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► **To cite this version:**

Jean-Paul Gaudillière, Andrew McDowell, Claire Beaudevin, Claudia Lang. Introduction: Health Universalism and the Health of Others. Jean-Paul Gaudillière; Andrew McDowell; Claudia Lang; Claire Beaudevin. Global Health for All. Knowledge, Politics, and Practices, Rutgers University Press, pp.5-27, 2022. hal-03694393

HAL Id: hal-03694393

<https://hal.science/hal-03694393v1>

Submitted on 26 Jul 2024

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Introduction

Health Universalism and the Health of Others

Jean-Paul Gaudillière, Andrew McDowell, Claire Beaudevin, and Claudia Lang

A compact building sits in a walled compound a few meters off a north-south artery that connects Mumbai's crowded western suburbs. This unassuming municipal tuberculosis (TB) clinic has been a buoy on the shifting seas of twentieth- and twenty-first-century health interventions. Though dusty, the clinic has been a locus of change and continuity in the entanglement of health, knowledge, and governance over the past one hundred years. A brief float with it on the currents of time introduces the central questions of this book.

In the early 1960s, just over a decade after India's independence, Mumbai's municipal government constructed this five-room building to be one of the city's six TB clinics. It was an example of the many infrastructural projects built and staffed as part of the decolonization process. Yet, since its inception, the clinic has been a site of care within global flows of medical ideas, materials, and people. Its construction as an outpost of care and governance within a rapidly expanding suburban space highlights health's centrality to postcolonial projects of internationalism, bilateral cooperation for development, and the new world order of global politics.

Starting at its founding and until the 1990s, the clinic served Mumbai's northwestern region and oversaw the treatment of some of the millions of Indians affected by TB. It housed a doctor, nurses, and technicians, as well as drugs, microscopes, and an x-ray machine. Physicians and nurses from across the city's hospitals and dispensaries referred patients they worried might be afflicted by TB to this particular clinic. Once a patient arrived, the clinician made a diagnosis and provided a month's course of medicine from the clinic's stocks. Health workers sent patients letters at home reminding them to take their medicine and attend monthly appointments. Coordinating treatment, distributing medicines, and caring for people who were spread across one-sixth of the growing city was a challenge, but one faced by many similar clinics across the country.

The TB care available here and throughout India followed a paradigm designed by an interdisciplinary group of Indian, UNESCO, and World Health Organization (WHO) experts at India's National Tuberculosis Institute. This group of experts based their protocol for in-home treatment of TB on a British Medical Research Council trial in Chennai—a city in southern India. This trial, in turn, had scaled up methods designed at a TB clinic in Delhi. The Delhi clinic's work was inspired by care given at a facility in Edinburgh. Already we can see the way flows of global and local knowledge intersected in the creation of the national treatment regime. Ultimately, the group hoped that the treatment program would be a temporary solution until a postcolonial India eradicated the disease through development.

In the early 1990s, however, global health experts began to question the program's efficacy. Epidemiologists worried that India's efforts had produced no documented epidemiological effect after thirty years. As these concerns reached the WHO and other institutions like the World Bank, actors there began to encourage India's minister of health to align the country's TB care with an emerging, standardized, WHO-supported intervention model. The clinic in northwest Mumbai was selected as a site to test the model, and quickly changes began to occur. Mumbai's municipal health authority, which had staffed, managed, and stocked the clinic since its opening, relocated the clinic's physician to make room for a clinician from the municipal TB department.

Funded by the bilateral agreement with Sweden that had earlier paid for TB drugs, and supervised by India's Ministry of Health and the WHO, the project carved out a small part of the clinic's catchment area to test a similar global health program within the Indian health system. For five years the clinic simultaneously ran two TB programs, the Indian program and the emerging global one. While India's existing system relied on patients' perceived needs, flexible diagnostic criteria, and monthly distribution of medicine, the new global health paradigm was characterized by urgency, intensified documentation, surveillance of patients as they took their medicine every other day at a health center, house-to-house patient follow-up, statistical measures of efficiency, and standardized drugs and diagnostic regimens. Eventually, the World Bank funded an expansion of this new program, and the clinic's remaining seven TB wards were decentralized. From 1997 onward, any municipal health center could provide TB treatment and any clinician was authorized to diagnose TB using a standard diagnostic protocol. Patients no longer needed to visit a specialized clinic; instead, they could get TB care from health workers in

their neighborhoods. By 2000, the Mumbai clinic's paint had chipped and its gardens were overgrown. The region's supply of drugs and data flowed through the clinic, but patients rarely visited.

Unsurprisingly, the clinic languished, and in 2010 a local legislator proposed expanding the building and turning it into a TB hospital (Gurav 2011). The city government, however, denied the request, saying that TB was on the decline and there was no need for such a hospital (Banerjee 2012). Just two years later, Mumbai was launched back into the global health spotlight, this time because the city became a hotspot when a nearby private hospital reported several cases of extremely drug-resistant TB bacteria (Udwadia, Amale et al. 2012). Quickly, the Mumbai clinic was transformed into an administrative center housing the area's district TB officer—a technocrat in charge of the management of TB services. By 2019, the clinic had a new coat of paint but the district TB officer has moved. Today, it serves as a laboratory identifying about ten new drug-resistant TB patients each month and provides TB treatment to about a hundred patients. Those with drug-resistant forms of the disease receive a week's worth of medicine. Others receive a month-long course of medicine, as they had thirty years before. But all of them now also get a mobile phone-based treatment adherence system. Today's patients also receive a nutritional supplement or conditional cash transfer and access to a counselor who has a master's degree in social work to help with this multidrug resistant tuberculosis. In addition, each patient is tested for HIV and diabetes before beginning TB treatment. What was once a vertical, disease-specific approach to TB intervention seems to have grown branches. The clinic is once again a node in a larger health apparatus linked to priority diseases, psychosocial support, and new forms of governance through incentives. Each step of the way, the clinic, though a constant site of health intervention, has been deeply changed by global transformations.

This clinic is an example of what we call *health universalism*. Health universalism is a constellation that includes ideas about health's universal possibility, practices of making health universally recognizable and measurable, and discourses on universal human rights. The relations between each of these components has shifted through time. These shifts allow health universalism to encompass our three, often separately studied, domains of research: international health, global health, and health globalization processes. Throughout this book we engage health universalism as an often failed aspiration for human commensurability and ubiquitous

development that grounds and authorizes important ways of knowing and intervening in health at a global scale. Though we take a critical lens on health and other forms of universalism, health universalism is an essential if not unquestionable social fact for the actors we observe, read about, and exchange with.

For historians, this particular clinic's place in health universalism raises a question of periodization. It simultaneously confirms and troubles narratives of a transition from a regime of international health, characterized by national boundaries and bilateral aid, and a model of global health, crowded by nonstate actors who determine priorities and fund health interventions across borders. The clinic shows something else. It suggests that though the 1990s brought significant change, important aspects of previous health interventions continue. This book works through this paradox of continuity and rupture to consider the practices that make global health simultaneously new and deeply marked by a history of infrastructures, markets, and circulations of objects and ideas.

