BOSTON UNIVERSITY

The Frederick S. Pardee Center
for the Study of the Longer-Range Future

Symposium on Global Health & the Social Sciences

CONFERENCE REPORT
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Executive Summary

On November 9 and 10, 2017 nearly 30 leading political scientists, anthropologists, and sociologists gathered for a two-day "Symposium on Global Health and the Social Sciences," with the aim of understanding the contributions of three social science disciplines (anthropology, political science and sociology) to global health; discussing what opportunities exist for further research by the disciplines; and deliberating about what more could be done to galvanize greater interest in research on global health among the disciplines. Symposium participants considered these issues in light of five themes: global health governance, reproductive health and human rights, universalism, infectious disease response, and access to pharmaceuticals. The symposium was sponsored by Boston University's Fredrick S. Pardee Center for the Study of the Longer-Range Future.

This report provides a summary of the discussions that occurred at this seminal gathering and is intended to stimulate discussion among the broader social sciences community about the role we can play in global health research going forward.

Anthony Janetos, Director of Boston University's Pardee Center for the Study of the Longer-Range Future, welcomed symposium participants.

What can social scientists contribute to the study of global health[1]? While the contributions of public health scholars to research on global health is long-standing, work by the social science disciplines on global health — in particular, by sociologists, political scientists, and to a lesser extent, anthropologists — has tended to remain thin and isolated. The post-Cold War era of global health has been marked by four principle changes: demographic transition with an aging population globally; newly emerging epidemiological challenges (such as increasing prevalence of non-communicable diseases, HIV/AIDS and the Ebola epidemic); new global health institutions that have sought to raise awareness and channel science and technology towards combating global health challenges; and, massive new funding to address these issues (**Figure 1**).

Unfortunately, research by sociologists and political scientists on these important global changes has been scant. With the exception of medical anthropology — which was itself born out of a post-World War II turn towards health aid as a form of diplomatic soft power — the orientation of American social sciences has instead continued to remain largely focused on health problems in the U.S. In the field of medical sociology for instance, the number of publications with a focus on international health topics has increased negligibly over the past 30 years. Political science, too, has lagged behind in its focus on the politics and governance of global health challenges.[2] As Eduardo Gómez puts it, "Both political scientists and global health scholars still have a long way to go to ensure that their theoretical and empirical approaches complement and build off of each other" (Gómez 2016, p. 4). Anthropology, for reasons of disciplinary history, epistemology, and focus has contributed much more to the study of global health. Yet, anthropology too has been less attentive to the transnational *institutions* of global health. And anthropologists of global health have worked in something of a

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1   No consensus definition of global health exists. However, robust debate over the meaning of global health has taken place in public health and medical journals (Koplan et al 2009; Fried et al 2010; Beaglehole and Bonita 2010). Greene et al note that it was coined to refer to "health problems and interventions extending beyond national boundaries, including those between developed and developing countries" (2013: 34).
2   Gómez, Eduardo J. 2016. "Introduction: The State of Political Science Research in Global Health Politics and Policy." Global Health Governance 10(3):3–8.

FIGURE 1. EXPLOSION OF FUNDING FOR GLOBAL HEALTH (1990–2017)
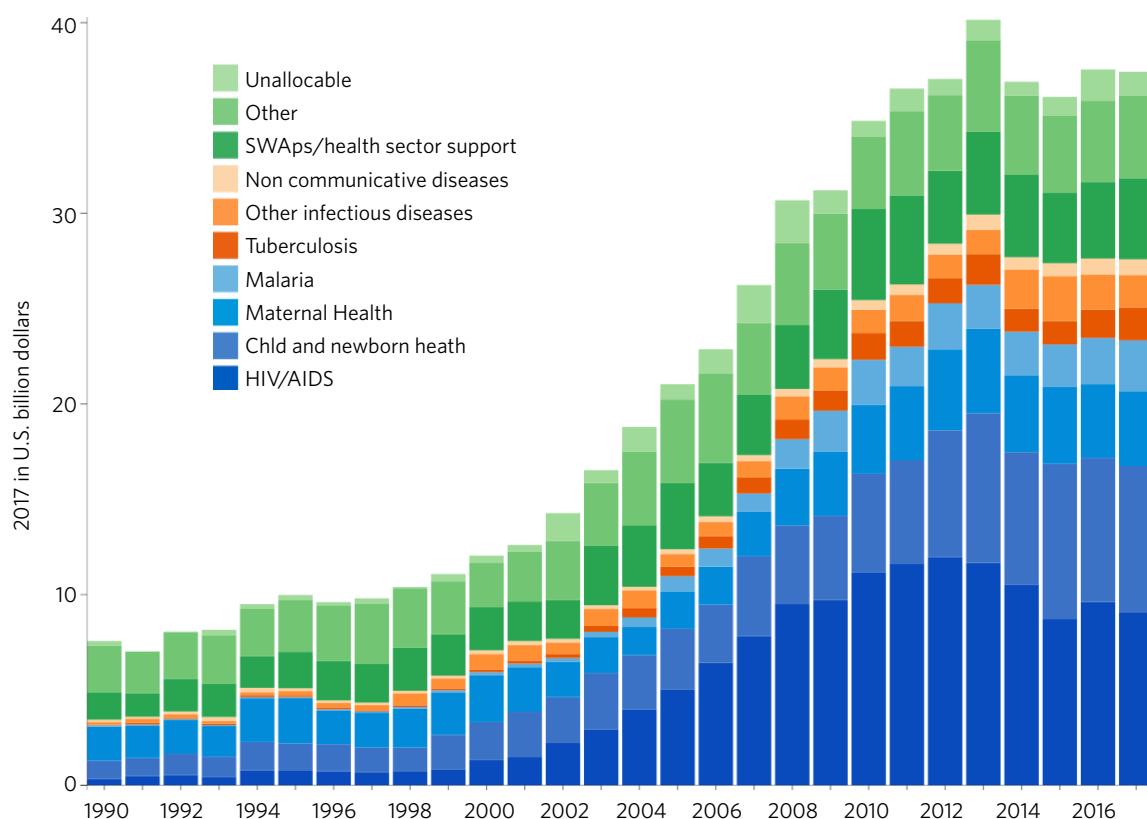
Source: Institute for Health Metrics and Evaluation (IHME). **Financing Global Health Visualization**. Seattle, WA: IHME, University of Washington, 2017. Available from http://ihmeuw.org/4eum. (Accessed May 31, 2018)

disciplinary silo, collaborating with biological scientists and medical professionals but far less frequently with fellow social scientists. In general, this points to the great deal of work that is still to be done to understand the intersecting and diverging epistemological approaches, theoretical assumptions, methodological procedures, findings, and implications across these three social science fields.

The symposium centered on a simple premise: Why isn't there a greater focus on global health within the core social science disciplines? What new opportunities does the study of global health offer the social sciences? What might the disciplines gain from greater engagement with the problems of global health, and what might they offer the problems of global health? And how can the rigor of the social sciences be brought to bear on the problems of global health?

The agenda included presentations and discussions organized around five themes including: *global health governance, reproductive health and human rights, universalism, infectious disease response, and access to pharmaceuticals.* Each scholar produced a brief summary paper as the basis of his or her presentation. During lively discussion sessions, the group shared insights about various methods and approaches used among the three disciplines. Discussion offered participants a better understanding of what each discipline has contributed to the study of global health, the constraints and challenges

they face, and the future opportunities that each discipline is poised to make in research on global health. Everyone present noted the remarkable opportunity for social scientists to make greater contributions to the study of global health. But, there were also important discussions about the power dynamics that often keep the boundaries between disciplines stubbornly separate.

These conversations, which naturally took many detours — and which danced between epistemology, ethics, methods, data sources, and large and diverse literature — are challenging to summarize. But, the excitement and engagement in the room during these two days was palpable and a few clear themes emerged:

- Although research on global health has often been thought of as primarily focused on the empirical, rather than the theoretical, greater engagement with the problems of global health offers social scientists rich opportunities for contributing to solutions to real world problems and to make important new theoretical contributions. New ways of understanding global health problems can emerge from thinking about them in relation to classical theories that haven't been applied before. Furthermore, there is potentially much to be gained from examining how concepts and theory from one social science discipline might be leveraged in other ones.

- While quantitative methodologies, such as randomized control trials (RTCs), are ascendant both within the social science disciplines and in schools of public health, qualitative work within the social sciences has much to offer the study of global health, for example, in the study of the cultural worlds of elites; the way local meaning structures work (or don't) in different settings; and in examining the conditions under which disease response differs across time, space, and disease category.

- Critical studies of global health are well-positioned to help policymakers see issues in new ways and to address blind spots that may otherwise be invisible, particularly related to the implementation phase of the policy process. Greater efforts are needed to link practitioner communities to important research in this area that might be beneficial to these enterprises.

- As the community of social scientists doing research on global health grows, to maximize our potential and open meaningful new pathways for discussion and collaboration, it is important to be mindful of the power structures and incentives that orient our disciplines (which shape individual and collective research agendas). We need to be reflexive and listen closely to the needs and concerns of research subjects, so that contributions are not just beneficial to the researcher but to the community more broadly.

It is our hope that this conference report can spur more meaningful conversations about global health research among the fields of anthropology, political science, and sociology more broadly. Although there may not yet be consensus about the existence of a distinct, fully-fledged field of global health studies within and across the social sciences, we hope that these conversations and this summary can move this domain of social inquiry in the direction of greater coherence, shared knowledge, and community.

OPENING REMARKS:

ANTHROPOLOGY, POLITICAL SCIENCE, AND SOCIOLOGY IN GLOBAL HEALTH

The Symposium on Global Health and the Social Sciences opened with remarks from Lynn Morgan[3], Evan Lieberman[4], and Jason Beckfield[5] who each sketched the history and current view of their respective discipline's contributions to the study of global health.

For Morgan, anthropology is fundamentally the study of human cultural diversity using its signature method—participant observation and ethnography—which primarily involves "sitting around and listening to people." Conducting ethnography in global health requires a heightened focus on the close-quarters practice of reflexive listening and participant observation. By slowing down, engaging in socially close observation, and documenting the processes and meanings constructed by those engaged in global health activities, new findings are possible that would otherwise be invisible to social scientists.

From left: Evan Lieberman, Lynn Morgan, Jason Beckfield

Anthropology, when compared to both sociology and political science, has a long history of being deeply tied to global health efforts. In the 1950s, in the field that was then called "international health," anthropologists were regularly enlisted as "culture brokers" by the post-World War II United Nations agencies and development apparatus. They offered development agencies much-needed on-the-ground interpretation and explanation of the health and cultural practices of locals far from the metropole of North America and Europe. Frequently, anthropologists were hired by development projects to help experts design "culturally appropriate" international health interventions including recommendations as to how the local public might interpret or misconstrue these programs. In the 1970s, as the subfield of medical anthropology took hold within the academy, anthropology took a more critical turn in its analysis of western biomedicine. Anthropology's generally colonial assumptions and hegemonic reach came under scrutiny. George Foster[6] and Judith Justice's[7] work — now seen as relatively conservative — critically explored health interventions in low-income and post-colonial settings demonstrating the often self-serving nature of much of what counted as "global health." However, just as anthropologists became increasingly critical in their analysis of the structural and political forces shaping their work, they were also benefiting from increasing calls for "cultural competency" in medicine.[8]

Today, the global health enterprise is expanding rapidly, with a dramatic influx of new resources, research, people, and projects. Unfortunately, the observations being made by anthropologists are not comforting: the conditions that have led to the expanded global health endeavor have done too little to alter the structural factors that prevent so many people from gaining access to needed services. Some questions that should preoccupy the future anthropological work on the global health enterprise are: 1) how does global health constitute its subjects? and, 2) how are the purveyors of global health imagined? These are questions that anthropology is well-positioned to continue to explore.

