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On sitting and doing: Ethnography as action in global health

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ABSTRACT

Contemporary discussions within the arenas of medical anthropology and global health are often restricted by the driving imperatives to "do something" about a particular health problem. Drawing on ethnographic fieldwork conducted in Nepal in 1997, which sought to follow the translation of AIDS prevention policies into local awareness, this paper addresses the need to revitalize theories of ethnography for an understanding of global health goals. The Nepal example underscores how the path toward decisions is never entirely clear, nor is it always obvious who benefits or loses from different approaches, even as public health discourse seeks to set a strict agenda around what the problem is and what should be done about it. Ethnography shows that definitions of *what* matters as well as understandings of *why* certain things matter are formulated from specific social locations. The paper therefore advocates for a practice of patient ethnographic "sitting" as a means to understanding, as a form of critical reflexivity, and as a diagnostic of the politics of relevance.

But we can't just sit around thinking about those things! We have to do something!

Comment to Pigg from a global health intern

Introduction

In the expert field now self-identified as global public health, "relevance" is discursively and institutionally policed through a moral distinction between "just sitting around" and "really doing something." Ethnographers frequently find that their work puts them in an awkward position in relation to this discourse: the very curiosity arising out of engagement with everyday realities directs the ethnographer toward issues that mainstream global health problem-solvers see as veering off topic, away from the task at hand. Whereas global public-health policy looks to ethnography solely as a source of information, pertinent to its goals, ethnographers see their task quite differently, holding that the purpose of patient ethnography is to listen and to be in situ, a practice that opens up a space for the questioning of received certainties through a responsiveness to multiple viewpoints and contested perspectives. We call this critical reflexivity. Its aim is to provoke revelations about the processes that themselves arrange varied perspectives. We ask how some come to carry authority while others can be disregarded, and what occurs as a result. Thus it is that so many ethnographers working within, carrying out research on, or just spending time in the vicinity of global health end up questioning many of the accepted terms on which global health action is predicated (for instance, Brada, 2011; Erikson, 2012; Lorway & Khan, 2013; Pigg, 2005; Yates-Doerr, 2013).

This paper explores how it is that ethnography leads us into knowledge, in order to ask how we might think about the relevance of ethnography to global health. To be clear, it is *not* a general argument for or against applying anthropological insights to the understanding of public health problems. Anthropologists can of course contribute to interdisciplinary conversations on health problems. However, in the face of intensifying demands on ethnographers to subsume their insights to ever narrower, utilitarian goals, I argue that it is important to recognize both the unique character of ethnographic praxis and its inevitably awkward relationship to the unfolding historical phenomenon of global health. Catching the reader up in a story from my own research, I explore the emergent, spontaneous, dialogical, and ambiguous work of ethnographic fieldwork itself.

Ethnographers are trained to revise their ideas of how they are coming to knowledge as the people with whom they spend time facilitate or thwart the ethnographer's imagined plan. Against the idea that it is unproductive to "just sit around," I recuperate a positive view of "sitting" in this article in order to invoke the long-standing methodological starting point of ethnography: being with people, being in a particular somewhere with a particular set of people, being with different sets of people, in various places. An ethnographic insistence on sitting, being, noticing, and reflecting stands in stark contrast to the dismissive view that "sitting" and

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"thinking" merely drag confident, useful action down into a mire of doubt and criticism. I deliberately put forward a re-invigorated metaphor of "sitting" as a counter to the neoliberal ethic of speed and efficiency that has become normalized, and moralized, in the ways global health activity makes things happen.

This argument joins a wider conversation about how we might understand the current salience of the "global health" frame. Janes and Corbett (2009) tackle the question by applying a traditional political-economic conceptualization of transnational globalization processes. To the extent that these processes converge on well-delineated health issues, research into them can advertise itself to be contributing directly to "social justice and the remediation of structural violence where it is the most severe" (176). Janes and Corbett identify research areas: the explanation of local health inequalities; the circulation of biomedical ideas and technologies; the formation and execution of policies; and the operations of new types of nonstate organizations in health interventions. Yet when they (169) insist that "the ultimate goal" must always be "to reduce global health inequalities," they foreclose directions of inquiry that might emerge through ethnographic discovery by prematurely containing what should be investigated within the allowable terms and values of dominant global expertise and a concomitant set of already legible criticisms. It is only within such frames that any ethnographer could always know, at each step along the way, that her work is on track and contributing to the "ultimate goal."

