Globhealth ERC Project

From International to Global: Knowledge, Diseases and the Postwar Government of Health

ABSTRACTS

An international conference to be held in Paris
February, 12th-14th, 2015

From International to Global: Knowledge, Diseases and the Postwar Government of Health.

An international conference to be held in Domaine de Bierville. February, 12th-14th, 2015.

In the 1980s and 1990s, the HIV epidemic was the most discussed issue in international health organizations and was increasingly labeled as a global phenomenon. Within this context, "global" referred to various aspects of the epidemic: its scale and the fact that contamination occurred in all countries of the world; the need for coordinated and generalized actions implying programs to be implemented in all countries; the creation of new institutions operating worldwide involved in funding or standardization of prevention (later treatment) protocols; the specificity of problems associated with North-South inequalities and with the fact that the majority of HIV-contamination took place in developing or underdeveloped countries, African in the first place.

In spite of its visibility, one may wonder what is actually global health and what is new in it. The aim of this conference is to discuss the various ways in which this question has been recently addressed by anthropologists, sociologists or historians of health and medicine in order to explore the numerous issues the spreading of the "global" raises, focusing on processes of globalization rather than entering essentialist debates about the true nature of the "global". The conference will in particular discuss three aspects of what could be the agenda for a better understanding of the transition from international to global health, which took place during the past thirty years: historicization, localization and critical engagement.

History is needed to balance a widespread fascination for most recent innovations, be they technical, institutional or social; a fascination, which results in the danger of taking the tree for the forest, the future for the present, the experimental for the routine. Localization is needed because the 'international' or the 'global' are not given but complex and collectively constructed realities. As the term 'glocal' reminds us: globalization does not exist outside processes of generalization from – circulation and aggregation of - local practices while any global agenda or program only becomes real when adopted, resisted and adapted by local actors. Critical engagement is needed since the global is never a view from nowhere. It is always somebody's global, making specific actors, targets and tools highly visible while erasing others, thus producing new hierarchies of power and new inequalities.

The conference is the first event in a series of initiatives originating in the ERC project GLOBHEALTH. This project consists in a social and historical study of the transition between the two regimes, which have characterized the government of health after World War II: first, the regime of international public health, dominating during the first decades of the postwar era, which was centered on eradication policies, nation-states and international UN organizations; second, the present regime of global health, which emerged in the 1980s and is centered on risk management and chronic diseases, market-driven regulations, and private-public alliances. This transition will be approached in terms of actors, forms of knowledge, tools and practices. The project thus targets the tensions and social dynamics underlying four core issues:

- the reconfiguration of health economic governance around the markets
- the emergence of post-national institutions of health governance
- the limits of the therapeutic revolution and drug access policies
- the multiple epidemiological transitions and the management of risks

GLOBHEALTH approaches these questions through a series of specific and local studies in order to in order to grasp how categories, standardized treatment regimens, industrial products, management tools or specific specialties have become elements in our present global government of health. The four fields selected are tuberculosis, mental health, traditional medicine and medical genetics. The project includes historical and anthropological investigations of practices in both international and local sites with strong interests in: a) the changing roles of WHO; b) the developments taking place in non-Western countries, India and East Africa in the first place.

Thursday, February 12th

12h30	Arrival at "Domaine de Bierville"
13h – 14h	Lunch
14h – 14h30	*Welcome and General Introduction* – Jean-Paul Gaudillière (Cermes3, Inserm-EHESS, Paris)
14h30 – 15h30	*Keynote lecture* "In search for Global Health" Didier Fassin (Institute for Advanced Studies Princeton)
15h30 – 15h45	Coffee break
15h45 – 18h45	*Panel 1 – Global Psychiatry: From Colonial Histories to World Mental Health* Introduction – Anne M. Lovell (Cermes3, Inserm-Université Paris Descartes) "Nervousness as Concept and Mood for a Colonial Situation" Nancy Rose Hunt (University of Michigan, Ann Harbor) "Decolonizing, Nationalizing and Globalizing the History of Psychiatry: From Colonial to Cross-Cultural Psychiatry in Nigeria" Matthew M. Heaton (Virginia Tech, Blacksburgh) "Psychiatry on the Edge: Society and Science in the History of Mental Health Institutions in India" James H. Mills (University of Strathclyde, Glasgow) "Critiques of PTSD in Global Health Programs: An Engaged Anthropological Perspective" Byron Good (Harvard University) and Mary-Jo Del Vecchio Good (Harvard University, Cambridge MA) Comments – Laurence Kirmayer (McGill University, Montreal)
19h30	Dinner