Next, Evan Lieberman apologized on behalf of his discipline, political science: "What has political science done for global health lately? Sadly, not enough." Lieberman explained that too few political scientists are engaged in global health research and that political science is by far the social science that has made the most modest contributions to global health. This is at least partially because political scientists haven't recognized that the study of global health challenges offers potentially strong theoretical opportunities. Also, the more recent trend towards statistical causal inference and randomized control trials (RCTs) has distracted from more direct, problem-oriented questions. But, because political science is fundamentally about the study of the political competition over scarce and valued resources — and since scarcity of resources is a structuring reality of global health challenges — there should be much more effort from the political science field overall. In that spirit, Lieberman offered five possible research directions for political scientists that might also bear relevance to other disciplines as well:

1. **Global health initiatives as efforts to build governance realms:** How do nations and sub-national territories build states and develop governance authority? What role do non-state actors play in these governance efforts? What forms do regional and global governance take in global health?

2. **The role of political regimes:** What is the relationship (perhaps tenuous?) between democracy and public health outcomes? Authoritarianism?

3. **Trust in information and ideas:** Scientific ideas and trust in public authorities are key in global health governance—how does the trustworthiness of authorities develop, grow, or contract? How are credible messages formed and disseminated? How are human rights normalized and diffused? What is the role of the law and the courts in global health?

4. **Political economy of regulation and trade:** Trade regimes regulate and structure pharmaceutical and diagnostic costs—how do regimes get established? How do they change? What impact do they have for wider access to life-saving interventions?

5. **The politics of identity and inequality:** How can we better understand personal identity correlates for health? How can gender politics be mainstreamed within global health, especially with regards to political representation?

Finally, Jason Beckfield gave an overview of the contributions of sociology to the study of global health by beginning with a disclaimer: multi-disciplinary engagement across sociology, anthropology, and political science is something that is often discussed, but very rarely happens. Beckfield asked why sociologists aren't more engaged in studies of global health. Sociology is already deeply invested in exploring the ways that social context is a primary driver for health and social inequalities. Where are there more and larger inequalities than in global health?

Similar to Lieberman's analysis of the relatively light engagement to date by political scientists, Beckfield posited that a strong theoretical hook was likely to be more effective in engaging sociologists as well as a better opportunity to engage across disciplines. For sociology, global health presents a strategic site for theorizing: 1) how institutions distribute valued social goods; 2) the notion of the health-equity tradeoff; 3) the field of social stratification through institutions, resources, and decisions; 4) inequalities related to participation in and the consequences of global governance arrangements and the role of international and transnational organizations in them; and, 5) the highly nationalized and hyper-unequal financing of health care services globally. Engaging in these empirically and theoretically rich veins of research and practice, however, will not be easy. Again, as Lieberman alluded to for political science, sociology is increasingly turning towards field-based RCTs. These research methods may be able to produce evidence that is extraordinarily precise and internally valid to the study population, but may have no external validity whatsoever. Similarly, Beckfield expressed skepticism about the promise of "Big Data," which is often a "mile wide but an inch deep," and produces findings that were already well known.

Taken together, these introductory presentations about the three main social scientific disciplines clarified the extent to which and how each has engaged in studying global health challenges, some of the key epistemological and disciplinary challenges they each face, as well as potential future research directions in a redoubled effort in global health studies. All three noted the challenge of engaging mainstream professional academics within their disciplines in the empirical and theoretical problems of global health; the increasing dominance of hyper-positivist research methods, especially RCTs; and, the challenge — but also promise — of engaging in more interdisciplinary global health research projects that bridge the domains of anthropology, political science, and sociology, leveraging the analytic strength of each.

PANEL 1:

GLOBAL HEALTH GOVERNANCE

The first panel provided perspectives from Andrew Lakoff,[9] Jeremy Shiffman,[10] and Shiri Noy[11] on how their respective disciplines have studied the role of global governance institutions in global health. Building off of the introductory presentations and speaking with his training as an anthropologist in mind, Lakoff reaffirmed that global health studies are core to the discipline — particularly the study of the experience of health and illness in non-Western settings as people encounter an expansive global-medical health enterprise. Lakoff's particular expertise involves the anthropology of science, technology, and medicine, which takes the field of global health itself as its object, along with the forms of knowledge and techniques of intervention that operate within it. Anthropology can be distinguished from other approaches by its method, ethos, and object. Its method is ethnography, or sustained engagement with the thought-style of a given community in order to describe the view of their world from within. The ethos is one of critique — careful inquiry into the basic assumptions that underlie the dominant models of medical knowledge and caregiving. Anthropology's object, however, cannot be taken for granted because we cannot assume *a priori* that the field of global health even necessarily exists. For Lakoff, anthropology of global health governance seeks specificities and begins with the concrete. Ethnographic research uses specific, concrete details to show how we can follow technologies, practices, people, and goods to piece together global health practices and techniques. Key questions that should animate anthropology's inquiry into global health governance include: 1) What governmental practices constitute global health as a possible field of intervention? 2) What norms and rationalities hold together assemblages of actors that collaborate in making global health a governable object?

Melani Cammett and James McGuire

Lakoff then gave four key examples of the type of anthropological research on global health governance that he hopes can serve as inspiration:

1. His own work on how health practitioners devise interventions for mental health problems in Argentina in which a lack of scientific infrastructure creates controversies over measurement criteria, privately-owned and privately-stored data shapes the practices of doctors, and pharmaceutical audits function as a governmental practice that shapes the field.[12]

2. Peter Redfield's research on technology and bioethics in humanitarianism, particularly the "humanitarian kit" which is cloistered in European warehouses only to deploy "when needed."[13,14]

3. Decision instruments deployed by the WHO and national health agencies in deciding whether to declare an outbreak of infectious disease a global health emergency.[15]

4. Biosecurity as a crucial element of governance of global health, which focuses on securing borders and containing outbreaks.[16]

Next, Jeremy Shiffman discussed the ways that political science has explored the challenges of global health governance. Shiffman sees three main challenges facing political scientists in expanding research on global health governance: 1) the need to better characterize the relationship between political scientists' work and international relations theory, and what constitutes the boundaries of the community of political scientists working on global health; 2) defining the issues of primary concern amongst the existing political scientists that do currently work on global health issues; and, 3) the fact that the discipline is divided into three distinct subfields — international relations, comparative politics, and public policy. For Shiffman, the study of global health governance for political scientists best fits within the subfield of international relations since it is looking at the interactions between nation states and other non-state actors.

For international relations scholars, one big question is: What are the roles, interests, and norms that shape the behavior of states, organizations and other actors in global health governance? These types of questions can be deployed in studying the bureaucratic dynamics inside of global health institutions such as the WHO, including how non-health related institutions and organizations impact population health, and how health issues become related to security and states come to frame them as threats. Another important question is: What constitutes the best institutional arrangement for the governance of global health? Previously, global health governance was dominated by states and large-scale international organizations. Today, however, global health governance is far more fragmented into discrete projects, financed by a multiplicity of donors, and governed by a multipolar network of actors.

12 Lakoff, Andrew. 2005. "The Private Life of Numbers: Database firms and the Government of Expertise in Argentina." In: *Global Assemblages: Technology, Politics and Ethics as Anthropological Problems.* Boston: Blackwell.
13 Bornstein, Eric. and Peter Redfield. 2011. Forces of Compassion: Humanitarianism between ethics and politics. Santa Fe: SAR Press.
14 Redfield, Peter. 2015. "Medical Vulnerability, or Where There Is No Kit." limn.it/medical-vulnerability-or-where-there-is-no-kit.
15 White, Alexander I. R. 2018. "Global Risks, Divergent Pandemics: Contrasting Responses to Bubonic Plague and Smallpox in 1901 Cape Town." *Social Science History*, 42(1):135-158.
16 Lakoff, Andrew and Stephen J. Collier. (Ed.). 2008. *Biosecurity Interventions: Global Health and Security in Question.* New York: Columbia University Press.

Despite the importance and theoretical promise of these empirical threads, to date studies of global health governance have thus far remained at the margins of international relations theory. Why is this the case? Shiffman perceives that many in the international relations field view global health issues as rarely rising to the level of high politics, in contrast with terrorism, nuclear weapons, etc. Additionally, some of the concepts within international relations theories can be fairly Eurocentric, making their application to subaltern global health challenges less direct. However, international relations theorists are keenly concerned with the way that global governance roles, norms, and interests shape the behaviors in the global arena. Kathryn Sikkink and Martha Finnemore are making good progress on this front.[17]

If political science is to expand its contributions to the study of global governance of global health, there remain some very practical questions about how to better share ideas and build community. First, how does one delineate the community of political scientists who work in the field of global health governance? Who constitutes this community? Second, how is knowledge being disseminated? How is it communicated? What are the overlaps? Who is excluded? What biases exist? To date, much of the scholarship on global health governance remains buried within the respective journals of political science and (more frequently) public health. New ways of sharing this work with policy makers and broader publics should be established. One promising development is that the International Studies Association has a newly formed global health section.[18]

Finally, Shiri Noy discussed sociology's work on global governance and global health. For Noy, the anthropological approach focuses on study of knowledge, culture, and the uses of artifacts and material products in shaping governmental practices and techniques, while political scientists tend to focus on norms and their diffusion (or not) through state and non-state institutions. Sociologists primarily focus on power and inequality to organize their thinking about global health governance. As a result, sociologists often have a hard time precisely defining global health governance. According to Noy, sociology views global governance as the efforts by states and international organizations to identify, negotiate, understand, and respond to health challenges that transcend national borders. In her own work on the World Bank,[19] she and others have asked the question: How do international organizations influence global health priorities, goals, and outcomes? How do national governments negotiate, reflect, and refract global health recommendations and resources?

The findings within the field are robust and growing. For instance, sociological research has shown that international organizations often work at cross-purposes, contradicting efforts within the same organization or across organizations. For example, the World Bank's structural adjustment policies are tied to loans in ways that force austerity measures for poor countries and have actually led to poorer outcomes, at least in sub-Saharan Africa. At the same time, the World Bank makes grants and loans with the explicit aim of improving health care delivery. Additionally, global health-focused international organizations exist within a broader field of institutionalized pressures — from funders, recipients, civil society, professional organizations, and other actors — that profoundly shape their practices and are a major source of inequality globally.

17 Finnemore, Martha and Kathryn Sikkink. (1998). International Norm Dynamics and Political Change. *International Organization, 52*(4), 887-917.
18 ISA Global Health Section: http://www.isanet.org/ISA/Sections/GHS
19 Noy, Shiri. 2017. "Healthy targets? World Bank projects and targeted health programmes and policies in Costa Rica, Argentina, and Peru, 1980-2005." *Oxford Development Studies,* 1-20.