This problem of change and stability strikes anthropologists, too. In more anthropological language, the question of global health and this specific Mumbai clinic is one of event and continuity (Sahlins 1981; Das 1996; Caton 2005). Does a shift in meaning and practice always make an event? Does the pilot project that shifted the way TB care was practiced here, and in India more broadly, constitute an event across other scales? Or does attention to the long process of change in the postcolonial world better situate practice and meaning? *Global Health for All* works through these issues of history and social life as continuity or rupture by carefully tracing the emergence of a global health regime from within a model of international health. Even though we use the term "global health" to describe the current discourse, the book shows that these two paradigms are not entirely separate entities but rather parallel ways of thinking about health.

We define "global health" as an umbrella term created by European and North American organizations working self-consciously to advance health and development on a global scale. Global health is neither a discipline nor a discrete set of practices that scholars can easily delineate. Instead, the term encompasses thirty years of multifaceted and diverse interventions on the health of others, particularly people considered vulnerable and living in "low- and middle-income" countries. Global health is a grand narrative, but one that, in practice, rarely lives up to

proclamations about what it is, does, or will do. Like its constituent parts—medicine, science, governance, globalization, and markets—it operates on multiple levels. Each instantiation of global health—the actors involved, the forms of knowledge produced and mobilized, the targets selected, the tools tested and implemented—is therefore context-specific, locally situated, and bound to time.

Simultaneously, global health, as a powerful field of interventions and practices, is a social, historical, and political construct of the late twentieth century. Its existence has deep roots in the neoliberal project, its agenda, and its constellation of tools. These tools affect the government of lives based on a number of factors: economic discourses of performance and cost-effectiveness; the reinvention of public institutions and state bodies as regulators for markets; and the promotion of individual responsibility and rational investments (i.e., governmentality in health). In other words, we contend that global health is not a mere reflection of epidemiological data or pressing (basic) needs: it is a biopolitics of disease and development.

We make the following arguments. First, understanding global health across time and space requires mapping the entanglements of the field of global health—which is a set of institutions, forms of knowledge and instruments mobilized in programs, and actors who understand themselves as practitioners of global health—and less formal and more varied arenas of health globalization such as circulations of health personnel, patients, or drugs. Second, global health moves across multiple scales. In order to understand how its knowledge, interventions, and practices crosscut levels from the local to the global, it is indispensable to attend to their entanglements and look at the ways in which these scales become contextually relevant and mobilized. Third, global health's practices of knowing and doing are forms of neoliberal rationality and economization that disguise the political processes of technocratic governing and apportioning of collective resources in vocabularies of evidence-based intervention, efficiency, inclusion, and operability. In many but not all of our contexts, the state's role as provider and organizer of health care has been transformed by neoliberal reason and its advocates to render it an implementer of health programs rather than a space for debate about them. Thus, we suggest that local interventions facilitate the spread and standardization of projects, politics, and subjectivities authorized by neoclassical economic concepts of efficiency, competition, and

human capital instead of rights, politics, and public debate. We contextualize the stakes of these arguments by introducing the themes of periodization, scale, standardization, and neoliberalism.

Periodization

Defining historical periods is an important part of a historian's work, and the historiography of international health has produced its own delineation of the path to the regime of global health. The idea that post-1945 international health initiatives belong to three very different moments may not be uncontested, but it has acquired definite currency (Brown, Cueto et al. 2006; Birn 2009; Packard 2016). Scholars thus argue that the emergence of global health signals the end of an exceptional moment, the decades from 1965 to 1985, that had in turn supplanted an earlier moment of postcolonial and postwar reorganization of powers and infrastructures in the 1945–1965 period.

Historians suggest that during the 1960s and 1970s, self-defined Third World countries led and benefited from widespread critiques of colonial legacies and the hegemony of industrialized countries, pushed for alternatives to the international economic order and classical development strategies, and allied with international health experts. Together, they created what became known as the Primary Health Care Strategy, an original form of social medicine for the Global South. Then, the neoliberal reforms of the 1980s and 1990s brought that moment to an end and enabled the rise of global health. Although often viewed as a third period in this tripartite narrative, global health shares many features with the early days of international health. Continuities include a strong endorsement of biomedicine, the priority given to vertical programs targeting infectious disorders, and the decisive role of bilateral aid (from the United States or Scandinavian countries).

Our aim is not to offer an alternative narrative, perhaps stressing, for instance, the novelty of the global health decades with their unprecedented conjunction of actors, targets, tools, and modalities of intervention. Rather than defining a new regime, the book tries to change the granularity of the time line, looking at the juxtaposition between heterogeneous temporalities and between various combinations of change and continuity. We show, for instance, that depending on programs, countries, or collectives observed, what happens within and around the WHO blurs the classical tripartition of the period between 1945 and 2010, revealing decisive continuities through the 1960s and 1970s and the 1990s and 2000s.

Diversifying the lens on change and continuity through time also challenges the narrative of the WHO as a dominant, international, and social-medicine-oriented organization. Even during the 1970s, the years of its most visible influence, the WHO remained a weak institution. By mandate and intention, it did not operate on its own. It relied on a web of collaborations with powerful players like the World Bank or the United States Agency for International Development (USAID), and it was often disconnected from the dynamics of health planning in individual countries. The economization of health issues, a pattern emblematic of the WHO's adaptation to the new international order (Chorev 2012), will thus appear as a new form of prioritization. It is characterized by new tools for evaluating cost and effectiveness, but we show it is also rooted in previous and more political forms of triage that is applied when prioritizing health issues.

Attentiveness to space as well as time does not imply that our chapters avoid any kind of periodization—that is, any attempt at identifying patterns of action and assessing their coalescence in time. Four chronological premises, whose meaning will unfold through the entire book, are essential. First, a major reorganization of international health took place in the 1990s in concert with the neoliberal redefinition of the international economic and political order. This reorganization affected actors, targets, and the tools of intervention. Second, many priorities for integrating health, development, and economic growth that emerged in the 1990s have never become targets of global health investment or intervention. As a consequence, global health shares many characteristics with international health as it existed in the immediate postwar period. Third, the “Third World” has vanished in a world deeply affected by the end of the Cold War and industrial delocalization. As a result, the Global South lost its political and economic influence. Rapidly increasing inequalities within countries and new international hierarchies have emerged—for instance between new global players like China and those who have benefited less from globalization, like most countries in sub-Saharan Africa. Fourth, the 2010s were years of mounting challenges to global health as a domain of action built on the fundamental premise that resources and expertise reside in the Global North while most pressing health problems affect populations in the Global South. The 2009 economic crisis and its cortege of austerity policies, first of all in Europe, have indeed made visible the shared and mounting importance of scarcity and economic triage beyond the usual divide between our health and the health of others. Ten years later, the COVID-19 pandemic has revealed other—even less expected—layers of circulation and convergence with material resources, as well as social and

technical means of intervention imported on a grand scale from Asia into Euro-America as well as Africa.

In other words, rather than offering one single alternative periodization, *Global Health for All* suggests that different time frames are needed to render the multiple ways in which the past of international health is shaping the present of global health.

A Field and What Else?

