GLOBAL HEALTH POLICY, LOCAL REALITIES

The Fallacy of the Level Playing Field

edited by

Linda M. Whiteford & Lenore Manderson

DIRECTIONS IN APPLIED ANTHROPOLOGY

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Linda M. Whiteford
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Introduction: Health, Globalization, and the Fallacy of the Level Playing Field

Lenore Manderson and Linda M. Whiteford

This book is born of our common and contradictory experiences. Our work as anthropologists and our personal histories cause us to cross continents on numerous occasions and, in so doing, to reflect on who we are, what we do, and where we are going. We meet primarily in two ways. Most expensively, reflecting the privilege of most of us, we attend professional meetings around the globe, where the Hilton hotel in which we stay might be a Hilton anywhere else. The point of globalization, in one respect, is precisely this—the "local" is the color that adds a slight frisson to travel, a variation on the menu or an item in the gift shop. Otherwise, but for the plane trip, we are always at home, wherever we are. More often, we meet via the information technology we increasingly take for granted. It is through this media too that we maintain contact with our research sites, our colleagues in other countries and communities, our students, and our friends. We participate in international health debates and programs, attend workshops, and discuss how health policies might be implemented in different places. We help to develop the tools to ensure that this occurs, we undertake field visits to explore local conditions, we advise bilateral and international agencies, and we work with colleagues to translate the ideas developed (centrally) for their local delivery.

Globalization captures the transcendence of geopolitical boundaries. The term is used widely to refer to the political, economic, and demographic processes that occur within and between nations. Health experience, status, policies, and programs also transcend national boundaries and are carried out in the nexus between global forces and socially constructed local identities. Too often, international health planners design programs based on the assumption that "all else is equal" and that each recipient

nation shares the same "level playing field." The assumption of uniformity of context may be necessary to the process of planning global health programs but also may create needless barriers to their effective execution. This book addresses the intersections and tensions between global processes and local identities as they affect health.

Intergovernmental agencies, nongovernmental organizations, and individual countries filter and mediate between local realities and global categorizations of health, illness, and risk. This volume uses as its focus an analysis of how socially constructed local identities understood in the context of the globalization of health render the playing field uneven. The authors of the chapters in this book challenge the assumption of the "level playing field" by analyzing the consequences of the globalization of humanitarian and health-related projects that fail to recognize local ethnic and national identities. An "economy of knowledge" perspective explores the process by which various types of knowledge and ideology are transformed into cultural capital and examines the dynamic tensions between international health agencies' mandates and guidelines and powerful centralized governmental agendas, supports, and sanctions. We look at the way in which ideologies of best practice—such as advocating bottom-up programs and community-based interventions—are often introduced where the basic social preconditions for success are lacking, or where community structures and resources are inadequate to respond to such program goals. We discuss how the HIV/AIDS epidemic and other international health crises, such as those related to child survival, force us to reexamine the construction of dominant discourses, power, and authority.

As anthropologists, we are also well aware of the discordance between center and periphery, global ideal and local reality. The anthropological creed of "culture" insists on the importance of context. Particular economic, political, and social systems that evolve in one place and time do not "naturally" transfer to a different setting. Hence the democratic ideals of government of Western Europe are not easily or happily translated into, for instance, a Southeast Asian setting; the values of capitalism transmogrify in the villages of China; notions of freedom have very different meanings in France, Nigeria, or El Salvador. Yet many of us involved in international health have worked toward goals for human well-being—"health for all" optimistically by the year 2000 as though the transfer were complete—yet the economic inequalities of nations mean that poorer countries lack resources and are strained even to meet the most basic health needs. Social, economic, and political circumstances result in different priorities for health and welfare, diverse national and local objectives, time lines, goals and targets, and very different structures and institutions. While we have worked with both international agencies and local communities toward public health and the public good, we have been

aware—or have gained awareness—of the importance of the local setting and the constraints and difficulties in the local translation of knowledge.