Friday, February 13th

9h – 10h	*Keynote lecture* "We Have Never Been Global: Explaining the WHO's Response to Ebola" Nitsan Chorev (Brown University, Providence)
10h – 11h30	*Panel 2 – Globalizing Techniques and Products in Asian Medicine* Introduction – Laurent Pordié (Cermes3, CNRS, Paris) "Nature Cure and Global Health" Joseph S. Alter (University of Pittsbrugh) From Scarcity to Profit: Traditional Medicine and Global Health Stephan Kloos (Austrian Academy of Science, Viena)
11h30 – 11h45	Coffee Break
11h45 – 13h15	*Panel 2 – Globalizing Techniques and Products in Asian Medicine* "You've Got the Point: Seeking the Meaning of Acupuncture in its Techno-Political Bodyscape" Wen-Hua Kuo (National Yang-Ming University, Taipei) "*Outside the Establishment*: Standardization and Contingency in 'Classical' Chinese Medicine" Mei Zhuan (University of California - Irvine) Comments – Mark Nichter (University of Arizona, Tucson)
13h15 – 14h15	Lunch
14h15 – 15h15	*Keynote lecture:* « Metrics of the Global Sovereign: Numbers and Stories in Global Health » Vincanne Adams (University of California - San Francisco)
15h15 – 15h30	Coffee Break
15h30 – 18h	*Panel 3 – Medical Genetics and Genetic Testing in the South* Introduction – Claire Beaudevin (Cermes3, CNRS, Paris) "Finding the Global in the Local: Constructing Population in Genome-Wide Association Studies" Steve Sturdy (University of Edinburgh) "Rare Genetic Disease in Globalizing Public Health Genomics: The Case of Li-Fraumeni and R337h in Brazil" Sahra Gibbon (University College, London)

	"Sickle-Cell Anemia in Brazil: Hereditary Condition and Racial Identity" Ilana Löwy (Cermes3, Inserm, Paris) Comments – Soraya de Chadarevian (University of California - Los Angeles)
18h30 – 19h30	*Discussion with the PhD and postdoctoral researchers currently participating in the GLOBHEALTH project:* Mandy Geise, Caroline Meier zu Biesen, Anabel Rodriguez
19h30	Dinner

Saturday, February 14th

8h30 – 9h30	*Keynote lecture:* "The Global Menace and its Interruptions" Sarah Hodges (University of Warwick)
9h30 – 11h	*Panel 4 – The Control of a Neglected Disease: DOTS and Tuberculosis* Introduction – Christoph Gradmann (University of Oslo) "The Historical Origin of WHO Policies to Control the Transmission of Tuberculosis and the Influence of the East African Tuberculosis Trials" David Macfadyen (University of Glasgow) "*I Can Assure You, DOTS Is Not Happening Here"*: South Africa's Changing TB Treatment Practices and the Advent of Extensively Drug Resistant Tuberculosis" Erica Dwyer (University of Pennsylvania, Philadelphia)
11h – 11h15	Coffee Break
11h15 – 13h15	"Innovating Tuberculosis Control in India" Nora Engel (Maastricht University) "Lessons Learnt from the DOTS Strategy for TB Control in Nepal" Ian Harper (University of Edinburgh) Comments : Christian Bonah (Strasbourg University)
13h15 – 14h30	Lunch
14h30	Departure from Bierville

ABSTRACTS

KEYNOTE

In search for Global Health

Didier Fassin (Institute for Advanced Studies Princeton)

PANEL 1

Global Psychiatry: From Colonial Histories to World Mental Health

Introduction

Anne M. Lovell *(Inserm-Cermes3, Paris)*

Nervousmess as Concept and Mood for a colonial Situation

Nancy Rose Hunt *(University of Michigan, Ann Arbor)*

Why is a concept of nervousness productive for rethinking colonial situations, their social pathologies, and a complex range of empirical histories? I will discuss its use and manifestations in a history of Congo's Equateur region, including as Conradian idiom, neurasthenic category, suicide, a securitizing state, and a vernacular healing template found among women in a zone where overwork was intense and infertility rates high. The empirical resonances and metaphorical quotations are many. What is gained in using it as a concept that collects and sorts out diverse moods, tonalities, and deeds? Much more than shifting back and forth between the colonial and the vernacular, the institutional and individual, I will insist. Rather, nervousness opens up a multi-faceted way of writing a history of a mood. In so doing, it widens histories of the psychiatric or mental health beyond diagnostic categories old and new, while opening awareness to other relevant moods: wonder, joy, bitterness, and the like.