What is global health as an object of study? Is it a material thing? An obscure creation of the imagination? An empty signifier? If we start from the term itself, we see a fairly recent departure from earlier vocabularies of international health governance. Before the late 1980s, medical and public health literature barely used the term “global health” (Gaudillière 2014a; Weisz, Cambrosio et al. 2017). During the 1990s, however, the term began to spread through articles, editorials, statements, and annual reports as a neologism used by new health actors to describe their work and their goals. It was particularly common in documents emanating from a seemingly new set of actors and institutions, such as the Bill and Melinda Gates Foundation, the Harvard Initiative for Global Health, The Lancet, the Global Fund, the TB Alliance, and the Global Alliance for Vaccines and Immunization (known as Gavi, the Vaccine Alliance), among others.

Global health’s claims for novelty, however, go beyond its name and those organizations described by it. Global health also includes targets and tools designed to consciously differ from what had come before. These new targets were novel diseases, such as HIV/AIDS or multidrug-resistant tuberculosis (MDR-TB), but also an unprecedented rise of noncommunicable diseases including mental health issues. Medical and public health literature endorsing the global health label stresses an unprecedented epidemiological situation in which a burden of chronic disorders is now shared between industrialized countries and large segments of the population in middle- and low-income countries. Proposals and pleas for action also place global health at arm’s length from early developments in international health, particularly programs and strategies now perceived to be failed or obsolete, such as primary health care or centralized, state-run interventions. Champions of global health stress the need for participation and individual

empowerment. They argue for a new ethic of efficiency and for the reliance on tools such as policymaking trials, audits, and cost-benefit analysis. All of these ideas are folded into the new term.

These particularities suggest that global health is not simply a domain or a specialty within the vast world of health. It is a field with its own rules and practices. As Pierre Bourdieu argued, the notion of “field” is useful in thinking about a certain genre of social spaces that are not only sites of interactions but abstract territories that gather together a limited set of actors, assembled in a closed space, to engage in a competitive game governed by formal as well as many informal rules (Bourdieu 1976, 1984). Following Bourdieu, the social sciences have theorized the field as a set of relationships and rules between actors animated by the same values, pursuing the accumulation of varied but shared forms of capital (Martin 2003). When in a shared field, actors “feel” the same kind of constraints, have tacit agreements about how to perform certain actions, and understand their rights and responsibilities. They are equipped with acquired dispositions and learned habitus indispensable to playing the game. The concept of field thus resonates with ideas of norms, boundaries, coherence, and homogeneity.

Approaching global health as a field is therefore a convenient way to think about its institutional, political, and economic dimensions. It allows us to look at the ways in which entities claiming to foster and practice global health implement similar resources and (mostly tacit) rules for their researchers and experts, their financing mechanisms, their measurements and evaluation procedures, their priority targets and programs, their own implementing bodies, and their local partners. Such a perspective echoes attempts to understand globalization as the making of specific fields beyond the boundaries of the nation-state, from geopolitics to humanitarianism (Go and Krause 2016).

For a decade, historians have been the most effective promoters of an understanding of global health as a field. They suggest that the field is made of new institutional and political arrangements for intervening in the health of others. They have accordingly argued that global health is regulated or dominated by institutions, like those we listed earlier, which define and implement disease-oriented, technology-driven, and highly selective programs that funnel funding and attention to the big three communicable disorders (HIV, TB, and malaria), as well as maternal and child health. Historical work identifies structures and instructions that define, act

in, and police the global health field. *Global Health for All* follows this work in the sense that we argue that global health has emerged as a field following transformations that started in the 1980s, lasted for a quarter of a century, and remain active but contested.

Leaving things at that would, however, be deeply insufficient because global health is not merely a field. Anthropologists most often consider local iterations and particular projects in which global health actors figure as distant donors. From their perspective, the very people who act on behalf of global health seem to figure in the scene from offstage. While historians have looked at global health as a field, the anthropological approach addresses the shortcomings of the field model by exploring multiple and not necessarily overlapping circulations of concepts, techniques, people, and goods. They aim to synthesize global health as a field and the circulations that enter, transect, or encircle it, by arguing that the existence of global health as a field depends on the much broader processes of health globalization that take place both within and outside it. We call these processes of *health globalization arenas*.

A comparison of how globalization operates in domains as diverse as tuberculosis or Asian traditional medicines illustrates why distinguishing between global health as a field and health globalization as a series of arenas is useful. Global tuberculosis management is a paradigmatic example of the vertical logic that historians of global health have singled out. Tuberculosis intervention follows the rules of the global health field and defines its boundaries, while existing studies show a web of actors—such as the Global Fund, the World Bank, the WHO, more than a hundred nation-states, and an even more diverse palette of nongovernmental organizations (NGOs) in the field of global health's TB interventions (Koch 2013; McMillen 2015; Brimnes 2016). These actors engage and stabilize the field by following the rules of standardized, single-disease, low-cost, high-effect programs. Together, this network promotes the DOTS (directly observed treatment short-course) strategy, a standardized and focused package of medical knowledge, accounting, and pharmaceuticals. DOTS and its implementers have so effectively followed the rules of the field that it has retained a central place in global health for nearly thirty years. Metrics depict DOTS as one of the most cost-effective interventions in global health, and treatment strategies that diverge from it are quickly escorted off the field, portrayed as naïve alternatives or costly utopianism.

Conversely, we can view the growth of markets for traditional medicines as operating outside the logic of global health while adjacent to its networks. Therapeutic preparations found in the Chinese and Indian medical traditions have become major health products. They circulate all over Asia as well as East Africa, well beyond their initial territorial base. This circulation has, however, taken place outside the global health field, circumventing its players and rules and only occasionally breaching its borders. Unsurprisingly, historians and anthropologists have not accounted for this circulation when considering contemporary health universalism. In spite of the WHO's proclaimed push for the integration of "traditional medicines," these medicines circulate without the endorsement of any significant global health institution or actor, not even the WHO. Asian herbal formulations are therapeutic goods made global through processes of industrialization and trade whose circulation and use are invisible in the global health field.

In other words, the DOTS strategy against tuberculosis is integral to global health as a field while the circulation of traditional medicines has little obvious connection to it. However, this circulation reveals a global collection of actors, tools, and targets related to the most recent wave of economic globalization. When viewed from the perspective of these traditional medicines, the globalization of health is made possible by processes ranging from the direct transfer of industrial goods manufactured in Asia to the generalization (and contestation) of intellectual property rules. Large foundations and their intervention programs are nowhere to be found, but this is a form of health globalization nonetheless. Such goods and services emerge around the field as an effect of processes and patterns of action unconnected with the game. These ensembles of ideas, practices, objects, and actors are the arenas where the globalization of health takes shape.

Building on both historical and anthropological studies of globalization, this book thus proposes to supplement the notion of the field with the idea of arenas. Arenas are the less homogeneous and more dynamic social worlds where the processes of health globalization operate (Bonneuil, Joly et al. 2008). Health globalization as discursive and material engagement that makes health-related entities movable, and perhaps general, is thus not reducible to the global health field described by a set of dedicated programs and institutional actors. It also involves the worlds of finance, commerce, industry, development, education, international law, as well as traditional and social media. Looking into arenas of health globalization brings to the fore other dynamics

and tensions than those at stake in the big programs and their focus on drug access, and helps escape a strictly North American and European understanding of what global health is, or should be, about. Such a perspective allows this book to move beyond the silo logic that has characterized much social science scholarship on global health and health universalism, viewing it only from the inner circle of global health actors.

