Scrambling for Africa

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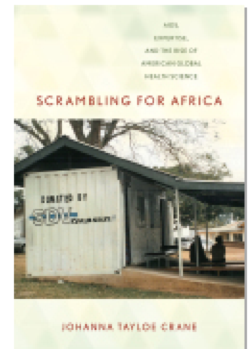

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Chapter 5

Doing Global Health

While in Uganda in 2009, I ended up with an unexpected invitation to have dinner with a group of visiting undergraduate students from a prestigious university in the American Southeast. The students were participating in "The Kampala Project," a one-month volunteer program sponsored by their school and based in the capital city. The theme of the 2009 Kampala Project trip was HIV/AIDS, and, not surprisingly, many of the participating students were on a pre-medical track. One student took a particular interest in me after hearing that I was a medical anthropologist and that my research involved interviewing HIV doctors in Uganda. Over dinner, I listened to this very self-possessed young woman describe her experiences as a volunteer at the IDI's HIV clinic. She excitedly described shadowing the clinic's Ugandan doctors and how, under their supervision, they would sometimes let her conduct initial clinical assessments of patients.

Having done some hospital volunteer work back in the United States, the student was familiar with medical terminology and wielded it with confidence. She recounted how she would examine a patient and recognize

herpes zoster (also known as shingles, an opportunistic infection that comes with AIDS) or the skin rash that can be a side effect of the antiretroviral drug nevirapine. She described encountering a patient who seemed dehydrated, prompting her to ask the Ugandan doctor she was shadowing, "Why don't you check his capillary refill?" The doctor (knowingly, it seems) responded, "You try," aware that she would struggle to see results on the patient's dark skin. He also tested her recognition of herpes zoster on a patient, which she had said she thought didn't have the "characteristic redness," by again reminding her that this wouldn't be the case on black skin (the student herself was white). This student was so confident in her abilities and self-possessed in her demeanor that I assumed she was heading into her senior year and likely already at work on applications to medical school. Thus, I was somewhat shocked when she told me that she had just completed her freshman year of college. She was, in other words, a teenager. Towards the end of our conversation, she broke out of her sophisticated medical prose and lapsed into a more adolescent mode of speaking: "What really sucks," she told me, "is that nothing I'm learning will be applicable where I work back home." The urban hospital where she volunteered in the southern U.S. had a very low HIV caseload, she said. Getting to "see 300 HIV patients a day" was something she would never have the chance to do at home.

This student, like increasing numbers of American undergraduates, wanted a global health experience, and the Kampala Project gave her one such opportunity. As such, she is likely not very different from many of the ambitious but well-meaning students who have populated my own classes in medical anthropology. In some ways, she is also not unlike some of the American HIV scientists described in this ethnography. Both were drawn to work in Africa both by a desire to ameliorate bodily suffering and by the unparalleled learning opportunities afforded by ready access to thousands of HIV patients.

Global Health and the New Scramble for Africa

Undergraduate service learning programs and scientific research by top-notch scholars are just two of the diverse kinds of activities that American universities are investing in under the umbrella of "global health." This

field, which also includes international clinical training opportunities for U.S. medical students and residents, educational programs for clinicians and researchers in low-income countries, and transnational scientific collaborations between wealthy and poor countries, has seen a dramatic expansion in American academia over the past decade (Merson and Page 2009). As of 2008, nearly half of U.S. medical schools and their affiliated institutions included "initiatives, institutes, centers, or offices" dedicated to "global health" (Crump and Sugarman 2008). Global health courses, majors, and minors have become increasingly "hot" within undergraduate programs (Brown 2008), and in response to student and faculty demand for global health opportunities, universities are both founding new departments and changing the names of existing programs to ally themselves with this emerging field.[1]

