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INTRODUCTION

Politics and practices of global health: Critical ethnographies of health systems

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Over the past decade, growing recognition that weak health systems threaten global health progress has galvanised renewed global and national commitment to strengthening health systems (Hafner & Shiffman, 2012). Global health leaders from the World Health Organization to the GAVI Alliance, national governments and donors today endorse the goal of health system strengthening (HSS), though there is little, if any consensus on what this entails. Mirroring the business-oriented and technical bias of dominant global health actors (Birn, 2006), HSS is often approached as a technical challenge, focused on efforts to strengthen implementation and management structures within health service delivery, with little attention to the politics and social relations that shape health systems. This special issue aims to demonstrate the potential of ethnographic enquiry to reinvigorate a political – rather than technical – debate about 'health systems'.

With the emergence of a new global health subfield of health policy and systems research (HPSR), there have been important calls for a social scientific perspective that challenges the biomedical and technocratic understanding of health system policies and practices (Gilson et al., 2011). This budding field of research, however, has a long way to go before it establishes methodological rigour and liberates itself from the threat of 'disciplinary capture' by dominant health research traditions driven by utilitarian or instrumental views of health systems and policies (Bennet, 2007; Sheikh et al., 2011). As it develops, HPSR will hopefully engage productively with the conceptual and theoretical roots of disciplines that have traditionally had a strong analytical focus on the social and political aspects of health systems, including social medicine and medical anthropology (Holmes, Greene, & Stonington, 2014).

The articles in this special issue argue that medical anthropology – and the core ethnographic method – is particularly well-placed to bring forth a social and political, rather than purely techno-managerial perspective in the study of the politics and practices of diverse health systems. From the 1970s onwards, medical anthropologists have demonstrated how medical systems can be best examined within larger historical, economic and political contexts (Janzen, 1978; Kleinman, 1978). Since the 1990s, anthropological research within a critical interpretative tradition has extended the study of medical systems to offer

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critical perspectives on the emerging global health field, examining the assumptions that frame problems of relevance to health and 'why concepts and interventions do or do not translate across borders, language and cultural groups' (Hansen, Holmes, & Lindemann, 2013, p. 116). Reviewing anthropology's contribution to global health, Janes and Corbett (2009) outline four principal areas of critical analysis, including health inequities in political and economic contexts; the impact of local worlds on the assemblages of science and technology that circulate globally; international health programmes and policies; and the reconfiguration of the social relations of international health development.

Ethnography is uniquely suited to understand how global health policies and programmes interact with weak health care systems to critically shape people's access to health care and experiences of ill health and care-seeking (e.g. Castro & Singer, 2004; Pigg, 1997; Whiteford & Manderson, 2000), and the health systems' role in expressing and reproducing the 'structural violence' that shapes the unequal distribution of global health problems from HIV/AIDS to tuberculosis (TB), cancer and maternal mortality (e.g. Farmer, 2004; Fassin, 2007; Janes & Chuluundorj, 2004; Livingstone, 2012). Ethnography has also powerfully helped to document the local consequences of structural adjustment and privatisation of the health sector (e.g. Foley, 2010; Pfeiffer, 2003, 2004; Pfeiffer & Chapman, 2010).

While often focused on 'local' experiences, anthropologists are increasingly turning their attention to the internal dynamics of the global health enterprise itself, including those shaping public–private partnerships like the Glona Fund to Fight AIDS etc rather than HIV, Tuberculosis and Malaria (Kapilashrami & McPake, 2012). Building on earlier analyses of international health bureaucracies (Foster, 1977; Justice, 1987), anthropologists have begun to study the politics of global health evidence production and research (Béhague & Storeng, 2008; Geissler & Molyneux, 2011; Lambert, 2013) and the discourses underpinning global health work (Lakoff, 2010). These include how the rise of 'audit culture' and business-oriented approaches shape global-level debates about health systems (Storeng & Behague, 2014), the popularity of neoliberal policy solutions like 'pay for performance' (Magrath & Nichter, 2012) and the use of rights regimes in securing access to medicines within national health systems (Biehl, Petryna, Gertner, Amon, & Picon, 2009). Others trace how core global health practices like vaccination are enacted at the interfaces between the global and the local (Roalkvam, McNeill, & Blume, 2013).