Global forces are not acultural or supracultural. They are, rather, historical artifacts that derive from Western domination; they reflect Western values of rationality, competition, and progress, in which context there is an implicit assumption that with modernization, local "traditional" institutions and structures will be replaced by Western systems and patterns. As B. Geddes notes (1997a:2), globalization is neither the result of industrialization nor market dominance alone, although our evidence of globalization tends to have an economic take: consider the introduction of multi-country currency such as the euro (without apparent irony in the choice of name of the currency), or continuous mergers of national and multinational companies across continents as well as more proximate borders. The structural, fiscal, and strategic links between industrial centers and peripheries highlight how economic globalization—the production and distribution of goods—is tied to issues of world governance. But this is accompanied with a cultural dominance, best illustrated, perhaps, by the resistances that occur in contradiction to these apparent homogenizing trends: the development of local identities, the reemerging importance of ethnicity, the demands for autonomy, self-government, and independence, or the civil wars in Asia, Africa, and Europe, for example.

At the same time, it behooves us to remember that globalization is merely an old book in a new cover: imperialism and colonialism had the same purposes and encouraged the same eclecticism and synchrony. Not surprisingly, the issues that we explore in this volume have a historic resonance. International health policies, for example, date not from the most recent priorities of the World Bank, but from the efforts of nineteenth-century colonial powers to control the spread of disease that would threaten their economic well-being. The use of wireless systems nearly a century ago for epidemiological surveillance differs from optic fiber and internet communications today by virtue of technical difference but not by virtue of intent (Manderson 1995).

Globalization ignores national boundaries. Its superficial face, tied to the flow of commodities, is one of taste and market manipulation—the pervasiveness of Coca-Cola and Hershey's chocolate in Manila as well as in New York. But this is not a one-way traffic of cultural products: San Miguel Beer and Durian are available in New York as well as in Manila. In this context, globalization conceptually accommodates both postmodern notions of syncretism and the underlying principles of the political economy of late monopoly capitalism. In this context, it is worth highlighting the way in which the global economy both engineers and ignores political groupings. As we wrote this introduction, the war in Kosovo continued. Hundreds of thousands of people were homeless; NATO continued to drop

bombs in an attempt to force a change in Serbian policy against people then categorized as "ethnic Albanians" (as opposed, for instance, to "displaced Kosovars"). The international aid machinery worked overtime to provide the most rudimentary food and medical supplies to people in camps. Televisions carry news of the war as it happens; and we are now old hands as real-time witnesses of the dropping of bombs and the discovery of corpses, and updates of events of the "theater of war" are precisely that—"theater" (see Kleinman and Kleinman 1997). Families keep each other informed—and keep hope alive—between nations, via the Internet. And McDonald's has reopened three fast-food outlets in Belgrade War notwithstanding, globalization respects no boundaries.

Hence globalization is not only about commerce or the construction of taste. It is also about local politics, international government, strategic alliances, power and force, and communication systems. In the case of the wars of the former Yugoslavia, it provides the rhetorical and moral basis for intervention from other, outside forces. In more benign contexts, globalization is a process that blurs or renders irrelevant national identity, while forging transnational and transcultural identities (Altman 1994). The dramatic changes in international communication systems and the constant movement of people as tourists and workers facilitate this process, or the creation of what in the 1940s to 1950s was called "the third culture"—an international culture (Nancy O. Lurie, personal communication).

The discourse on globalization's impact on cultural form and practice in international health is still limited. In this book, we want to inject the insights of globalization theory into international public health practices. Common agendas and definitions of health and well-being, operationalized in specific policies and programs, are set nationally or at a state level. But even these are very much influenced and increasingly shaped by wider governmental purposes. The eradication of smallpox is the best historical example; the worldwide adoption of the Expanded Programme on Immunization, global efforts to eradicate polio by the year 2000, to control malaria within and between countries, and so on, are all contemporary examples. Indeed, even practices that are supposed to counter the homogenizing effects of globalization are advocated and implemented through global governance: WHO (World Health Organization) programs, for instance, promote community participation and bottom-up approaches to agendas that have, after all, been predetermined and prioritized at the center (Fisher 1997).

Within countries, there is ongoing tension between local cultural demands and national goals and targets. Policies of multiculturalism designed to accommodate difference respond to this tension, superficially privileging the cultural over the epidemiological. To some degree, too, under a cloak of pragmatism, even international government acknowledges that real differences need to be addressed and valued. Hence the efforts of WHO programs to develop instruments, protocols, and procedures that

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acknowledge and work with, not against, local practice. The World Health Organization's (1978) advocacy of the use of traditional practitioners and therapies in primary health care is an early instance. So too are more recent developments of focused ethnographic instruments to identify local lexicon for the incorporation into health education material to prevent life-threatening illness (e.g., Gove and Pelto 1994).