Decolonizing, Nationalizing, and Globalizing the History of Psychiatry: From Colonial to Cross-Cultural Psychiatry in Nigeria

Matthew M. Heaton *(Virginia Tech, Blacksburgh)*

Histories of psychiatry tend to focus on western actors: there is a large corpus of scholarship on the development of psychiatric theory and practice in

Europe and the United States in the nineteenth and twentieth centuries. A smaller, but still significant historiography on colonial psychiatry in Africa and Asia has revealed the ways that the politics and ideology of European imperialism affected and was affected by the developing sciences of the mind. However, the historical development of psychiatry globally since the decolonization of European Empires in the mid-twentieth century remains largely unexamined. This has led to a scenario in which contemporary "global" conceptions of mental health and illness are often perceived as an insidious form of "western" hegemony. This paper seeks to complicate the ways the global history of psychiatry is told by bringing non-western psychiatrists into the story. Through an examination of the activities of Nigerian psychiatrists from the 1950s to 1980s, I will show that the incorporation of non-western psychiatrists into networks of psychiatric knowledge production and dissemination transformed "western" psychiatry into a more cross-culturally universalist and globally inclusive set of ideas about the nature of mental illness in humans since approximately the 1950s. While the medical psychiatry perspective on mental health represents just one of many epistemologies of mental health that exist in the contemporary world, it is nevertheless one that has been particularly powerful partly because of its adaptability and partly because of changing geopolitical circumstances that allowed for transformations in psychiatric practice in much of the world.

Psychiatry on the Edge: Society and Science in the History of Mental Health Institutions in India

James H. Mills *(University of Strathclyde, Glasgow)*

On 6th August 2001 a fire in a small hostel attached to a local mosque started just before dawn in Erwadi, a town on the south coast of India. The building was made from thatch material and burned quickly. By the time it was brought under control two hours later, twenty-eight of those inside had died or suffered injuries that would eventually kill them. Many had been unable to escape as they were chained to their beds. They were there as Muslim pilgrims believed that a bathing well in the area can cure mental illness. Traditional cures of the type available in Erwadi attribute mental illness to possession by evil spirits requiring a spiritual cleansing. This incident prompted a brief period of media attention on the issue of mental health in India and on community, government and medical responses to it. Critics pointed to an underfunded system of state psychiatry, a poorly regulated private sector, and a resulting range of human rights abuses and poor outcomes for patients. This paper places the episode in historical context, to show that despite history that stretches back two centuries in south Asia, psychiatry has always occupied a marginal position in Indian science and society. It concludes by examining the local cultural and political forces that have ensured that it has remained there.

Critiques of PTSD in Global Health Programs: An Engaged Anthropological Perspective

Byron J. Good *(Harvard University)* and Mary-Jo DelVecchio Good *(Harvard University, Cambridge MA)*

The category PTSD emerged from a history of psychiatrists' responses to war trauma, the discovery of sexual abuse in families, and efforts to treat disorders associated with the Vietnam War. More recently, PTSD has been mobilized to respond to natural disasters and violent conflict and made the object of global health interventions associated with humanitarian organizations. The deployment of PTSD and trauma treatment by humanitarian organizations have been subject to strong critique. Anthropologists have criticized PTSD as professionalization of natural responses to violence and disasters. A group of human rights activists and critics of development programs have criticized humanitarian interventions for trauma, arguing that "for the vast majority of survivors posttraumatic stress is a pseudocondition, a reframing of the understandable suffering of war as a technical problem to which short-term technical solutions like counseling are applicable" (Summerfield 1999:1449).

This paper reviews the critiques of PTSD from the perspective of engaged anthropologists working in post-conflict mental health settings. Based on work in Aceh, Indonesia, we argue that disorders quite similar to those described as PTSD are found in diverse post-conflict settings, and mental health interventions can be quite effective in treating the psychological remainders of violence. We discuss ways in which local cultural responses to conflict-related trauma may be effective, but provide examples of conditions that do not respond to local practices, for which medical interventions are effective. The theorization of culture in these debates and the effects of the positioning of the ethnographer will be discussed in the conclusion.

