

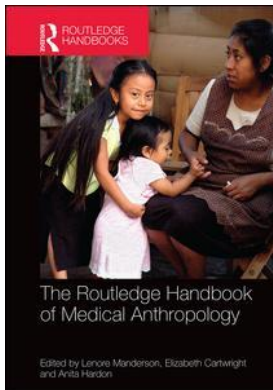
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Dr. Rahim and Nepalese Boy after Earthquake, 2015. Yangri, Nepal.
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About the photograph

Dr Fahim Rahim, a nephrologist, helps a sick child in Yangri, Nepal, following the 7.8 magnitude earthquake that struck the area in May 2015. Nearly one billion people living in remote parts of the world lack access to adequate biomedical care, and in times of natural disaster, they become significantly much more difficult to reach to provide aid. An unknown observer took the photograph for him.

—Beenish Mannan

How the Logics of Biomedical Practice Travel

*Elizabeth Cartwright, Anita Hardon
and Lenore Manderson*

Biomedicine travels; it is a malleable and mobile set of practices and ideas. It travels with practitioners and is used in far-flung places. It travels via educational strategies and via the use of accepted and codified texts that set the ‘standards’ of diagnostics and treatment. Educational approaches travel out from large, well-funded teaching institutions to rural areas, then to more remote and less well-resourced areas of the globe. Biomedicine travels via books and training sessions and via the Internet in and out of clinical spaces, weaving itself into homes, public buildings, and the most remote nooks and crannies of the world. Practitioners and patients, who in the past had much less access to biomedical technologies, use it in ways unique to local situations. Many times, in low-resource settings, biomedical protocols are enacted using only parts of the system for which they were originally designed. Inadequate hospital infrastructure, lack of medications, difficulties in the procurement of medical supplies, and lack of fully trained personnel all create situations that result in incomplete diagnostic and treatment regimens and less than optimal outcomes, as we have noted already.

In this chapter, we trace some of the many ways that the logics of biomedical practice travel. The case studies we include show how biomedicine travels via changes in medical education curricula (Georges and Davis-Floyd), changes in market demand (Gerrits and Hörbst), via medical education experiences (Benton), and with humanitarian relief efforts—with their ambiguous and sometimes contested results (see the cases from Frankfurter and Redfield). In each of these case studies, we see that biomedicine is not the unassailably dominant force that we might think. Rather, it is a way of being and doing the work of healing that, when confronted with different local contexts, results in a plethora of hybrid ideas among both patients and practitioners. Biomedical elements are grafted onto partial clinical infrastructures, pharmacopeia, and various pre-existing systems of healing (see Karchmer 2010).

One response to the perceived ‘need’ for biomedical ‘help’ in resource low settings is for biomedical practitioners from the global North to bring their skills directly to the region in question. This occurs in two ways: by offering care to people during natural disasters, wars, and epidemics, and by providing intermittent medical and surgical interventions where such care is not locally available—fistula repairs, cataract surgery, oral and maxillofacial surgery, for example. Local health care systems and public health programs may be underdeveloped or under-resourced, and medical staff lack specialist training, hence the role of external providers to work with locals to strengthen capacity, as occurs through development assistance with international NGOs such as Save the

Children and World Vision. Other international organizations provide more specific services: the Fred Hollows Foundation, for instance, focuses on treatable and preventable vision problems; Hamlin Fistula Ethiopia operates primarily to treat obstetric fistula for women and girls in that one country; Mercy Ships provides surgical and medical care off the shores of Africa. In other emergency contexts, including where health systems are damaged or destroyed, groups such as Médecins Sans Frontières (MSF) and other nongovernmental organizations (NGOs), and the militaries of donor nations, necessarily care for large numbers of people under these circumstances.

The complexities of humanitarian interventions have recently come under study by medical anthropologists (Bornstein and Redfield 2010); the meanings of donating time, money, and expertise differ culturally, as do expectations of the continuation of aid and the actual uses of donated money and goods. Often, local practitioners work side by side with humanitarian volunteers, learning new aspects of biomedicine within the context of the unfolding crisis or in managing particularly challenging surgical and other procedures. The details of how biomedical knowledge is passed between practitioners in situations, like the Ebola outbreak of 2014 that took place in Sierra Leone, Guinea, and Liberia, illustrate how biomedical knowledge is disseminated, understood, and retained over time in settings where there are multiple, often competing forms of ethnophysiological understandings. We return to the topic of Ebola towards the end of this chapter.

Biomedical Interruptus

While doctors, surgeons, and students training to be health care professionals have taken biomedical treatments to people in need of medical assistance—sharpening their own skills in the process—there has been limited progress in providing adequate medical training for local residents of resource-poor areas to become fully trained in medicine, nursing, dentistry, and midwifery, or in public health (Ezeh et al. 2010). Education is expensive, often requiring those who want to become health care professionals to relocate to urban areas, far from their rural or otherwise marginalized homes. The expense, time lost from family obligations, and inadequate educational preparation during primary and secondary school create situations where academic success, especially at higher levels of education, is very difficult to achieve even for the most intelligent and dedicated of students. Health care professionals in large urban centers often don't want to or can't leave their families and jobs to relocate to more rural/underserved areas; thus, extensive regions of the world are 'served' by clinics that are understaffed and under-resourced, and which are only minimally effective at best.

The difficulty of enticing health care professionals to work in rural areas has been addressed in part by transporting patients to the nearest urban center with some semblance of hospital facilities. Transporting patients to urban hospitals can be difficult, dangerous, and expensive; untrained taxi and bus drivers often provide patient transport because there are no medically outfitted ambulances—let alone functioning emergency medical systems (EMS) that include medics, communication, triage and supportive medical decision making and treatment during the long hours of transport to the nearest, best-equipped hospital. Even those urban hospitals are often incapable of treating the patients that arrive at their doorsteps, due to lack of facilities, general medical staff, specialist skills, medications, and supplies. Moreover, poor conditions of employment and limited opportunities for on-the-job training make it difficult for personnel to do their jobs well. These deficiencies create clinical landscapes that have meager assemblages of possibilities—both physical and intellectual.

Livingston (2012) ethnographically describes one of these partially equipped, resource-poor hospitals in her book *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic*. She takes us into a barely functioning ward in Botswana where patients arrive with advanced cancers: they have tumors protruding from their bodies, they are cachexic and in unbearable

pain. At the hospital they receive the most basic, and oftentimes futile, care. The practitioners in her book, the doctors and nurses and aides, work in conditions where they are called upon to personally sacrifice a great deal for their patients, and they do. The scenes she describes are beyond imagining for the lucky minority of the people on this planet who live in well-resourced settings. For the majority of humanity, these scenes are all too familiar.

Non-standard clinical practices emerge where there is less institutional and/or administrative oversight; clinicians who dwell in the electronic periphery of Internet connectivity are operating at and with a disadvantage. Many of the case studies in this chapter, and indeed, in the entire volume, are located in this Internet-outback. Practitioners have incomplete tool sets and experience difficulty upgrading their skills and knowledge compared with those who reside in core connectivity spots and have easy access to such information, as we considered in Chapter 8. These landscapes—physical and virtual—are superimposed upon one another. Physical spaces are accessed by roads, cars, planes, mini-buses, and foot, resulting in a particular geographic distribution of medicines and diagnostic tools that define how biomedicine is experienced by practitioners and their patients. This physical landscape is now overlaid by an Internet landscape. The quality, reliability, and cost of Internet services create a filter—one that can change quickly for better or for worse depending on the quality of the telecommunications systems upon which they depend. These two landscapes—the physical and the virtual—when viewed simultaneously, can work together to create more access to biomedical understandings for those on the periphery, as we have described in Chapter 8, or they can cut off communities of practitioners and their patients from many aspects of biomedicine that could improve their practices and their outcomes.

Exchanging Contesting Paradigms

The cases in this chapter illustrate the ways that the techniques and bodily movements of clinical practice travel and are shared between practitioners from very different places and clinical spaces. These new ways of enacting biomedicine are taught and re-taught in settings that have very different access to the tools of the trade—pharmaceuticals, medical instrumentation, and biomedically trained staff. Nia Georges and Robbie Davis-Floyd, in the case study that follows, illustrate that the transferring of medical paradigms through education and training is not a one-time event. Contesting biomedical (or slightly less-biomedical) perspectives on the manner in which practitioners should interact with their patients can be entertained and sometimes taken on as the definitive clinical protocol in light of the arrival of new biomedical ideas and information. Georges and Davis-Floyd illustrate how a critique of biomedicine travels from midwives and alternative birth practitioners in the US into standard, hospital birthing protocols in Brazil.

15.1 Humanistic Obstetrics in Brazil

Eugenia Georges and Robbie Davis-Floyd

Question: Where does your passion come from?

João Batista: From my heart. I believe in justice and rights, and women in Brazil have neither, and their rights are most violated during birth, even the rich ones. It's ironic that the rich women have the worst treatment and they believe they have the best. . . . I want every ob professor to teach this to his residents: The woman is the center of care!

Throughout Latin America, 'humanization' is the unifying concept around which social movements to demedicalize and transform childbirth care have coalesced. In the 1980s, feminist, environmentalist, human rights and other oppositional movements began to proliferate in the democratizing

aftermath of authoritarian rule. Since then, Brazilian humanization activists, like their counterparts in other countries, have engaged in ongoing political struggles to produce new meanings and cultural categories with which to challenge dominant medical discourses (Alvarez et al. 1998). Although a diverse project, humanization at its core is grounded in the principle that safe, respectful and supportive maternity care, free of unnecessary medical interventions, is a woman's human right as a citizen of the nation. Following this logic, unnecessary obstetrical interventions have come to be redefined as a category of violence against women—'obstetrical violence.'¹ The humanization movement insists that care of mother and infant consist exclusively of 'best practices' that are supported by up-to-date, evidence-based medicine. The objectives of humanization are simultaneously ethical (promoting women's rights to respect and autonomy and committing doctors to protecting those rights) and instrumental (improving outcomes for mother and infant).

Here, we describe our research with 32 Brazilian obstetricians (half men, half women) who have chosen to replace the conventional obstetrics in which they were trained with a humanistic approach.² Humorously, they call themselves 'the good guys and girls.' For some, the preponderance of the scientific evidence in favor of supporting normal, physiologic birth was most important in their decision to transform their practices; for others, it was allegiance to humanistic values rooted in their intersecting affiliations with feminism, left-wing politics, liberation theology, environmentalism, traditional medicine and midwifery, and New Age or older spiritual beliefs. Despite their differences, however, they typically shared an ethos that blended, or at least honored, all these dimensions to varying degrees. Some had private practices that catered to highly motivated, middle-class women—those who, in one doctor's words, were "100 percent to 10,000 percent committed to normal birth." These interviewees attended homebirths almost exclusively and had cesarean rates of 7 to 10 percent. Others in private practice had cesarean rates of 14 to 30 percent, because they chose to care for all who came to them, believing that every woman has the right to a humanized birth, whether a natural birth at home or in hospital or a scheduled cesarean section. Others worked in the public health system, providing care mainly for poor women. Some interviewees occupied influential positions in the Ministry of Health; others held faculty positions at some of Brazil's most prestigious universities.