Jeremy Shiffman delivered remarks on the role of political science in global health.

All of this work has important implications for what we know about global health and how we move our theoretical and empirical agenda forward. How do we theorize the state's role in the governance of global health? How do organizations reflect, refract, and challenge power and inequality in health at many levels of analysis (community organizations, state level, and international organizations)? What is the relationship between global and local policies, and the politics that shape them, in terms of population-level health outcomes? Noy said we need to extend the theoretic scope beyond international organizations and what are normally considered global governance institutions. To accomplish this, we will need to build better middle-range theories or theories of diffusion that pull from and extend sociology's world polity and world systems theories. Substantively, we also need to better account for new actors in the global health field as well as look beyond the current dominant issues and topics in global health, such as HIV/AIDS. Methodologically, there is promise in innovative use of social network analysis as well as different forms of robust mixed-methods research.

PANEL 2:
REPRODUCTIVE HEALTH AND HUMAN RIGHTS

The second panel included Claire Wendland,[20] Christina Ewig,[21] and Siri Suh[22] who discussed how their respective disciplines construct and approach the study of reproductive health and human rights.

Claire Wendland began by noting that anthropology has historically studied human reproduction in faraway places and has provided insights into reproductive practices that have been exoticized and often normatively judged. Typically, questions have taken three forms: 1) How do people make decisions about reproduction, with what aims and under what constraints? 2) What reproductive practices are considered normal or abnormal, acceptable or unacceptable, how do these judgments vary within and among communities, and how do they change over time? And 3) When there is conflict or uncertainty about reproduction (or reproductive rights, or human rights more broadly), what happens and why?

Referencing the previous conversations, Wendland explained that the issue with RCTs is that they are often used by social scientists in situations where they are not suitable. Ethnography—the signature method of anthropologists—is especially useful 1) for uncovering the unintended effects of reproductive health policies, practices, and technologies as these effects unfold over time, 2) for explaining the logic and creativity behind seemingly irrational practices and/or understanding the effects of policies, innovations, programs, and particular technologies, and 3) unearthing the social pressures and cultural assumptions embedded in even the most mechanical technologies or the most apparently rational reproductive-health policies. Examples of this research include studies of women seeking care outside of the formal medical system, the ways that medical technologies, such as obstetric ultrasound, are altering attitudes and practices in childbirth, and Mark Hunter's work on state-based policies to address reproduction in South Africa.[23]

In terms of opportunities for future research, Wendland mentioned that anthropology could be doing more to understand how patriarchy operates, although there is a growing research agenda on the culture of people in positions of power. Finally, anthropology should continue to challenge the facile ways numbers are used. Often, through sheer repetition, quantitative analyses turn "uncertain results into meaningful facts" which can enable data and evidence to reproduce power dynamics. Anthropology could better contribute to this effort to clarify the meaning and context of such analyses by challenging the use of opaque jargon and eliminating pay walls that lead to unequal access to information. By expanding the use of social media and open access journals, anthropologists can help bring greater attention to the widespread infringements on reproductive rights.

Christina Ewig explained how political science has contributed to knowledge about reproductive health and human rights through quantifying the connections between reproductive health outcomes and the formal types of rights conferred by states. This domain of study brings to the fore questions about individual autonomy on family decision-making, such as those described in the Cairo Accords of 1994. Things become much more complicated when these formal rules give way to meaning-making processes in relationships, culture, family, and religion. Specifically, political science

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20 Professor and Associate Chair of Anthropology at the University of Wisconsin-Madison
21 Professor of Public Affairs and the Faculty Director of the Center on Women, Gender and Public Policy at the Humphrey School of Public Affairs at the University of Minnesota
22 Assistant Professor in the Department of Gender, Women and Sexuality Studies at the University of Minnesota
23 Hunter, Mark. 2010. *Love in the Time of AIDS: Inequality, gender, and rights in South Africa.* Bloomington: Indiana University Press.

has engaged with the following empirical question threads: What causes change in reproductive health policies? How do movements for more or fewer reproductive health choices organize and strategize? How do formal international agreements, multi- or bilateral agencies and/or broader global discourses influence reproductive health policies? How has this discourse, especially in relation to population control, affected global health and the movements/outcomes on the ground?

From left: Jeremy Shiffman, Claire Wendland, Siri Suh, Michael Reich

Within the existing political science literature, advancing liberal reproductive rights requires a secular context with strong public support, along with pro-liberalization social movement organizing, and support by left-wing governments. However, historically, tensions that can debilitate movements have arisen from the violent histories involving efforts to limit reproductive autonomy along race and class lines. Looking forward, political science should focus on new empirical puzzles within reproductive health and human rights such as: What implications does the growing influence of political populism have for reproductive health and rights? What impact might the emergence of new infectious diseases have on reproductive health policies, such as Zika? How will changing technologies and their impact on reproductive health affect reproductive health politics? Finally, how will the use of human rights frames by both the right and left affect political mobilizations and the development of laws over the long term?

Finally, Siri Suh began her presentation by noting that, for sociologists, reproduction is fundamentally political and social, not limited to the biological processes of individual bodies. Key research in this discipline includes Rene Almeling's view of reproduction as a social/biological process which must account for race, gender, and class as mediators for this process[24]; work on abortion activists' strategies and their effect on the national abortion debate[25]; Miranda Waggoner's work tracing the reach of the state into the bodies of women through pre-conception care[26]; Dorothy Roberts' intersectional lens exploring how identities affect reproductive experiences and outcomes[27]; and finally, the concept of reproductive justice versus reproductive rights as a framing more inclusive of the inequalities faced by low-income women of color.

Historically, U.S. sociologists have limited their analysis of reproduction to the domestic context. The omission of global perspectives is particularly puzzling given that the concepts of reproductive health and reproductive rights were mobilized during the early 1990s by feminist activists from both the global North and South, in response to concerns about global population control and as an explicit rejection of the U.S. government's neoliberal development agenda. Currently, conservative

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24 Almeling, Rene. 2015. "Reproduction." *Annual Review of Sociology*, Vol. 41: 423-442
25 Luker, Kristin. 1985. *Abortion and the Politics of Motherhood*. Berkeley: University of California Press. Bottom of Form
26 Waggoner, Miranda R. 2017. *The Zero Trimester: Pre-pregnancy care and the politics of reproductive risk*. Berkeley: University of California Press.
27 Roberts, Dorothy E. 2012. *Fatal Invention: How science, politics, and big business re-create race in the twenty-first century*. New York: New Press

anti-abortion policies continue to dominate, most recently demonstrated by President Donald Trump's reinstatement of the "Global Gag Rule" that extends deep restrictions on federal aid for family planning activities, barring any reference or services for abortion.[28] Looking forward, Suh asked, how can sociologists better incorporate global perspectives on reproductive health and rights? Suh said that sociologists should study the role of the U.S. in global systems of reproductive governance and the ways that ideologies are translated into foreign aid policies, development paradigms, and health interventions. Current work by Jade Sasser and colleagues[29] that traces the continuities between population control and investments in family planning in the Global South offers a promising example of work in this area, as is ongoing research in Senegal that explores the fact-making processes of abortion and its transnational methods of regulation.[30] Suh recommended extending studies of reproduction beyond the sub-disciplines of medical sociology and population studies into the sociology of development, science and technology studies, global and transnational sociology, and historical sociology in order to ask and investigate epistemologically rich, globally oriented questions about how reproduction intersects with other discursive, technological, professional, and institutional forms of power. Finally, the recent petition to the American Sociological Association to create a new section on the sociology of reproduction represents an important opportunity to increase the visibility of reproduction as an object of intra-disciplinary sociological analysis and to center the global in our studies of reproduction.

28 Gezinski, Lindsay B. 2012. "The Global Gag Rule: Impacts of Conservative Ideology on Women's Health." *International Social Work* 55(6):837–49.

29 Hartmann, Betsy, Anne Hendrixson, and Jade Sasser, 2016. "Population, sustainable development, and gender equity." In Leach, M. *Gender equality and sustainable development*. New York: Routledge.

30 Suh, Siri. 2017. "Accounting for abortion: Accomplishing transnational reproductive governance through post-abortion care in Senegal." *Global Public Health*, 13(6):662-679.

PANEL 3:

UNIVERSALISM

The third panel featured Salmaan Keshavjee,[31] Joseph Wong,[32] and Joseph Harris[33] in a broad discussion of anthropology, political science, and sociology's contributions and ways of understanding the notion of universalism in the health sphere, especially as it connects with the current global push for universal health coverage, access to medicine, and other social services.

Keshavjee began with the idea that anthropology's approach is one that supports a plural idea of culture: people approach and construct their cultural lives in different ways, but they are inherently equal in worth. Normatively, there is a fundamental shared humanity that leads us to a shared set of aspirations. It's through this lens that universalism allows for the creation of equality through essentializing dominant ideas and norms. In this way, global health has been shaped by ideas of the universal imposed upon the particularity of human experience. Historically, this has played out through the intersection of dominant neoliberalism and the right to health: David Harvey's work articulately demonstrates the myriad ways neoliberalism has penetrated how we relate to each other and to the state.[34] Other anthropologists have further characterized this relationship: Sunder Rajan[35] and Melinda Cooper[36] show how neoliberal thinking has penetrated into the biological sciences; James Ferguson[37] and Michael Goldman[38] show how neoliberalism has in many ways become a dominant, all-encompassing discourse; Jean and John Comaroff[39] have exposed the phenomenology of neoliberalism and how communities make sense of neoliberal reality and experience; and, scholars such as Susannah Sawyer[40] and Jeffrey Juris[41] explore how communities fight back and mobilize social movement responses to neoliberal domination.

Since anthropology is the study of the human experience of the particular, how can anthropology contribute to our understanding of the ways universalist ideas are understood and negotiated in different settings? João Biehl[42] shows how the relatively poor state of Brazil attempts to advance and realize the right to health and yet still constructs zones of abandonment. Similarly, Stephen J. Collier's[43] book on the post-Soviet social policies shows how neoliberal ideas in Russia are mobilized to preserve social values. Looking forward, there is an opportunity for anthropology to focus on universal claims as objects themselves, as well as the interaction between universal ideals, human rights, economic constructions, racism, and nationalism. Today, human rights claims are almost always tied to arguments of economic importance. More often than not, human rights claims are defended not because of their fundamental universality and inalienability, but because they contribute to economic growth.

31 Associate Professor of Global Health and Social Medicine at Harvard Medical School
32 Ralph and Roz Halbert Professor of Innovation and Professor of Political Science at the University of Toronto
33 Assistant Professor of Sociology at Boston University
34 Harvey, David. 2005. *A Brief History of Neoliberalism*. Oxford: Oxford University Press.
35 Sunder, Rajan Kaushik. 2006. *Biocapital: The Constitution of Postgenomic Life.* Durham: Duke University Press.
36 Cooper, Melinda. 2008. *Life as Surplus: Biotechnology and Capitalism in the Neoliberal Era.* Seattle: University of Washington Press.
37 Ferguson, James. 1990.*The Anti-Politics Machine: "development," depoliticization, and bureaucratic power in Lesotho.* Cambridge: Cambridge University Press.
38 Goldman, Michael. 1998. *Privatizing Nature: political struggles for the global commons.* New Brunswick: Rutgers University Press
39 Comaroff, Jean and John L. Comaroff. 2001.*Millennial capitalism and the culture of neoliberalism.* Durham: Duke University Press.
40 Sawyer, Susannah. 2004. *Crude Chronicles: Indigenous Politics, Multinational Oil, and Neoliberalism in Ecuador.* Durham: Duke University Press
41 Juris, Jeffrey S. 2008. *Networking Futures*. Durham: Duke University Press.
42 Biehl, Joao G. 2005. *Vita: Life in a zone of social abandonment*. Berkeley: University of California Press.
43 Collier, Stephen J. 2011. *Post-Soviet social: Neoliberalism, social modernity, biopolitics*. Princeton: Princeton University Press.