Comments

Laurence Kirmayer *(McGill University, Montreal)*

KEYNOTE

We Have Never Been Global: Explaining the WHO's Response to Ebola

Nitsan Chorev *(Brown University, Providence)*

The international community has been slow to respond to the Ebola outbreaks in Guinea, Sierra Leone, and Liberia. Critics point out that it took the World Health Organization (WHO) six months before it declared the outbreak an international public health emergency; and the WHO, like other international organizations and national governments, found it difficult to manage the crisis effectively. Has the WHO failed its mission? And if so, why did it? In this presentation, I identify the political compromises of the past 20 years that have led the WHO to its current vulnerable (if not, as some would argue, incompetent) position. These political compromises – an organizational response to neoliberal reforms taking place elsewhere – have weakened the WHO's control over its budget and the content of its policies, and narrowed the scope of its jurisdiction. One consequence of those compromises has been the emergence of a fragmented global health regime, one that has many strengths but that is especially unfit to establish the kind of local health systems that have been so tragically missing in the current Ebola crisis. If the response to Ebola is any indication, the transition from international to global has never in fact occurred. If it has occurred, it certainly has not fulfilled its promise.

PANEL 2

Globalizing Techniques and Products in Asian Medicine

Introduction

Laurent Pordié *(CNRS-Cermes3, Paris)*

Nature Cure and Global Health

Joseph S. Alter *(University of Pittsburgh)*

Invented in 19th century Germany, and then "reinvented" by Mahatma Gandhi in London and South Africa, Nature Cure has been thoroughly professionalized in the context of modern India, where those involved in its institutionalization were inspired by Sylvester Graham, John Harvey Kellogg and Bernarr McFadden, among others. Nature Cure is, therefore, a striking example of cosmopolitan medicine shaped by a history of 20th century global health. This has several different dimensions. First, Nature Cure – in Leipzig, London, Cape Town, and Battle Creek, as well as in Jamnagar, Urilikanchan and other towns in India – took shape in direct opposition to problems of

public health associated with late industrial urbanization, alienation and sanitation. As such it developed as a political ecology of the modern body. Second, Nature Cure came to be embodied as a practical philosophy of health in direct opposition to the institutionalization and professionalization of biomedicine in the late 19th and early 20th century, a period of time when germ theory and immunization produced a particular kind of global hegemony in the context of colonialism. Finally, the cosmopolitan features of Nature Cure are intimately linked to the emergence of early 19th century class distinctions and the globalization of these distinctions as a manifestation of intimately embodied but dislocated global cultural formations. In this paper several examples of contemporary products and policies are used to illustrate these general points.

From Scarcity to Profit: Traditional Medicine and Global Health

Stephan Kloos *(Austrian Academy of Sciences, Vienna)*

This paper is a preliminary exploration of the relationship between global health and traditional (Asian) medicines, with particular focus on the case of Sowa Rigpa, also known as Tibetan medicine. Since the beginnings of colonial and missionary medicine, their evolution into international health and more recently global health, the field and its problems were defined in exclusively biomedical terms. All the while, so-called traditional medicines have remained an essential health resource for a majority of people around the world, operating not merely on the local or national, but increasingly also a global scale. This discrepancy highlights the fact that despite its name and vision, "global health" is a narrowly defined and exclusive field, whose relationship to health in the global context is far from self-evident but rather needs to be explained. Traditional medicine in the contemporary context offers a productive analytic angle to do so.

Since the early 2000s, traditional Asian medicines, including Sowa Rigpa, have undergone rapid processes of industrialization, pharmaceuticalization and commodification, which not only enabled their globalization but also rendered them valuable resources in political and economic terms. During the same time, the WHO has repeatedly acknowledged the potential role of traditional medicine in global health. I argue that the two trends are connected, and that the emergence of a strong traditional pharmaceutical industry in Asia is redefining traditional medicine, global health, and the ambiguous relationship between them.

You've got the Point: Seeking the Meaning of Acupuncture in its Techno-Political Bodyscape

Wen-Hua Kuo *(National Yang-Ming University, Taipei)*

Acupuncture is an essential part of East Asian medicines. A peculiar way of reading and treating people via meridians inside their bodies punctuated by

regulatory points, it has been used as a therapy for thousands of years, and it has been scientifically studied for over one hundred years, without losing popularity after the wide acceptance of bio-medicine in East Asia. In spite of its systematic nature and clinical efficacy, there were no standard names or locations for acupuncture points until the 1980s. Like other components of East Asian medical traditions, acupuncture points look similar, but they are located and function differently according to the tradition to which they belong. Thus, with the modernization of alternative medicine, an attempt to harmonize these points was launched by the World Health Organization as a foundation to advance research and learning of acupuncture worldwide. Even so, not much progress has been made since its two attempts at standardization, one from 1983 to 1989 on nomenclature and the other from 2003 to 2008 on location.