For example, Ivo Lopez and João Batista worked as clinical directors of Hospital Sofia Feldman in Belo Horizonte, Minas Gerais, a high-risk center providing tertiary-level care available to all women in the state. More than 50 nurse-midwives practice there along with 20 obstetricians; 14 doulas are provided by the hospital for women who bring no companion. They have very low rates of forceps, vacuum extraction, and episiotomy (around 8 percent for each); electronic fetal monitoring is used only intermittently; delayed cord clamping and vertical births are the norm. Sofia Feldman is widely regarded as an exemplar of humanistic practice in the international childbirth movement. In December 2012, Director João Batista stated:

Our cesarean rate is 24 percent . . . one of the lowest in Brazil—but last year it was only 20 percent—it went up four percent in one year [when] there was a huge increase in high-risk women sent to us from all over the state. We are the biggest high-risk hospital in the state—so our PNMR is 14.4/1000. Ten percent of our babies are preterm. More than 50 percent of the babies here are from other cities. Maybe we are doing the best we can. [Preterm labor and premature rupture of membranes are common—hypertension is the really big one]. If they come to us early, we can stop it, but most are sent late.

When we asked him, "Are you afraid of birth?" he responded, "No. I am afraid of not doing all I can for women."

Guidance from Books and Films

Working in relative isolation because they did not know of each other when they began their new trajectories (mostly in the late 1980s and the 1990s), these humanistic obstetricians undertook a process of self-education to effect their personal and professional transformations. In almost all instances, this process was profoundly influenced and guided by a common corpus of resources, including texts by international advocates of childbirth reform. These included the works of French doctors and reformers Frederick Leboyer and Michel Odent, the Uruguayan obstetrician Roberto Caldeyro-Barcia, British authors and activists Sheila Kitzinger and Janet Balaskas, and US writers

Marsden Wagner, Penny Simkin, Marshall Klaus, Henci Goer, Elizabeth Davis, and Robbie Davis-Floyd. Melania Amorim explained:

I started my Master of Science Program [in 1993]. And I was introduced to evidence-based medicine. I also had to read philosophy of science and I was introduced to Thomas Kuhn and research on scientific revolutions. And I began to think, “Oh! It can be different.” And I started to read about the [standard obstetrical] procedures . . . and I could realize that they were not necessary! That there was no evidence to support my practice. But I couldn’t realize, why, with so much evidence against these procedures, they always have been performed by other obstetricians. . . . And so finally I encountered Robbie’s book *Birth as an American Rite of Passage*, and I could understand what evidence-based medicine didn’t explain—why these procedures have been maintained for decades with no scientific evidence. And that’s why her book changed my life.

There were domestic critiques of conventional childbirth too. Moysés Paciornik’s book *Aprenda a Nascer e a Viver com os Índios (Learn How to Live and Give Birth Like the Indians)* and film *Birth in the Squatting Position (1979)*, as well as the birthing chairs he designed to simulate the benefits of the squatting position (*parto salvagem*, ‘savage birth’), had a significant impact on alternative birth activists not only in Brazil but also internationally. Hugo Sabatino, professor of obstetrics at UNICAMP, was also an early pioneer whose teachings and writings on squatting birth were highly influential in stimulating the movement for humanized birth. And Dr. Jose Galba de Araujo, in the state of Ceará in the 1970s and 1980s, worked to humanize hospital birth and provide support to the rural midwives in his catchment area; his work remains influential today. Not only did these texts and individuals serve as exemplars—some of their international authors, such as Odent, Wagner, and Davis-Floyd, themselves developed close ties to the humanization movement, visiting Brazil on numerous occasions, offering workshops and delivering keynote speeches at conferences.

Guidance from Midwives

Another source of guidance was the reevaluation of midwives. The contributions of traditional midwives were recognized, and occasionally romanticized, as part of the more general valorization of the experiences of subaltern and Indigenous women (Tornquist 2004: 62). In some rural areas, especially the Amazon region, Indigenous midwives still play important roles in childbirth. Some of the older obstetricians we interviewed expressed respect and appreciation for the skills of the midwives who had assisted their mothers and other relatives. Two of our interviewees, Claudio Paciornik (son of Moysés) and Bernadette Boussada, had learned directly from traditional midwives. Claudio and his father spent years observing the birth practices of the Kaingang and Guarani tribes on Indian reserves in Ibirama and Xanxare in South Brazil during the 1970s. Bernadette, in contrast, met traditional midwives for the first time when she was assigned after residency as the sole obstetrician in the only maternity hospital in the remote city of Coração de Jesus, Minas Gerais, for one year (1997–1998). Three *parteiros tradicionais* working in the hospital as auxiliary nurses became both her assistants and her guides. The two most important things they taught her were respect for the woman and respect for the physiology of birth. She watched them treating women with kindness, attending labor without interfering, and using movement and upright positions. She slowly started to practice more and more like they did. The first intervention she gave up was Kristeller (pushing on the abdomen), then forced pushing (yelling at the woman to “Push, push!”), then episiotomy, “then all the rest of it all at once!”

In addition to supporting the remaining Indigenous midwives in Brazil, all of our interviewees believed that ideally, professional midwives should be the primary birth attendants in Brazil because they are or should be the experts in normal physiological birth. When there are professional midwives in their cities, our interviewees are generally happy to work with them and support them however they can. They lament their scarcity (professional midwives attend less than 10 percent of Brazilian births) and some actively work to create and support midwifery programs and to develop birth centers in which the ‘midwifery model of care’ can be actively implemented. They try to practice the midwifery model, based on keeping the woman at the center and on understanding and facilitating normal physiological birth with a minimum of interventions. Some even call themselves “midwife-obstetricians,” yet Carla noted, “I would like to say I’m a midwife, but I can’t say

that because I have this little monster in my head saying, ‘Oh, shouldn’t I do an episiotomy?’ I’m an obstetrician, I’m a teacher.” In turn, given their general ostracism by their technocratic colleagues, these obstetricians usually receive their primary emotional and psychological support from their local midwives, doulas, and birth activists.

Social Movements and Networks

In 1993, ReHuNa (Rede pela Humanização do parto e Nascimento), the Network for the Humanization of Childbirth, was officially formed as an NGO to advocate for a woman’s right to a humane and respectful childbirth experience grounded in scientifically sound practices. ReHuNa is composed predominantly of obstetricians, gynecologists, public health doctors, nurses, professional midwives, and other highly educated professionals. Their dual identities as professional experts and movement activists have enabled many members to move between the state sector and civil society and participate in the democratic institutions constructed to bridge them. Our interviewees credited ReHuNa (which some of them were instrumental in creating) and other activist networks as critical sources of knowledge, support and guidance. Many met each other for the first time at ReHuNa conferences, and were delighted to discover that they were part of a community of like-minded alternative practitioners. Today humanistic obstetricians keep in touch via Facebook and other social media, where they engage in vigorous debates over such issues as whether it is wise and safe to assist a woman with two or more previous cesareans to give birth vaginally, how best to turn a breech baby, what constitutes optimal nutrition during labor, and so on. Melania Amorim described her discovery of the Internet chat group *Parto Nosso* (Our Birth) as “magic. . . . It was a revolution in our life because you could find persons whose thoughts were similar to ours. We were not crazy. We were accepted, we were stimulated.” When they experience ostracism or outright persecution from their technocratic colleagues (often called *cesaristas* for their routine use of cesareans, as opposed to *vaginalistas*—another term by which our ‘good guy’ interviewees may identify themselves), they turn to these activist networks for both advice and support.

The Process of Transformation

Even for those whose narratives of transformation highlight a pivot point—an ‘aha moment’ in which their perspectives abruptly shifted—changing their day-to-day practice was in almost all cases a slow and painful process that required the conscious choice to dissociate themselves from their habitual forms of thinking and acting. As Ricardo Jones (2009: 292) eloquently put it, “between rationality and fear, there was a considerable space still to cross.” Changing deeply embodied knowledge and habits typically occurred “step by step, step by step” (Paulo Batistuta) and could take years to complete. For many, the episiotomy was one of the hardest routines to give up. Carla Polido noted:

[As a student at UNICAMP] I saw squatting births with Dr. Hugo [Sabatino] but it didn’t influence me—the other professors said he was a lunatic, “That’s for savages!” At the time I also thought that those women were too demanding. Today I *want* women to have demands, but at the time, I was Dr. House—I was the boss. We didn’t value the woman, we thought that we were the stars of the show, not her. From there was a whole process, one birth after another. The toughest thing for me to stop doing was the episiotomy. I had this fear of the perineum blowing up!

Even once convinced that a procedure was unnecessary, finally relinquishing it was sometimes still a struggle, as Marilena Pereira described regarding a homebirth she attended:

Many times, I still couldn’t believe it would be OK not to cut. When the birth would start, I’d say to myself, “It’s going to tear, it’s going to tear,” and I would cut. Sometimes I would succeed in not cutting, but I was afraid, really afraid, so many times I would cut. [It took me] the next two years to give up doing episiotomies.

Yet give them up they did, soon discovering that upright positions were much more likely to prevent vaginal tears. The routine use of Pitocin to speed labor was quick to go; hard to learn was the patience it takes to attend births without rushing the process. Helio Bergo noted:

When I started with squatting birth . . . I saw that there was no need any more for forceps and other aggressive and invasive methods. . . . Little by little I was learning to watch the rhythms and this is what enchanted me. Do not intervene. [Just] watch . . . I learned from attending homebirths. To respect the rhythm was the hardest thing to learn. And it's what brought me the most benefits. When I learned how to do that, things became easy. But it was hard to let go . . . to not intervene. Because there are moments when, without any doubt, it is necessary to intervene. To know, to decide which moment it is, without intervening prematurely, is difficult.

During residency, Carla Daher was shocked and horrified that thirsty laboring women were not allowed to drink. She began to offer them water and to encourage them to move around. Like Helio Bergo, she learned from a sympathetic colleague “to be patient, to just watch women work, to be nice.” She gave up manual extraction of the placenta because she saw it as “unnecessary and cruel.” As a result, her obstetric chief called her practice “messy” and made sure she was the only resident in her cohort not hired by the hospital from which she graduated. (She later went into private practice.)

For our interviewees, giving up routine interventions meant placing great emphasis on treating their patients as individuals. The five-minute standard question and answer sessions were replaced with prenatal visits lasting an hour or more, childbirth education classes which they often taught themselves, and discussion sessions in which their patients could come together in groups and ask all the questions they wished. Those in private practice made conscious decisions to limit the number of patients they took on so they could provide high-quality humanistic care. They accepted lower salaries (and often ostracism from other obstetricians) as the price to pay for the much greater levels of satisfaction they experienced.

Conclusion

Although their numbers are small, these obstetricians and their colleagues have managed to provide options for humanistic maternity care, including homebirth, in nearly every major city in Brazil. They have succeeded in creating a few exemplary institutionalized humanistic practices such as Hospital Sofia Feldman and the Maternity Department of the University of Santa Catarina. Some of our interviewees are promoting large-scale policy change via influential positions in the Ministry of Health. Some are instrumental in Rede Cegonha (the Stork Network), inaugurated in 2011 to transform maternity care throughout the nation's Unified Health System (SUS), within which 76 percent of Brazilian births take place (Brazil SUS nd:10). This program is designed to lower maternal mortality and the national caesarean rate, which in 2012 averaged 55 percent nationally and reaches 80–95 percent in private hospitals,³ by replacing the dominant technocratic model of maternity care with a humanized paradigm. Our research on the roles of our interlocutors in this new program and on their unfolding transformations in practice is ongoing and will be further presented in future publications.

