Competency 1A

Preface

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This book, several years in the making, derives from a class titled Case Studies in Global Health: Biosocial Perspectives, first taught at Harvard College in 2008. That same year, several articles appeared in the U.S. popular press noting that global health was a hot topic among students.[1] New class offerings and even undergraduate degrees in global health were being offered in over a dozen American universities. Such programs, sometimes hastily concocted, presented what was termed a new discipline.

But global health, while a marked improvement on its forebear "international health," remains a collection of problems rather than a discipline. The collection of problems explored in this book and in complementary teaching materials—problems ranging from epidemics (from AIDS to polio to noncommunicable diseases) and the development of new technologies (preventatives, diagnostics, treatments) to the effective delivery of these technologies to those most in need—all turn on the quest for *equity*.

The just and equitable distribution of the risk of suffering and of tools to lessen or prevent it is too often the unaddressed problem in global health. No one sets out to ignore equity, but the way we frame issues of causality and response typically fails to give it due consideration. Equity is less the proverbial elephant in the room than the elephant lumbering around a maze of screens dividing that room into a series of confined spaces.

This myopia is changing. We are starting to lift our heads to see the entire room and the elephant in it. The roots of global health are to be found, we argue in chapter 3, in colonial medicine, a series of practices in which the concept of equity played a small role, and in international health, which gained prominence through nineteenth-

century efforts to control the spread of epidemics between countries and became a precursor of this past decade's efflorescence of interest in global health. During the latter decades of the twentieth century, discussions of equity and justice occurred but in a peculiarly parochial manner, with certain givens: the world was divided into three worlds (first, second, third) or, more typically, into nation-states separated by borders across which pathogens readily moved, even as resources were stuck in customs.

Combining anthropology, sociology, history, political economy, and other "resocializing disciplines" with fields like epidemiology, demography, clinical practice, molecular biology, and economics allows us to build a coherent new field that might better be termed "global health equity."[2] It is this multidisciplinary approach, which leads us from the large-scale to the local and from the social to the molecular, that permits us to take a properly *biosocial* approach to what are, without exception, biosocial problems. Such is the central thesis of this book, and also the approach adopted in each chapter.

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If global health is now merely a collection of problems, what might it take to forge a new discipline? Historians of science know what investments were required to build modern chemistry, physics, genetics, or molecular biology: basic principles had to be demonstrated, labs had to be funded, and institutions had to be reorganized, often over several decades. What might it take to build a science of health care delivery that is properly biosocial? Since the biological and the social have traditionally been handled by different disciplines, building the field will certainly demand a multidisciplinary approach. More than theoretical understanding, articulating the biological and the social aspects of health care delivery will require significant new investments in research and training, which are, happily, the principal concerns of a university.[3]

For both ethical and pedagogic reasons, research and training cannot occur without engaging in the *delivery* of health care to the sick (or to those likely to become sick). This reality is what drives doctors and nurses to spend most of their time training in teaching hospitals and clinics rather than in labs, classrooms, or libraries. It also drives our conviction that building a science of health care delivery will be a more complex challenge than that encompassed by most of the current mottoes and proclamations of our research universities.

How might we integrate research and training and service to build

the field already known (if prematurely) as "global health," whether in settings of poverty or of plenty? This question is largely ignored by nongovernmental organizations (NGOs) and other service providers, public and private. It's also too rarely posed within the university, in part because it's clear that honest answers will invoke the need for substantial new investments and that these investments should be especially—commensurately—large in settings of great poverty. It's hard enough to conduct research on health disparities in rich countries and harder still to explore them in the poorest ones, unless there is a clear commitment to addressing them. Most study-abroad experiences in global health take place in affluent or middle-income settings as opposed to the poorest places: in South Africa rather than Burundi; in Brazil rather than Haiti; in France rather than Moldova, to name a few cases. But this habit falls short of the mission implied in the words "global health."