A similar example was the work conducted following the change of international organizational leadership in HIV/AIDS, from the Global Programme on AIDS (GPA) to the combined program of the WHO, United Nations Development Programme (UNDP), and World Bank known as United Nations AIDS (UNAIDS). UNAIDS was distinguished from GPA as having an "expanded response" to HIV/AIDS, and in this context took steps to tailor national AIDS programs to local circumstances (see Chapter 2). Yet, exactly how this was to occur in the context of a vast and centralized network of experts, committees, and funding agencies was left undetermined. The resulting approach was to support strengthening institutional capacity in policy and planning, and to enhance the administrative processes and structures required to translate policy into programs. This has led, inter alia, to advocating a policy of contextual assessment and program review as components of the national strategy. This enlightened policy encouraged countries to assess the suitability of the national programs in light of national social, economic, and political changes, and in light of epidemiological changes relating to HIV/AIDS. In sum, local factors deemed relevant to understanding and responding to the transmission of infection included population issues (migration, fertility, and mortality rates), social structure, political and economic systems, education and communication, the institutional environment, and human rights issues (Aboagye-Kwarteng, Manderson, and Msiska 1997). However, the mechanisms by which to transform the enlightened policy into actions were not provided, and failing that, the policy was rendered void of effect.

Even the most well intentioned of these approaches assumes at some point a level playing field—or, at least, it is not explicit how policies might be both locally and internationally comparable. For over twenty years now the WHO has advocated primary health care as a means of improving the access of the poor to basic medical care and treatment, and there is a substantial literature on the introduction of primary health care and on translating disease control programs locally. But the descriptions of these processes largely gloss over the tensions in the implementation of centrally generated, vertical programs (which remain the primary means by which countries attempt to reduce infectious disease) and adaptations to distinctive, localized realities (critical to program sustainability).

Accordingly, much of the policy work in the area of primary health care and community participation is idealistic. The enthusiastic literature advocating a strong role of people in conceiving, contributing to, and sustaining

quality health services often overlooks that fact that the pilot projects along these lines have been highly resource intensive and, in the long term, nonsustainable. In particular, arguments for community participation have often overlooked the impediments to partnerships between central government authorities and local bodies, and have ignored the resource, structural, institutional, and personal preconditions for improved health. Most elusive and ephemeral, and therefore easiest to overlook, are the local histories and local identities that allow community participation programs to become actualized within their institutional and political contexts. The complex and problematic reality of contextualizing policy in the arena of international health programs is the focus of Part 1.

The chapters in Part 1 focus on the localization of international health policy. In Chapter 1, Judith Justice reviews the development and history of child survival programs and compares their efficaciousness across countries. She notes that child survival strategies had enormous political appeal through the 1980s and 1990s and, in consequence, were able to attract substantial resources and sustained input from both the WHO and UNICEF. The interventions were simple: full immunization and oral rehydration therapy for diarrhea disease, with other adjunct programs such as monitoring child growth and breastfeeding. Immunization had an immediate appeal, promising to drive down infant and child mortality in poor countries. Other interventions were attractive because of their simplicity and cost-effectiveness. As Justice illustrates, however, this approach was selective and by-passed major problems in the delivery of primary health care. In addition, the approach proceeded without community participation to establish local health priorities and implement programs, despite the WHO's commitment to this model. The themes in this chapter anticipate those of succeeding contributions: tensions between donors and recipients, providers and clients, and the global and the local.

Chapter 2 addresses the globalization of HIV/AIDS policies and programs as international agencies themselves have queried how to translate worldwide policies of prevention, control, and care to local circumstances. Richard Parker sets forth a series of paradoxes derived from his analysis of the processes of globalization, capitalist development, and international health. According to Parker, the spread of HIV infection has been along fault lines created by the structures of oppression, social cleavage, and inequality. The paradoxes Parker identifies embeds his analysis in the world arena of international lending practices, development agendas, and the dynamics of power. Parker elegantly articulates the concern with a policy process dominated by the most powerful of the players—international banking and its connected institutions—and the inability of such a process to alleviate human suffering rather than to administer it.

Parker's paradoxes are based on international HIV/AIDS policies and highlight the contradictions and dilemmas between priorities of prevention

or administration, legitimizing local or international concepts, and standardized or individualized programs within the political economy of international health. The continued colonization of health is manifested in Parker's analysis of the structure of oppression crystallized in the HIV/AIDS epidemic.