Wong began the discussion of political science's contribution to conversations about universalism in global health with a question: how do we get important "stuff" — including aid, vouchers, birth certificates, medicines and immunizations — to poor people who are very difficult to reach? A major domain of research within political science focuses on the role of the welfare state as an apparatus that should have the capacity to progressively extract resources and allocate/redistribute those resources through programs focused on the most vulnerable. The modern welfare state emerged as an Anglo-European phenomenon at a particular moment in history that required formal institutional structure. Fundamentally, the development of the welfare state was about protecting workers, relying on an economic logic of maximizing the productive capacity of a population. But just as the market has insiders and outsiders, so too does the welfare state. How should the welfare state deal with the millions of people who live in informal settlements, often have no registration with the state (and are therefore invisible), and are often excluded from accessing any state-sponsored social and economic rights?

In other words, how do we reach those who are hard to reach? This comes down to questions of state capacity and its ability to target and deliver goods and services with precision. Given the politics of redistribution, the cost to reach those who are hardest to reach increases at the margins. The further out the state reaches, the more costly delivering needed services becomes. From where do we generate this political will? The conventional wisdom within power resources theory in political science says that there must be the organization and mobilization of workers. But, at the same time, the poorest and most marginalized are often also the most incapable of mobilizing. Here, work by Joseph Harris describes the potential of "professional movements" — composed of elites from esteemed professions, frequently doctors and lawyers — who mobilized[44] to win major progressive reforms on behalf of those in need in Thailand, Brazil and South Africa. An empirical analogy can also be found in the epidemiology literature: the challenge and cost dynamics of eradication versus control of polio in India. In pursuing an eradication goal, the short-term costs increase rapidly to achieve marginal reductions in incidence. In the long run, however, there are tremendous economic savings in successfully accomplishing eradication. The question then becomes: what does it cost to get to zero, and what does it take to mobilize the political commitments necessary to redistribute these resources?

Finally, Joseph Harris discussed sociology's approach to studying universalism. Classical work on universalism within sociology centered on European and North American experiences related to social struggles for new social and economic rights. For Harris, universalism in the domain of health gained prominence as a moral frame during the HIV/AIDS epidemic when social movements sought to extend access to medication and treatment globally. As his research demonstrates, the early 2000s saw a wave of countries making substantial commitments to universal health coverage despite the high financial costs—Thailand being the case he had studied most closely. The claims and efforts to promote "health universalism," however, exposed the ways that citizens enjoy unequal benefits, stratified along the lines of race, ethnicity, and levels of poverty.

Conversations related to health universalism within sociology have so far curiously existed, for the most part, outside of broader discussions of contemporary global health challenges. Instead, this research has focused on differing theoretical explanations for why universalistic welfare states arise and the variation that exists between them. Different welfare structures bound citizen to state in different ways: social democratic welfare regimes (such as the Scandinavian countries) or

44 Harris, Joseph. 2017. *Achieving Access: Professional Movements and the Politics of Health Universalism.* Ithaca: Cornell University Press.

more conservative regimes (such as rapidly developing Rwanda). Within the sociological literature, researchers have begun to acknowledge the role of actors other than the state — such as the family, NGOs, and religious groups — as key providers of basic healthcare services,[45] as well as the possibility of new and emerging regional and supranational forms of social provision that can more readily serve mobile populations. They have also pointed to the persistence of "traditional medicine" and the emergence of new hybrid forms of Western and traditional medical treatments alongside the broader phenomenon of "medicalization" — the process whereby ordinary human conditions are increasingly defined as medical problems — a process that is itself grounded in Western biomedicine.

From left: Nitsan Chorev, Christina Ewig, Joseph Harris

Looking forward, Harris acknowledged that few sociological contributions have been explicitly concerned with the rise of epidemics, the explosion of health financing, and the new institutions and organizations that figure so prominently into the contemporary geography and practice of global health, like the Gates Foundation. Additionally, policy domains such as cash transfers (conditional and unconditional) as tools to advance health universalism are ripe for study by sociologists. Harris sees an important opportunity to study the mechanisms that lead health universalism to work (or not work) in practice, and to operate differently in subnational spaces. There is also an opportunity to contribute to discourse that seeks to move beyond rigid frames that pitch means-tested welfare targeting against universalistic approaches and instead find interesting hybrid approaches that have both practical and theoretical significance.

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45 Gough, Ian and Geof Wood, eds. 2004. *Insecurity and Welfare Regimes in Asia, Africa, and Latin America.* New York: Cambridge University Press.

PANEL 4:

INFECTIOUS DISEASES

The fourth panel on the study of infectious diseases in global health included anthropologist Adia Benton,[46] and political scientist Prerna Singh.[47] (Claire Decoteau[48] unfortunately was not able to be at the Symposium, but her discussion paper was read aloud by Susan Bell and is included as Appendix 2).

Benton began the session with reminding the group of the paradigmatic shifts that have occurred in global health over the past 70 to 80 years, during which the discipline of anthropology has "figured as the handmaiden of first colonialism, and then of developmentalist projects." Throughout history, the types of pathogens and sense of risk/danger have been interpreted and understood through the lens of the available disease theories of the time. So, even though Rudolf Virchow argued that social inequality causes disease, he also did so because he did not think that germs cause disease. Today, anthropology focuses more on how political economy and ecology have structured the transmission of disease in patterned ways. Key to this understanding is the notion that power relations shape the capacity to articulate causality. The power to name "culture" as the root of disease was aided and abetted by anthropology. For example, the conversation around Ebola — partially driven by anthropologists — has focused on how exoticized culture affects its transmission dynamics. Exploring the linguistic codes used by dominant actors — CNN, epidemiologists, anthropologists, etc — can show how the power of metaphor informs policy concerns.

From left: Anthony Janetos, Prerna Singh, Adia Benton

In discussing political science's contributions to infectious disease and global health social science, Singh noted that we are in a time of unprecedented anxiety about infectious disease, evidenced in popular culture through the "epidemic infection" horror film genre (zombie movies, *Outbreak*, etc.). Singh argued that what animates this intense interest/fear is the fact that infectious disease does not respect political-economic boundaries; disease can spread silently, with impunity, even across the most tightly controlled borders. Because infectious disease does not respect constructed national and subnational boundaries, it makes for a perfect concern for international relation scholars.

However, there exists a paradox: although infectious diseases should not (and do not) respect national boundaries, it is true that different population-level vulnerability to infectious disease is stratified by sociopolitical and corresponding economic conditions. How are we to reconcile this? Political scientists have often thought about the control of infectious disease as a milestone or proxy measure of state capacity. These measures are seen as: 1) indicators of social welfare and population well-being, 2) measures of the strength of the welfare state and its capacity to provide valued public

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46 Assistant Professor of Anthropology at Northwestern University
47 Mahatma Gandhi Assistant Professor of Political Science and International and Public Affairs at Brown University
48 Associate Professor of Sociology at the University of Illinois-Chicago

goods, or, 3) the strength of non-state welfare provision. Thus in the political science literature, infectious disease control figures as proxy measure or milestone, not an outcome in itself.

Another way political scientists have framed the study of infectious diseases is as the "war" against contagion. "War" against infectious diseases has been one of the main mechanisms by which the state has extended into domains previously controlled by the church, family, and other institutions. State attempts to control infectious disease involve coercion and compliance. Thus, similar to the case made by Charles Tilly[49], one could argue that wars against disease actually *make* states. One could judge "state capacity" by the ability of states to control infectious disease (state commitment + ability to implement necessary policy = state capacity to control). Thus, comparative political scholars have a framework for understanding "capacity" that overly focuses on top-down processes. One way forward is to bring in a bottom-up perspective, namely, what shapes or determines popular responses to disease technologies (which in turn influences the state's commitment to and ability to implement policy in response to infectious disease threats)? In other words, state capacity rests critically on a state's ability to elicit popular compliance (akin to something like taxation, volunteer armies, etc).

Looking forward to areas for future research, how can states elicit compliance, and under what conditions do societies give or withhold that compliance? For Singh, this is the frontier of public health today. For most infectious diseases, it's not a question of knowing the appropriate technology of clinical intervention, nor is it a technical challenge of provision. Fundamentally, control of infectious disease is a challenge of eliciting compliance by states from populations. Singh concluded with two key points: 1) we need to theorize from the starting point of specific infectious diseases and their particular pathology, epidemiology, and history, and 2) political scientists need to take health seriously in their work on comparative politics. She also emphasized two challenges going forward: 1) political science needs to better integrate multiple methods — qualitative methods, RCTs, and comparative historical analysis — and, 2) political science needs to build insights from other disciplines (sociology, psychology, anthropology) but also other sub-fields within political science (IR, political theory, etc.).

Claire Decoteau's Symposium paper is included in full as Appendix 2.

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49 Tilly, Charles. 1992. *Coercion, Capital, and European States, Ad 990-1992.* Rev. pbk. ed. Cambridge, MA: Blackwell.

PANEL 5:

ACCESS TO PHARMACEUTICALS

The final panel included Johanna Crane,[50] Nitsan Chorev,[51] Veronika Wirtz,[52] and Jesse Bump[53] (who presented on behalf of Michael Reich).[54] Together the group discussed the contributions and approaches to studying the challenge of access to pharmaceuticals within global health across their disciplines.

Crane began with an introduction to the anthropology of pharmaceuticals and its emphasis on looking at the "social lives of pharmaceuticals" (see Whyte, Van der Geest, and Harden[55]). For anthropologists, Crane noted, it is useful to think of pharmaceuticals as both biologically and socially active entities — to explore how the bio and the social interact across time and space. She laid out three key empirical puzzles that have been a focus in anthropological research: 1) How have HIV medications impacted social life, particularly in Africa? 2) How has the lack of access to pharmaceuticals impacted the practice of medicine in places marked by poverty? 3) How do pharmaceutical research, design, and the markets that allocate them, reflect and reproduce the structure of global inequities in pharmaceutical access?

For the first puzzle, the concept of "therapeutic citizenship" is useful: the "stateless citizen" is constituted in relation to a general framework of biological and therapeutic need via transnational providers. This concept reveals the kinds of claims people make and the types of resources they draw on when the state is unwilling or incapable of providing basic social protections. This work relates to literature on subjectivity and identity. For instance, how do people access important resources that are contingent upon identifying or "coming out" as HIV-positive (see, Vinh-Kim Nguyen 2010[56])? Julie Livingston's *Improvising Medicine*[57] relates to the second puzzle and the ways that cancer therapies are improvised in the face of stock and staff shortages in cancer clinics in Botswana. Finally, for the third puzzle, the literature on the ways that inequalities get embedded into the design and development of technologies is important. For example, research on antiretrovirals has been conducted using a variant of the HIV virus predominant in the U.S. and Europe, which is not the dominant variant globally. Similar examples include a human papilloma virus vaccine optimized to U.S. strains and cochlear implants that do not recognize tonal languages. In short, global social networks and resource flows shape the science, and the raw materials of science, in ways that create inequalities and constrain the availability and usefulness of drugs and other technologies for some patients and not others.