Departing from a simple interpretation that claims such negotiations as purely diplomatic in the political context of East Asia, this paper aims to explore the changing meaning of acupuncture points as they are disputed and transformed among the experts assigned to establish standards. Echoing Bruno Latour's notion of modernity as creating separated human and non-human actors, this paper takes a philosophical approach, arguing that the process of naming and locating acupuncture points in fact creates something in between. These points, as this paper will show, are neither pure nominal sites on the human body nor independent non-human artifacts. The standardization of acupuncture points has given them new bodily and therapeutic identities together with a presumption of the body that is universal. Meanwhile, these points also give acupuncture a new form during its modernization. The ambiguity among medical traditions turns itself into different readings on this standard body created for acupuncture that aims to be scientific.

"Outside of the Establishment": Standardization and Contingency in "Classical" Chinese Medicine

Mei Zhan *(University of California, Irvine)*

As the marketization and privatization of healthcare deepens in post-socialist China, a cohort of young entrepreneurial practitioners have begun their quest for a new kind of classical Chinese medicine through private clinical and pedagogical practices at the margins of state planning and bureaucracy. Self-consciously positioned "outside of the establishment", they forge networks of practitioners, entrepreneurs, patients, and grassroots activists in exploring occult texts and Daoist analytics—in particular, "heaven and human are one"—that were marginalized in the standardized and scientized Traditional Chinese Medicine (TCM). In this talk I suggest that, rather than simple rejections of TCM (in spite of the rhetoric) or attempts in resurrecting the ancient and spiritual, experiments in classical Chinese medicine are decidedly forward looking and globally oriented projects that harness market mechanisms and Daoist analytics in producing a "preventive medicine" for

cosmopolitan lifestyles in urban China. This emergent classical Chinese medicine emphasizes personalization and contingency in specific herbal prescriptions, acupuncture treatments, and the particularity of each patient and illness (especially chronic illness). Importantly, the quest for personalization "outside of the establishment" enlists and markets strategies of standardization—from global business model and procedure, to the industrial production of pre-packaged herbal extracts aimed at eliminating uncertainties and accommodating the tempo of modern life. Experiments in classical Chinese medicine are thus entangled in post-socialist healthcare policies as they are in the unfolding global medicine. And through these entanglements they nourish nascent critiques of the Modern as well as possibilities for thinking critically and living thoughtfully in a profoundly disharmonious world.

Comments

Mark Nichter *(University of Arizona, Tucson)*

KEYNOTE

Metrics of the Global Sovereign: Numbers and Stories in Global Health

Vincanne Adams *(University of California, San Francisco)*

The recent shift from International Health Development to Global Health Sciences in the now fifty-year-old post-colonial infrastructure of transnational health aid is not a simple substitution of new bottles for old wine. Emergent trends in Global Health reveal more complex transformations in the practices of audit, funding, and intervention in the effort to improve health outcomes on a global scale. One of the most important features of this shift has been the growing reliance on specific kinds of quantitative metrics that make use of evidence-based measures, experimental research platforms, and cost-effectiveness rubrics for even the most intractable problems and most promising interventions. Collectively these trends pose a problem of knowledge in relation to how we understand efficacy but also how we come to terms with the new Œglobal sovereign[1] a flexible assemblage of data production, number crunching and profit-sourcing that asks all exercises of intervention to work within its terms and limits. At the same time, ethnography pushes us to see the remainder, or residuals, of these trends that appear as stories of single lives saved, struggles won and relationships emergent. Stories carry an emotional surfeit that might be read as both antidote and engine in the markets of global health today. This lecture offers preliminary insights about these global health trends.