Notes

1. In 2010, for example, Venezuela became the first nation in the world to recognize obstetrical violence as a legal category and punishable offence.
2. We use the terms ‘humanized’ and ‘humanistic’ for the sake of clarity and simplicity. Many of our interviewees considered themselves to be not only humanistic (keeping the focus on the woman, treating her with kindness and respect), but also holistic (perceiving the body as energy and birth as a spiritual process) (see Davis-Floyd 2001).
3. Maria Esther Vilela, Women's Health Coordinator, Brazilian Ministry of Health, personal communication, March 26, 2014.

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In the case study above, we have seen how a *critique* of biomedical obstetrics travels. Through books, seminars, and writing in scientific journals and through social media, the dissident voices of midwives and other alternative birth practitioners and advocates from the US, Canada, and Europe have influenced colleagues the world over. These authors show how the highly intrusive medical techniques routinely practiced by mainstream biomedical obstetricians are being challenged and how a critical consciousness is developing among some obstetricians in Latin America with respect to unneeded interventions in the birthing process.

Elizabeth Cartwright has been working with a group of US doctors who are carrying out a series of teaching seminars on the implementation of diagnostic sonography in rural Peru. Using a sonogram machine that was donated to the small clinic a few years ago, and never put into clinical practice because none of the Peruvian practitioners knew how to operate it, the medical doctors associated with Cartwright's projects have shown Peruvian doctors how to do obstetrical examinations with their sonogram machine. The curiosity of local Quechua-speaking women about the images and what can or cannot be seen about their babies importantly informs how the medical practitioners use the technology within their clinical setting. The discourses surrounding childbirth are changed with the introduction of this machine, notions of risk are different with the sonogram, and expectations and blame now include the 'machine.' This is similar to the process that occurs in clinical settings where monitoring equipment like the electronic fetal monitor is used (Gammeltoft 2007; Georges 2008). Practitioners become dependent on the output of the machine to assess maternal and fetal wellbeing (Cartwright 1998), while at the same time losing the more embodied and experiential knowledge and ways of seeing and assessing a birthing woman (van der Sijpt 2014).

Technologies that fundamentally change biological processes, such as the following case study on the transfer of the technology of assisted reproduction to sub-Saharan Africa, are also moving on an increasingly large scale to areas of the globe that formerly did not have access to them. The innovators that establish clinics and hospitals based on new technologies stand to earn a great deal of money, as they change local practices in related fields and create a medical workforce that has new skill sets, educational needs, and future aspirations. In the following case study, Gerrits and Hörbst highlight how ARTs have opened up a lucrative entrepreneurial space in sub-Saharan Africa.

15.2 Entrepreneurial Barren Grounds

Trudie Gerrits and Viola Hörbst

Assisted reproductive technologies (ARTs) are increasingly becoming available in the global South. In sub-Saharan African countries, they are predominantly offered in private clinics. Private clinics providing these and other new technologies have dramatically changed the landscape of health care in the region, forming an integral component of African health care in the twenty-first century.

In Ghana, private clinics offering ARTs have become a ‘booming’ business over the last decade.¹ These clinics have mainly been founded by gynecologists trained abroad in assisted reproduction, particularly in Europe, before returning to Ghana to start their own clinics.² This phenomenon suggests that the ‘brain drain’ is not a straightforward phenomenon; while some well-trained African professionals leave their countries to work elsewhere, leaving the local health care system without their expertise, others return as medical entrepreneurs.

The rise of the private health sector in sub-Saharan African countries (including Ghana) occurred as part of structural adjustment programs in the 1980s and 1990s. This increase of free health markets in the global South is often criticized for boosting inequalities in health care. In the field of ARTs, private clinics are sometimes seen as exploiting poor and desperate women and men in need of fertility treatment. The high costs of these treatments, and the (ab)use of gamete donors and surrogates, are usually discussed in terms of “stratified reproduction” (Inhorn and Birenbaum-Carmeli 2008). Here, we show how the initiatives of these entrepreneurial doctors trigger professional opportunities and aspirations and new forms of entrepreneurship. The cases we present also provide a glimpse of the cultural changes induced by these entrepreneurial initiatives. Thus, we revive the anthropological—transactionalist—notion that conceptualizes entrepreneurs as individuals acting out of self-interest and by doing so, forming an impetus for cultural change (Barth 1967). We suggest, too, that the various entrepreneurs involved in the business of ARTs hold structurally different positions, which make them unequal actors in this field.

Below, we draw on the life stories of four professionals involved in the market of ARTs, and show how this created professional opportunities and aspirations in life. These stories highlight the prospects of different actors in the ART business: they concern a gynecologist; an embryologist; the director of an agency intermediating between ‘wish parents,’ donors, and surrogates; and a woman acting as a surrogate. Pseudonyms are used for the professionals and the clinic.

From Gynecologist to Clinic Director

Dr. Aidoo founded the LeLena Clinic in 1985. Before that he worked for 19 years in Germany where he studied medicine and specialized in gynecology. He decided to return home and to invest his savings to start a gynecological clinic in Ghana. He felt that “as a medical doctor he could be more useful in Ghana than in Germany.” At that time, Ghana experienced dramatic economic decline and political unrest: “The conditions were very, very bad: hunger, and there was a *coupe d’état*. The economic situation was very, very bad. . . . Apart from that, it is not by chance that God had me born here . . . I have a duty here.”

Back in Ghana, Dr. Aidoo found that infertility was a major problem, and he returned to Germany again to further specialize in in-vitro fertilization (IVF). In 1995, he carried out the first successful IVF in Ghana in his own clinic. His successes received a lot of media attention—in particular the births of twins, triplets, and higher-order multiples. His reputation grew rapidly in Ghana and beyond. His patients now come from all over Ghana and from neighboring West African countries, such as Gabon, Cameroon, Ivory Coast, and Mali. Some of his clients were Ghanaians living in Europe and the US, returning ‘home’ for treatment.

Over the years, with bank loans, Dr. Aidoo gradually expanded his clinic. In 2012 the clinic performed a total of 630 IVF treatments, and by 2013, the clinic employed around 130 staff members, including health professionals, administrative and support staff. In addition to ‘conventional’ IVF, the clinic offered treatments using donor gametes and surrogacy. The number of treatments per annum decreased in recent years, probably due to the recent presence of other fertility clinics: Dr. Aidoo believes that his success encouraged others to get involved in the IVF business.

This growing competition did not prevent Dr. Aidoo from investing in the future of the clinic; rather it made him into a flexible entrepreneur. In 2012 he started constructing a new building to expand the fertility clinic. Given his new competition, he decided to turn the building into an intensive care unit, another area of health care in Ghana that, he claims, needed urgent attention.

While he presents himself—again—as a pioneer, addressing the exigent health needs of the Ghanaian population, most Ghanaians cannot afford the treatments in his clinic. Most of his clients were middle class, highly educated, and/or own or work in private companies. LeLena Clinic had served

the fertility needs of the happy few and generated employment for many people (within and beyond the clinic); and the clinic brought prosperity to Dr. Aidoo, as a taxi driver commented by pointing to his Mercedes Benz, parked in front of the clinic: “He has a huge car park—like the pop stars in America—and many properties too. Dr. [Aidoo] is a very, very wealthy man.”

From Laboratory Technician to Clinical Embryologist and More

Embryological laboratory work is an indispensable part of IVF treatments, but a scarce specialization in Ghana (and the entire African continent). Clinic directors have to invest heavily to recruit international embryologists and/or in training local laboratory staff. In 2013, Richard was in charge of the IVF lab work at LeLena Clinic. He started working there in 2001, initially in the general laboratory, but soon Dr. Aidoo gave him the opportunity to work in the IVF lab. The senior lab technician was supposed to train him on-the-job, but this did not work out well, as Richard complained: “For 3 years I was only observing.” When the senior technician suddenly left the clinic in 2004, Richard had to take over his job, but felt ill prepared to do so. Dr. Aidoo hired a German embryologist to train him, both on-the-job in the clinic and in Germany. Additionally, Dr. Aidoo sent Richard to international conferences and training courses abroad. Richard repeatedly stated: “I am very grateful to all people that helped me achieve this, and I owe it to God as well. I am very grateful to Dr. Aidoo.”

Recently Richard obtained his Master’s in Clinical Embryology from a UK university (that he financed himself), as a result of which he is one of the best-educated ART professionals in Ghana. Upon his return, new opportunities and aspirations soon developed. He started teaching at university level and is now dreaming about “picking the excellent students and training them to work in clinics.” He plans to do his PhD and envisions an academic future as a university professor in human embryology. Reflecting on his prospects, he confirms that he is “thinking of the money too,” as do others in this field. Some months after Gerrits’s last fieldwork visit, Richard explained on the phone that he had been dismissed from the clinic for unclear reasons. Yet, with his scarce embryological expertise, he had full confidence in his future employability.

From Infertile Woman to Director of an Intermediary Agency

Agencies acting as intermediaries between wish parents and gamete donors and surrogates form a recent spin-off of the introduction of ARTs in Ghana. Both clinics Gerrits studied offered treatments with donor materials and surrogacy, and made use of intermediary agencies to treat non-medical issues.

The director of one such agency is Janet, a Ghanaian woman. For a long time she resided in the USA, where she underwent two failed IVF treatments. In 2001 she returned to Ghana to do further IVF, but again the treatment failed. When she asked her Ghanaian gynecologist about the possibility of surrogacy in Ghana, he replied that technically he could do it, but he added: “Where in Ghana are you going to find a surrogate? Because of our culture, it is so difficult.” However, Janet managed to find a woman who was willing to carry her embryos to term and Janet became the happy mother of twins. Her lawyer settled the legal issues, which was not easy as Janet explained: “In Ghana, of course, it was new. So, we didn’t have any laws that say you couldn’t do it, at the same time we did not have any laws that said you could do it.”

At the request of her gynecologist, Janet started to think of ways to help other couples find a surrogate. A year later, she started her own agency, but in 2004 she did so “with big media attention,” as she did not want it “to be a secret thing.” In 2013 the agency had intermediated the birth of 42 children (most of them twins or triplets) using surrogacy and the birth of approximately 300 children using egg and sperm donation. The donors were university students who were in need of money to pay for their fees; the surrogates were single mothers, minimally 25 years old, who wanted “to improve their life conditions.” Janet characterizes the major part of her clients as “career people, like lawyers and bankers. People, who . . . have spent all their life in school or in their career. By the time they realize they are forty, or forty plus, then it dawns on them that ‘this is my problem.’” While initially acting out of self-interest, Janet introduced new (cultural) practices into the Ghanaian society, which in turn enabled her to run a profitable business.

From Single Mother to Surrogate to the Owner of a ‘Chop Bar’

Akuba is one of the women whose temporary job consisted of carrying the child(ren) for so-called wish parents or owners. When Gerrits first met her, she was pregnant with twins and hospitalized in LeLena Clinic, where she was supposed to stay until delivery. Akuba explained that a taxi driver had informed her about the work of donors. She had been desperate: her husband had passed away in a car accident when she was carrying her third child and his family had left her without any financial support. Her job at a filling station provided her with insufficient income to care for her children. After the conversation with the taxi driver, she visited LeLena Clinic, where she learned that she was qualified to be a surrogate—she was single and had given birth to at least one child. After passing the intake interview and a series of physical examinations, she was accepted. She received some information about the process (from embryo transfer to C-section) and about the babies: “They let you know that the babies are not for you. They give somebody’s eggs to you. You know that. The eggs are not from you. The sperm is not my husband’s. It is not my brood. I just carry them in my body.” Moreover, Akuba was told that she was not to be in contact with the ‘owners,’ and would not see the children after birth.