Chorev began her summary of sociology's contribution to the study of access to pharmaceuticals, with the reverse question: What can global health contribute to sociology? Should global health be considered a sociological sub-discipline? While there has yet to be a unified intellectual agenda for global health within sociology, there is currently more shared space and opportunity for a field to emerge now than ever before. Currently, the conversation in sociology around access to

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50 Associate Professor of Anthropology at the University of Washington-Bothell
51 Harmon Family Professor of Sociology and International Studies at Brown University
52 Associate Professor of Global Health at Boston University
53 Lecturer on Global Health Policy at Harvard School of Public Health
54 Taro Takemi Research Professor of International Health Policy at Harvard School of Public Health
55 Whyte, Susan R., SjaakVan der Geest, and Anita Hardon. 2002. *Social Lives of Medicines*. Cambridge, UK; New York: Cambridge University Press.
56 Nguyen, Vinh-Kim. 2010. *The Republic of Therapy: Triage and sovereignty in West Africa's time of AIDS*. Durham, NC: Duke University Press.
57 Livingston, Julie. 2012. *Improvising medicine: An African oncology ward in an emerging cancer epidemic*. Durham: Duke University Press.

pharmaceuticals is taking a number of different tracks, including engagement with debates over: 1) political sociology and theories of state bureaucracy, 2) social movements and transnational advocacy networks, 3) theories of international organizations and international relations, and, 4) social and economic development. Hence, global health research that exists within sociology is mostly framed into debates as "case studies" contributing to other sub-disciplines, rather than having a discrete interest in global health as the focus.

Looking forward, Chorev believes that the field of global health in sociology could "mature" into having its own unique intellectual agenda, set of theories, arguments, etc. In other words, global health could become a legitimate sub-discipline within sociology. For that, we need to identify the uniqueness of global health studies (e.g. where bodies and politics meet) and begin asking questions that are in the service of a sociology of global health, rather than of other sub-disciplines within sociology.

Next Veronika Wirtz discussed public health perspectives on the challenge of access to pharmaceuticals within global health. She framed public health as fundamentally multi-disciplinary — public health schools and departments often have faculty that span biostatistics, health economics, political science, anthropology, etc. The Lancet Commission on Universal Health Coverage and Access to Essential Medicines[58] has made key contributions to the debate about access to pharmaceuticals. This large-scale convening and research initiative, involving more than a dozen senior public health scholars and officials, found that access to essential medicines requires complex considerations including adequate financing of essential medicines; affordable essential medicines; ensuring medicines' quality and safety; promoting safe and efficient use of medicines; promoting research and development (R&D) on missing essential medicines; and creating accountability by measuring progress.
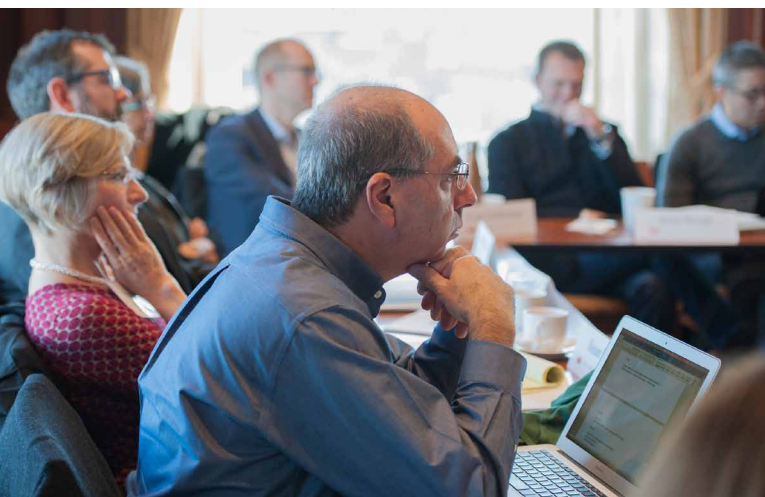
Looking forward, Wirtz identified three key remaining research directions: 1) How can countries with low coverage of health insurance guarantee that everyone can access medicines? 2) What steps can be taken to remove falsified and substandard medicines from the marketplace? And, 3) What structures and processes need to be created to track progress of access-to-medicines programs and policies? These challenges require changing the incentive structure within global health and pharmaceutical development more broadly to one that ensures equitable access to affordable and quality-assured medicines.

Finally, Bump began his brief remarks with a striking claim: less than one percent of all faculty at the Harvard School of Public Health are dedicated to the issue of access to medicines. Despite the fact that pharmaceuticals are a huge issue in real health system and government budgets, very few people are actually working on this issue. Despite its importance, it remains a niche area. For political science, access to pharmaceuticals — a study of distributions — is of particular relevance to global health questions. The study of agenda setting and issue framing is crucial to understanding how issues get onto an agenda. Applied political analysis is also useful. Michael Reich has created a software platform that produces sophisticated, visual political analyses which has formed the underpinning of executive seminars led by Reich at the World Bank and elsewhere.[59] These types of tools are useful to government agencies, non-governmental organizations, foundations, and business organizations but mostly new to academic scholars.

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58 http://www.thelancet.com/commissions/essential-medicines
59 http://www.polimap.com/poliuses.html

More broadly, Bump urged the group to consider working across the ideological disconnects that often exist between experts and actors focused on global health problems. Our shared question is: how can we mobilize these differences in perspective, politics, and epistemology to advance global health goals? He suggested that the group examine their own personal political economies that are shaped by membership in the academy and other institutions. If the group could better understand the incentive structure that they are embedded within, there would be a greater appreciation for the limits and opportunities to influence powerful global health actors and policy makers.

Finally, Bump urged symposium participants to keep in mind some of the important lessons of colonialism—in particular to be mindful that the search for ways to incorporate and engage the social sciences more fully in the study of global health should not be unidirectional but should be informed by the needs of people living in the Global South. He proposed three ways for social science to better integrate itself within global health: 1) Use social science to get governments to do what you want. This means that one must go to people and ask what they want. It's often easier to get work opportunities than money. 2) Improve institutions and organizations with the knowledge generated by these social science disciplines. 3) Inform and guide advocates: we have an opportunity to better equip citizens with the tools to understand and act on issues that matter to them.

Susan Bell and James McGuire

CLOSING REMARKS

Melani Cammett[60] delivered the first set of closing remarks, from the perspective of political science. She asked, what is it that each of these disciplines bring to global health? Yes, the disciplines' methodological differences could be leveraged more effectively, but disciplines shouldn't be defined by their method. Diverse methods complement one another and can be leveraged effectively in tandem; this symposium was meant, in part, to explore new ways of producing global health knowledge. Fundamentally, what each scholar is exploring are individually meaningful lives and the structural inequalities that shape and impede their health realities. Fundamentally, everyone participating in the Symposium has an overarching interest in power and context, but that power sits in different places and is seen in different ways by each scholar and discipline.

What are areas for possible collaboration? Cammett described a few:

1. Many people made the case for collaboration on urgent problems. She emphasized Claire Decoteau's point that critique is essential.

2. We need to explore the ways that research methods complement each other. If RCTs are deployed, then it is essential to actually understand the context because otherwise interpretation will be completely inappropriate and generalizability impossible.

3. We should question how people experience disease, how the state works to control disease, as well as how those experiences intersect with the many processes of social stratification and identity formation.

4. The case was made for how different kinds of questions inform social science research methods. In this, the absence of historians at the Symposium was striking. Historians would likely have had very valuable insight to contribute.

5. Finally, theoretical concepts like "therapeutic citizenship" in anthropology should be easily transportable to other disciplines; we should look for and actively cultivate this shared theoretical language and conceptual territory.

Susan Bell's[61] summary comments centered on the importance of the concept of *reflexivity* within critique. She advocated that we be self-reflexive about who we are: the assumptions we've made, the approaches we take, and the networks we occupy. Anthropologists, due in part to their particular history and tie to colonialism, have fine-tuned this skill, more so perhaps, than other disciplines. Regarding collaboration, Bell said that the more diversity you incorporate as a researcher (in terms of perspectives, positionality, history, disciplines), the more likely you are to produce better work. Diversity forces you to produce more nuanced, complex, and interesting work. In teaching, we have an opportunity to explore multiple levels of intervention and study in global health. It requires a reflexive analysis of what it means to go and "save the other." As our students wrestle with these analyses and go through these experiences, it gives us a useful mirror to revisit our own perspectives and biases. The experience of teaching should be utilized to further our own reflexivity. For next steps, Bell suggested that we consider a database or website to summarize some of these findings and the breadth of literature we've summarized and discussed. We have a chance to build a community of like-minded scholars. Finally, we can all continue to think about the limits of who we are, what we do, and what we

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60 Clarence Dillon Professor of International Affairs in the Department of Government at Harvard University
61 Professor of Sociology and Head, Department of Sociology at Drexel University

can do. The reality is that our impact will always be partial — but this realization can allow us to be more self-reflexive and critical about the work in which we choose to engage.

Finally, James McGuire[62] laid out four topics and themes that emerged over the course of the Symposium and their opportunities for further development:

1. Subnational analysis: Prerna Singh and others at this Symposium are making causal inferences on the basis of subnational rather than cross-national comparisons. In some ways such comparisons are problematic. More than countries, proximate subnational units often share intermingled histories, populations, and policy legacies, violating the expectation that units of analysis will be independent. Moreover, subnational units are heavily constrained by national-level histories, laws, institutions, and policies, possibly to the extent that they cannot be considered autonomous entities. In other respects, however, causal inference is easier at the subnational than at the cross-national level. Provinces and municipalities are less heterogeneous than countries in culture and history, reducing (though not eliminating) the problem of omitted variable bias. Subnational units are also less heterogeneous than countries in measuring such variables as economic affluence and health outcomes, reducing the problem of measurement error. So, analysis of health policies and health outcomes at the provincial and municipal level has both strengths and weaknesses. Arguably, however, it has been underexploited as a basis upon which to generate, elaborate, and evaluate propositions about the causes and consequences of health care and disease control initiatives.

2. Health successes under authoritarian regimes: Rwanda was mentioned as a paradoxical example of health success under a relatively undemocratic regime. This is not the only case of spectacular gains in health status in unlikely circumstances, including military occupation, dictatorship, and war. During WWI and WWII, despite the terrible toll of battle deaths, there were spectacular improvements in life expectancy in Britain[63] and in major continental European cities.[64] It's well worth studying what caused these surprising outcomes.

3. Takeup ("demand side") of health services: Singh mentioned the importance of studying not just the state's commitment to and capacity for implementing disease control initiatives, but also the public's reception of these initiatives. Clearly, health services have to be utilized, as well as provided, in order to affect health status.