PANEL 3

Medical Genetics and Genetic Testing in the South

Introduction
Claire Beaudevin *(CNRS-Cermes3, Paris)*

Finding the global in the local: constructing population in genome-wide association studies
Steve Sturdy *(University of Edinburgh, UK)*

Over the past decade, genome-wide association studies (GWAS) have emerged as a favoured methodology for identifying genetic and genomic risk in humans. Such studies are necessarily population-specific, but from the start there has been concern that spurious findings might occur as a consequence of "population structure", understood as meaning the presence of genetically distinct sub-populations or extraneous populations within the study population. Such extraneous populations include members of immigrant or other non-indigenous populations. The need to characterise population structure for GWAS purposes was one of the main incentives driving the HapMap and other haplotype mapping projects. In this respect, all GWAS, including those (the majority) conducted in the global North, must take account explicitly or implicitly of global population structure including the genomics of the South. This paper will examine how ideas of "population" and "population structure" are constructed and realised within GWAS, and how in effect this necessarily brings the global into the local in the construction of genomic risk, and all that implies for global health.

'Rare' genetic disease in globalizing public health genomics; the case of Li-fraumeni and R337h in Brazil
Sahra Gibbon *(University College London, UK)*

An interest on 'rare' genetic disease has long been part of an agenda of medical genetic research, seen as an opportunity to identify the molecular pathways of what are often seen as 'neglected diseases'. Within the context of a globalizing agenda for genetic research and health care where 'global health' is increasingly seen as necessarily informed by and having to account for genomics, the focus on 'rare' genetic diseases is becoming prominent. In this context the meaning of 'rare' is being both mobilized and questioned. As expanding epidemiological data of diverse population databases reveal the variable frequency of genetic markers and the issues of 'underserved' populations and health disparities come to the fore, there is a re-signification

of the relevance of rare genetic diseases, in ways that are often linked to expanding market resources and its beneficiaries.
This paper seeks to simultaneously historicise and localize the growing interest in 'rare genetic diseases' as part of a global discourse on genomic health care by focusing on the case of a particular cancer syndrome known as Li-fraumeni, in the context of an emerging field of Brazilian cancer genetics. Presenting findings from ethnographic research working with and alongside Brazilian cancer geneticists it reflects on how a purportedly 'rare' cancer syndrome is being constituted at the interface with transnational research agendas. It shows how identification of a particular genetic marker R337h associated with high population prevalence in the south of Brazil is used as a resource in both identifying the clinical needs of 'neglected' genetic conditions and to raise questions about the very parameters of how 'rare' diseases are defined and pursued. In this way it seeks to show how a focus on genomics in the transition from international to global health is characterized by a multiplicity of discourses where both the global and the local participate in constituting its meaning, relevance and scope.

Sickle cell anemia in Brazil: hereditary condition and racial identity
Ilana Löwy (*Inserm-Cermes3, France*)

Sickle cell anemia is one of the most frequent genetic diseases in Brazil, with an estimated prevalence of 25,000-30,000 cases. This pathology is an important cause of premature mortality in children and young people, especially in lower socio-economic strata. Sickle cell anemia is more prevalent in the Northern part of Brazil than in the South. Only a fraction of Brazilian carriers of the sickle trait are aware of their status. Since 2001, the Brazilian government has included sickle cell anemia in the national neonatal screening program, in order to improve treatment and reduce mortality, especially among children. The efficacy of screening for this disease has, however, been uneven. Screening – and treatment – is better organized in the richer states of South of Brazil, where this condition is relatively rare, and is less efficient in the North-East, where sickle cell anemia is much more frequent. Genetic counseling of carriers of the sickle trait has a limited scope, since abortion for fetal indications is illegal in Brazil, and preimplantation genetic diagnosis is accessible only to the highest social strata, where the prevalence of the sickle trait is very low.
Management of sickle cell anemia in Brazil is entangled with the racial question, or rather with the very specific form of this question in that country. While in the US sickle trait is strongly associated with Black ethnicity, the strongest direct association of this trait in Brazil is with poverty. Poverty is in turn correlated with a darker skin color, black (*preto*) or brown (*padro*). On the other hand, a darker skin color seem to be only weakly associated in Brazil with the presence of biological markers that denote an African descent. From the 1990s on Black populations in Brazil have organized their demands around the identification of sickle cell anemia as a 'black problem'. By consequence, the discourse about this pathology presents it at the same time

as a condition that can happen to "everyone' and a specific black issue. The 'Africanization' of sickle cell in Brazil concerns international networks as well. Brazilian experts collaborate with African ones in the framework of Global Sickle Cell Disease Network (GSCDN), and the poster of a recent meeting of this network held in Rio de Janeiro in November 2014, depicted a head of an African woman.
My talk will discuss the multiple faces of sickle cell anemia in Brazil as a genetic disease, 'black' disease, pathology of the poor, public health problem, and link between Brazilian and African populations.