It's not that there aren't important questions to be answered in South Africa, Brazil, China, Russia, France, or the United States; there are many questions, and investigating them in such countries will help to inform a genuinely *global* health, as we've argued many times.[4] Disparities of wealth, like epidemics, transcend national and other administrative borders and remind us of links, rather than disjunctures, between settings of affluence and privation. But many of our students want to follow the economic gradient down to some of the poorest and most disrupted places on the face of the earth. They want to learn how to work in the places that are in greatest need of modern medicine and public health. A new generation of students and trainees has been explicit about the importance of equity, as Richard Horton, editor of *The Lancet,* noted recently: "Global health is an attitude. It is a way of looking at the world. It is about the universal nature of our human predicament. It is a statement about our commitment to health as a fundamental quality of liberty and equity."[5]

It is for this new generation of students and trainees, who draw on precisely this commitment, that we wrote this book. These students are to be found at Harvard and other research universities in the United States, just as they are to be found in Europe and India and China and Brazil and in the places we work as service providers (Haiti, Burundi, Rwanda, Lesotho, the Navajo Nation, and elsewhere). They are found everywhere, regardless of nationality, region, religion, clinical specialty, or social status, since they do indeed constitute a global generation and have embraced, as Horton observes, a commitment to equity.

But global health needs to move well beyond an attitude. To substantiate that attitude, we need to build a new discipline. This book's authors and contributors believe that global health must be "more than just a hobby." This was the title of an editorial I wrote in the *Harvard Crimson,* in an effort to convince the members of our own university that resources dedicated to global health were investments in the university's core mission; similar arguments apply to other research universities as well.[6]

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In writing this preface, I have mentioned at least a half-dozen relevant scholarly disciplines as institutions ranging from public health providers and NGOs to teaching hospitals and research universities. Is it really necessary to take such a complex approach to what some would consider straightforward problems? The issues with which global health is concerned are many and various, and a book like this one addresses a varied public, including undergraduates, medical and nursing students, students of public health, members and supporters of NGOs, and others seeking to understand global health equity. We believe that what we have to say should matter as well to managers, policymakers, and all those seeking to improve health care delivery in the community, the clinic, and the hospital. Taken together with its supplementary materials available online, this book is meant to be a "toolkit" (a term imposed on us by our students) offered to practitioners, including experienced ones, of global hope.

Undergraduates who hope to address health disparities have a long road ahead of them. For future physicians, there is a traditional path outlined by our institutions of training: first the BA, then medical school, followed by internship, residency, and sometimes fellowship. After clinical training, if an academic path is pursued, comes the transition to practitioner-teacher: from trainee to faculty member. Each teacher of this undergraduate course at Harvard has been through precisely this course of training, the sort of training that for generations has produced cardiologists, infectious-disease practitioners, oncologists, psychiatrists, and every other kind of medical specialist.

But what path lies before the student planning a career in global health? Less than ten years ago, almost no such training opportunities existed; they are only now being created. The authors of this book and other materials would be proud to be thought of as midwives to a long-

overdue delivery. As the collection of problems turns into a discipline, there will be more and more demand for training and credentialing at every level.

Doctors are, as noted, only a small part of what is needed. Nurses, laboratory technicians, and managers are equally necessary, as are those born in resource-poor settings who have great talent but almost no chance to start up the same professional ladder. For example, there is plenty of cancer in the rural reaches of Haiti and Rwanda, but there are no oncologists, nor are there any oncology training programs. There is plenty of trauma in the hills and mountains of rural Nepal, but orthopedists are rare or absent. If global health is to be "more than just a hobby," it must embrace the training challenges on both sides of the rich-poor divide. For every Harvard student trained, there must be at least a dozen more in the developing world who would benefit from training. No sustainable model of global health ignores the challenge of training in radically different settings (Cambridge, Massachusetts, and Mirebalais, Haiti, say). Yet most resource-rich universities seek to avoid this unpleasant reality. While they recognize the relevance of global health and acknowledge the need for bilateral training programs, generously funded tracks are absent.[7]

A comprehensive view would see and acknowledge the truly global pool of talent out there. Our students and trainees, at every level and in every setting, want us to build this new field; faculty and administrators agree, as do colleagues and patients around the globe. Linking service to training and research will help elevate global health to the level of academic prestige afforded genetics, say, or systems biology.