Akuba only informed one person about her stay in this clinic in Ghana; others were told that she was traveling to South Africa to work. During her stay in the clinic—where she felt very well treated—a relative took care of her children, who she missed enormously. A fortnight after she delivered the twins, she was thrilled to return home, taking presents “from South Africa” for her children.

Akuba did not regret having been a surrogate. When Gerrits met her again (four months after the delivery), Akuba proudly showed her the ‘chop bar’—a small street restaurant—she had set up. She had also bought a plot to build her own house and had rented an apartment; and she was proud that she could now pay school fees, buy better food, and meet the health expenses for her children. Akuba had been able to sustainably invest the money earned through surrogacy; some other surrogates, though, were less fortunate: they had to spend their money paying debts, and meeting the costs of funerals and relatives’ health bills.

Akuba, though, was concerned that her chop bar would not bring her enough money to actually build a house on her plot. Therefore, she considered working as surrogate once again. Her hesitations clearly illustrate the two sides of being a surrogate: it is very attractive, as it gives a woman (of her socioeconomic stratum) access to a sum of money that she would not be able to earn with any other job; yet, it also requires a huge investment of her body and life—including missing her children—turning this new form of entrepreneurship into a demanding and ambiguous enterprise.

Our cases confirm insights from other studies that the introduction of ARTs in the global South rather privileges the rich to access these treatments and exclude the poor, who may even get more frustrated about their fertility problem as the treatments are available in the country, yet not accessible to them (Hörbst 2012: 184). Our study also underlines that certain bodies (of poor women) are more ‘bio-available’ (Cohen 2008) than others to serve infertile couple’s wish to have children. Both forms of stratified reproduction clearly increase inequalities in (access to) health.

In our contribution we have particularly drawn attention to the inequalities that exist between various types of entrepreneurs, resulting from the structurally different positions they hold. The degree to which they can profit from their entrepreneurship and the extent to which they can act as independent entrepreneurs varies hugely. The higher they stand on the societal and professional ladder, the more means to invest and safeguard their interests they have. Those at lower societal levels are more vulnerable, less autonomous, and for some, particularly surrogates and donors, the involvement in the ART market is only temporary and comes with serious (bodily) risks. While there may be economic stimuli resulting from the private health market in the contemporary neoliberalist era in the global South, this private market maintains and even reinforces power differentials and inequalities.

Finally, we have shown how therapeutic innovations to address infertility in the global South take place without the support of international donors or public money in the private health sector. This is in contrast to many other (reproductive) health issues where African states heavily

depend on foreign aid (Hörbst and Wolf 2014). The autonomy from foreign money turns the ART clinic directors into independent decision makers regarding financial, medical-technical, and ethical questions. In a context where—to date—no ART regulations exist and effective quality control is hardly applied, the doctors' autonomous decision making highly shape the ways in which clinical practices and treatments are offered to patients. Subsequently questions emerge to which extent business interests and benefits impair medical practices (Hörbst and Gerrits 2015). As this autonomy is—presumably—a characteristic of private clinical entrepreneurs in Ghana and elsewhere in sub-Saharan Africa, our article provides a glimpse of future configurations of the health care system in Africa. With an increasing flow of various biomedical technologies to this continent our article thus hints at important new fields of anthropological research for future exploration.

Notes

1. In 2013, a minimum of eight private clinics were known to offer ARTs in Ghana.
2. This case study draws on data collected as part of the comparative project 'Dynamics and Differences of Assisted Reproduction in Sub-Saharan Africa' (<http://ssaart.wordpress.com>). Here, we only use data from the Ghana study and mainly from one of the clinics. Ethical permission for the study was received from the Noguchi Memorial Institute for Medical Research-IRB.

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As described in this case study, women seeking to become pregnant have new options for trying to influence their biological processes—and those who can provide such services as IVF or surrogacy are in the position to profit from their work. The meanings associated with these 'new' kinds of pregnancies are embedded in the extant cultural meanings of conception, birthing, motherhood and fatherhood. These meanings play into culturally informed marketing techniques as well as the pricing of the commodity of fertility.

In his *Birth of the Clinic: An Archaeology of Medical Perception* (1973), Michel Foucault demonstrates how biomedicine developed in tandem with evolving scientific knowledge of the world as well as in step with changing social norms. The spread and uptake of biomedicine happens in a much less linear fashion in the twenty-first century. Information is exchanged rapidly and often incompletely. Implementation is enacted, not within institutions that have long histories of biomedical development, but rather that are new to the game of 'doing biomedicine.' As the case studies in this chapter show, the resulting configurations of technology and their social relational matrices are reflective of different historical traditions and different access to the accouterments of the hospital-clinic-industrial-complex. Medical anthropologists need to be sensitive to the way in which biomedicine is a rapidly changing assemblage (Lock and Nguyen 2010). In highly technological health systems electronic databases and oversight have led to the guidelines of medicine becoming more standardized and the judgment of clinical practice is changing from one based on a relationship that takes place in person to one that is mandated to be performed in a standardized manner and monitored

closely by insurance companies who pay for health. 'Big data' will increasingly create opportunities to store, link, and collect patient data that will lead to different kinds of analytics, and these analytics will be used to change the way that hospitals are run and how care is given. But in the Internet-outback, older forms of practice may still be those based on human-to-human caring and thus may be superior in some ways. In less-resourced settings, clinicians, like other kinds of healers from different local and broader cultural traditions, necessarily rely on their capacity to interact with their patients and to 'read' their bodily and behavioral signs and symptoms.

Biopower, understood as the state-level control over populations through establishing norms related to the body, then enforced through mandating behaviors based on those norms, is changing rapidly as more and more medical knowledge is located on the Internet and in repositories of big data. As discussed in Chapter 8, the everyday habitus of many practitioners has changed, and they are becoming increasingly dependent on 'smart' technologies such as smartphones and tablets. The current medical doctors in resource-high countries are accustomed to not needing to recall information beyond where it can be immediately accessed on their mobile devices; practitioners in the Internet-outback still have to rely on traditional medical tomes, intuition, and only sometimes their electronic technologies.

The Politics of Global Surgery

Global health is changing rapidly as progress is made in some areas, while other areas remain intractable or even worsening; conditions and resources change in response to shifts in economies, environmental transformations, and wars (see also Chapters 11 and 13). Global surgery is one aspect of global health that has lagged behind in its goal of expanding cadres of well-trained and well-resourced surgeons and facilities worldwide. As Mamta Swaroop, MD, FACS, writes on the Association for Academic Surgery official blog,

Approximately 5 billion out of 7 billion people in the world have no access to basic surgical care. Lack of access to safe and timely surgical care results in more deaths and disability than HIV/AIDS, tuberculosis and malaria combined (Meara and Greenberg 2015). Although international priorities are starting to reflect the importance of non-communicable diseases, provision for essential services lags behind.

(Swaroop 2015)

Below, Adia Benton follows the politics of the developing sub-specialty of global surgery within the larger field of global health. Benton focuses on the academic side of global surgery. In the academy, funding is competitive and the stakes are high for getting particular specialties recognized and on the agenda of all kinds of funding agencies.

15.3 Surgery and the Cultural Politics of Global Health

Adia Benton

In late January 2014, I attended the first of three commission meetings on global surgery, organized by *The Lancet*, one of the world's leading medical journals, and by Harvard Medical School, Lund University (Sweden), and King's College London, to address lack of access to surgical care in resource-poor countries. Attendance at the meeting in Boston was by invitation-only; invitations were distributed to a relatively small and select group of global health and surgical practitioners. After learning about the closed meeting through social media and professional contacts, I managed to secure an invitation to attend and observe in the second day's proceedings.

In a tightly packed program, speakers came to the podium to give presentations about issues that matter most in mainstream public health: cost-effectiveness; metrics of prevalence, disability, and mortality; institutional capacity building; global advocacy and policy stakeholder buy-in. Social justice and equity were notably muted in these discussions, but as in many mainstream public health projects, their relevance as an underlying motivation for action was nonetheless present. Surgeons, health and welfare ministers, prominent non-surgeon clinicians, and economists and health policy analysts from all over the world made brief presentations. The commissioners, a group of experts who would ultimately co-author the report of these meetings, sat near the front of the room in an area reserved for them. The commissioners represented a diverse swath of experts in health economics, engineering, surgery and public health, and hailed from each major region: Western Europe, southern and West Africa, and the Pacific.

Amidst concerns about transparency among the growing community of global surgery advocates, the presentations streamed live on the Internet for those who were not invited and unable to attend. Meeting conveners used social media platforms like Twitter and Facebook to foster a sense of openness and inclusion. Virtual and live attendees tweeted about the presentations, using the official meeting hashtag, #LGCOS1. Following Twitter chatter about the meeting provided me an opportunity to track interest in global surgery, gauge reactions to meeting proceedings, and visualize the ephemeral and shifting connections among global health actors—whether they were seated in the meeting room or observing with their smartphones halfway across the world. At times, it was difficult to determine where the (virtual) Twitter discussions began and live (meeting room) ones ended. Tweeted questions were read aloud by moderators during Q&A sessions; tweeters who recognized me in the room and were familiar with my research urged me to step up to the microphone. As the global surgery ‘twitterati’—individuals who amassed a following on Twitter and frequently tweeted under the #globalsurgery hashtag—commented upon and posed questions about the presentations, audience members in the small meeting room quietly interacted with their counterparts in the room and in distance locales online.

When Paul Farmer, a well-regarded infectious disease physician and anthropologist, came to the podium, @bnwomeh, a surgeon tweeting from US Midwest, claimed to be #starstruck. He posted a picture of an article Farmer had co-authored with fellow physician-anthropologist and World Bank President, Jim Yong Kim, daring any onlooker to deny they had cited it in their work or referenced it on their presentation slides. The tweet started a chain of comments on the article’s most referenced line, that surgery is ‘the neglected stepchild of global health,’ and garnered reverential recognition of Farmer’s and Kim’s commitment to improving access to surgical care among the world’s poor.

The surgeon’s tweet was both a joke and a provocation for its readers to contemplate—if only for a second—the strategies that global surgery advocates used for this newly delineated sub-discipline within global health. In particular, in his tweet, @bnwomeh called attention to the conventions (some might say, politics) of scholarly publication traditions, which implicitly require an author to situate one’s work in relation to the existing literature. Not all articles are citation-worthy. As in other fields within global health, to become a well-respected scholar, one must also demonstrate facility with and knowledge about the state-of-art developments in their field; one must exhibit the ability to discern good science from rubbish—to cite the appropriate people and publications.

To reference the Farmer-Kim paper, specifically, was also to signal a strategic ideological alliance with a rich legacy of social medicine and anthropological critique of public health. Global surgery advocates’ frequent reference to this paper for its evocative storybook-inspired kinship metaphor (‘neglected stepchild’) also suggested that the surgeons who are at the center of this movement had not yet found—and perhaps were not trying to find—their own powerful language to describe surgery’s marginal and seemingly abandoned status within global health.

