ann
Travis, Phyllida, Sara Bennett, Andy Haines, Tikki Pang, Zulfiqar Bhutta, Adnan A. Hyder, Nancy R. Pielmeier, Anne Mills, and Timothy Evans