4. Documentation: Our inability to know precisely how many children have no birth certificate should not be allowed to deter us from studying the causes and consequences of lack of documentation. Studying why some people lack documents is important and extremely neglected, especially in the study of "takeup." The issue of documentation is fundamental and *intrinsically* important: it involves recognition by the government of personhood, a basic human right that is not protected everywhere.

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62 Professor and Chair of the Department of Government at Wesleyan University
63 Sen, Amartya.1983. *Poverty and Famines: An Essay on Entitlement and Deprivation.* New York: Oxford University Press.
64 Winter, Jay and Jean-Louis Robert (Eds). 1999. *Capital Cities at War: Paris, London, Berlin, 1914-1919*. New York: Cambridge University Press

CONCLUSION:

TOWARDS A FIELD OF GLOBAL HEALTH STUDIES IN THE SOCIAL SCIENCES?

The social scientific study of global health challenges is complex and involves multiple disciplines with very different orientations. But, throughout the conversations at the Symposium, there was a sense of hope and opportunity that greater engagement by social science researchers with the problems of global health can both spark exciting new theoretical contributions while at the same time generating more robust evidence for interventions that improve the lives of the poor and marginalized around the world. To borrow (and adapt) some language from past American Sociology Association President Michael Burawoy,[65] participants puzzled over ways that new research in this area might contribute to both the advancement of "professional" social science (in which theoretical contributions are highly valued) and "policy" social science (conducted in response to real world problems) and new forms of social science that might be in the service of both kinds of social science as well as others.[66] In this regard, one could imagine the utility of an investigation of "global health" as an object itself that explores such issues as why now, why here, in what respects, and with what effects. The Symposium closed with discussion of what might be some useful additional outputs to come from the discussions in the months and years ahead. These might include additional meetings,

Scholars of anthropology, political science, and sociology during a discussion session at the first-ever Symposium on Global Health and the Social Sciences held at Boston University.

a website or database that makes social science contributions to global health more accessible to public health researchers, and/or a journal article or set of articles derived from the conference proceedings. More deliberation is clearly needed amongst social science scholars doing research on global health that builds on the initial discussions held at the Symposium. We hope that the conversations held over these two days, the conference report, the cross-disciplinary reference list included as an appendix of this report, and other additional outputs stemming from the symposium to be developed over the coming months can spur much more rigorous evidence, policy-specific recommendations, critical challenges to the assumptions and normative bases of global health work in practice, and engagements with subaltern communities who bear the brunt of what we write about. Onward!

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65 Burawoy, Michael. 2005. "For public sociology." *American Sociological Review*, 70(1): 4-28.

66 While "professional" and "policy" social sciences were the two primary, if implicit, reference points in the conversation, discussion also pointed to ample opportunities for contributions to "critical" and "public" social sciences, to use Burawoy's terms.

APPENDIX 1:

SYMPOSIUM PARTICIPANTS' BIOGRAPHIES

Cynthia Barakatt is the Associate Director of the Frederick S.Pardee Center for the Study of the Longer-Range Future at Boston University where she oversees the development and implementation of the Center's programs and activities, and directs the Center's outreach efforts, publications program, and the Graduate Summer Fellows Program. With a background in communications and environmental management and policy, she is interested in developing effective methods and strategies for making complex environmental science information easily accessible to non-scientific audiences. She previously worked as a communications specialist for two state environmental agencies and a large international environmental consulting firm, and served as an administrator for a university-based environmental research and education center. Prior to joining the Pardee Center in 2008, she served as Director of Training for the Leopold Leadership Program.

Jason Beckfield is Professor of Sociology and Associate Director of the Center for Population and Development Studies at Harvard University. He specializes in the relationship between social policy and social inequality, and is currently writing a book about how political sociology and social epidemiology can learn from one another and develop new explanations for the uneven distribution of population health. The book is under contract with Oxford University Press and is tentatively titled *The Political Sociology of Population Health*.

Beckfield's research on global health has deepened through trans-disciplinary collaboration. His work with Nancy Krieger's group produced a series of articles that evaluate political-sociological determinants of health inequalities, several published in the *American Journal of Public Health*. With an international team of researchers led by Clare Bambra, Beckfield developed a general institutional theory of social inequalities in health, which was published as "An institutional theory of welfare state effects on the distribution of population health" in *Social Theory and Health* in 2015.

Susan E. Bell is Professor and Department Head in the Department of Sociology at Drexel University. Her scholarship examines patient cultures, embodied health movements, women's health, the changing culture and structure of biomedicine, and visual and performative ways of understanding illness. In the field of global health, she is working on a book project in which she investigates the global flow of biomedical knowledge and spatial permeability by listening to and analyzing stories constructed in interactions between immigrant and refugee patient populations and staff in U.S. hospital outpatient clinics. Related to this is a study of the career pathways and experiences of physicians who enter the U.S. as refugees. Her newest global health project is with a collaborative, interdisciplinary social science network that is documenting and critically analyzing the social lives of the Zika virus, with funding from the American Sociological Association and the Wellcome Trust (https://www.zssn.org/). Recent global health publications include "Placing Care: Embodying Architecture in Hospital Clinics for Immigrant and Refugee Patients (*Sociology of Health & Illness* 2017) and *Reimagining (Bio)Medicalization, Pharmaceuticals and Genetics: Old Critiques and New Engagements* (Routledge 2015) (co-edited with Anne Figert).

Adia Benton is an Assistant Professor of Anthropology and African Studies at Northwestern University, where she is affiliated with the Science in Human Culture Program. She is the author of *HIV Exceptionalism: Development through Disease in Sierra Leone* (University of Minnesota Press, 2015), which won the Rachel Carson Prize from the Society for the Social Studies of Science in 2017.

Her current research is on the role of ideology in global health, using as a case study the growing movement to fully incorporate surgical care into commonsense notions of "global health." Her other writing has touched on the politics of anthropological knowledge in infectious disease outbreak response (and most recently, the response to the West African Ebola outbreak), racial hierarchies in humanitarianism and development, and techniques of enumeration in gender-based violence programs. She has a PhD in social anthropology from Harvard University, an MPH in international health from the Rollins School of Public Health at Emory University, and an AB in Human Biology from Brown University. She has held a postdoctoral fellowship at Dartmouth College and visiting positions at Oberlin College and in the Department of Global Health and Social Medicine at Harvard Medical School.

Jesse B. Bump is Lecturer on Global Health Policy in the Department of Global Health and Population, and Executive Director of the Takemi Program in International Health at the Harvard T.H. Chan School of Public Health. Dr. Bump's research focuses on the historical, political, and economic forces that are among the most fundamental determinants of ill health and the effectiveness of related institutions. His research addresses major themes in global health history, and in the political economy of global health to analyze these macro forces and develop strategies to navigate better solutions within them. Projects have investigated the history of child health problems such as diarrheal disease and congenital syphilis to explain how issues rise and fall on the global health agenda and to produce strategies to better align political visibility with health needs; the historical development of health systems and the implications for development assistance in that area; and the political economy of policy making and implementation in areas such as universal health coverage, humanitarian assistance, tobacco control, and nutrition governance. Dr. Bump holds a Baccalaureate in Astronomy and History from Amherst College, a Master in Public Health from Harvard University and a PhD in the History of Science, Medicine, and Technology from the Johns Hopkins University. Previously he was a Takemi Fellow at the Harvard School of Public Health and then Assistant Professor in the Department of International Health at Georgetown University.

Melani Cammett is Clarence Dillon Professor of International Affairs in the Department of Government at Harvard University and holds a secondary faculty appointment in the Harvard Chan School of Public Health. Cammett's books include *Compassionate Communalism: Welfare and Sectarianism in Lebanon* (Cornell University Press 2014), which won the American Political Science Association (APSA) Giovanni Sartori Book Award and the Honorable Mention for the APSA Gregory Luebbert Book Award; *A Political Economy of the Middle East* (co-authored with Ishac Diwan, Westview Press 2015); *The Politics of Non-State Social Welfare in the Global South* (co-edited with Lauren Morris MacLean, Cornell University Press, 2014), which received the Honorable Mention for the ARNOVA book award; and *Globalization and Business Politics in North Africa* (Cambridge University Press, 2007). Her current research explores governance and social service provision, identity politics and post-conflict institutional arrangements, primarily in the Middle East. She is also working on a new project on the long-term historical roots of development trajectories in the region. Cammett has published numerous articles in academic and policy journals, consults for development policy organizations, and is the recipient of various fellowships and awards. She currently serves as a Commissioner on the Lancet Commission on Syria.

Margaret Czerwienski is a fourth year doctoral student in the department of Anthropology, studying how novel heath econometrics (i.e. DALYs, QALYs, etc.) function to shape or delimit the scope, form, and nature of global humanitarian and philanthropic health projects and funding. Margaret also

has a Master's in Public Health from the University of Michigan School of Public Health and a B.A. in Women's Studies from the University of Michigan. Prior to coming to Harvard, Margaret worked for several years in the field of women's health, including as a birth doula, a surgical assistant and counselor at a reproductive health center, and a research coordinator for a study creating computer models of pelvic floor muscle stretch during labor and birth. In her spare time, Margaret enjoys reading Nietzsche, hiking, playing board games, and adventuring of all sorts.

Nitsan Chorev is the Harmon Family Professor of Sociology and International & Public Affairs at Brown University. Among other publications, she is the author of *Remaking U.S. Trade Policy: From Protectionism to Globalization* (Cornell University Press, 2007) and of *The World Health Organization between North and South* (Cornell University Press, 2012). She is currently working on a book manuscript on foreign aid, which investigates the effect of foreign aid on local pharmaceutical production in Kenya, Tanzania and Uganda, both in the 1980s and in the current era.

Johanna T. Crane is an Associate Professor of Science, Technology, and Society and Global Studies at the University of Washington's Bothell campus. She is the author of the 2013 book *Scrambling for Africa: AIDS, Expertise, and the Rise of American Global Health Science*, an ethnography of transnational HIV research and scientific politics in the U.S. and Uganda. Dr. Crane earned her PhDfrom the UCSF/UC Berkeley Joint Program in Medical Anthropology in 2007 and has held fellowships at Cornell University, the University of Pennsylvania, and the National Institutes of Health. She is currently spending her sabbatical as a visiting scholar at the Hastings Center for Bioethics and an instructor within the Bard Prison Initiative. In addition to continued work on global health partnerships, she is also engaged in a new project focused on aging, chronic illness, and ethics and technologies of care within the U.S. prison system.

Claire Decoteau is an Associate Professor of Sociology at the University of Illinois at Chicago. Broadly, her research focuses on the social construction of health and disease, the politics of knowledge production, and peoples' grounded experiences with healing and health care systems. Her book, *Ancestors and Antiretrovirals: The Biopolitics of HIV/AIDS in Post-Apartheid South Africa* (2013, University of Chicago Press) traces the politics of AIDS in South Africa from 1994 through 2010 analyzing: the political economy of the post-apartheid health system, the shifting symbolic struggles over the signification of HIV/AIDS, and the ways in which communities profoundly affected by the epidemic incorporate culturally hybrid subjectivities, informed by both indigenous and biomedical healing paradigms. This book was awarded three honorable mentions for outstanding book awards from ASA sections: Medical Sociology; Science, Knowledge and Technology; and the Theory Section. Decoteau is writing a new book analyzing the epistemic communities Somali refugees in Toronto and Minneapolis have forged to make sense of their children's vulnerability to autism. This is the first study of autism to explore the racial, class and national implications of autism etiology and politics.