A 2009 survey showed that a total of forty-one universities in North America (mostly in the United States) had created "pan-university institutes, centers, and the like" devoted to global health, and that an additional eleven schools had established global health programs within existing departments or divisions (Merson and Page 2009, 3). Furthermore, many schools house student programs and research projects that while clearly of a "global health" nature, are not officially administered by the university's office or department of global health. (For example, the undergraduate program in Kampala described above was overseen by the university's service learning program, not by its Institute of Global Health). Notably, the growth of interest in global health is significant enough that nonacademic entities are seeking to capitalize on it: for example, Seattle's Chamber of Commerce recently launched an organization called the Washington Global Health Alliance in an attempt to harness the city's sizable global health activity—some have called it an "industry"—for local economic development (Paulson 2008; Heim 2010). Similarly, a 2010 conference in Boston touted "New England's Strategic Advantage" in the field of global health, pointing to its high concentration of research institutions and bioscience companies (Powell 2010). Thus, in the United States, "global health"

1. For example, the University of Washington established a new Department of Global Health in 2007, and in 2008 the Department of Social Medicine at Harvard changed its name to the Department of Global Health and Social Medicine because, according to its website, it wished to "reflect the growth of interest in global health among students and faculty."

is emerging as a powerful force for mobilizing resources and action both within and outside the academy.

In this final chapter, I focus specifically on the rise of global health within American higher education and academic medicine, with the goal of exploring how the field is producing both new forms of alliance and inequality between academic institutions in the United States and those in the global South, particularly in Africa. In doing so, I draw upon my experiences as a participant-observer at a series of academic global health conferences as well as within Dr. Beale's research program in Uganda. My analysis borrows from Lisa Malkki's concept of "sedentarist metaphysics" in order to emphasize the ways in which global health, as envisioned in the American academy, encourages the mobility of particular bodies while requiring others to remain geographically rooted in place (Malkki 1992). In this scenario, ailing patients in Africa are positioned as offering certain kinds of valuable knowledge opportunities to highly mobile North American students and researchers.

This chapter also represents an effort to interrogate the discourse of "partnership" within academic global health in North America, particularly in relation to institutions in Africa (see also Gerrets 2009). The existence and success of academic global health programs depend upon the ability of U.S. universities to establish ties with clinics, teaching hospitals, and universities in low-income countries willing to serve as hosts for American students, medical residents, and research faculty. Countries in eastern and southern Africa have become some of the most popular locations for U.S. academic global health programs in search of host institutions, as they offer relative political stability as well as an English-speaking elite due to their status as former British colonies. Some partnerships, including one between Johns Hopkins University and Makerere University in Uganda, and another between Indiana University and Moi University in Kenya, are relatively long-standing and predate both PEPFAR and the current wave of global health enthusiasm. Many more, such as the University of California at San Francisco's program at Muhimbili University in Tanzania, the UPenn-Botswana Partnership in Gabarone, Cornell University's relationship with Kilimanjaro Christian Medical College in Moshi, Tanzania, and the Weill Cornell Medical School's partnership with Bugando University College of Health Sciences in Mwanza, Tanzania (recently renamed Weill-Bugando University of Health Sciences), have been established within the last decade.

In the course of my research, more than one American HIV researcher has described the rapidity of this expansion to me with some concern. As U.S. research universities rush to establish partnerships that can give their students and faculty opportunities to work in "resource-poor" African settings, some faculty worry that the juggernaut of global health science is engendering a twenty-first-century academic "scramble for Africa" (Crane 2010b).