It takes a bit of work to think through the intersection of the circulation of arenas and the structure of a field. Critics suggest that “circulation” as an analytical category tacitly endorses the idea that the world is a flat and empty space where entities move freely escaping power structures. As the historian Frederick Cooper once pointed out, stressing circulations and their role in globalization often goes with a certain fascination with flows, hubs, connectivity, and openness without much attention granted to the question of how the very same circulations are predicated on—and reinforce—strong hierarchies (Cooper 2005). Two examples of arenas emerging around and intersecting with the field of global health—the investment gap in noncommunicable diseases with its links to the circulation of biomedical pharmaceuticals, and biosecurity—may help elucidate their relationship.

The relationship between the global health field and its contiguous arenas of health globalization is not always smooth, and the question of power often results in tensions and unmet aspirations. One such tension exists in the difference between the importance attributed to noncommunicable diseases (such as cardiovascular diseases, diabetes, and mental health disorders) by global health actors and the actual funding allocated to treatment of these types of health challenges, what some have called “the investment gap.” This discrepancy between stated priorities and funding may be interpreted in two different, though not incompatible, ways. A field approach focuses on the global health field and its actors; the other attends to health globalization arenas. A field interpretation focuses on the actors, structures, and deeply seated imaginaries that participated in the emergence of global health and characterize its current operations. This interpretation reveals the power of a historical focus on infectious disease and highlights an overwhelming continuity between international health and global health. It suggests that the investment gap is the predictable result of a field in which noncommunicable diseases, by virtue of their chronic status and their absence of cure, cannot play by the rules. An arena or health globalization

interpretation in contrast reveals the massive circulation and consumption of pharmaceuticals for noncommunicable diseases.

Looking at the pharmaceuticals that enter the field of global health or circulate in the arenas of health globalization working in and across investment gaps reveals hierarchies and power relationships that we call arenas. The contemporary flows of pharmaceutical goods, whether formal or informal, go hand in hand with the preserved influence of North American and European pharmaceutical corporations and the growth of a new international trading order starting in the early 1980s. The new ways that goods are produced and travel, value is created, wealth is appropriated, and markets are constructed have radically altered North-South as well as South-South circulations and power gradients. In short, an analysis of global health as only a field fails to register innumerable forms of health at a global scale and the multiple arenas like these pharmaceutical flows.

Biosecurity is also an arena of health globalization. Biosecurity's concern is a globally universal risk of infectious disease, which is a form of health universalism, but its practices of preserving rather than producing health cannot reconcile with the rules of practice in the global health field. Scholars have shown that biosecurity concerns the planning, preparedness, and buildup of systems to stabilize existing health infrastructure and physical as well as economic well-being in emergencies (Collier, Lakoff et al. 2004; Lakoff and Collier 2008; Lakoff 2010a, 2010b; Caduff 2015; Lakoff 2017). These concerns are quite different from global health's usual interventions on the health of others through patching broken systems, treating endemic infectious disease, and assessing the need and efficacy of treatments to bring about health. Biosecurity was surprisingly absent from our sites and archives of practice. Biosecurity's absence in these spaces suggests that although it affects the operation of global health, it is peripheral to the everyday practices of imagining and implementing global health interventions, revealing an autonomous arena.

An understanding of global health across time and space requires understanding the entanglements of the field of global health—as a set of institutions, forms of knowledge and instruments mobilized in programs, and actors who understand themselves as representatives of global health—and the less formal and more varied arenas of health globalization—such as circulations of health personnel, patients, or drugs. To do so, we suggest that scholars must also attend to scales and take a roving perspective.

The Game of Scales

Global health moves across multiple scales. Its knowledge, interventions, and practices crosscut the globe, region, community, and nation. Inspired by French historians who argued for the methodological importance of scale (Revel 1996), we follow moves between scales, attending to their entanglements and looking at the ways that scales become contextually relevant and practically mobilized.

We take scaling in global health as our object of investigation. The problem of generalization and localization and of scalable and non-scalable knowledge and action lies at the heart of the very pretense and the actual practice of understanding the health of others and intervening in it. A primary health care depression program in Kerala, India, crosses scales by linking local development priorities and the government of health with global agendas of moving mental health from the margins to the center of development programs. A GeneXpert machine in a hospital in Tanzania or India tells us as about tuberculosis as a priority of global actors and about local policies and health systems, genomic technology markets, global health infrastructures, and “off the grid” technological fixes. It tells as much about failures as creativity. These grids and the question of what is included in them relate to scale and scalability as well as issues of coverage, penetration, and implementation that reveal globalization’s motors and global health’s values.

Focusing on configurations of knowledge and action while considering the multiple social worlds of global health, we create a historiography and ethnography of shifting health configurations—international public health and global health—deployed at multiple scales. By working at the sites and in the archives of global-health-oriented knowledge production and practical intervention, we reveal actors, processes, and forms of action that transcend the distinctions between the global, the national, and the local. Combining scales allows us to consider specific diseases, care practices, technologies, and medical specialties, not only in relation to transnational health management and larger social and economic patterns but also within their local and concrete historical settings. We cross and combine scales by exploring globalization processes, looking at the making of knowledge, the production and commercialization of health goods, the implementation of public health programs, and routine medical work.

Using the case studies drawn from our own mobile and roving fieldwork as well as iterative, comparative conversations about findings in other sites and other times, we aim to understand how categories, standardized diseases and treatment regimens, industrial products, management tools, and specialties have become elements in the global government of health. We look at the production of the World Bank's pathbreaking "World Health Reports" in New York, as well as the negotiations around antimalarial medicines at the WHO in Geneva. We follow the circulation of international experts seeking to implement programs in national contexts and observe care in research, treatment, and management sites. We explore the reconfigurations of health regimes and the peculiar assemblages of science, medicine, economy, and politics associated with global health by telling big stories alongside and sometimes through small ones. What we face are, for example, global health actors in Washington producing documents that are supposed to organize Ghana, India, or Senegal, or, on the other hand, policymakers in Kerala trying to redefine development on the basis of their own terms while avoiding most but not all of global health's infrastructure.

Following global health actors, targets, and tools, as well as processes of health globalization, across scales resembles multisited ethnography. In the last decades, multisited ethnography has emerged as a methodology for exploring a field dispersed across space and scale by following people, technologies, and techniques in various locations (Marcus 1995). Crosscutting dichotomies such as the global and the local, multisited research allows an ethnographic engagement with large-scale entities even while focusing on everyday life and small-scale events and processes. Anthropologists have most fruitfully used this method to explore political, economic, environmental, or scientific global assemblages (Ong and Collier 2005). In the process, they have created opportunities to understand a convergence of new historiographic registers and structures while remaining attentive to local processes.

By ethnographically and historically following global health across sites and scales, *Global Health for All* engages the global and the local as sites as well as processes of siting or localizing at the same time. We follow global health across scales even while we take scaling processes and their frictions in global health as our object of investigation. What emerges is more than a multisited ethnography and history of global health. It is an assemblage of inquiries showing that

scalability or the ability to expand is both difficult and central to global health, made possible by manifold, intense standardizations.