Much of this research has unfortunately been off the radar of the global health research community, despite the fact that it deals with issues that are clearly germane to understanding how health systems function (Prince & Marsland, 2013). This is partly because anthropologists tend to publish in specialist, disciplinary journals, but also because of the mistaken tendency within the broader global health field to dismiss such qualitative forms of enquiry as insufficiently rigorous to inform public health policy and practice. In recent years, however, anthropologists have become more self-aware about how to engage with the global health field and make an impact on public policy (Hansen et al., 2013; Pigg, 2013; Singer, 2012). A critical perspective and a commitment to a 'health systems agenda' have been identified as among medical anthropology's core contributions to the field of global health (Biehl & Petryna, 2013; Janes & Corbett, 2009; Mishra, 2013; Nichter, 2008; Pfeiffer & Nichter, 2008, p. 42). Although there is disagreement within the discipline about the nature and modes of engagement, there is certainly consensus on the value of ethnographic enquiry (Fassin, 2010; Holmes, Greene, & Stonington, 2014; Martin et al., 2013; Pigg, 2013).

Through ethnography, anthropologists are in a position to contribute to the HPSR network's aim to introduce social scientific forms of evidence into a research tradition

that has been dominated by a narrowly defined and biomedically dominated 'hierarchy of evidence' (Lambert, 2013). Health system-based ethnographies can act as powerful antidotes or correctives to the personal and institutional ideology, abstracted data and conventional wisdom or bias on which wide-reaching policy decisions are made, thereby ensuring that the evidence base that frames global health debates is 'inclusive and represents multiple dimensions of the human experience, including the voices of those affected by global processes' (Pfeiffer & Nichter, 2008, p. 43). As Feierman, Kleinman, Stewart, Farmer, and Das (2010, p. 122) argue, through multi-sited studies of the relative knowledge and power of different actors – from impoverished patients to global decision-makers – anthropology is capable of addressing 'blockages in the upward flow of information from localities and regional centres, about realities of professional practice and about patients' lives and conditions of treatment'. Ethnography applied to the study of global health is thus much more than the use of qualitative methods. It is also about questioning the categories that we take for granted, asking awkward questions and interrogating the social relations, histories and politics that shape the way we think about health (Lambert, 2013; Lambert & McKevitt, 2002).

The eight articles in this special issue come out of two workshops at the University of Oslo in 2013, convened to discuss ethnography's role in understanding health systems. The articles draw on multi-sited and multi-layered ethnographic research conducted in Kenya, Burkina Faso, Mongolia, Gambia and three Indian states, as well as within the centres of global health power. The authors ask questions about the relationships between policy, discourse and practice, privileging the perspectives of a range of global health actors – from health care users in Mongolia, to community health workers in India, medical doctors in Kenya, health bureaucrats and non-governmental organizations (NGOs) in Burkina Faso and representatives of global health organisations operating at the international level. We thus take ethnography beyond the traditional preoccupation with the 'local', responding to recent calls on anthropologists to become more sophisticated when 'studying up' and conducting multi-sited ethnographies of multiple stakeholders in health systems, donor communities and emerging global health networks (Pfeiffer & Nichter, 2008).

The first paper, by Katerini T. Storeng, examines how global health initiatives (GHIs) have appropriated the rhetoric of health system strengthening (HSS). Drawing on ethnographic research within the GAVI Alliance (which funds vaccines in poor countries) and the global health arena in which this initiative is situated, Storeng argues that GAVI's HSS support has become emblematic of the so-called 'Gates approach' to global health, focused on targeted technical solutions with clear, measurable outcomes. In spite of adopting rhetoric supportive of 'holistic' health systems, she shows how GHIs like GAVI have come to capture the global debate about HSS in favour of their disease-specific approach and ethos.

The impact of GHIs on local health systems is taken up in Ruth Prince and Phelgona Otieno's research from Kenya. They examine how medical practitioners in public hospitals in effect work in the shadow-lands of global health, contrasting their limited access to medical technologies and the dilapidated infrastructure of the public health system with the well-resourced, globally-funded HIV clinics nearby. Prince and Otieno examine how these contrasting working environments impact on professional ambitions, commitments and 'good enough' medical practices.