Christina Ewig is Professor of Public Affairs and Director of the Center on Women, Gender and Public Policy at the Humphrey School of Public Affairs at the University of Minnesota. Professor Ewig's research centers on the politics of gender and race in Latin America. She has published widely on gender, race and social policy reforms in Latin America. Her current research investigates whether the rise of women and indigenous peoples into political office in Latin America has made a difference for the kinds of policy that is produced. Her book, *Second-Wave Neoliberalism: Gender,*

Race and Health Sector Reform in Peru (Penn State University Press, 2010) won the Flora Tristán award for best book on Peru from the Peru Section of the Latin American Studies Association. Her articles have appeared in *Comparative Political Studies*, *Feminist Studies*, *Social Science & Medicine, World Development*, and *Social Politics* among other journals.

Joseph Harris is Assistant Professor of Sociology at Boston University. He conducts comparative and historical research that lies at the intersection of sociology, public policy, and global health. He is the author of *Achieving Access: Professional Movements and the Politics of Health Universalism* (Cornell University Press, 2017). His current Fulbright-funded research project explores the diffusion of Thailand's public health policies abroad. His other work examines the politics of social policy in the industrializing world; comparative understanding of state capacity, bureaucratic autonomy, and the developmental state; and the emergent sociology of global health. Dr. Harris has served as a consultant to the United Nations Development Programme and the World Bank, most recently as Specialist on the Political Economy of Healthcare Reform for the Japan-World Bank Project on Universal Coverage. He is a past recipient of two Fulbright scholarships and a Henry Luce Scholarship and holds a Master's in Public Affairs from Princeton's Woodrow Wilson School of Public and International Affairs. He received his doctorate in Sociology from the University of Wisconsin-Madison and served as Lecturer at the University of Chicago's School of Public Policy Studies before joining the faculty at BU. In 2017, Dr. Harris received the Gitner Award for Distinguished Teaching. He currently serves as Associate Editor at *Social Science and Medicine*.

Carmen Jacqueline Ho is a PhD Candidate at the University of Toronto in the Department of Political Science. Currently, she holds a 2017-18 Fulbright Canada Award at the Harvard School of Public Health with the Takemi Program in International Health. Her doctoral dissertation investigates the United Nations "Scaling Up Nutrition" agreement and its ability to elicit national health reform in country signatories. To explain variation in policy reform, she compares state capacity and regime type in the cases of Cambodia, Indonesia, Laos, and the Philippines, where she conducted her fieldwork. More broadly, Carmen is interested in three research questions, with a focus on public health in Asia's low and middle-income countries: What explains why certain countries adopt and implement equitable social welfare policies, while others do not? Under what conditions do non-state actors facilitate social welfare policy reform? And what are the political consequences of non-state social welfare provision? Her research has been funded by the Social Sciences and Humanities Research Council of Canada, Ontario Provincial Government, International Development Research Centre, and other institutions.

Anthony C. Janetos is Director of the Frederick S. Pardee Center for the Study of the Longer-Range Future and the Frederick S. Pardee Professor of Earth & Environment at Boston University. He has devoted his career to high-impact global change science and policy, earning international recognition for his scholarship. He is the author of numerous papers in both natural and social science journals on a range of topics related to his primary research interest, the interaction of land systems with human needs and climate change. A recognized leader in the scientific community, he chairs several national and international committees that oversee scientific pursuits and educational policies related to various natural science disciplines. Prior to joining Boston University in 2013, Prof. Janetos served as Director of the Joint Global Change Research Institute at the University of Maryland for six years. Prior to that, he held executive leadership positions at institutions including the U.S. Environmental Protection Agency, NASA, World Resources Institute, and the Heinz Center for Science, Economics, and the Environment. He has served on several national and international

study teams, including working as a co-chair of the U.S. National Assessment of the Potential Consequences of Climate Variability and Change. He has been an Intergovernmental Panel on Climate Change Lead Author and Coordinating Lead Author, and has served on multiple National Research Council Committees and Boards. He currently chairs the National Science Foundation's Advisory Committee on Environmental Research and Education, as well as the National Academy of Sciences Committee to Advise the U.S. Global Change Research Program.

Salmaan Keshavjee is Associate Professor in the Department of Global Health and Social Medicine and Department of Medicine at Harvard Medical School, and Director of Harvard Medical School's Center for Global Health Delivery–Dubai. He also serves as a physician in the Division of Global Health Equity at the Brigham and Women's Hospital. He conducted doctoral research in medical anthropology at Harvard University on the health transition in post-Soviet Tajikistan. He has worked with the Division of Global Health Equity and the Boston-based non-profit, Partners In Health, on the implementation of a multidrug-resistant tuberculosis (MDR-TB) treatment program in Tomsk, Russia. Between 2006 and 2008, Dr. Keshavjee set up the first community-based treatment program to treat patients co-infected with HIV and MDR-TB in Lesotho. Between 2007 and 2010, Dr. Keshavjee served as the chair of the Green Light Committee Initiative, a Stop TB Partnership/ WHO initiative which helped countries gain access to high-quality second-line anti-TB drugs so they can provide treatment for people with MDR-TB. He is a co-founder of Advance Access & Delivery, a non-profit committed to addressing critical challenges in access to medicines and the delivery of comprehensive healthcare, particularly for economically and socially marginalized groups. Dr. Keshavjee's anthropological work focuses on the anthropology of policy and healthcare delivery. He is the author of *Blind Spot: How Neoliberalism Infiltrated Global Health* (2014). Dr. Keshavjee received his ScM from the Harvard School of Public Health in 1993, his PhD in Anthropology and Middle Eastern Studies from Harvard University in 1998, and his MD from Stanford University in 2001.

Andrew Lakoff holds a joint appointment in the Departments of Sociology and Communication at the University of Southern California. He was trained as an anthropologist of science and medicine, and has conducted research in Argentina, France and the United States. His areas of interest include globalization processes, the history of the human sciences, contemporary social theory, and risk society. Lakoff's first book, *Pharmaceutical Reason: Knowledge and Value in Global Psychiatry* (Cambridge, 2005), examines the role of the global circulation of pharmaceuticals in the spread of biological models of human behavior. He has also co-edited a book titled *Global Pharmaceuticals: Ethics, Markets, Practice* (Duke, 2006), and has published articles on visual technology and the behavioral sciences, on the history of attention deficit disorder, on antidepressants and the placebo effect, and on forms of expertise in global health. Lakoff's current research concerns the recent articulation of expertise in public health and security in a global context, and his recent book publications include the co-edited volume, *Biosecurity Interventions: Global Health and Security in Question* (Columbia University Press, 2008), and the edited volume *Disaster and the Politics of Intervention* (Columbia University Press, 2010). His newest book, *Global Health in a Time of Emergency*, is forthcoming from the University of California Press.

Evan Lieberman is the Total Professor of Political Science and Contemporary Africa at MIT. Previously a member of the faculty at Princeton University for 12 years, and a Robert Wood Johnson Health Policy Scholar at Yale University, Lieberman received his PhD from the University of California, Berkeley, and his BA from Princeton. Lieberman's research is concerned with democratic governance, risk perception, the causes and consequences of ethnic conflict, and the determinants

of good governance and policy-making, particularly in sub-Saharan Africa and in the area of public health. He also writes and teaches on research methods. Lieberman is the author of two scholarly books, *Race and Regionalism in the Politics of Taxation* (Cambridge University Press, 2003) and *Boundaries of Contagion: How Ethnic Politics Have Shaped Government Responses to AIDS* (Princeton University Press, 2009) and numerous articles, which have been published in *World Politics, the American Political Science Review, World Development, Comparative Political Studies,* and other journals. He received the 2014 David Collier mid-career achievement award.

James W. McGuire is Professor and Chair in the Department of Government at Wesleyan University, where he received the Binswanger Prize for Excellence in Teaching. His BA is from Swarthmore and his PhD is from the University of California, Berkeley. He specializes in the comparative politics of developing countries, focusing on democracy, social welfare policies, and public health. He is the author of *Peronism without Perón: Unions, Parties, and Democracy in Argentina* (Stanford University Press, 1997) and of *Wealth, Health, and Democracy in East Asia and Latin America* (Cambridge University Press, 2010), which won the 2011 Stein Rokkan Prize for Comparative Social Science Research. His recent research has involved Latin American social policies, regime type and infant mortality, the conceptualization of democracy, growth and inequality in Latin America and East Asia, conditional cash transfers in Ecuador, economic development in contemporary Cuba, and the impact of women legislators on health outcomes.

Lynn M. Morgan, Mary E. Woolley Professor of Anthropology at Mount Holyoke College, is a medical anthropologist and feminist science studies scholar who has authored and edited three books — *Icons of Life: A Cultural History of Human Embryos* (University of California Press, 2009), *Community Participation in Health: The Politics of Primary Care in Costa Rica* (Cambridge, 1993), and *Fetal Subjects, Feminist Positions* (University of Pennsylvania Press, 1999) – and over 35 articles. Her awards include the Rachel Carson Prize from the Society for the Social Studies of Science (4S) for *Icons of Life*, and fellowships from the National Science Foundation, National Endowment for Humanities, Social Science Research Council, and the School for Advanced Research. She is currently writing about the backlash against reproductive rights movements in Latin America.

Shiri Noy is Assistant Professor of Sociology and Adjunct Assistant Professor of Global and Area Studies at the University of Wyoming. Her research examines global governance, development, and political culture and how these processes influence social inequality and public policy, especially in health. Her book, *Banking on Health: The World Bank and Health Sector Reform in Latin America* (Palgrave Macmillan 2017) is a mixed methods analysis that addresses the puzzle of why the World Bank was unable to effect sweeping neoliberal reforms in health in Latin America in the 1980s and beyond. Her research on global health has also been published in the *International Journal of Comparative Sociology, Sociology of Development,* and *Oxford Development Studies* among other outlets.

Michael R. Reich is the Taro Takemi Research Professor of International Health Policy at the Harvard T.H. Chan School of Public Health. He received his PhD in political science from Yale University in 1981 and has been a member of the Harvard faculty since 1983. Dr. Reich has research interests in the political economy of pharmaceutical policy, access to medicines, and public-private partnerships, and has published extensively on these topics. He coauthored a widely used book on health systems, *Getting Health Reform Right: A Guide to Improving Performance and Equity* (Oxford University Press, 2004, with M.J. Roberts, W.C. Hsiao, and P. Berman). In 2008, Reich published a book with Laura J. Frost on *Access: How do Good Health Technologies Get to Poor People in Poor Countries?* (Harvard University Press, 2008). He was a member of the Lancet Commission on

Essential Medicines Policies, which published its report in fall 2016. He is also a founding Editor-in-Chief of the new journal *Health Systems & Reform*, now in its third year.