Chapter 3, by Linda M. Whiteford, examines how the political and economic histories of nations shape local identities, which in turn influence the effectiveness of disease prevention and control activities. Citizen responses to dengue fever control programs in Cuba and the Dominican Republic demonstrate how local identities shape community members' willingness to participate in government-initiated health programs, and to see the utility of such initiatives in the longer term. Her chapter on local identities, globalization, and the commodification of health takes as its starting point Michael Kearney's definition of globalization, which refers to "social, economic, cultural and demographic processes that take place within nations but also transcend them, and which places local processes, identities, and units of analysis in a global context" (Kearney 1995:548). Whiteford notes, however, that the focus on global processes may blind health planners to local differences and circumstances with self-defeating consequences. Whiteford's attention to local identities and their idioms of hope and despair illuminates the leitmotif running throughout the book: the ways in which global economic, political, and communications systems vibrate with and against local circumstances, contingencies, and contexts. In health, the local circumstances are environmental, ecological, and epidemiological as well as political, social, and ideological, and for this reason single solutions are rarely appropriate. Vector habitat and behavior are critical in malaria control, for example, and the practice of indoor house spraying by malaria control programs in many countries makes no sense when the primary vector is exophilic and exophagic and disease transmission is in the forest, not the village. And as Whiteford illustrates with respect to dengue fever, public health planners continually struggle with the intersection of global agendas and local settings, and communities struggle to understand the kinds of programs that they are being offered and in which they are expected to participate.

In Chapter 4, Peter van Eeuwijk explores issues of state and local discourse further in his discussion of globalization and its meanings to villagers in Minahasa, Indonesia. Here, issues of development, the incursion of the cash economy, the role of multinational organizations, and the relationship of the nation-state to local communities are all corralled as evidence of *globalisasi*. He makes an important point about these processes. Even in relatively isolated areas of Indonesia, the term *globalization* has been incorporated into everyday parlance, but there is a local nuance to understandings of the relationships of international economic, political, and cultural relations to local circumstance.

The economic transitions that have occurred in north Sulawesi—and in other settings described in this volume such as Uganda and Vietnam—highlight the nature of the deregulated market with globalization. Countries, communities, and individuals participate as producers and consumers in an increasingly interdependent, internationalized economy that takes little responsibility for their welfare, and nation-states have little leverage in minimizing the exploitations that occur via this process. Further, as Geddes (1997b) argues, the weaker the bargaining power of the country, the greater its vulnerability to transnational business and multinational forces either with respect to access to resources or production (e.g., conditions of employees in off-shore industries) or with respect to trade. As Unwin and colleagues argue (1998), while tobacco companies are being prosecuted in the United States and Australia, they continue to expand their markets in low-income countries (many of which are also tobacco-producing countries that are reluctant, therefore, to follow developed nations' leads to inhibit tobacco use). The examples of the marketing of drugs and infant formula in this volume provide further evidence of the contradictions that exist in promoting "free trade" that enhances the profits flowing to the largest, most powerful and richest multinational corporations. Poor countries and communities service an internationalized economy without the political leverage of economic power to protect their citizens.

Minahasan villagers' readiness to use *globalisasi* as a catch-all explanation of the twists and turns of economics and politics locally and nationally is enhanced by their access to global communication (notwithstanding that television sets sit unused, in the absence of electricity). But there are, as many of the authors in this volume illustrate, strong trends also to (re)assert cultural difference, to establish the autonomy and integrity of cultural communities, and to reject the homogenizing demands of "global culture," although, paradoxically, often via the media of global communication.

In Part 2, "The Global Pharmacy," David Craig for Vietnam and Susan R. Whyte and Harriet Birungi for Uganda describe how multinational corporations impact people's daily health practices. In most poor countries worldwide, drugs prescribed by local professionals are available over-the-counter or on the street. These drugs—designed to deal with unpleasant symptoms of illness, to control pain, to prevent the development of certain conditions and ailments, or to control underlying causes of discomfort—are produced, distributed, and marketed primarily by multinational drug companies. This governs the choice, cost, and availability of various drugs, influences prescription patterns, and encourages self-medication and overuse of drugs. Often the consequences are serious for both public and personal health, including the development of iatrogenic ailments and drug resistance of pathogens and the use of unnecessary and dangerous substances

(see, for example, Silverman 1976; Van der Geest and Whyte 1988; Kanji et al. 1992; Rozemberg and Manderson 1998).