Comments
Soraya de Chadarevian (*University of California, Los Angeles, USA*)

KEYNOTE

The Global Menace and its Interruptions

Sarah Hodges *(University of Warwick)*

For some time now, I have been concerned that in embracing a language of 'global' to frame our histories of science, technology and medicine (STM), we lose more than we gain. In very general terms, the dilemma is as follows. On the one hand, there is widespread acknowledgement that there are aspects of historical phenomena that both precede and exceed histories of imperialism and colonialism. In light of this, there have been calls for something to help us better articulate differences as well as the sinews that connect (1) the dominant careers of STM across the North Atlantic and (2) the many other careers of STM that fit awkwardly at best within this geography and its dominant epistemology. On the other hand, so far, the scholarly use of the term 'global' has failed to provide an analytic toolkit to illuminate the shared predicaments and peculiarities of STM across these 'elsewheres.' Whereas historians' engagement with 'postcolonial' has allowed us to think through and across many very different places, and to see connections between places as produced out of specific moral and material histories, historians often—and perhaps inadvertently—mobilise 'global' as a residual category into which almost any 'elsewhere' can be made to fit. Further, a number of us have pointed out other grounds for 'global' worries—not just about what the term global is made to *hold*, but also about what it *does*. Many 'global skeptics' articulate an uneasiness with the dominant tropes for telling global histories; in particular, 'global flows' and 'global connections'. What, we ask, do 'global flows' flow over? What does 'global flow' talk illuminate, and what does it obscure? There is much ground for unease.
In this talk, contra flows, I ask if thinking with 'the interruption' might deliver a more robust 'global' historiography for STM. This is because I suspect that pursuing histories of interruptions might better illuminate relationships

between *dominant* and *subordinated*. In so doing, histories of interruptions might open up scholarly terrain that the 'global' currently covers in such an unsatisfying manner.

PANEL 4
The Control of a Neglected Disease: DOTS and Tuberculosis

The historical origin of WHO policies to control the transmission of tuberculosis and the influence of the East African Tuberculosis Trials on policies of treatment

David Macfadyen *(University of Glasgow)*

The historian, Sunil Amrith, saw tuberculosis as an 'illuminating lens' for viewing the globalization of health.1 He also examined the roles of medical and social research in shaping international tuberculosis control policies. These are the two strands of the present paper which is based, first, on recent historical research by the writer on the origins of global health2 and, second, on experience in Africa during a period when new measures for controlling tuberculosis were being investigated.

The paper begins by showing that, when WHO became operational in 1948, it was compelled, through lack of resources, to influence health practices within nation-states largely by advice from WHO Expert Committees. A year before WHO was formally established, an Expert Committee on Tuberculosis met in Paris. At this first meeting, a structure of cooperation between WHO and UNICEF was conceived, effectively creating a role for WHO that the Organization aspires to fill today – acting as an international manager of global health, bringing together the supplies and expertise of different organisations. The reports of the WHO Expert Committees on Tuberculosis and of the UNICEF/WHO Joint Committee on Health Policy are important sources for historians, since they record the changing technology of tuberculosis control and changes of direction in policies of health care.

The paper goes on to show that assessing the effectiveness of antituberculosis therapy, which began in the 1940s, marked an historical transition in epidemiological methods. It describes how the scope of epidemiological methodology widened when *policies* of treatment were compared, rather than drug regimens, as illustrated by the East African/British Medical Research Council Tuberculosis Trials of the 1960s. Such studies of treatment policy contributed to the development of the WHO programme of directly-observed short-course treatment (DOTS) in the last decade of the Twentieth Century.

The conclusion of this analysis is that WHO's aspiration to achieve a 'TB-Free World' by 2050 will require more than technical measures: it requires the sort of broad cooperation that the League of Nations Health Organisation established with a few nation-states in the 1930s to help them in their

attempts to extend health care to all their citizens.

1 Amrith, S. (2002). Plague of poverty. The World Health Organization, tuberculosis and international development 1945–1980, p. 3.
2 Macfadyen, D. (2014). The Genealogy of WHO and UNICEF and the Intersecting Careers of Melville Mackenzie (1889-1972) and Ludwik Rajchman (1881-1965), MD Thesis, University of Glasgow.