So why haven't we caught up with the aspirations of our constituents? When historians look back at the current era, I believe that they will see twenty-first-century medicine in the broad biosocial perspective outlined in this book. They might note the worldwide eradication of smallpox in 1977; the promise and failure of universal primary care ("health for all by the year 2000"); the decline of public and private funding of public health systems ("structural adjustment"); the advent of new or "emerging" epidemics, most notably AIDS and drug-resistant infections, whether bacterial or viral or parasitic; the socialization for scarcity evident in late twentieth-century debates over new epidemics (usually taking the form of pitting prevention and care); the sudden injection of new funds to fight these epidemics in the first years of the twenty-first century; the success of these efforts (which showed

that sometimes treatment *is* prevention); and the positive synergies that emerged from these investments, which led, when used wisely, to what was termed "health systems strengthening."

Finally, I hope that historians will note the role of universities and NGO partners who sought to contribute to the burgeoning discipline of global health, which came to include, however tardily, training and research programs focused on global health equity. Building such programs for college students, medical students, interns, residents, and junior faculty at Harvard and its teaching hospitals has not been easy. The training of medical professionals is heavily subsidized by the U.S. government, and this funding remains unavailable for those who see health equity in truly global terms. In other words, the training and research agenda of our country hasn't yet caught up with programs like the President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis and Malaria, which are among the most ambitious global health programs in history.

The need to catch up is real. When I started my medical training at Harvard in 1984, there were three other students (of the one hundred fifty in our class) who reliably expressed interest in global health. A quarter-century later, that number has swelled to fifty. A third of the students plan careers addressing health disparities in resource-poor settings; more than half are interested in global health equity as defined in this book. Indeed, training programs do not keep pace with demand.

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Yet building training and research programs is just one part of reimagining global health. An even bigger part lies in addressing health disparities directly, by delivering high-quality services to those who have never before enjoyed them. That said, a division of labor (between service and research and training) is important and indeed necessary. We believe that conceptual work can inform service, research, and training—and it is this dimension of global health need that a textbook can seek to address.

The training materials developed for this undergraduate course, for "Introduction to Social Medicine" (required at Harvard Medical School), and for the Global Health Delivery courses offered with the Harvard School of Public Health all draw on key theoretical constructs we deemed important to the practice of global health work, whether at the level of policymakers or practitioners.[8] Useful concepts—from Foucault's "biopower" to Berger and Luckmann's "social construc-

tion of knowledge" to Merton's exploration of the "unintended consequences of purposive social action," which we consider in the second chapter of this volume—are largely absent from the global public health literature. Someone might justifiably ask whether such notions are necessary to achieve global health equity, or whether they are simply too abstract, philosophical, and speculative. We contend that such concepts inform the biosocial analysis requisite for meaningful action based on understanding of complex problems in complex settings. These concepts can also inform frameworks justifying efforts to address health disparities—health as a human right, public health as a public good, and health services as investments in economic development, for example.

It is good to have the desire and the capacity to practice medicine and an orientation that supports the public good. But when issues of implementation lead to pragmatic quandaries, it is essential to have deep and broad analyses of the problems. One case in point: the interaction of NGOs and what are considered "failing" public health care systems. A medical provider working with a global health NGO might be led to think that the most efficient path to ensuring the best care for the many is to replace public systems with private charitable care, the kind of care the contributors to this volume are, perhaps, most familiar with. But no private entity can meet the whole range of interlocking needs of a system to support healthy human lives, and no NGO is capable of conferring *rights* to those in need of them. NGOs can at most establish a provider-client relation within a framework of legal rights that only a state can confer. This textbook seeks to make evident the links between what are here called neoliberal policies and the witting or unwitting weakening of public-sector health systems.