The response by the World Health Organization (1987) was to regulate marketing by drug companies, to insist upon standard labels and pricing, and to improve the control of distribution, registration, and manufacturing. This resulted in identifying "essential drugs," deemed basic or vital to primary health care, and in developing policies to control the availability of other pharmaceuticals. In addition, policies were developed to control the use of drugs through polypharmacy (e.g., the prescription of two, three, or four drugs, often similar in clinical effect) and prescribing drugs for symptomatic relief only (e.g., as is the case with cough medicines). As Whyte and Birungi and Craig suggest, these codes and national generic drug laws have had limited impact on people's use of pharmaceuticals, and multinational companies continue to market their products in ways that affect prescribing practices, pharmacy provision of drugs, and consumer expectations and behavior.

In Chapter 5, "The King's Law Stops at the Village Gate: Local and Global Pharmacy Regulation in Vietnam," David Craig explores the workings of multinational drug companies, and how the marketing and availability of pharmaceuticals fit with local ideas of the management of illness in Vietnam. In Part 1, current neoliberal economic policies are manifest through decentralization and deregulation; Part 2 provides case studies from Vietnam and Uganda that revisit the consequences of decentralization in the global marketplace. Craig provides powerful examples from the highly contested arena of globalization of pharmaceutical regulation, and its equally complex local-level application. As Craig points out, modes of regulation promoted globally are at considerable odds with national and local political and regulatory forms and where the local modes of regulation are too often overlooked. Yet these local regulatory modes can be seen as local development and a sign of active participation, itself a reflection of a move away from governmental responsibility and a shift toward greater individual and community responsibility. Effective decisionmaking, however, is dependent upon the provision of sufficient and appropriate data, often provided by extralocal authorities. As the Vietnam case demonstrates, data come in many forms, not the least of which is practice knowledge derived from personal experience, and if local and global understandings of drug use are to be symbiotic, they will, as Craig writes, have to be reconciled primarily at the household level.

In each country setting, the nature of pharmaceutical business and its impact on people's health take on rather different turns. In Chapter 6, "The Business of Medicines and the Politics of Knowledge in Uganda," Susan Reynolds Whyte and Harriet Birungi write about their involvement in a project on international drug policy and the local context of action. They

situate their analysis in the global discourse on rational use of drugs and the tension between the arguments for standardization of drug policies—as promoted by the WHO under the rubric of the Drug Action Programme and competing forces that propose that local use is always right. Whyte and Birungi write that they hope to offer a more differentiated and pragmatic approach to anthropological assessments of the commodification of health. This chapter moves forward, with their careful and thought-provoking analysis, the discussion of applied medical anthropology, globalization, and international health policies.

Part 3, "Relocating Bodies and Body Parts," is concerned with the movement and location of people as permanent settlers and as refugees, and—through a quirk in our own imaginations—the immigration of technological know-how to enable the transplantation of body organs. Chapters 7 and 8 focus on the global displacement of people, their dislocation/resettlement, and the public health issues that are implicit in this process. Migration has become an increasingly important phenomenon in recent years, and its ease is indeed an example of globalization. Affluent nations increasingly find their borders difficult to police, as recognized de facto in Europe via changes in citizenship and "community membership." Everywhere illegal immigration is an increasingly common problem; people slip across national boundaries and/or overstay tourist or student visas. Other people move around to meet the labor force needs of different sites, working often for poor pay and in substandard conditions to earn hard currency that is then remitted to support families in their homelands. The personal health costs of this movement of bodies—a modern take on an old form of slavery—has yet to be calculated. However, in most places, whether employed legally or illegally, in the formal or informal sector (e.g., as construction laborers, domestic servants, soldiers, or sex workers), migrants are highly vulnerable, lack civil rights protection, and are subject to racism and other structural discriminations. Further, as Bruenjes suggests (1997:134), the official ideologies of temporary migration, including those that provide the policy context for the care of refugees, create an expectation of return that may be unrealistic for refugees. They also provide a rationale for host countries to ignore human rights and public health obligations.

At the same time, ethnic and religious tensions, and environmental disasters, displace millions of people on a daily basis. Geddes (1997a:5) suggests that population movement is without regard for "lines drawn on maps" where poverty is endemic, and where "displaced people, often despairing and hopeless, search for somewhere less threatening and less devastated than their home environments" to reorder their existence. People move now not because of the "bright lights" that characterized such movement in the 1960s and 1970s, but because the social, political, economic,

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