Perhaps in response to these postcolonial anxieties, the term "partnership" has emerged as a key word within this new arena or "social world" of global health (Clarke and Star 2003). Host institutions in Africa and elsewhere in the global South are described as "partners," and Northern global health leaders cite "real" or "true" partnership with poor countries as a key factor distinguishing global health from its predecessor fields of international health and tropical medicine, which are seen as having operated in a more top-down, paternalistic mode (Koplan et al. 2009). Nonetheless, in a 2008 article, health scholars from UCSF, the University of Cape Town, and Muhimbili University expressed concern that global health partnerships were being defined primarily by and for Northern institutions. They cautioned, "there is a danger that all this new energy for global health will result in [global health] becoming an activity developed through the lens of rich countries, ostensibly for the benefit of poor countries, but without the key ingredients of a mutually agreed, collaborative endeavor" (MacFarlane, Jacobs, and Kaaya 2008, 384). In its present incarnation, they argued, "global health" risked becoming merely a means by which universities could "brand" themselves in a competitive educational market (ibid., 392). In my own work, time spent among the leadership of this emerging field reveals that "global health" remains an arena shaped by power and inequality, in which the needs and voices of "partner" institutions in the global South are often marginalized and opportunities remain stratified, despite the best intentions of all involved.

"Global Health" as an Ethnographic Object

My concern in this chapter lies primarily with academic global health; in other words, global health activities taking place within universities and medical schools, and which therefore incorporate some kind of commitment

to learning or scientific knowledge production. U.S. universities are investing greater and greater resources into the development of programs related to global health, and are major competitors for government and foundation grants aimed at addressing global health needs. The analysis presented here draws primarily from my experiences as a participant-observer at the meetings of a fledging organization called the Consortium of Universities for Global Health (CUGH), and is supplemented by relevant information taken from my fieldwork among U.S. and Ugandan HIV researchers.

The CUGH was founded in 2008 for the purposes of giving North American universities active in global health a place to share ideas and experiences, and to shape the future of education and research in the field. In order to become a full member of the organization, a university must house a multidisciplinary global health program, pay $4,000 in annual dues, and "have at least one substantive, current, long-term relationship with an international partner university in a low- or middle-income country" (Consortium of Universities for Global Health 2012. (Universities in low-income countries that have existing partnerships with CUGH universities are able to join for free.) Initially funded by grants from the Gates and Rockefeller foundations, by 2011 the Consortium was increasingly supported by membership dues from over fifty North American universities—twice the number of members it had only a year earlier. The number of non–dues paying "partner members" had also increased in that time, from three to fourteen, nearly all affiliates of either Johns Hopkins or the University of Washington. The organization's inaugural meeting was held in 2008 in San Francisco, and fifty representatives from twenty universities were invited to attend. The group's first annual meeting, held one year later in 2009, took place on the campus of the U.S. National Institutes of Health and was much larger, with over 250 attendees from more than fifty universities participating. In 2010, the CUGH had its first open meeting (previous meetings had been by invitation) at the University of Washington in Seattle, and nearly 900 people attended.

Why study an organization like the CUGH? In a now-classic essay on the importance of "studying up," Laura Nader urged anthropologists to turn their ethnographic attention not just to the poor and underprivileged, but also to institutions of wealth and power. "Anthropologists," she argued, "have a great deal to contribute to the processes whereby power and respon-

sibility are exercised in the United States" (Nader 1972, 284). The state of anthropology is different now than when Nader first published this piece in 1969, and the subject of power and its exercise is now a major focus of ethnographic studies both in the United States and elsewhere. Nonetheless, her intervention remains relevant, and provides a useful perspective from which to approach "global health" as an ethnographic object.