Jon Shaffer is a PhDstudent in sociology at Boston University where his research interests exist at the intersection of global health, human rights, science and technology studies, and social movements. Previously, Jon launched a community organizing platform with Partners In Health called PIH Engage (engage.pih.org), which has supported more than 100 teams of volunteer community organizers, thousands of new grassroots supporters, raised nearly one million dollars, and developed new capacity to advocate for policies that advance the human right to health. Before that, he worked to develop, launch, and lead GlobeMed (www.globemed.org) which has engaged thousands of university students in the global health equity movement. When not organizing or reading, Jon loves going for runs, playing KanJam, and learning to strum the guitar.

Jeremy Shiffman is Professor in the Department of Public Administration and Policy at American University in Washington, DC. A political scientist by training, his research focuses on the politics of health policy-making in low-income countries, and the global governance of health and social development. His research has been funded by the Gates, MacArthur, and Rockafeller Foundations and the United States Agency for International Development amongst other organizations. His work has appeared in multiple journals, including *The Lancet*, *The American Journal of Public Health* and *Population and Development Review*. He is the inaugural recipient of the Gary and Stacey Jacobs Award for excellence in health policy research, and was named scholar-teacher of the year at American University's School of Public Affairs in 2017. Across his career, he has received six awards for excellence in teaching. He has served on multiple technical advisory committees for organizations working in global health and development, including the World Health Organization and Save the Children. He received a BA *summa cum laude* from Yale University in philosophy, and MA from Johns Hopkins University (SAIS) in international relations, and a PhDfrom the University of Michigan in political science.

Prerna Singh is Mahatma Gandhi Assistant Professor of Political Science and International Studies and faculty fellow at the Watson Institute, and co-convenor of the Brown-Harvard-MIT Joint Seminar in South Asian Politics. She completed her PhD and MA from the Department of Politics at Princeton University, the tripos in social and political studies from Cambridge University, UK, and a BA (Honors) in economics from Delhi University. Prior to joining Brown, she taught in the Department of Government at Harvard University. She has also been a junior fellow at the Harvard Academy for International and Area Studies and held a pre-doctoral research fellowship at the Center for Advanced Study for India (CASI) at the University of Pennsylvania.

Her book, *How Solidarity Works for Welfare: Subnationalism and Social Development in India*, was published by Cambridge University Press in their Comparative Politics series earlier this year. The book is a comparative historical analysis of the very different evolution of social policy and welfare systems across states in India, and the critical role that a sense of social solidarity and political community has played therein. She traces the striking divergences in education and health policy and outcomes across Indian states to differences in the strength of their subnational identification. The book was awarded the Woodrow Wilson prize by the American Political Science Association for the best book published in politics and international relations in the last year, and the Barrington Moore prize for the best book published in comparative historical sociology in the last year by the American Sociological Association.

Siri Suh is Assistant Professor in Gender and Women's Studies and Global Studies at the University of Minnesota. Her research bridges the fields of medical anthropology and sociology, population and development studies, and feminist and post-colonial science and technology studies. She received her PhD in Sociomedical Sciences and MPH from Columbia University and her BA in Sociology from the University of California, Berkeley. Suh's research has been funded by the American Association of University Women, the American Council of Learned Societies, the Social Science Research Council and the National Institute of Child Health and Human Development. She has conducted research on maternal and reproductive health with the United Nations Fund for Population Activities, Management Sciences for Health, and the Guttmacher Institute. Suh's current book project, *Obstetric Ambiguities: Reproductive Governance, Evidence and Global Abortion Politics in Senegal*, explores how selective epidemiological and demographic fact-making about women and abortion exacerbates reproductive health inequalities in Senegal. In July 2018, she will join the faculty in the Department of Sociology at Brandeis University.

Claire Wendland is a professor in the Departments of Anthropology and Obstetrics & Gynecology at University of Wisconsin-Madison. She is a physician who worked as an obstetrician-gynecologist on the Navajo reservation before turning to medical anthropology. Her research primarily explores healing expertise in African settings. In *A Heart for the Work: Journeys through an African Medical School,* the first ethnography of a medical school in the global South, Wendland described the intellectual and professional journeys of Malawian medical students over the course of their studies. Her current research project, again in Malawi, explores explanations for maternal death in a context in which mortality rates are very high while the uncertainties surrounding any given death are substantial.

Veronika J. Wirtz is an Associate Professor in the Department of Global Health at the Boston University School of Public Health, where she is also Director of the World Health Organization Collaborating Center in Pharmaceutical Policy. Between 2014 and 2016 she was the Co-Chair of The Lancet Commission on Essential Medicine Policies which published its report *Essential Medicines for Universal Health Coverage* in Fall 2016. She has worked as a technical advisor for various international organizations, among them the World Health Organization, the Pan American Health Organization, the Global Fund to fight AIDS, Tuberculosis and Malaria, the Bill and Melinda Gates Foundation and Alliance for Health Systems and Policy Research. She is a Visiting Professor of the National Institute of Public Health (INSP), Mexico where she was a faculty member between 2005 and 2012. She received her training as a pharmacist from Albert-Ludwigs-University in Freiburg, Germany and her Master in Clinical Pharmacy and PhD from the University of London, UK.

Joseph Wong is the Ralph and Roz Halbert Professor of Innovation at the Munk School, University of Toronto. He held the Canada Research Chair in Health and Development in the Department of Political Science for two full terms, ending in 2016. Professor Wong has published extensively in the fields of comparative politics, public policy and democratization, with a regional focus on Asia. He is currently the Associate Vice President and Vice Provost, International, of the University of Toronto.

APPENDIX 2:

CLAIRE DECOTEAU'S SYMPOSIUM PAPER

Editor's note: Claire Decoteau (Associate Professor of Sociology at the University of Illinois at Chicago) was unable to attend the symposium but provided the following brief discussion paper.

Global Health Precis
Infectious Disease

I have reservations about speaking on behalf of my discipline or offering a definitive statement about its approach to infectious disease for a number of reasons. First, I do not see myself as representative of my discipline and therefore feel poorly poised to define its normative dimensions. Second, I cannot really speak to the disciplinary approach to infectious disease, but can provide some insight on the sociological response to AIDS in particular (while recognizing that AIDS is a very exceptional infectious disease in a number of important ways). Third, I believe that global health work necessitates an interdisciplinary response and therefore, my own work and much of the work I admire is cross or transdisciplinary. Fourth, I have concerns about the boundaries we draw (and therefore the disciplining we do) when we suggest a particular approach is categorically sociological. What in fact bounds sociologists together — a way of posing questions, a theory of causality, attention to structural dimensions, a methodological framework? Do we mean sociology as it is defined and practiced in the United States? My own work is much closer to anthropological accounts than it is to the quantitative studies being done on HIV/AIDS within my own discipline; therefore disciplinary lines are not necessarily those that have the most meaning epistemologically speaking.

Rather than providing a comprehensive assessment of AIDS scholarship in sociology, I offer a series of important and interesting analyses of HIV/AIDS that have been made by both established and younger scholars in recent years.

There are many sociologists who have analyzed the macro-political dynamics that structure health inequality and public health responses to infectious disease. Such analysts focus their attention on structural adjustment programs and other processes of neoliberalization, intellectual property rights and the pharmaceuticalization of disease response, and the regulatory practices of international institutions like UNAIDS and the World Health Organization.

A subset of such approaches focuses on the organizational dimensions of these international responses. For example, Ann Swidler and Susan Watkin's book, *Fraught Embrace* analyzes prevention campaigns in Malawi, detailing the relationship between donor organizations (and their fantasies of intervention and salvation) and the brokers who link these organizations to national players and the local communities they are meant to serve. The authors paint this enterprise as chaotic, uneven, and capricious, which undermines the efforts to rationalize Africans' sexual behavior. Drawing on fieldwork in HIV clinics in the U.S., South Africa, Thailand and Uganda, Carol Heimer is analyzing how clinical trials shape medical practice by transforming organizational dynamics and the prioritization of research values differently in wealthy and poor countries.

There is a series of important scholarship on the practices of sexuality and transmission, disrupting and problematizing the presumptions of prevention campaigns and interrogating the real ways in which people fall in love, transact intimacy and forge identities through their sexuality. For example, in *Love, Money and HIV,* Sanyu Mojola draws on extensive ethnographic, interview and survey data in Kenya to unpack the puzzling fact that young women with an education have higher rates of HIV than the

poor. Her explanation is that women learn western consumption and stylization techniques in school, which increases their demand for money and desire to engage in sexual relations with older men. Robert Wyrod, in his book, *AIDS and Masculinity in the African City,* draws on 10 years of ethnographic observation in Kampala to examine the ways in which AIDS has altered masculinity but nonetheless served to sustain male privilege, disrupting narratives about Uganda's great success in preventing HIV transmission. Héctor Carrillo has two important books on sexuality and HIV. The first, *The Night is Young,* draws on ethnographic data in Guadalajara showing that HIV prevention campaigns are contradicted by the ways in which Mexican youth contend with everyday struggles in and through their sexual expressions, practices and identities. His new book, *Pathways of Desire*, grapples with the topic of sexual migration, following gay Mexican men who travel to the U.S. seeking health care and sexual relationships with American men. The analysis challenges existing stereotypes that men would migrate because the U.S. is a more "sexually enlightened country." As such, Carrillo unpacks sexual globalization and challenges existing scripts about the relationship between the global north and south.

A final important thread to highlight focuses on social movement mobilization around HIV/AIDS and the dual causal relationship between social movements and both states and global forces. In some cases social movements can make new spaces and policies (pushing for incorporation and transformation in governing) and in other cases, social movements are themselves transformed by global processes, epistemes and norms. Here I highlight two recent dissertations on the topic.

Gowri Vijayakumar draws on ethnographic participant observation and extensive interviews with sex worker social movements in Kolkata, Bangalore and Nairobi. She analyzes shifts in the ways in which states respond to sex workers in these locations, analyzing the gendered effects on state policy within the context of the epidemic and globalization. Yan Long examines the rise and fall of China's AIDS activism by three distinct groups: urban gay males, female sex workers and peasants infected by contaminated blood. According to Long, transnational institutions are responsible for both the ascent and decline of AIDS activism in China because the prevention and treatment models promoted were laced with cultural scripts and modes of action that transformed local mobilizations and state responses to them.

AIDS has profoundly reshaped the world in the last 40 years — it has restructured global institutions, economic policies, biomedical science and the biomedical industrial complex, sexual identities and behaviors and the world of social movement organizing. It has decimated entire communities and generations. Despite all of the attention it has gotten, there are also tremendous absences and silences in the attention it has received. The exclusions and occlusions that it has engendered require ongoing recognition and analysis. But AIDS is also not going away. As Peter Piot has recently warned, HIV/AIDS has always been approached as an emergency, short-term crisis, and yet we need to marshal the political and economic will to build long-term sustainable solutions (2015: 160). This is an especially important message in the current era when many AIDS organizations and social movements are losing financial and political investment, despite the fact that new infections are still high, millions of people still lack access to therapies and support let alone clean water, sustainable housing and food, security and employment. If anything, over the past three-and-a-half decades, responding to HIV/AIDS has become more complicated, demanding more nuanced and creative approaches and policies. The structural dynamics that are syndemic with HIV/ AIDS are also still far from being resolved and worse, are often blatantly ignored. Problems such as endemic poverty, housing shortages, lack of security, gender violence — these are the landscapes in which HIV/AIDS flourishes and which require our ongoing attention.

APPENDIX 3:

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