Standardization

Anthropologists and historians have developed a great number of anxieties while studying global health's practices of standardization. For those whose interest and livelihood is the local and particular, global health's foundational assumptions, discourses, and practices are alarming in their dismissal and erasure of local particularities and complexities in favor of efforts to scale up and compare. However, when we take steps to understand how standardization works among those hoping to achieve it and those at whom it is aimed, we find new insights about global health's inner-workings.

Comparability is both a necessary condition and an effect of technology, metrics, and medicine itself. Making bodies, communications, diseases, pharmaceuticals, and molecules comparable if not standard is central to knowing and intervening in global health. It also makes aspirations of universal health possible. With the transition from international public health to global health, a global scale of comparability that was once unnecessary and impossible moved to center stage because global health requires comparability of intervention, data collection, and the linking of cause and effect across locations and contexts.

Standardization, like comparability, is a double object. It is both a process and a product. We engage it in both forms. As process, standardization abides in practices that define and police an acceptable range of diversity as a basis for comparison and scaling up. For example, continuous and iterative standardization operates in practices that identify the acceptable range of variation in a pharmaceutical's active ingredient content or those that develop ranges of safe and unsafe blood pressure. Based on expert opinions of normal and abnormal, standardization moves processually from deciding on acceptable ranges of variation to describing appropriate actions based on these identified variables. The results of these practices bring us to a second kind of standardization. Standardization as product is the state of being standard or fitting into these ranges of acceptable variation.

Standardization tools pervade and animate the work of the WHO, the Gates Foundation, and the Institute for Health Metrics and Evaluation (IHME). The WHO constructs standards of care, like

DOTS for TB or mental health interventions. Markets and regulators develop guides for technical specifications of drugs and technologies. Unified tools like disability-adjusted life years (DALYs) aspire to build standardized measures of cause and effect. Nonetheless, even in the center of the global health field, where these processes, constructions, and developments are put into practice, their effects remain slippery. They rarely bring about stable standardization as a product. Standardization as similarity is partial and as much a motor of diversity as uniformity. Noelle Sullivan provides an example of the tension between standardization as process and product in her study of the ways that global health funders' financial accounting and transparency techniques produce standardized reports of supported activities despite incredible diversity (Sullivan 2017). She shows that although Tanzanian grantees returned financial report worksheets to funders in the necessary standardized format, the very process that these reports represented relied on divergent ways of knowing and representing the world. Similarly, Wenzel Geissler argues that standardization processes that do not necessarily lead to standardized practice are part of global health's "unknown knowns" (Geissler 2013a). Replete with failed standardization and "unknown knowns," our work shows that more than standardization occurs when standardized metrics, technologies, pharmaceuticals, and ways of knowing are put to work. Our inquiries reveal four points of comparability that guide practices of standardization within global health. They coalesce to enable the field's tentative imagination of a globally similar humanity and the interventions designed for its health. They include standardization of pharmaceuticals, biological commensurability of bodies, metrics, and universalist knowledge. First, the standardization of pharmaceuticals means that the production of health requires globally shared processes of comparability in biomedicine and its pharmacopoeia, but also processes and protocols that are standard enough to move across production contexts and locations. The tightly coupled activities of drug companies, physicians, pharmacists, the public, and judicial actors, in addition to administrative and state actors, regulate and standardize the development, marketing, and use of pharmaceuticals (Gaudillière and Hess 2013). Because global health relies on drugs and their markets, many of these pharmaceutical standardization practices occur through the international regulation of drug development, circulation, and use. Regulations are negotiated in diverse places, such as WHO expert committees, Lancet commissions, international medical societies, OECD (Organization for Economic Cooperation

and Development) commissions, and all these organizations produce systematic reviews outlining best practices.

Randomized control trials (RCTs) became the standard protocol for pharmaceutical innovation and drug development in the 1960s and have expanded into complex experiments in the era of global health (Marks 1997; Gaudillière 2008; Gaudillière and Hess 2013). Aiming to demonstrate safety and efficacy, these trials are grounded in supposedly universal biological bodies and ignore the social contexts in which pharmaceuticals and other interventions operate (Biehl and Petryna 2013; Brives, Le Marcis et al. 2016; Hardon and Pool 2016; Hardon and Sanabria 2017). Commercial interests and the power of the industry shape these standardized practices of evidence-making (Petryna 2009; Sunder Rajan 2017), and clinical trials shape pharmaceuticals' action in bodies. Pharmaceutical standardization through RCT experiments—often outsourced to research areas such as India, Poland, or Gambia—reconfigure patients and their value by assuming that all nonpathological bodies are generally interchangeable. Similarly, global “harmonization”—a process linking places through commensurable standards—brings national laws in line with global regulatory frameworks and thus facilitates clinical trials' offshoring (Petryna 2009; Sunder Rajan 2017). We add to this discussion showing that pharmaceutical standardization is also shaped by the production and circulation of drugs in markets. While bioequivalence and prequalification standards regulate the market by creating equivalences between global health drugs and their effects, networks and practices of illicit political economies subvert these very standards of drug markets and their transactions.

Standardization regimes also govern the development and circulation of traditional medicines such as Ayurveda or Chinese medicine that, although not part of global health as a field, have become important factors in larger processes of health globalization. Standardization in industrialized Ayurvedic drugs not only produces uniform combinations of plants, good production practices, and laboratory-based quality control but also neotraditional drugs that address standardized, and presumably universal, diseases and biological bodies (Pordié and Gaudillière 2014a, 2014b). Combined, these two dimensions of standardization have major effects on the construction of markets and the global circulation of these products.

These forms of pharmaceutical or industrial standardization result in a second form of global health comparability that Lock and Nguyen (2018) have called “biological commensurability” to

describe changes in the body and ways of thinking about the body made possible by biomedicine. Biological commensurability “allows people to be sorted into standardized groups and populations because their biology is assumed to be the same” (Lock and Nguyen 2018, 176). Biomedicine uses biology to compare bodies and lives globally by measuring them as deviations from norm. Biology’s standardized bodies are both the basis and the effect of global health’s universalizing practices of knowing and intervening in the health of others. Universalized biomedical diseases in commensurable bodies are enabled and reinforced by standardized global health policies, research, and interventions. Biologically commensurable bodies are the basis for an understanding of globally shared risk (of being exposed to pathogens) and universalism or “biological humanism” in global health (Rees 2014). Anthropologists have challenged the idea of universal bodies, and the tendency to disentangle bodies from social relations, by emphasizing variation and situatedness of knowing and experiencing not only health and disease but also, and more importantly, biologies and vitalities themselves.

The third process of comparability in global health occurs through metrics. Metrics in global health hold the promise of an economic calculus that allows experts to know, count, and intervene in bodies in a value-neutral, politically unbiased way. We carefully document the centrality of the Global Burden of Disease studies and its DALY metrics in global health and follow its production and use over time and space. The DALY metrics as the epitome of the “economization of life” (Murphy 2017) in global health provides a technoscientific imaginary of comparison, linking disability, morbidity, risk, and productivity.