Although anthropologists have made important contributions to the analysis of postcolonial power relations within global health projects, especially in the field of HIV/AIDS, the ethnographic lens has not usually focused on the field's power brokers. The CUGH brings together some of the most influential individuals and institutions in academic medicine today. Its meetings are populated by prominent and powerful researchers from the most prestigious universities in the United States and Canada, as well as by a select group of elite researchers from low and middle-income countries. This high level of symbolic capital gives the CUGH considerable power over the shape and priorities of global health as a field. Furthermore, this group wields significant influence in both higher education and politics, as was evidenced by the speakers and panelists appearing at the 2009 conference. This meeting included a panel comprised of the presidents of Duke, Emory, Johns Hopkins, the University of Washington, and Boston University, and featured prominent speakers connected to the federal government, including NIH Director Francis Collins, Obama administration Global AIDS Coordinator Eric Goosby, the Office of Management and Budget's Ezekiel Emmanuel (a slot that, on earlier versions of the agenda, was filled by Secretary of State Hillary Clinton), and J. Stephen Morrison from the Center for Strategic and International Studies, a K Street think tank. In addition, the meeting itself was followed by a Congressional briefing. Given its influence, the CUGH is a particularly valuable venue in which to "study up" in global health. In doing so I follow not only Laura Nader's directive, but the urgings of James Pfieffer, Mark Nichter, and the Critical Anthropology of Global Health special interest group, who recently argued that medical anthropologists can make a valuable contribution to redressing inequality by "illuminating the social processes, power relations, development culture, and discourses that drive the global health enterprise" (Pfeiffer and Nichter et al. 2008, 413; see also Janes and Corbett 2009).

The Rise of Global Health

"Global health" is often described as having emerged out of the older fields of tropical medicine and international health, though the question of whether it is truly distinctive is debated, even among those who describe themselves as within the field (Bunyavanich and Walkup 2001). The phrase became increasingly visible in the 1990s, spurred in part by the WHO's efforts to "refashion itself as a coordinator, strategic planner, and leader of 'global health' initiatives" as it attempted reclaim some of the power and visibility it had lost to the World Bank's growing international health programs during the 1980s and 1990s (Brown, Cueto, and Fee 2006, 69). Notably, as a term, "global health" appears most commonly in North America. For example, a 2008 search of the PubMed medical literature database found that 87 percent of articles by authors with affiliations with university global health programs were North American (Macfarlane et al. 2008, 389).

As I described in chapter 1, the field of global health may operate both within a register of protection, in which its primary focus is international health security, and within a register of compassionate aid, in which it concerns itself foremost with the alleviation of suffering and health inequalities. North American universities pursuing global health activities do so primarily within this second register of compassion, pairing it with a scientific mission in which international research and medical education are valorized as humanitarian endeavors ("saving lives"). In the case of HIV/AIDS, these two registers have always coexisted but the salience of each has shifted over time. At the dawn of the treatment era in the mid-1990s, AIDS was emblematic of the emerging infectious diseases worldview (King 2002), demonstrating the globalization of disease, the porousness of borders, and—as described in chapter 1—the threat posed to the American public by potential "super bugs." By contrast, ten years later, AIDS is invoked primarily as a humanitarian concern. Moreover, it seems distinctly rooted in place; its primary symbolic register is not so much global, but African. Within the American academy, the severity of the AIDS epidemic in parts of the African continent is envisioned less as a security threat and more as a scientific and humanitarian opportunity to "do" global health.

The current juggernaut of activity within academic global health has its roots in the U.S. government response to the African AIDS epidemic. PEP-

FAR represents the "largest ever international public health program" (Rottenburg 2009, 424), and, according to its website, the largest expenditure any government has ever made toward a single disease internationally. Because the vast majority of PEPFAR money goes toward funding HIV/AIDS programs in Africa, the program has also ushered in an era of unprecedented involvement in African health by the American state and its collaborating institutions. Significantly, PEPFAR funds travel not only through the State Department and government agencies such as the U.S. Agency for International Development (USAID) and CDC, but also through both public and private U.S. universities. In 2007, three of the top ten PEPFAR grant recipients were American universities engaged in HIV treatment, prevention services, and vaccine research in thirteen different countries, twelve of which were in sub-Saharan Africa.[2] In addition, many other universities work with PEPFAR as "subpartners" to primary grant recipients (AVERT 2008). In this way, the advent of PEPFAR has facilitated the expansion of American academic involvement in public health in Africa by laying some of the institutional groundwork for the scaling-up of global health partnerships between American and African institutions.