The tweet and the responses to it constituted a diagnostic event in the ebb and flow of ‘transnational’ communication about and within the global surgery movement. The event indexed several important issues related to global surgery’s struggles to achieve legitimacy and to be fully adopted into an ever-expanding global health family, in relation to the ‘cultural politics’ of global health. Global surgery advocates have faced and continue to face multiple challenges in their quest to achieve legitimacy and acceptance in the field. Research and publication are one strategy they have used to reach their goals. While they have venues like *The World Journal of Surgery*, which started in 1977, for instance, to publish, their work has only recently received sustained attention in mainstream medical journals, as in the case of a special edition of *The Lancet* in 2014.

Global Surgery's Imperial and Military Roots

'Global surgery' is relatively new, in the sense that surgeons, anesthesiologists, and their colleagues in wealthy countries have only recently begun to carve out a specific place in mainstream public health initiatives that target low- and middle-income countries. Global health, generally associated with longer-term development programs, has also been subject to the same critiques as its development counterparts. The most frequent critique is that personnel, ideas, and funding from wealthy countries travel to and dictate health priorities of poorer ones. For the field's critics working within and outside its boundaries, this relationship has the potential to be neocolonial in its approach and aims. Thus, most global health institutions, including newly emerging ones aiming to address disparities in and unequal access to surgical care, attempt to confront this critique head-on and from the outset of projects.

Priorities in global health are largely oriented towards primary health care and low-cost preventive measures. These measures include prenatal care, 'attended' childbirths, childhood immunizations, management and treatment of common childhood illnesses, and infectious disease control. While surgery's importance for obstetric conditions is well articulated and accepted as global health orthodoxy, the significance of surgical care for treating victims of accidents and injuries, cancer, and other conditions has been marginalized in global health discourse, even as they constitute a significant health burden in global health metrics and indices.

However, transnational surgery projects have long existed. This is not simply because modern surgery travels and circulates to places under the umbrella of charitable biomedicine; it is also because surgery was uniquely implicated in the expansion of imperialism, and in the optimization of military forces, imperial and national, in combat. Many technological advances in surgery, moreover, resulted from need to treat a range of battlefield injuries. New weapons and war technologies have gone hand-in-hand with progress in surgical diagnostics, instruments, and techniques.

Surgery has also been a significant aspect of missionary and humanitarian interventions. From the colonial era through today, missionaries have set up hospitals in the most difficult-to-reach places; in some underserved areas, the only clinicians trained in surgery may be located in mission hospitals. Charities and non-governmental organizations that primarily perform surgeries, like Mercy Ships or Operation Smile, set up shop for weeks at a time, operating on patients who would otherwise have been unable to access surgical services. While many of these missions have relied on short-term international labor, they now appear to be operating under development principles—providing 'sustainable' and long-term solutions to lack of surgical care in certain places through education, training, and logistics management. And in humanitarian emergencies, whether coupled with military forces or not, surgery for conflict- and disaster-related injuries and conditions are foregrounded in a medical response.

Radical Health Movements, Delayed Acceptance

The primary health care movement, which came to its peak with the WHO Declaration of Health for All in Alma Ata in 1978, featured contestations and debates about what kinds of care come under the rubric of 'primary health.' Primary health care proponents saw the model as revolutionary, central to liberation movements occurring in places like southern Africa at the time. Enlisting surgeons, specifically, who had largely been left out of the conversations about primary health care—particularly with the problem of 'appropriate technology' looming large—became an important goal for the program's architects. On June 29, 1980, Halfdan Mahler, then Director-General of the World Health Organization (WHO), addressed an audience at the Biennial World Congress of the International College of Surgeons in Mexico City. He urged surgeons to join a burgeoning primary health care movement:

Surgery is a practical affair. It has to be by its very nature. . . . It cannot escape the political, social and economic factors that influence all human endeavours. Social injustice is socially unjust in any field of endeavour, and the world will not tolerate it for much longer. So the distribution of surgical resources in countries throughout the world must come under scrutiny in the same way as any other intellectual, scientific, technical, social or economic commodity. The era of only the best for the few and nothing for the many is drawing to a close. . . .

Surgery clearly has an important role to play in primary health care and in the services supporting it. . . . primary health care includes the appropriate treatment of common diseases and injuries. Surgical first aid is therefore an essential part of it. Without it, in spite of preventive measures aimed for example at preventing accidents, people will not have faith in primary health care. . . .

This is the challenge I want to face with you. Conventional solutions are not likely to be very satisfactory. . . . There are tens of thousands of drugs on the world market, and only a few years ago the problem of getting essential drugs to the masses appeared just as intransigent to solution as the problem of providing essential surgery for the masses. So we set up a committee of experts on pharmacology and they arrived at a list of about 200 essential drugs that could cover most requirements. Could the international surgical community do the same for surgery? (Mahler 1980)

This official acknowledgment of the need for surgery to be a part of primary health care highlights surgery's 'practical' nature, its potential for realizing social and political justice, and, perhaps most notably, its potential for legitimizing primary health care as a model. Yet, despite the mounting enthusiasm about surgery in the immediate post-Alma Ata period, Mahler's plea to the surgeons largely went unaddressed by major international health institutions such as the WHO in the years that followed, leaving individual humanitarian service organizations to bridge the gap. Major institutions instead first focused on 'appropriate technologies' that could be delivered at low cost and with minimal training. The emancipatory potential of primary health care was further dulled by Cold War politics and international financial institutional responses to the 1982 Latin American debt crisis (Cueto 2004; Werner et al. 1997). Growing interest in health as a way to cultivate 'human capital' accompanied, and perhaps, encouraged greater involvement by World Bank in health issues. A focus by the World Bank on health also meant a fundamental shift in how health was conceived within health organizations, more broadly. The 'health for all' mandate of Alma Ata soon became 'investing in health,' with health being a function of human capital and oriented towards productivity, efficiency, and meaningful participation in a market economy.

Eventually, the list of essential surgical services that Mahler requested in 1980 was developed for use by the WHO, leading to the establishment of the Global Initiative for Essential and Emergency Surgical Care (GIEESC) in 2005. This initiative centers on promoting a set of training tools for district hospitals and 'surgical capacity' checklists. Even with this increasing recognition by mainstream global health institutions, the GIEESC faced almost certain dissolution. Plans were made to shut down the program. The input by a network of influential clinicians was able to secure support for the initiative's continuation, suggesting that expanded access to surgical care may be picking up support—precarious, though it may be—among global health power brokers.

Research funding agencies like the US National Institutes of Health (NIH) and among academic associations are beginning to pay attention to access to surgical care; the fact that the Global Commission mentioned earlier in this essay, exists, for example, is evidence of the growing recognition of surgery within these realms. And this is part of the strategy for legitimacy. So the logic goes: procuring research funding both enhances and reflects significance of the research problem; it also institutionalizes an issue and grants it validity and value within academic research disciplines. One surgeon, who had devoted much of his career to addressing surgical access, told me that although he had no interest in pursuing a career in academic surgery, he soon recognized that conducting and publishing research was the only way to bring attention to the need for improved access to surgical care. He began with the rudimentary data collection tools provided by the WHO, but soon branched out into more complicated and costly research involving population-based surveys. Within a short period of time, he and his co-authors—most of whom were developing country nationals—had become noted experts in the field.

Conclusion

Access to surgical care has been peripheral to global health priorities but is becoming increasingly important as various forms of cancer, road accidents, and injuries—conditions that may require surgical interventions—gain prominence within the field of global health. The long tradition of scattered programs and interventions across the globe involving surgery appears to be shifting as global surgery advocates publish scholarly papers, build research portfolios at academic institutions, and push for better training, equipment, and supplies for performing safe surgeries in resource-poor settings. Professional associations are intensifying their global outreach, as they did in the 1960s and 1970s to the lead-up to Alma Ata: the Academic Association of Surgery (AAS) has a global affairs section and supports clinical training, and knowledge transfer between resource-poor settings in both the developed and developing world.

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Benton sheds light on some of the behind-the-scenes politics that either support or defeat the spread of international surgical training. Beyond the good intentions of medical practitioners—especially in this case, those in academe—there is always the question of who is paying for the expensive training missions, educational materials, medical equipment, and travel for teams of trainers; the resources needed to make surgical systems of care sustainable are often inadequate or non-existent. While surgeons dedicated to improving global health through disseminating their skills are addressing a slow-moving ‘train wreck’ of increasing trauma from more motorized vehicle travel and the recognized need for basic surgeries, too, the next section of this chapter deals with a faster ‘train wreck’—we turn to consider the out-of-control, fast-moving, deadly Ebola epidemic of 2014 that took place primarily in Guinea, Sierra Leone, and Liberia.

What Ebola Teaches Us

Death is dangerous from a cultural perspective: it underscores the unpredictability of life; unsettled souls and poses a threat to the living; and one death may be the harbinger of other deaths. This is literal when death is due to infection; hence the stigma commonly associated historically with the plague, smallpox, and tuberculosis (Goffman 1963) and in contemporary society, still with tuberculosis and now also with HIV. Ebola is the most recent virulent epidemic. By 1 April 2015, a year after the first cases of the current epidemic were diagnosed in West Africa, the World Health Organization had estimated a total of 25,000 cases and at least 10,000 deaths from the virus, many not reported. Medical anthropologists have played a major role in this epidemic for several reasons that highlight the social life of any disease, including by effective use of the Internet (<http://www.ebola-anthropology.net/>), and have drawn attention to the economic and political factors that have shaped transmission and control, the logics of public health, and the importance of working with, not despite, populations.

Ebola is transmitted through contact with blood and body fluids, including sweat, and so ordinary close human contact is a risk factor for infection. Consequently, close family members and health care providers caring for those who are sick are at high risk for infection. Practices around the care of the dead increase risk of infection, particularly in communities where bodies are washed and wrapped before internment. In the early months of the epidemic, in an atmosphere of heightened emergency and increased fear, there was little engagement with communities; consequently, communities resisted the demands placed on them to report cases of fever and death. During this period, Médecins Sans Frontières (see Redfield’s case study, this chapter) played a major role in delivering medical care; until December 2014, almost all people with suspected Ebola infection were treated in MSF clinics primarily because of the fragile infrastructure, limited capacity of government hospitals, and the direct loss of the lives of local health providers. But communities themselves also drew on local knowledge of previous epidemics, of smallpox, for instance, to initiate quarantine and so to try to limit the spread of the virus.

Ebola impacted heavily on select communities in Guinea, Liberia, and especially Sierra Leone, already with fragile health services and limited systems in place to manage medical emergencies. As Raphael Frankfurter describes, hospitals rapidly became overcrowded and cemeteries ran out of space; villages at times of necessity resorted to mass graves.

15.4 ‘Safe Burials’ and the 2014–2015 Ebola Outbreak in Sierra Leone

Raphael Frankfurter

In late March 2014, the World Health Organization reported that the Guinean Ministry of Health had identified an outbreak of Ebola Virus Disease in the remote forests on the border with eastern Sierra Leone. An extremely contagious illness with no known cure, Ebola had been recognized and controlled in a series of outbreaks, almost exclusively in central Africa, over nearly four decades, but an outbreak had never been identified before in West Africa. Though it took months to recognize the hemorrhagic illness slowly spreading across rural Guinea, epidemiologists suspect that the outbreak began as early as December 2013.