Finally, global health also knows and intervenes on bodies through universalist knowledge produced in research collaborations between NGOs, philanthropic foundations, hospitals, and universities. Research sites with highly standardized protocols turn vitalities and suffering into countable statistical units, measurable outcomes, and fiscal value; produce well-resourced islands or enclaves of global health science, care, and data (Geissler 2013a; Adams 2016a, 2016b; Sullivan 2017; Mahajan 2018); and aspire to shape policies, guidelines, and standards. Critics have contested the preference for hegemonic forms of knowledge production over slow qualitative research by asking what counts as knowledge and whose knowledge counts in global health (Reid-Henry 2010; Adams and Biehl 2016). Processes that simultaneously create standards, foster global equivalence, and bracket context represent a troubling set of changes in

global conditions of possibility and imagination. They allow global health to appear as rational and natural despite the unsuccessful imposition of standardization, which actually opens spaces of unpredictability, chance, and diversity. While we agree with critics who point to the seductiveness and danger of standardizing processes for knowing and intervening in global health, we contend that although processes of knowing the world may be harmonized, ways of being and taking action in the world are rarely as uniform as they might seem. In short, life overflows and subverts standardizing biopolitics.

Tracing standardization as these four processes and products, our inquiries reveal little of the standardized fiscalization of lives—the turning of lives and vitalities into fiscally meaningful forms—that Adams (2016a) and other critics of globalization warn of. Social life is far too audacious to be completely controlled and stabilized. Even those physicians and health care workers intensely enmeshed in global health's standardizing impetus seem to muddle attempts to engage processes of standardization and to bring about prescribed forms of bodily existence. Nonetheless, comparability makes up one of the key tenets of global health and its entanglement with accounting brought about by neoliberalism.

What Is Neoliberal about Global Health?

Neoliberalism—a theory of economics that rejected Keynesian planning in favor of unplanned markets and streamlined bureaucracies—is folded into the tools and systems that guide global health. Throughout this book, we will explore some of the ways that neoliberalism entered global health and its effects on health interventions at a global scale. Attention to global health's neoliberal proclivities is not new. Global health scholars—historians as well as anthropologists—suggest that neoliberalism entered global health during the meteoric decline of state services ushered in by the structural adjustment programs of the 1980s and 1990s (Escobar 1995; Kim 2000; Comaroff 2007; Fassin 2007; Pfeiffer and Chapman 2010; Packard 2016; Erikson 2019). They argue that structural adjustment programs promoted a form of neoliberalism—called anarchic-neoliberalism—in which the market is deemed the sole organizing force in social and political life. These programs orchestrated the decline of state-run health infrastructures like clinics and hospitals, while the NGOs, philanthropies, and market strategies that funded care in the state's absence reinforced neoliberal ideology's power in global health. These same scholars suggest that by the dawn of the twenty-first century, neoliberalism had taken over global health

and eroded the state's role in health care. They point to examples like the Bamako Initiative's misguided revolving drug fund, increases in the private provision of care and diminishing state services, and the supranational priority-setting role of organizations like the Gates Foundation, the President's Emergency Plan for AIDS Relief (PEPFAR), and the Global Fund (Pfeiffer 2013; Keshavjee 2014; McGoey 2015; Adams 2016b). Nonetheless, analyses of what makes these projects neoliberal and market-based, or what role the state might now be playing, are limited. Even fewer have examined the individual recipients of health interventions or the social effects of neoliberalism in health.

Many who reveal strong links between global health and the spread of markets organized by neoliberalism have focused on post-Soviet or Soviet satellite states during the turbulent period created by the fall of the Soviet Union and World Bank intervention in the former Soviet bloc (Farmer 2005; Petryna 2009; Collier 2011; Koch 2013; Keshavjee 2014). These are illuminating but extreme examples of the state retreating from its role as caregiver. Developing our understanding of a global phenomenon based solely on these cases overlooks the processes of evaluation and triage used by technocrats and global health experts in order to make collective decisions about which public services should be shed and which strengthened. In most cases of global health restructuring, particularly in those contexts less affected by the fall of the Soviet Union, the state's role in attending to its citizens' health was deeply transformed, but not necessarily reduced, through subtle processes of optimization, partnership, and evidence-based policy.

Although neoliberalism cuts across public, private, and global health spheres, the state remains part of global health conversations and data-making. It is a bearer of expertise, policy, and institutional power; a configuration of jurisdictional and regulatory space; and a provider of pastoral care for populations. Despite its persistence, the state is inflected by neoliberalism precisely through the tools and value systems that state actors—politicians, technocrats, and physicians—use to interpret action and make decisions about health. In this way, the state and national bureaucracies remain stakeholders in global health while their roles, processes of legitimation, and logics of social organization have changed. How can the shared role of state and nonstate global health actors be understood and critically analyzed in light of the relationship between global health and neoliberalism?

To address this question, we find new strategies for interpreting neoliberal theory and its impacts on the state. Accounts of global health by anthropologists often interpret the field's ways of knowing and intervening as politics and anti-politics (Ferguson 1990; Harper and Parker 2014; Parker and Allen 2014; Taylor and Harper 2014). In other words, they attend to the ways that some forms of global health action are debated while others are seemingly uncontested. They are concerned about the ways many global health actions seem uncontestedly practical, to the extent of foreclosing politics, debate, and alternative action. We extend these critiques by focusing on the ways that global health's practices of knowing and doing are forms of neoliberal reason and economization, which disguise the political action of governing and apportioning collective resources in vocabularies of evidence-based intervention, efficiency, inclusion, and operability. In many but not all of our contexts, the state's role in health care has been transformed by neoliberal reason and its advocates from a space for debate about health priorities to a simple implementer of health programs. We suggest that interventions facilitate the spread and standardization of projects, politics, and subjectivities authorized by neoclassical economics' concepts of efficiency, competition, and human capital instead of rights, politics, and public debate.

David Reubi has identified what he calls "audit epidemiology" as one effect of the efficiency, performance, and management discourse in global health (Reubi 2018). Drawing from scholarship on neoliberal audit practices that govern and incentivize efficiency in business and the public sector (Power 1997; Strathern 2000), Reubi argues that just because large global health foundations and institutions lack public accountability and democratic processes in their decision making, it does not mean that no accountability exists. Rather, accountability, like the state, persists but is transformed. He shows that neoliberalism shifts accountability away from elected political actors, who voters could potentially hold responsible, to sites of policymaking, in which experts make decisions about which programs to attempt or continue on the basis of performance, efficient use of funds, and promise of epidemiologically verifiable effects (Nguyen 2009). Indeed, neoliberal thinkers like Ludwig von Mises (1944) argue that this method is more equitable than decisions based on political gain or bureaucratic inertia. In its own eyes, neoliberal reason enters health care through discourses and practices of efficiency, performance, optimization, and measurement linked to fairness and equity. This entry gives economic logic and epidemiological audit central roles as forms of moral conduct devoid of political

machination. They also hinge on a positive evaluation of competition and human capital as catalysts for health and development. However, as we show, neoliberal prioritizations are political decisions framed as practical ones.