Defining Global Health

Since its founding in 2008, the Consortium of Universities for Global Health has emerged as a leading voice in defining and shaping global health as a field, largely due to due to its prominent and well-connected leadership. As numerous science studies scholars have noted, defining the boundaries of what does and does not count as "science" is a powerful act, as it accords legitimacy to certain kinds of knowledge and practice while excluding others (Gieryn 1999). Likewise, as "global health science" rises in scientific prominence and as a funding priority, the ability to define the field—and thus

2. In 2007, Harvard University received PEPFAR funds for programs in Botswana, Nigeria, Tanzania, and Vietnam; Columbia University ran PEPFAR-funded projects in Cameroon, Côte d'Ivoire, Ethiopia, Kenya, Mozambique, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia; and the University of Maryland received PEPFAR funds for a vaccine research program in Nigeria (AVERT 2008).

who and what lie in and outside of it—becomes a consequential exercise in inclusion and exclusion.

One of the priorities of the CUGH's inaugural meeting in 2008 was to produce "a common definition of global health." This definition was later published on behalf of the consortium in a widely cited article in the medical journal *The Lancet* (Koplan et al. 2009). In the published article, the CUGH authors are diligent about distancing global health from the older fields of international health and tropical medicine, which are seen as embodying outdated and paternalistic modes of relating between wealthy and poor nations. As such, they ally their preference for the term "global health" over "international health" to "a shift in philosophy and attitude that emphasizes the mutuality of real partnership, a pooling of expertise and knowledge, and a two-way flow between developed and developing countries" (ibid., 1994). At the 2008 meeting, the lead author of the *Lancet* article made this point somewhat more bluntly, stating, "Global health recognizes that the developed world does not have a monopoly on good ideas." In this way, global health leaders can be seen as positioning the field morally by allying it with an ethic of partnership and equity that the older fields are seen as lacking.

But what if, despite this aspiration to partnership, "global health" is itself an idea of the "resource-rich" world? This possibility is revealed when we compare the *Lancet* article's definition of global health with the CUGH conference discussions that surrounded it. The second morning of the 2008 conference included a panel titled "Perspectives from Our Global Health Partners," which featured the four conference participants who had been invited to represent "partner" institutions in the global South. Of the fifty conference attendees, these were the only scientists not from North American institutions, a fact that did not go unnoticed by some of the Americans. (As one researcher from the Rockefeller Foundation said to me, "If having an international partner is what got us invited to this conference, why weren't we required to bring our partners?") The four international panelists were senior academic researchers from Haiti, Mexico, Bangladesh, and Uganda. The list of their Northern partner institutions read like a check-list of elite American schools—Harvard, Cornell, Johns Hopkins, Columbia, University of Michigan, and UCSF, among others—plus government agencies such as the NIH and USAID. But unlike their American colleagues, who had spent most of the previous day in discussions about how to improve

global health education opportunities for their undergraduate and medical students, the international panelists expressed uncertainty and sometimes skepticism regarding the term "global health" itself and what it meant to "do" global health.

For example, Mushtaque Chowdhury, Dean of the School of Public Health at BRAC University in Bangladesh, assured the audience that "what we do in Bangladesh is global health, though we don't call it global health." Mario Rodriguez-Lopez from the National Institute of Public Health in Cuernavaca, Mexico—by his own account, the least well-known of the four panelists—recounted a conversation from the day before with Jeff Koplan, Vice President for Global Health at Emory University and leader of the CUGH's effort to forge a common definition of global health. Koplan had told him, "What you are doing in Mesoamerica is global health!" to which Rodriguez-Lopez responded, "Ah yes, I only just realized it!" Nelson Sewankambo, Professor of Medicine and Principal of the Makerere University College of Health Sciences in Kampala, Uganda, was more confrontational. Sewankambo asserted, "When you see it the way I see it, people are not discussing global health. . . . How do *our* students learn global health? By coming North? By staying home? You need to examine what global health actually means from other countries' perspectives." Jean William Pape, an internationally known AIDS researcher and founder of the Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections (GHESKIO) in Port-au-Prince, echoed these sentiments by arguing in favor of a consortium that was global, rather than North American, in membership, telling the audience, "How can you talk about collaboration when you are thinking one way and you don't even know how the other side is thinking? Yesterday we heard lots of issues relevant to Northern institutions. A *global* consortium is a great idea. You need to include partners early on."