Ebola is a zoonotic disease, endemic in a host species until it jumps to humans in a cross-species transmission event. This is thought to occur when a hunter or cook is exposed to the body fluids of an infected animal—often bats or monkeys, which are eaten as a major source of protein in many areas of remote West Africa. Those who are exposed undergo a 7–21 day incubation period during which they show no symptoms and are not infectious. Next, the early symptoms of Ebola are identical to far more common tropical illnesses like malaria and typhoid: sudden onset of a fever, fatigue, and abdominal pain. Patients begin to exhibit ‘wet’ symptoms like severe diarrhea and vomiting, and in the later stages of the disease some patients begin to bleed out of their gums, eyes, ears, and anus. The disease is transmitted solely via infected body fluids after the patient is symptomatic; as the disease progresses and the viral load increases, these fluids become increasingly contagious. Patients who only have ‘dry’ symptoms are hardly contagious; vomit and body fluids contain a larger amount of virus, comatose patients spread the disease with increasing intensity, and corpses are extremely contagious. Up to 90 percent of patients die with no rehydration or supportive care; with proper medical support that number can drop to well below 1 percent. The only means of controlling the disease from spreading is to isolate patients while they are sick, cared for by health workers wearing thick protective equipment obscuring their faces and bodies. Corpses must be wrapped in plastic bags, drenched with chlorine and buried by ‘Safe Burial’ teams wearing hazmat suits. In much of West Africa where families care for ill and dying family members in the home and intimately handle corpses before burying, communities and families may resist these restrictions on touching and caring for the ill and dead. For this reason, ‘cultural practices’ and ‘burial beliefs’ are often listed as primary modes of transmission and obstacles for responding health workers to overcome in order to contain the spread of the disease (Nielsen et al. 2015).

In late May 2014 the first cases of Ebola were publicly reported in a remote region of Sierra Leone. Seven people who had attended the funeral of a local healer in Guinea returned to Kailahun District, exhibiting the signs of the disease. In the time since the outbreak had been identified in Guinea, the Sierra Leone Ministry of Health had developed a strict protocol and response system for suspected cases: patients would be isolated in their community’s clinic, blood samples would be rushed to a well-equipped hospital in Kenema with isolation facilities, and if positive the patients would be transported rapidly in designated Ebola ambulances to Kenema for basic care. What the response protocol did not account for, however, was a plan to communicate to families, empathetically and transparently, what was happening to patients after they entered the Ebola response system.

Within days of the first cases, things began to go awry. Families barged into the local clinic removing confirmed Ebola patients awaiting transport. Rumors began circulating within Kailahun and throughout the eastern regions of the country: “They’re bringing people to Kenema to die! Once they take them away they don’t come back!” Very quickly, those in affected villages came to know that Ebola was a near-certain terminal illness. Family members claimed they were not informed when, where, or even if their relatives died and were buried after they were whisked away from their community’s clinic by men in hazmat suits. The families of the initial patients soon

contracted the disease, and as the bodies of those who had succumbed were prepared for burial, scores of funeral-goers contracted Ebola. Some patients presented to clinics, and ill-prepared nurses found themselves at high risk. Within two months, the Kenema hospital isolation center had largely shut down: the doctor in charge and dozens of nurses had fallen ill and died. As the outbreak spread, so too did a flurry of shallow discourse and education campaigns organized by the Ministry of Health and responding non-governmental organizations (NGOs) aimed at halting ‘harmful cultural practices’ associated with the spread of the illness. “These people refuse to believe!” a local health authority told me in June. “Their cultural practices”—caring for and touching the ill in their homes— “are bringing it on themselves and the country.”

By late October, treatment centers were overwhelmed, and nearly every hospital in the country had closed. A near-constant stream of possible Ebola patients weaved its way towards the capital city Freetown’s hospitals, only to be turned away when facilities were at capacity. Meanwhile, health officials were faced with massive numbers of infected corpses. The Sierra Leone government identified large burial plots staffed by ‘volunteer’ grave-diggers across Freetown and hired more ‘Safe Burial’ teams. The Ministry of Health developed a sluggish but improving Alert Hotline to report sick and dead bodies in homes, but responding epidemiologists insisted that cataloguing and tracking the numbers of dead bodies was critical. “We’re trying to create a system so that in any remote clinic in the country, the nurse will wake up in the morning, count their dead bodies, call it in and then get them in the ground,” one expert explained at a coordination meeting in Freetown. The apparatus for processing the bodies involved creating an asocial system, where corpses would be taken promptly and far away from their families. But the emphasis on counting—in addition to burying, often slowing the response process—seemed to emerge from three broad goals: (1) to provide a means of determining where response resources should be concentrated, as a proxy measurement of the epidemiology of the disease; (2) as a way of enforcing the government-run ‘safe-burial’ system, and (3) to generate valued empirical public health data on how such an outbreak would run its unfettered course. In some districts, ‘Safe Burial’ teams apparently waited next to corpses for hours for separate teams of epidemiological officers to arrive and take a test swab to catalogue the body as ‘Ebola-positive’ or ‘Ebola-negative.’

By November 2014, ambulances wailed all night answering the backlog of ‘live alerts’ and ‘death alerts’ in Freetown. The World Health Organization (2014) released recommendations for “Safe and Dignified Burials” (my emphasis), which mandated that bodies be buried in the vicinity of victims’ families, communities be asked to participate in burying the coffin, and family members be informed of patients’ outcomes, but these standards proved difficult to implement. Overwhelmed health workers and NGOs found it difficult to keep up with the number of corpses even without ‘community assistance’ and even more difficult to track where patients had come from when they entered large NGO Ebola Treatment Units. In the mornings in Freetown, amidst hundreds of billboards imploring citizens DO NOT TOUCH DEAD BODIES: CALL 117 FOR A SAFE BURIAL TEAM, clusters of people huddled in the street, each surrounding a corpse. Many victims seemed to have crawled from their homes at night, but the outbreak also seemed to have reached a certain threshold of destruction so that an increasing number of dead or dying victims were being dumped on the street by their families.

Kono District, a remote region in eastern Sierra Leone known both for its rich diamond flats and as the former epicenter of the country’s 10-year civil war, was largely spared from the Ebola outbreak until late 2014. The region is extremely impoverished; the health care system in disrepair. There were two doctors for nearly 540,000 people, under-5 mortality rates often hovered above 2 percent, and most public clinics in rural villages were barely functional. In the context of this poverty, history of war, government reconstruction plans that had yet to materialize, and the whirlwind of humanitarian NGOs that had come and gone in the wake of the civil war, the population—largely from the Kono tribe—are known to navigate a particularly rich landscape of local and traditional healers rather than, or in tandem with, seeking biomedical care at their local clinics. Though the forms of care that these local healers practice vary—some specializing in herbal remedies, some in divining sorcery, some in extracting bullets shot by ‘witch guns,’ and some in creating amulets to protect from illness—the relationships that patients develop with local healers are profound, long-term, and intimate. Healers often treat patients in their homes, encouraging the participation of the patient’s family in tactile rituals and processes of healing like washing the ill, massaging and applying herbal ointments, and hand-feeding herbal medicines. Other healers maintain ‘healing compounds’ where patients come to live alongside others for long-term treatment, creating bonds of solidarity among patients with similar conditions. Though differing beliefs in the causality of illness inform these practices, these

local processes of caregiving serve as a rather pragmatic source of solidarity that enable patients to make-do through chronic and cruel poverty and disease.

Burials and funerals are similarly empathic and central events in Kono life. When a person dies in the home, immediate family members often communicate the death by wailing and sobbing as neighbors come to pay their respects. The male or female village elders then prepare the body for burial, by intricately washing the corpse and clothing it in a white sheet. Body washing is an especially elaborate ritual for the first-born in a family, including anointing the corpse so as to prevent the death from spreading to other children. The parents are also specially washed. For certain highly ranked members of the Kono male and female ‘Secret Societies’—local organizations into which adolescents are initiated and then trained in the cultural knowledge, history, and day-to-day skills of Kono life—the *Sowei* (female society heads) or *Pomasu* (male society heads) are involved in the cleansing process. If there is a series of deaths in a family, diviners may also be called to investigate the corpse to ascertain the cause of death.

In many funerals, the corpse, shrouded in white, is displayed in an open coffin as large numbers of relatives gather to mourn. The immediate family often wails the loudest, comforted on all sides by relatives crying in sympathy. Before the coffin is brought to the burial plot, many of those at the funeral rush up to kneel at the foot of the coffin, touching the corpse through the white sheet one last time or kissing the coffin. Since the Kono tribe is half Muslim and half Christian, the final stages of the funeral are often directed by a pastor or imam according to religious tradition.

Though most of these rituals serve to ensure that the deceased is at rest and will not torment the living, many in Kono emphasize that the most critical aspect of a funeral is an emotional one. “People show you all kinds of concern—even people who never showed you concern when you were alive,” a student from an interior village explained to me. Such expressions of empathy are particularly important for those in Kono who live in such proximity to serious illness and death. “People make sure that they wash you and the corpse fine, they go and cry with you—they make sure that everyone cries on the body, they dress them in white satin, follow the body to the cemetery. This is about showing concern.” These funeral rituals bring families and relatives together for last-goodbyes and joint ritual, turning the uncertainty, chaos, and tragedy of a death into tangible, choreographed, and collective practice. When I asked the student if he sought to perform these burial rituals because he believed they were critical to prepare for the afterlife, he paused. “For some, this is about different beliefs,” he said. “But for me, it is about tradition. I wish people to perform these rituals, for they are our tradition, but I do not *believe* 100 percent.”

In November, a series of imported cases that had turned into small transmission clusters overwhelmed the Kono Government Hospital’s isolation unit. The small, converted ward, intended to house only a few patients while they awaited transfer to a formal NGO Ebola Treatment Unit, filled with suspected Ebola patients, and many sent to the isolation unit as a precaution likely contracted the disease there. Over the next month, scores of bodies piled up as overworked ‘Safe Burial’ teams struggled to keep pace—by December, 40 infectious corpses were reported to be strewn in the isolation unit awaiting burial.

Without proper triage systems and frightened Ebola ‘suspects’ entering and leaving the isolation unit, nurses in the hospital were at great risk. Among those who contracted the disease in the hospital was Nurse Mamie Bangura, a nurse-aide in the women’s ward. “My mother wanted to be where the patients struggled, that’s what her job was,” Mark, her son, explained to me. “She thought she contracted the disease taking care of patients at night during her shift, when the doctors aren’t even there and she was the only nurse.” One evening when she was at home, Nurse Mamie reported feeling cold and feverish. She checked into the woman’s ward of the hospital that she had worked at, and the next evening she began to vomit. Her son continued:

They thought it was malaria, but when she vomited they pulled her to the [isolation] ward. They said they would quarantine the whole area, and all the patients in the hospital ran away. She went to the hospital on Friday; on Sunday they told us she has Ebola. When I went to visit her, they told me at the hospital that she had gone to an ‘Ebola place’ in Kailahun District (an Ebola Treatment Unit operated by Doctors Without Borders).