The transformative role of the private sector in health systems is profound, but underexplored in the literature. Karina Kielmann and colleagues analyse efforts to integrate private practitioners within India's national TB control programme through

public–private partnership mode. They examine the social relations and working roles that underpin a public–private initiative for directly observed treatment for TB in Western Maharashtra, India. They highlight the role of front-line health workers in mediating local terms of 'partnership' in a highly pluralistic and hierarchical health system, and demonstrate how such partnerships are both enabled and constrained by the wider cultures of pluralism, social hierarchy and paternalism that pervade working relationships in the Indian health system. In this environment, health workers' daily adjustments of professional and personal ethics constitute balancing acts in the divide between public and private health goals.

Extending the analysis of India's health system, Arima Mishra examines local meanings of HSS from the perspectives of community health workers charged with implementing India's National Rural Health Mission (NRHM). Based on ethnographic fieldwork in Odisha, India, she shows that, for these workers, the notions of teamwork and building trust with the community are critical components of providing comprehensive and integrated primary health care. However, their efforts to achieve these aims are in constant tension with the exigencies of narrow indicators for health system performance, the institutionalised privileging of statistical evidence over field-based knowledge and the highly hierarchical health bureaucratic structure that rests on top-down communications.

Such tensions in NRHM implementation are further discussed by Sidsel Roalkvam through her fieldwork in the state of Rajasthan, India. She examines health system reforms (in this case NRHM) as instruments of state governance that articulate citizenship through values of equity and rights. Locating NRHM in a policy shift from a welfare model to a rights regime, she argues that citizenship rights in health are rendered problematic through the overt technical instruments of efficiency and incentives-driven community demand. Far from addressing inequity and promoting greater public ownership of health, policy implementation in this context symbolises greater state surveillance attempting to produce healthy behaviour, however benevolent, aligned to the state and its bureaucrats' view of what is normal and proper.

Through historically informed ethnography from Mongolia, Benedikte V. Lindskog makes a strong argument for why equity in health service delivery must be analysed in relation to factors external to the health system. She shows how recurrent winter disasters and escalating rural to urban migration, combined with donor-driven neoliberal health sector reforms, have resulted in a fragmented health system that exacerbates lack of access to health services for poor in-migrants to the capital Ulaanbaatar and mobile herders in remote provinces.

Highlighting the importance of a longitudinal and historical perspective, Johanne Sundby, a gynaecologist and public health researcher, reflects on her two decades of observations of the evolving reproductive and maternal health policy landscape in The Gambia. Based on these observations, her article problematises national actors' inability to manoeuvre within a rapidly changing global policy context. She highlights the tension between local state autonomy and the donor-driven trend towards uniformity and top-down priority setting.

Also focused on reproductive health policy, Katerini T. Storeng and Fatoumata Ouattara's article analyses policy responses to unsafe abortion in Burkina Faso, where abortion-related mortality and morbidity constitute major social and health system challenges. This final paper in the special issue demonstrates how health policy is often shaped by actors operating at the interface of global and local norms. Political and moral negotiations between public health professionals, national bureaucrats and international

agencies and NGOs have resulted in widespread support for post-abortion care to prevent deaths from unsafe abortion in Burkina Faso, but also stifled debate about further legalisation or social determinants of abortion.

What brings the eight articles together is a shared concern with the 'the social processes, power relations, development culture and discourses that drive the global health enterprise' (Pfeiffer & Nichter, 2008, p. 413). Our starting point was that core global health concepts like health systems cannot be taken for granted, but must rather be understood in historical, political and social perspective. Thus, while the World Health Organization (WHO) defines health systems holistically as 'all organizations, people and actions whose primary intent is to promote, restore or maintain health' (WHO, 2007, p. 2), in global health discourse and practice, the notion of a 'health system' has often taken on different meanings, reflecting, as our papers show, distinct ideological convictions and political and even moral principles. The varied uses to which the notion of health systems has been put over the past two decades suggests that it is an emic term that is both polysemic and fluid, and which is ripe for social scientific investigation. The ethnographic studies published in this special issue help to discern the genealogy of the idea of health systems within international health, and help explain the changing and varied meanings of the term within public health policy, research and practice, across a wide variety of geographical settings, cutting across global and local levels. As such, these studies demonstrate how ethnography can serve as a powerful corrective to the tendency within global health to displace health systems debates from the political realm and recast them as technical debates about health care delivery.

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