The course on which *Reimagining Global Health* is based was designed by anthropologists who are also practicing physicians. The original course description read:

> This new undergraduate course will examine a collection of global health problems deeply rooted in rapidly changing social structures that transcend national and other administrative boundaries. The faculty will draw on field experience in Asia, Africa, and the Americas to explore several case studies (addressing AIDS, tuberculosis, malaria, mental illness, and other topics) and a diverse literature (including epidemiology, anthropology, history, and clinical medicine). This course seeks to introduce students to selected topics in a rapidly emerging and poorly defined field, with a focus on how broad biosocial analysis might be used to improve the delivery of

services designed to lessen the burden of disease, especially among those living in poverty.

The undergraduate course has been taught yearly since 2008. As we developed it, we worked with an overlapping group of colleagues at Harvard Medical School and its teaching hospitals to reconfigure a course called Introduction to Social Medicine, which was taken by all first-year medical students.[9] That reconfiguration benefitted from being the product of a group of like-minded practitioners; like all such collective efforts, it relies heavily on the limited experience of people accustomed to working together in certain times and places. We also worked with colleagues at Harvard Business School, the Brigham and Women's Hospital, and the Harvard School of Public Health to develop a series of "cases" (which means something quite different than it would in, say, an anthropology course) for students seeking to focus their careers on improving the delivery of health services broadly defined. One result, the Global Health Effectiveness Program, was one of the first joint teaching efforts ever between Harvard's schools of medicine and public health, entities that are physically separated by no more than a hundred yards. We developed new pedagogic materials that critically explore efforts to address some of the ranking problems of global health, from specific epidemics to the development of new technologies to the effective delivery of these tools.[10]

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In January of 2010, a large earthquake destroyed much of Port-au-Prince, the capital city of a country in which we (working with thousands of colleagues, most of them Haitian) were trying to advance the cause of global health equity by addressing disparities directly. The quake leveled Haiti's only large city and claimed, by some counts, a quarter of a million souls.[11] Less than a month after completing the second iteration of our courses for undergraduates and medical students, we found ourselves contemplating Haiti's ruined medical and training infrastructure. Here was an emergent global health crisis, occurring quite literally before our eyes. How might we marshal the resources of the university, and other partners, to assuage the suffering of the injured and of those who, while not injured directly, were unable to access the services they needed?

In the immediate short term, all our focus was on saving lives. In looking back over those first weeks after the quake—itself a daunt-

ing exercise[12]—it's possible to conclude that academic medical centers made a pretty decent showing. One of the greatest problems in an earthquake, inevitably, is crush injuries. From across the world, teams of surgeons and anesthesiologists and skilled surgical nurses traveled to Haiti to preserve life and, when possible, limb. Academic medical centers and NGOs joined Haitian authorities and able-bodied citizens seeking to provide relief. Support was widespread: by some estimates, more than half of all American households donated to earthquake relief.

In those first weeks, surgical teams saved thousands of lives—when they could build field capacity or invest in decent and undamaged infrastructure. But many first-time visitors found it difficult to function. Haiti's health care system, public and private, had been weak, disorganized, and overtaxed well before January 12, 2010. The zoo of NGOs working in Haiti prior to the quake was poorly coordinated and little supervised by Haitian authorities, local or national, and even less coordinated with each other. In other words, the chaos of those first weeks was by no means the result of the disaster alone.

The collapse of schools and clinical facilities in Port-au-Prince led some to speak of "building back better." In this view, the quake offered a chance to reimagine the city and its commons—from parks to schools to medical centers. The revelatory shock of the quake served to interrogate, and sometimes undermine, views of public health that had dominated timid efforts in the latter part of the twentieth century. If a reimagined view of global health offers, to paraphrase Richard Horton, a new way of looking at the world, what might a commitment to health equity look like in post-quake Haiti?