[A few days later] my uncle came to me and said: “Your mother died! Your mother has died of Ebola.” They buried her in Kailahun. I don’t know where, up to now nobody has told me. That’s the thing that’s been bothering me the most, I don’t feel good. I haven’t seen my mother’s grave. Two things make me feel bad: (1) that I never got to speak to her, and (2) that it’s my responsibility to bury her, I’m the first born child, but I don’t know where she’s buried. If I go

to the grave I will be able to photograph it, just know that it's her grave. "This is my mother's grave!" I'll be able to show my children and say, "This is your Granny's grave!" But I don't know.

Mark returned again and again to the fact that he never saw any of his mother's belongings after her death. This was certainly a result of infection-control protocols—all clothes, cell phones, ID cards, and other items are burned as soon as they enter an Ebola isolation unit—but Mark fixated on this fact as if it were the most uncomfortable sign of disrespect. His mother seemed to have disappeared without a funeral and without a trace. "A lot is on me now. . . . I'm responsible for my family. This is all bothering me now."

Soon after Nurse Mamie's death, the outbreak exploded in Kono District, with up to 27 new cases per day. A large surge in cases occurred in Kombeh village, where a well-known taxi driver named James had fallen sick after driving a seriously ill friend to the hospital in his taxi. Aware of his risk, James went to the hospital for screening and isolation but was turned away at the triage gate by confused and overwhelmed medical officers. He returned home, and died several days later with his family nearby. James's family notified the Ebola hotline that they had a corpse in the house that needed to be buried, but the village leaders reported that it took 36 hours for the epidemiological officers and burial team to arrive. All the while, James's corpse lay in the house until it was brought to the mosque nearby for pre-burial rituals. Some villagers reported that one third of the community wept over and cleaned the body. Ten days later, dozens of villagers were reported ill in their homes, and Kombeh became the most severe hotspot in Kono District.

Though transmission rates greatly declined in Kono after the alert hotline was improved and a series of small Ebola 'Community Care Centers' were constructed in remote villages for patients to be isolated close to their families, in 2015 all burials are still outlawed except for those run by the 'Safe Burial' teams. Even people who die in vehicle accidents or of old age are to be tested for Ebola and buried far from family members by the teams. Though in practice this probably means that the vast majority of ('unsafe') burials are done in secret, pickup trucks with masked men in white suits sitting in the open back shuttle back and forth from the hospital to villages to the burial ground all day long. Occasionally a lone vehicle trails with family members who wish to watch the body go into the ground from a distance.

The Ebola outbreak and the 'Safe Burial' process has clearly ruptured rituals and funerary practices, but some families continue to wash bodies of relatives who have died in their homes, resisting the instruction of health workers and Sierra Leonean law. But as these cases illustrate, the reasons why 'unsafe' burials have been practiced throughout the 2014 Ebola outbreak are entangled and ambiguous. Cultural practices, intimate expressions of affect and empathy towards the deceased and mourners, a desire among family members to maintain 'traditions,' and the pragmatic consequences of an under-resourced and ineffective Ebola response system unable to remove corpses promptly, have all contributed to the propagation of the disease through corpses. Ultimately, the optics of the 'Safe Burial' system—every dead body wrapped in an anonymous white bag, handled like a disease-threat by a team of men in biohazard suits—may actually be the most disruptive aspect of the outbreak. Ebola containment is atomizing and inherently counter-social. Dying, death, funerals, and burials have been turned from central, tactile, and intimate social processes to grave public health hazards: bodies are no longer the remnants of lives lived to be mourned at funerals but disease-carriers to be processed and removed. "They say 'Safe and Dignified,'" a Sierra Leonean colleague told me in Kono as we watched the burial team weave its way with a bagged corpse to the mass burial ground. " 'Safe,' maybe, but certainly not dignified. Where are the relatives at the back crying? Where are the hundreds of people paying their sympathies? This is what we here in Sierra Leone imagine for ourselves. No—safe and *undignified* burial is what this Ebola has done to us!"

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Frankfurter shows us how the epidemic played out on the ground. Practitioners relied on local networks of intelligence. Health workers in dedicated vehicles drove into villages where there were suspected cases of Ebola, entering houses to dispose of the clothing, bedding, and other items of those who had died, and swabbing corpses to confirm cause of death. Oftentimes they neither explained nor gained consent for these procedures and protocols from family members. They left with dead bodies, again without appropriate consent, disposing of the corpses in body bags—white for children, black for adults—ignoring the conventional use of white for all corpses. Ambulance drivers and body handlers suffered the most collateral damage. Colleagues from WHO working in Sierra Leone at the height of the epidemic in 2014 reported that paramedics were excluded from entering the hospitals to which they delivered those who were ill; instead, they were secluded in sheds in hospital yards, subjected to extreme stigma from other health workers and from their own families. Reduced transmission and the potential end of the present epidemic have occurred, and this has been facilitated through extensive community engagement, the provision of health information so that people understand how transmission occurs, and social mobilization to support communities where emergency responses might be required. The experience from Ebola emphasizes the need for consultation between epidemiologists, health workers, and communities and the significance of local traditions in the care of the dead both in relation to disease transmission and in regard for the dead and bereaved.

In the following case study, the final of this volume, Peter Redfield takes apart the logic of MSF, an NGO that was originally conceptualized in the 1970s as a non-political, quick-response team that would provide medical care in war zones and other crisis situations. MSF has grown over the ensuing decades to a very large, multinational player in the global health scene; MSF's impressive successes and now-established worldwide reach are also its greatest challenges.

15.5 Doctors Without Borders and the Global Emergency

Peter Redfield

For the contemporary aid world, the category of 'humanitarianism' commonly designates short-term relief work—actions intended to rescue people from immediate peril and promote their survival. Perhaps no organization exemplifies this emergency orientation more fully than Médecins Sans Frontières (Doctors Without Borders or MSF), which casts itself as a central actor of frontline medicine in crisis settings worldwide. Rushing breathlessly from site to site, the group has expanded from a ragtag French alternative Red Cross of the 1970s into a well-established multinational NGO known for both a combative tradition and excellent logistics. Moreover, it largely funds itself through private donations, with a budget now in the order of \$1 billion a year.¹ Relatively rich and independent, it can chart its own course to a greater degree than most aid actors. In conceptual terms the group identifies more strongly with humanitarianism than development, defining its commitments through present states of crisis rather than future goals. While its projects encompass a wide range of medical activities, many well beyond urgent care, MSF's sheer existence extends an ambulance ethos on a worldwide scale. The group's trajectory thus outlines both the possibilities and the limits of emergency medicine as a response to economic inequities and political violence. To illustrate its mode of urgent action, below I sketch a day in the life of one project, combatting a minor epidemic among civilians caught in a conflict zone.

A Case of Cholera

Near the end of 2004, I visited a cholera treatment center run by the Swiss branch of MSF in northern Uganda. The outbreak, focused in a displacement camp outside of Gulu, appeared to have run its course. Although the treatment center counted as an emergency project in the lexicon of the organization, the threat had subsided enough that there was little anxiety. Instead pressure came from

an internal source: in a few days MSF planned to close the center and move the equipment back to its local headquarters, with an eye toward redeploying it elsewhere. Due to this self-imposed deadline on top of their other work, the staff found themselves quite busy. After a morning meeting in Gulu that ran late, I joined a Dutch doctor, a Portuguese nurse and a Ugandan driver to travel to the camp. We threaded our way through the center of town, packed with a mix of storefronts and signs for aid agencies, and set off on the dusty and bumpy road. Along the way the doctor briefed me on the project. He was by now quite familiar with the disease, having seen it many times before, and was thoroughly comfortable with the prescribed treatment. "It's quick, so OK," he noted, and then added, "With rapid response it's easy."

Indeed, for MSF cholera treatment had become something of a routine. Over the second half of the twentieth century, the disease proved a common scourge of human displacement, regularly appearing in refugee settings where people crowded together with contaminated water and poor sanitation. Cholera outbreaks had helped inspire the group's development of a kit-based logistics system in the 1980s, with depots full of prepackaged equipment ready for deployment in emergency. Once on site, the cholera kit provided any medical team with the essential means to set up a sanitized treatment zone, and confine and rehydrate patients within it. Most of the time the approach proved quite reliable in quelling an outbreak and dramatically reducing mortality. The combination of assertive public health and basic clinical care transformed an exceptionally deadly disease into a relatively ordinary problem.

This particular case appeared a success as well. The compound, when we finally reached it, stood largely empty. Surrounded by a tall reed fence, with chlorine sanitation stations guarding its entrance and a large MSF flag flapping overhead, it resembled nothing as much as a minor colonial fort. Once through the sanitation barrier, we entered a set of large tents with beds set up for patients. Only a few were still occupied, and the patients and caregivers looked more bored than distressed. As the doctor explained, diarrheal cases continued to trickle in, including a few cholera patients, but the records for the last few weeks indicated the epidemic was at its tail end. Since this structure was a temporary outpost, they would refer patients to the local hospital and dismantle the center before the equipment started to disappear.

A bit later in a nearby government health center, we attended an impromptu presentation by a Ugandan doctor from the nearest hospital. The MSF team and the health center staff (along with a curious patient or two) gathered around his laptop computer as he shared a slideshow he had just prepared on the outbreak for an upcoming workshop. The slides told a triumphal story. Over the past two months the area had seen well over 200 cases of cholera, most from the camp we had just visited. Testing showed all the springs and borehole wells were contaminated, and early projections suggested as many as 3,000 people potentially at risk. However, once MSF staff had set up their center and authorities held an emergency camp meeting, the infection rate plummeted. In the end there were only eight deaths, far below what might have been. We congratulated the doctor on a nice presentation. While cautioning that at a larger research meeting the audience might want larger numbers, our team leader agreed that this appeared a successful case of quick response and prevention. Of course, he mused, MSF had never told him to calculate the cost; in contrast to other health projects, with emergencies that was never a priority. The Ugandan doctor quickly responded with dark humor. Maybe he should just tell the government to send all the displaced people back home. After all, in camp cholera kills them, and in the country rebels kill them. Same result, but the rebels are cheaper! This off-color joke provoked general laughter. It also acknowledged the larger context within which this small epidemic occurred: the long-running, low-intensity war in the surrounding region, and the government policy of concentrating civilians into crowded displacement camps. Neither the Ugandan doctor nor the MSF team could do much about these background conditions. They might stop the spread of cholera and save lives. They might further work to secure a better and more reliable water source for camp residents. The larger risk factors behind contagion, however, would remain.

That evening, on the way back to MSF's compound, we passed a car smashed on the side of the road, a crowd around it. We stopped to investigate and picked up one man, who was bleeding and holding his arm and finger. He appeared to be in shock and kept apologizing to anyone who will listen. The team did not linger to inquire about the accident; as one of them warned me, crowds can grow dangerous if rumors spread. Short on bandages in the first aid kit, the MSF nurse used a wad of tissue as a compress as our impromptu ambulance sped to the hospital where the Ugandan doctor worked. We transferred our unexpected patient to the emergency room, and then, having

effectively discharged him, we continued on home. By the next day the cholera treatment center had likewise folded its tents, its last occupants relocated to regular facilities, and its equipment dispersed to other projects.