"I can assure you, DOTS is not happening here": South Africa's changing TB treatment practices and the advent of Extensively Drug-Resistant Tuberculosis

Erica Dwyer *(University of Pennsylvania, Philadelphia)*

When the WHO developed the TB treatment strategy called DOTS (Directly observed therapy, short-course) in the mid 1990s it focused on drug-susceptible, sputum-smear positive, pulmonary tuberculosis – the form of TB that was both most infectious and most effectively treated. After the end of South African apartheid in 1994, the WHO saw an early opportunity to work with South Africa's new, unified Department of Health to put in place a model program that followed DOTS principles. Engagement with the WHO motivated and encouraged some South African administrators, clinicians, and researchers. Others worried that the WHO guidelines were too rigidly standardized and did not match local conditions. South Africa officially endorsed and introduced their version of DOTS strategy in 1996. In the context of a rising AIDS epidemic, a health system in transition, and numerous competing health problems, however, the South African implementation of WHO TB treatment policies was incomplete, at best, and a failure, at worst.

The limitations of South Africa's TB treatment program became blatantly clear in 2006 when American and South African researchers documented 52 deaths from extensively drug-resistant tuberculosis (XDR-TB) in the small rural town of Tugela Ferry, KwaZulu-Natal. This widely reported outbreak led to international fears about untreatable tuberculosis, but also prompted new, innovated programs for managing drug-resistant TB in a rural setting. Transnational policy makers, American academics, South African clinicians and government administrators all played crucial, productive roles in shaping the response to drug-resistant tuberculosis even as their relationships were shaped as much by tension as collaboration. Drawing on interviews with such American and South African experts I use the XDR-TB outbreak in Tugela Ferry as a lens through which through which to look back at the last three decades of tuberculosis care in South Africa. I dissect some of the provincial and international health politics that are reflected in the changing practices of the "TB DOTS" office in Tugela Ferry, as well as the recurring, contradictory claims that South Africa is a "DOTS country" but that "DOTS is not happening here."

Innovating tuberculosis control in India
Nora Engel *(Maastricht University)*

Innovating tuberculosis control in India Innovation for tuberculosis (TB) control is urgently needed and is often thought of as new drugs, diagnostics and vaccines that could be developed by the private sector or by global public-private partnerships. Using research on innovation practices in organizational, strategic, technological and service delivery aspects of public TB control in India, this paper shows that innovation for TB control is not a linear process of improvement, but rather a complicated, continuous undertaking across many worlds, as different actors have different perspectives and practices. Furthermore, control practices through supervision of healthcare providers, patients or data; through technologies such as drugs or diagnostics; through standardisation of guidelines; or through redefinition of problems- are ubiquitous and at the forefront of all TB-related activities. How can innovation be fostered without jeopardizing the control efforts? And how is an infectious disease to be controlled without stifling innovation? The results reveal a complex interplay of mutual influence and requirement in the dynamics of innovation and control in coping with Tuberculosis.

Lessons learnt from the DOTS strategy for TB control in Nepal
Ian Harper *(University of Edinburgh)*

Notes for presentation

1. DOTS to STOP TB in Nepal: A brief narrative history (1995 introduction of DOTS; 2027 introduction of STOP TB programme);
2. Self declared successes of the TB control programme in Nepal: increased detection and cure rates (to within the WHO proposed standards); 100 percent coverage of country with DOTS clinics; systematic recording and reporting; and first country to have nationwide rollout of DOTS Plus for the treatment of MDRTB;
3. Increased coordination between NGOs and government, with standardized protocols, treatment regimens etc.;
4. Ethnographic research (ESRC-DfID) suggests that the availability of drugs has changed over the years since DOTS introduction; more high quality Indian drugs in combined form on the market from reputable companies, and a decrease in the availability of uncombined single formulations.

Other issues:

1. Rigid implementation of DOTS and failure to approach problem as "patient centered";
2. Issue of access into the programme based on categorization of patients into type (1,2, and 3) for treatment purposes – denial of entry into programme for those who do not fit the categories;
3. Attempts to increase diagnosis through the introduction of GeneXpert

(a genetic test) have had mixed results: inequality on the system and increased finances have led to demands from government staff for payment to undertake the tests; expensive upkeep and maintenance; lack of fit with planning with Global Fund demands; shifts in the way that the disease is reported etc.;

4. Poor integration of TB / HIV services and vertical nature of the programme leads to lack of health system strengthening; compounded by the financial flows demanded of the Global Fund.

Comments

Christian Bonah *(Strasbourg University)*