Like some of our students, those of us who were experienced Haiti hands found ourselves torn between pessimism and hope, between inaction and bold initiatives. Whenever ambitious efforts to reimagine health care delivery won out, plans for new and improved hospitals and a proper health system were drawn up, and efforts to build new training programs proliferated. But plans and charrettes and reimagined medical centers were one thing; funding and implementation were quite another. As this book goes to press, more than three years after the quake, only a handful of hospitals have been rebuilt, and none of the downed university structures have been restored. The former Ministry of Health is a vacant lot, raked smooth. But one care delivery institution "reimagined" in the days after the earthquake has been designed and built and opened. The Hôpital Universitare de Mirebalais seeks

to link service delivery for the poor to training and research, precisely as outlined in so many chapters of this book. It links the dynamism of NGOs and other parts of the private sector to the mandate and need in the public sector. It is beautiful and modern and done.

Sadly, the forces of globalization and decline were not finished with Haiti. The most water-insecure country in the Western Hemisphere, Haiti was primed for a major cholera epidemic even before the quake, as sober reviews noted.[13] Imagining a robust response to cholera was easy. But a more anemic response prevailed behind closed doors and in conference rooms.

With more than a million displaced people living in camps and enduring repeated calls for an end to the distribution of free potable water (on the grounds that it was neither sustainable nor cost-effective, or that it was cutting into the business of water purveyors), some public health experts nonetheless, and of course incorrectly, predicted that cholera was "unlikely to occur" in Haiti.[14] It is hard, as we show in this book, to make claims of causality regarding epidemic disease. But one plausible scenario involved this political economy of proximity.[15] Sewage from one of the United Nations peacekeeper camps leaked directly into a tributary of Haiti's largest river—an unintended consequence, surely, but not an altogether unpredictable one. Regardless of its origin, the cholera pathogen spread rapidly throughout the region drained by the river system and then, more slowly during the dry season, across the country and into the Dominican Republic and beyond.

Building or rebuilding a proper water and sanitation system in Haiti would take, in the best case, many years. Clearly, tens of thousands of lives were in peril in any scenario that involved only slow forms of prevention; faster (if shorter-acting) modes of prevention, from handwashing to vaccination, were necessary and complementary, as were efforts to identify and treat every cholera case.[16] The same quarrels over prevention versus care registered in this book's accounting of twentieth-century epidemics occurred in the midst of the twenty-first century's largest cholera epidemic. The quarrels were generated by the same socialization for scarcity that has marked all health investments in settings of poverty or for the poor who live in affluent countries.[17]

This is a very personal preface, for a number of reasons. One is because this book, and the large quantity of teaching material we've developed over the past few years, represent a significant personal investment for many of us. Another, of course, is that the faculty (and many of the teaching fellows) have dedicated their careers to this effort.

Finally, this preface is personal because the quake and its aftershocks permeated my experience of teaching more than I could say comfortably in a classroom.

Despite the quake and its aftermath, my faith in the importance of the effort required to reimagine global health remains unshaken. If anything, the experience of the Haitian quake, which was mostly wretched, redoubled my own commitment to linking direct experience in settings such as Haiti to tools from social theory that might allow us to understand the consequences, intended and unintended, of social action and of inaction.

If anthropology, history, and the other resocializing disciplines share a common analytic purpose, it is to render whole what is hard to see as such. It is also to acknowledge that human experience of suffering in pain or injury—and of the individuals and institutions that seek to redress suffering—are difficult to render as abstractions of models or theories. Every account is partial, and none could hope to capture the complexity of human experience.[18] This book's chief shortcoming is that every report or case or chapter or review is thus necessarily and avowedly partial. Acknowledging partiality sometimes helps us to interrogate facile claims of causality. Many of these claims will be revealed, in time, to be immodest or flat-out wrong. The history of medicine and public health has repeatedly taught us that humility should infuse our practice and our teaching and all claims of causality. But humility need not lead to paralysis, and we hope that the reader is not caught between unreflective activism and an informed but ultimately paralytic skepticism.

We counsel neither, for long experience has shown us that this too is a false dichotomy, and more dangerous than most. Inaction is not a real option but rather an illusion, one maintained with difficulty in even the tallest ivory towers or most gated retreats. We live in one world, not three, and "reimagining global health" requires resocializing our understanding of it. We've tried to do as much in this book, and we invite you to join us.