The Medical Emergency

Popular media attests to the degree of entanglement between contemporary health care and dramatic moments of life-saving intervention. The heroic doctor of television dramas is very much an action figure: a master not only of diagnosis, but also of defibrillation, delicate surgery, and the administration of wonder drugs, all provided at the last minute with hope nearly lost. Yet the conceptual frame of the medical emergency, like the capacity to respond to one, is actually a relatively recent innovation. Michael Nurok (2003) has convincingly shown how terms like ‘accident,’ ‘reanimation,’ ‘resuscitation,’ ‘shock’ and ‘trauma’ only combined into their now-familiar ‘epistemological alignment’ early in the twentieth century, partly catalyzed by the First World War. The component parts of emergency care, from first aid kits and ambulances to emergency rooms staffed by dedicated specialists, emerged onto the landscape of wealthier countries in stages between the late nineteenth century and the late twentieth, with a particular boost in the decades after the Second World War. Details vary by national context, but at a general level—the level at which anthropologists usually engage the past—one might say that the medical emergency appeared alongside industrial society and biomedicine itself. Older strands extend deeper into traditions of experimentation and surgery, particularly forms associated with war.

This background history matters for three reasons. First, it recalls the extent that medical emergency reflects a particular cosmology of time and etiology—one that assumes human actors can and should influence outcomes at an immediate material level. This cosmology is formally secular, at least in the sense that it prioritizes a technical rather than a divine set of nonhuman actors. It also assumes a world of machinery, risk assessment, and accounting, compounded pharmaceuticals and electricity. The balance between life and death has moved away from concerns about spiritual transgression or proper burial and toward reverence for biological existence, purifying the value of ‘saving lives.’

Second, the conceptual lineage of the medical emergency underscores the importance of exceptional moments, a time outside of ordinary life when special equipment might be deployed and actions taken. This sense of exception is not identical to the state of exception in legal and political tradition, being located in human bodies rather than a collective body politic. Nonetheless, it remains intimately (if not always consciously) attached to claims of legal exception as well as the longer legacy of war.

Finally, the history of the medical emergency recalls that one of the many ways to distinguish maladies is by the temporality of their potential treatment. In some cases the sense of crisis is immediate and every moment counts. Others feature a slower rate of progression, whether positive or negative, and care becomes a long-term proposition. By definition emergency medicine—from its conceptual framework to its tools, traditions and attitudes—has never oriented itself toward extended care. Rather, it concentrates on the present, minimizing both history and future for the sake of current need. Indeed, a patient may be unconscious: an incapacitated body of unknown provenance, one that displays worrying signs and requires immediate treatment. In effect, the practical logic of emergency sorts through symptoms as much as it does desires. It thus can operate even in the absence of a speaking subject or known history. Action, rather than dialogue or contemplation, remains paramount; not acting may have deleterious consequences. All three of these points grow significant when extended to the realm of medical humanitarianism.

Life During Wartime

Like all other human groups, nongovernmental organizations have their histories and habits. In the case of Médecins Sans Frontières, emergency plays a prominent role in both. Although not all forms of humanitarianism have emphasized immediate response, MSF descended directly from the Red Cross lineage of responding to war and disasters. By the end of the 1960s, its parent movement had expanded from its original concern with the battlefield suffering of wounded soldiers to encompass the plight of civilians. It had also moved well beyond its original focus on Christian Europe to engage in the fallout of decolonization and the Cold War. Thus the Red Cross found itself embroiled in the Biafran conflict in Nigeria, as well as the bloody birth of Bangladesh, two events that provided a catalyst for the formation of MSF. In this literal sense the organization was

born from war. Although it would never limit itself to responding to conflict, conflict established its most defining norms. The group likewise appeared in the wake of fast transport, global communication and standardized emergency care for civilians, which in the French variation sent doctors straight to the scene of the accident. Imagining an organization of ‘borderless’ doctors, in other words, required more than humanitarian sentiment. It also required a particular configuration of possibilities, and a problem around which they might cohere. For MSF that problem was what its 1971 charter termed ‘populations in distress’—or in a formulation used in later publications, ‘populations in crisis.’

In operational terms MSF realized this classic *métier* of refugee work in camps on the border between Thailand and Cambodia in the late 1970s. For some key members, that experience stoked their ambitions to provide more efficacious care, as well as to develop a logistics system that would support moving rapidly from site to site. In rhetorical terms the organization’s first publicity campaign had already provided a revealing slogan for such ambitions, suggesting that for MSF there were “two billion people in their waiting room.” Given that the group was then but a tiny French initiative, hardly capable of delivering much to anyone, the slogan bore little relation to actual practice. Nonetheless, it both defined a problem, and established an expansive frame of potential response. If populations experienced distress worldwide, then care should adapt accordingly. The medical emergency had found a global scale.

By the time I began conducting research in the early 2000s, MSF had greatly expanded in size and scope beyond these modest beginnings. The name now encompassed a factious family of national sections, undertaking a shifting range of projects and initiatives around the world. Many of these extended well beyond the most immediate frame of emergency in medical terms, including such things as vaccination programs, psychosocial counseling, health education, pharmaceutical advocacy and the provision of AIDS drugs. In Uganda, where I did much of my fieldwork, the organization was involved in all of these pursuits in one fashion or another, as well as conducting epidemiological studies of drug protocols and responding to emergent diseases like Ebola (which surfaced in the same general setting a few years after the cholera outbreak described above). It launched a spinoff NGO involving traditional healers, and ran a garage facility to maintain vehicles for the wider region. In practice, the concept of crisis proved elastic. From the perspective of MSF, that was precisely one of its values in the formulation ‘populations in crisis,’ permitting a greater degree of latitude than was true with ‘emergency.’ Still, the group regularly fretted over the limits of its mission, alternately launching new experiments and drawing back from them. What should it try to do, and what should it leave to others?

A Global Band-aid

A humanitarian organization like MSF often encounters the question of why it does not address root problems. Is not crisis response—particularly the theatrical, media-saturated international variety—like applying a band-aid rather than treating the underlying pathology? MSF’s standard reply is staunchly realist. A crisis response remains limited by definition. Taking the medical metaphor seriously makes this clear: a band-aid, like an ambulance, seeks only to address an immediate problem, nothing less or more. For better or for worse that is precisely the temporal logic of emergency. To address chronic or future problems would require other equipment. It would also risk overlooking immediate needs, even as it might produce dependencies or new forms of domination, intended or not. For MSF lives cannot be exchanged, and a population should ultimately determine its own fate. Thus while the project of saving lives might have political implications and effects, it cannot substitute for a political plan or obscure political responsibility. From this perspective humanitarianism appears a limited, if vital endeavor, analogous to urgent care.

But the twin problems of scale and inequality pose other challenges. A billion dollars only goes so far, and charitable donations are not the basis of a viable, or sustainable, health care system. For this reason, the group issues regular moral exhortations and occasional denunciations aimed at those deemed responsible for the health of a given population. Governments and international agencies should do more, pharmaceutical corporations should charge less, problems should be solved at their roots. With this last point medical power reaches a limit. Violence, whether overt or structural, lies beyond a purely technical remedy. As MSF bitterly observed with regard to Rwanda in 1994, “you can’t stop genocide with doctors.”²

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Twenty years after the crisis in Rwanda, and a decade on from the cholera project described above, concerns about Ebola fill media headlines worldwide. Although the total number of dead has yet to reach the annual toll of cholera (let alone malaria or AIDS), the disease is extremely deadly and inspires fear in the manner of nineteenth-century outbreaks. Due to the mode of its transmission, the virus is unusually dangerous for health care workers, and ravages health care systems. Experimental treatment aside, biomedicine offers no cure for Ebola, only a reduction of mortality rates through supportive care. Amid the growing disaster in West Africa, MSF has received a new wave of attention, often cast in a heroic role as it struggles on the frontlines. Although overwhelmed and unable to offer treatment to those seeking it, the group recognized and proclaimed the severity of need earlier than most others, and its call for reinforcements have helped define a state of emergency. Its protocols for protective equipment have recently featured in discussions of shortcomings in the preparedness of US hospitals. As much as any official government body or intergovernmental agency, here an NGO defines a standard of action, however erratically and uncertainly life-saving. Yet at the same time, MSF has limited ability to actually solve the larger problem or rebuild health systems. An Ebola treatment center, just like one for cholera, is an immediate response, not a solution.

For all that emergency might offer humanitarians the allure of moral clarity—action as pure reaction—that clarity wavers when the frame widens. MSF continually opens programs in response to perceived crisis, and closes them when conditions return to a more ordinary state. In doing so, it confronts the fact that what counts as normal varies considerably from place to place, and that it cannot respond to all problems. Being ‘without borders’ the group continually struggles to define limits. The choices it makes factor in the work of other organizations and the larger realities of poverty and inequality, as well as its own relentless need to move on. Within the frame of a global emergency, there are always more lives to save.

Notes

1. *MSF International Financial Report 2013* gives the group’s overall income as just over 1,000 million Euro in 2013, up from about 938 million the year before. Of this amount, 89.5 percent came from private sources, the vast majority derived from nearly 5 million contributors worldwide.
2. <http://www.doctorswithoutborders.org/news-stories/field-news/new-msf-case-study-response-rwandan-genocide>

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Unexceptional Moments

While groups such as MSF provide care to those in need during ‘exceptional moments,’ anthropologists often work at the other end of the spectrum of excitement—that is, they usually dwell in the most unexceptional of times and places—places like the aftermath of the Ebola epidemic. It is unexceptional in many ways: most volunteers and their attendant medical equipment have packed up and left West Africa for home; the press has moved on to other topics. It is unexceptional because the after-effects of the epidemic are chronic in nature and their cure is uncertain. At this writing (September 2015), we are just beginning to understand the long-term effects of having lived through the 2014 Ebola epidemic; survivors of the disease caused by the Ebola virus are now, six months to a year after the infection, suffering from intense joint pain, headaches, and PTSD-like symptoms of depression and anxiety. A quarter of the survivors suffer from eye problems and blindness as the virus continues to survive in the eye long after it clears from the rest of the body. Ebola virus also seems to survive in semen,

increasing worries that it could be sexually transmitted (Grady 2015). The focus now shifts to treating the chronic effects of the epidemic, once more confronting the inadequacies of the medical systems of Guinea, Sierra Leone, and Liberia (see Henry and Shepler 2015). Post-aid scenarios are complex and show just how frail the immediate-response infrastructures of care are once the ‘emergency’ has past. It is also unexceptional in that, like most health problems, we haven’t vanquished Ebola; we may have, sort of, won the battle, but the outcome of the war is far more uncertain. The Ebola virus is simply carrying out its lifecycle in other mammals, quietly waiting to re-emerge through a chance encounter with a person interacting with an infected animal in the ever-present bush. Perhaps Ebola is reminding us that it is the unexceptional times that really deserve more attention.

The case studies in this chapter provide fine-grained analyses of how biomedical understandings and practice travel to far-flung places. They illustrate how biomedicine and its attendant clinical landscapes pulse back and forth across the globe, sometimes taking hold and taking off like a plant finding welcoming soil, sometimes changing beyond recognition and sometimes retreating back to its home institutions in places more welcoming. The process is not a one-way street, with a war or a flood or a shift in fortunes; clinical assemblages can vanish as quickly as they arrived. Biomedicine is extremely resource-intensive and therefore, quite possibly, not sustainable over the *long durée*, as global resources for interventions diminish, as the world population increases, and as natural resources become increasingly limited. In a century or two, the techniques and approaches of biomedicine will have changed beyond recognition, not only on the periphery, but also at the heart of what passes currently for state-of-the-art medical care.

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