In reality, growth-related priorities and neoliberal vocabularies replace other logics of health care provision, like human needs or citizenship, with its own. Wendy Brown writes of neoliberalism's tendency to reconfigure values by suggesting that "neoliberalism is a distinctive mode of reason, of production of subjects, a 'conduct of conduct,' and a scheme of valuation. It names a historically specific economic and political reaction against Keynesianism and democratic socialism, as well as a more generalized practice of 'economizing' spheres and activities heretofore governed by other tables of value" (Brown 2015, 21). Brown's omnibus mode of thinking about neoliberalism, as the economization of spheres—in our case health—and systems of value—in our case democratic decision making and state services as part of the social contract—is essential to our understanding of neoliberalism throughout this text. We present narratives that outline how "neoliberal political rationality does not merely marketize in the sense of monetizing all social conduct and social relations, but, more radically, casts them in an exclusively economic frame, one that has both epistemological and ontological dimensions" (Brown 2015, 62). For our purposes, we examine transitions in the "conduct of conduct" and the "tables of value" that state and other actors use to assess health-related activity to consider neoliberalism and global health's ways of imagining what is possible and practical. We find it an imagination in which both the possible and the practical are understood in selective economic terms. This monetization and transformation of social conduct and imaginary is the economization of health or even life.

Economization, or what Brown calls neoliberalism's conduct of conduct, does not supplant the state but enters it, "as Foucault puts it, to 'regulate society by the market'" (Brown 2015, 62). Michelle Murphy's work suggests that the economization of life "names the practices that differently value and govern life in terms of their ability to foster the macro-economy of the nation-state, such as life's ability to contribute to the gross domestic product of the nation" (Murphy 2017, 6). We define the economization of health as the evaluation of processes designed to transform illness into health based on their effects on well-being as part of national and international economies. More precisely, these economic effects include the production of

goods and services as well as the capacity of those transformed lives and health to consume, innovate, and maximize market potentialities. From this perspective, economization situates neoliberalism as just one of multiple and competing political economies jockeying to negotiate and interpret the relationship between populations, governance, and economics. It is one among several possible conducts of conduct that state and nonstate actors might use to attend to health.

Examining neoliberal reason first highlights its ability to move institutions away from existing values by reconfiguring reflexive systems of evaluation and interpretation. Second, it foregrounds neoliberalism's variability across space and time, allowing us to consider the ways that neoliberal reason shifts across contexts. In realms of health, neoliberal reason is always changing as it adapts to the kinds of political, economic, and health systems it meets. *Global Health for All* engages neoliberalism, then, as a variable process of economizing health that works through the use of tools to know, assess, and make decisions based on the zero-sum games of money and action. When viewed through the lens of neoliberalism, interventions based on other sets of values inevitably look like failures. Moreover, these tools make new projects seem like major breaks regardless of their similarity to earlier interventions. This is one part of global health's ambiguous origins.

We examine several examples of tools and discourses for a conduct of conduct aimed at maximizing a health investment's effects by optimizing its performance. They include metrics and the famous DALYs; the shifting role of expertise from clinicians to epidemiologists and economists; and new forms of prioritizing or triaging diseases based on effect on human capital and feasibility of intervention. We trace each to show how these forms of program evaluation at the birth of global health were part of the processes that proclaimed international health a failure. Similarly, we show how they continue to paint most interventions in the health of others as lacking efficiency, hampered by scarce resources, replete with gaps in capacity, and mired in local context, while insisting on the promises of effectively verified and documented cost-effective activities.

From the World Bank's 1993 report on investing in health to contemporary discourses of universal health coverage, competition and human capital have become central organizing tropes in global health's "conduct of conduct." Competition between public and private sectors to manage disease, as well as managing each other, is a way to compete for attention and funding

through the introduction of neoliberal reason in health. However, competition between the state and market are not the only forms of competition at work. We also find technologies competing for WHO and funder endorsement, competition between maladies for visibility, competition between hospitals and clinics, even competition between experts throughout the field. Each must prove its superiority through a series of inscription techniques and evaluative technologies that promise to maximize health with lower investments of money, capacity, and time (Akrich 1992). This is based on the presumption that quality of care in each sector increases when markets, states, and donors compete to provide the best care at the lowest cost. Decisions about an intervention's competitive advantage are made with built-in assumptions about who will pay, who can pay, and whose values count. It is crucial to remember that these assumptions guide the work of bureaucrats as well as global health funders, both of whom have bought in to neoliberal strategies of maximizing growth potential by identifying low-cost, high-margin products and interventions. The assumptions that structure the field do not overtly suggest that patients themselves compete for global health resources but that diseases, treatments, and forms of care are in competition to access scarce resources. In most cases, these competitions are adjudicated based on what Reubi calls audit epidemiology: a combination of their modeled potential effects on a population and their cost. We engage competition throughout the text by considering development, metrics, triage, and markets.

We also trace neoliberalism in global health by attending to human capital. Ideas about human capital economize health and make it a tool for speculative, neoliberal projects that encourage market participation, maximize the effects of minimal expenditure, and foment economic productivity. Despite its centrality, the idea of intervening in health in order to enhance human capital is rather new. For much of the twentieth century, economists considered health a positive side effect of state-led development. In a landmark reversal, however, in 1993 the World Bank health economists who authored the World Development Report: Investing in Health publicly argued that improving health would catalyze economic development, rather than result from it, primarily through an improvement in human capital. These economists and their entourage use "human capital" to refer to a whole theory of production that understands people as "ability-machines" with a combination of innate and learned capabilities necessary to produce goods and services (Foucault, Senellart et al. 2008, 226). Health interventions, they posited, would enhance these capabilities and thus individuals' participation in national cycles of production and

consumption. They imagined that once set in motion, increased human capital's potential effects on gross national product and global economies would be exponential, almost utopian. Indeed, in the human capital imaginary, the pastoral state acts to render itself obsolete. It must organize health care to start the cycle and then recede. At the same time, recipients of state care are no longer bearers of rights or citizens or even infectious risks to national populations. Instead, the state must triage individuals to funnel resources to people it identifies as potential producers, inventors, market innovators, and consumers. It hopes these individuals will, in turn, improve their health, grow their human capital, and participate in development. Global health's logic of human capital neoliberalizes and economizes health and human flourishing as sources of economic value and human capital rather than valuable in and of themselves. We trace the effects of this neoliberal economization across the field of global health.

Neoliberalization and its rationality has certain central tenets when it comes to health: namely, competition, efficiency, auditing, human capital, and triage. However, we have been careful to recognize that neoliberal logic results in specific assemblages that occasionally coalesce in shared values like efficiency, competition, and human capital. By doing so, we do not avoid the cold truths that health care infrastructures—often considered the state's purview—are generally in wretched states in contexts where global health is powerful. Rather, we understand this state of affairs to be both a condition of possibility for localized forms of neoliberal health care interventions and an effect of them. Neoliberalism in global health, though context-specific and situated, is alarming in its scope, its ability to expose health and life to the market, and its use of logics of economic gain to justify and critique national social safety nets. That it has entered the state's provision of care policies is even more concerning than the state's retreat from health care wholesale. We encourage readers to keep in mind that neoliberalism is inflecting the conduct of conduct, the players, and the game itself throughout this text. Our chapters considering triage, metrics, and markets reveal this influence directly, while other chapters highlight moments of contestation, elaboration, and infiltration.

Multi-Scalar Methodologies

The fifty-year-old TB clinic where we began is one of the many places that we take our readers on this anthropological and historical journey. Like any journey with two guides, the path is not always direct. At times, it veers off to consider objects that appear more interesting to one guide

or the other, but the richness of the conversation, we hope, makes the journey worth its deviations and pauses. This is the nature of our collective exploration and conversation. Our five-year project traverses four continents, thirteen countries, and sometimes peculiar parts of the Internet. It draws the authors into conversation about four topics that illustrate the range of different domains touched by global health today (tuberculosis, mental health, Asian medicines, and medical genetics). We approach health universalism by anchoring it in the past and present experiences of many of its protagonists—nurses, physicians, policymakers, staff of the WHO or the World Bank, and entrepreneurs.