In contrast, other anthropologists aim to understand the implications of current efforts to address something called health in a way that is represented as global. When the project is framed in this way, the theories of "global" versus "local" on which Janes and Corbett rely (and which limit ethnography to documentation of "the local") fall short. Brada (2011: 286; also Fassin, 2012) asks how do "some places, people, and health inequalities fall under the purview of 'global health' while others do not?" and "what are the effects of this delineation?" Currently, a new wave of anthropology, frustrated with the inadequacy of macro/micro and global/local frames to account for the messy interconnections their research reveals, have turned to other theoretical tools (beyond the scope of this paper to discuss) to make better sense of the processes of scaling, circulation, translation, and connection (for instance, Latour, 2005; Law, 2004). While the question of how to conceptualize such processes might seem esoteric, nonetheless, as Brada (2011: 287) puts it, "If so many mobilize so much behind such a thing as 'global health,' isn't it worth knowing how it is made and under what conditions?" We are observing globalizations-in-the-making, an emergent historical phenomenon that demands inquiry into the who, what, where, when, why, and how of all the activities that call themselves projects of global health. Something is happening, but it is an empirical question for researchers to suss out what it is. We are in the middle of it, but we understand it imperfectly.

Recently, Didier Fassin (2012: 114) has suggested that, just as political anthropologists do not hold themselves responsible for promoting democracy around the world, so too medical anthropologists are not necessarily obliged to be first and foremost "global apostles of health." Fassin interprets current calls for an engaged, solution-focused medical pinpointing health inequality (as seen in Janes & Corbett, 2009) as a response to very real and troubling forms of suffering. We are thus confronted with "contradictions between the ethical affirmation of the superior value of life and the empirical acknowledgment of the unequal worth of lives." But he advocates that anthropologists must operate on "the fine line between scientific detachment and moral involvement" because "our modest but crucial contribution to society—and in the present case to global health—is the critical thinking we bring to its understanding rather than the mere denunciation of its injustice" (2012: 114–115). In Fassin's analysis (2012), critique includes an awkward, uncomfortable reflexivity: "Our sole legitimacy to speak and our sole claim to be listened to depend on our capacity to contest untested assumptions, the most insidious being that on which we found our moral certainties."

Methods of presentation/methods of research

The story in the next section thwarts the assumption that what ethnographers do is gain an understanding of one social context and then, in a subsequent step, transport that information "up" or "outward" to another context in order to influence important others into right action. The anthropology *of* global health proceeds from the premise that there may be important things happening in the social arenas created by global-health activities other than those already accounted for by the medical and public-health frameworks that define problems and structure solutions. The improvisational praxis of ethnographic attentiveness is especially suited to discovering what these other important things might be. In order to convey that idea here, I use a storytelling format, because narrative better captures the complexity of a research praxis that unfolds in and through complicated intersubjective relationships.

Both the story I recount and the reflexive analysis I spin from it emerge from inductive, grounded analysis of interactions, settings, and commentary I witnessed during full-time ethnographic field research in Kathmandu, Nepal, January–August 1997. In order to examine public representations of AIDS, I collected educational materials produced by NGOs, newspaper reports in Nepali and English, and agency gray literature documentation. To understand how approaches to AIDS were shaped by the institutional structures of donor/in-country partnerships, I interviewed expatriate and Nepali program officers at most of the major donor agencies as well as within Nepali government divisions. After surveying all the Nepali NGOs contracted to carry out AIDS-related programs, either I or my Nepali research assistant, Ms. Abana Onta, interviewed at least one leader in the main NGOs that were still functioning in 1997. I developed a connection to a network of NGOs that frequently collaborated, and through these relationships I was invited to participate in outreach work, trainings, message development workshops, and planning meetings. Conversations during taxi rides, tea breaks, over meals, and during other casual moments were especially important to my realization of the contradictions inherent in the intermediary position of Nepali NGO workers. The incidents described below occurred in July 1997, toward the end of my research and at a point where I had already spent time talking to many, many people. The workshops I discuss were recorded, and I took notes on the interactions and tone of the discussion.

The Institutional Review Board for Research Ethics of Simon Fraser University vetted and approved the procedures, as did the Nepal Health Research Council. Oral informed consent was obtained for recorded interviews, as well as for ethnographic observation and participation. Notably, oral informed consent was an ongoing process that began when I introduced myself and my project to individuals or groups and was re-negotiated and re-affirmed in further interactions.

Kathmandu, 1997: "What if?"

It's 1997 and you are sitting in the tiny office of the UNAIDS representative in Nepal. You are there as an anthropologist with a research grant sufficient to pay your living expenses, hire a part-time Nepali research assistant, buy cassette tapes, and make photocopies of reports. Yours is a study of emerging public perceptions of AIDS. A lot of donor money landed in Nepal a few years ago