In our work, we privilege no single site of truth or validity and pursue the epistemic goal of understanding health universalism on the basis of, first, the addition of unexpected sites for observing interventions; second, a complementary focus on several knowledge- and evidence-producing locations; third, our decision to not favor one particular type of data over another. We look at the “local” beyond its role as a space for the application of norms or programs and contend that it is a multiplex space that produces and is produced by health universalism. This approach explains our focus on the conventional core of global health (e.g., diseases like TB and malaria and organizations such as the WHO and the World Bank), as well as some of its less explored margins (e.g., issues such as mental health, genetics, and traditional medicine and regions like the Middle East). Dealing simultaneously with these different streams and scales allows us to better differentiate the field of global health and its contiguous arenas of health globalization. By exploring these spaces, we tell a story complementary to mainstream international and global health narratives. We explore the global health beyond the headlines, which often focus on innovation, the Gates Foundation, and other global-scale actors, HIV and Ebola, and an “ailing” African continent. Our exploration spans the second half of the twentieth century through the beginning of the twenty-first, with a specific focus on the transition from international health to global health during the mid-1990s. Dealing with this period allows us to combine interviews, ethnographic observation, and access to archives up to the late 1990s in “global” (the WHO, the World Bank, the Swedish International Development Agency) as well as “local” (the Kerala Health Secretariat, the Kibong’oto hospital, researchers’ personal libraries) sites of memory and history. Our dual approach combines the interest of historians of health for what people say and do at a particular moment in time and medical anthropologists’ focus on what these very people mean to be saying or doing.

Admittedly, people in the field grant anthropologists and historians a certain—and shifting—place on the power ladder, defining what studying up or down means and where it might lead (Conti and O’Neil 2007). Moreover, in a multi-scale, multisited, and multidisciplinary endeavor like ours, the variation of positionality is significant. Our way through these shifting sands was regular, collective, and comparative discussions of the main arguments of this volume, which reached an apex in the collaborative writing of the book itself. This difficult separation of the researcher’s own positionality and the webs of significance and sociality that ensnare a researcher is more obvious in a collaborative project like ours. Research collectives often shape perceptions, and as our conversations turned into collective writing, our ethnographic gazes, whether informed by training in anthropology or history, tended to settle on similar objects (Latour and Woolgar 1979). Nonetheless, our own interests, trajectories, and subjectivities found their way through this book and its multiple voices. The latter becomes a chorus with the aggregation of our inquiries and the permanent interplay between descriptive and normative approaches.

Across the decades we examine, we deliberately study up and down in an attempt to reach “the most powerful strata” of international and global health, as well as the lives affected by the decisions of the latter (Nader 1972). Such a spectrum of exploration has practical consequences. We follow what Hugh Gusterson calls “polymorphous engagement,” which implies “interacting with informants across a number of dispersed sites, not just in local communities, and sometimes individual form; and . . . collecting data eclectically from a disparate array of sources in many different ways” (Gusterson 1997). The characters in this volume are as diverse as clinicians, ministers, hospitals, scientists, bureaucrats, medications, community health workers, reports, economists, DALYs, and WHO experts.

Blurring the disciplinary borders, we try to build bridges between past and present in order to fill two gaps: on the one hand, the chronological lapse left open by the relatively scarce historical inquiries into global health after 1990, and on the other, the scalar breach that anthropologists create when leaving the pre-1990 era to other fields. In so doing, we can rely on archival work of the pre-1970 decades; on archives and personal interviews from the 1970s to the 1990s; and on a combination of comprehensive ethnographies, personal interviews, and archives for the most recent period. In several instances, historians and anthropologists simultaneously conducted

fieldwork, allowing for on-the-ground multidisciplinary collection and analysis of data. Their collaborations have collected and interpreted stories new and old about health universalism.

The chapters that follow share insights generated when historians and anthropologists team up to examine the interaction between global health and health globalization as they negotiate change and continuity, standardization, and neoliberalism across shifting spatial and temporal scales. Each chapter takes a critical look at one interaction and invites readers to join in the work of situating global health within and beside broader realms of health globalization, rather than attending to a particular place or malady. The first chapter, “Localization in the Global,” considers the ways universalism establishes and problematizes particularity as “local.” It uses the term localization to show that health universalism takes particularity as a scalar problem to be addressed through processes such as circulation, experimentality, and community engagement. These processes constantly remake the relationships of the general and the particular across scales, diseases, and times. “Metrics for Development,” chapter 2, inverts this theme by recounting the social life of one of global health’s central tools, the disability-adjusted life year metric. The chapter shows how metrics are forms of standardization that attempt, but often fail, to render diseases and people comparable and equivalent. By doing so, the metric becomes a social actor that crosses and even constitutes scales. Comparability of diseases allows for a technocratic form of care and policy that is based on the predicted performance of scale-up interventions and treats all sufferers as similar but for their disease. Chapter 3, “Triage beyond the Clinic,” attends to political triage and economic triage to understand shifting ideas about who should create health care priorities and how. It reveals that a transformation from state-led to global-health-led prioritization is incomplete, but neoliberal ideas have altered the logic of prioritization to cultivate markets rather than participative citizens.

Chapter 4 on “Markets, Medicines, and Health Globalization” follows pharmaceutical markets out of the field of global health and into health globalization’s arenas. The chapter argues that pharmaceuticals are a technical form of health globalization and a condition of global health’s possibility. Charting four regimes of market construction, the chapter shows that global health is just one of the many ways that pharmaceutical markets circulate medicines and create arenas of health globalization. Continuing to scrutinize the processes that make health universal, chapter 5, “Tech for All,” focuses on technopacks as collections of technologies and techniques that render

health technical, transportable, and transferable without major infrastructural inputs. The chapter shows how important globalized flows of know-how and stuff are for global health. This interest in development through technical solutions returns the reader to questions of scale and space. Chapter 6, “Persistent Hospitals,” examines three of the crowded clinical spaces where global health technopacks land. This chapter reveals that hospitals, though often silenced in global health’s discourses, are a node of articulation between global health and health globalization as they provide, at times with great difficulty, the infrastructure in which global health and health globalization operate. Similarly, the chapter shows that even where global health is strongest, hospitals are often state-created tools to care for populations. As such, they provide an ideal site to trace the state’s twenty-first-century attempts to care for the market through caring for populations. Continuing the attention to health at scale as it shifts between global health’s field and health globalization’s arena, chapter 7 on “Provincializing the WHO” tells the story of the WHO’s incomplete transition into the global health field. Arguing that the WHO is both inadequate and indispensable to the health of others, the chapter shows how both global health NGOs and health globalization South-South cooperation pressure the WHO, despite its continued role as health’s global clearinghouse and political center. The epilogue discusses how the global COVID-19 pandemic, unfolding as we finalized this book, both reinforces and challenges the book’s core message: that global health and health globalization are dynamic interconnected social phenomena and that health in the last eighty years has become an object of management.