Overall, the partners' comments seemed to reflect that what North American institutions were calling "global health" was simply public health, or "business as usual," in their countries (MacFarlane et al. 2008, 384). If this is so, Sewankambo's question is a provocative one: how *do* students from "host" countries in the South learn global health? One possible answer is that they travel North, requiring Northern universities to reciprocate their global health training programs by hosting students from lower-income countries in Africa, Asia, and Latin America. The dean from BRAC University expressed a desire for such opportunities, but noted that whenever

his students tried to travel to the United States they had trouble getting their visas approved (at which point, a Canadian researcher yelled out, "Come to Canada!", eliciting laughter from the audience). Another possibility is that "global health" actually refers strictly to health care delivery and research in poor countries, which puts residents of these countries in the paradoxical position of needing to remain anchored in place in order to participate in "global" health. (This issue also arose during the 2009 CUGH meeting, when a Latin American member of the consortium's Education Committee wondered aloud how Southern institutions might initiate global health partnerships, asking her colleagues, "What do you do, look for an even poorer country to work in?")

This tension over the meaning of global health and who gets to define it was acknowledged by CUGH organizers both during the inaugural conference itself and in the report of the meeting's proceedings that was later published on the consortium's website. In the report—whose author is unnamed—the assertions that "global health is a Northern concept" and that "for the academic institution in the South, everyday public health, medical and nursing education and practices constitute 'global health' " are made on the first page (Consortium of Universities for Global Health 2008). But, significantly, these important points were not included in the much more widely read *Lancet* article that followed the conference, titled "Towards a Common Definition of Global Health," even though this article was coauthored by both Northern and Southern consortium members who attended the meeting, including some of the same researchers who had both made and acknowledged the objections described above. Instead, the *Lancet* article avoids any references to the postcolonial power dynamics of global health and speaks mainly in positive terms of its promise, offering up the following as a suggested definition: "Global health is an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide" (Koplan et al. 2009, 1995).

Locating Global Health

The question posed by Nelson Sewankambo—"How do *our* students learn global health?"—points to the ways in which "global health" relies upon a version of Lisa Malkki's "sedentarist metaphysics" (Malkki 1992). Malkki

defines this way of thinking as the "naturalization of the links between people and place" (ibid., 34). Although she proposed this term in reference to her studies of refugees, her analytic can also be applied here, albeit with some revisions. In her original configuration, issues of nation and indigeneity play a key part in sedentarist metaphysics: certain people belong in certain places—they are "native" or "indigenous" to these lands, and these lands are in turn located within nations that are also naturalized and territorialized as the "homeland." Consequently, displacement or movement away from one's homeland comes to be seen as pathological in that it disrupts or "spoils" the identity of the native, rendering him or her a "rootless" refugee (a narrative she shows refugees challenge with a variety of alternative, hybrid identities). Although the politics of indigeneity and nation do not play out as strongly in the sedentarist metaphysics I attribute to "global health," there are nonetheless significant and largely unspoken assumptions about people (specifically, bodies) and places underlying the field, its structure, and its practices. More precisely, global health relies upon a very strong notion of *bodies in place* in which certain kinds of patient bodies are linked to certain kinds of places, and, by extension, certain kinds of biomedical learning opportunities.

In the United States, many university-based global health programs emphasize the importance of hands-on international experience. At Cornell University, which established an instantly popular undergraduate minor in global health in 2007, students participating in the global health program are required to complete an eight-week internship abroad in a "resource-poor" setting (Cornell University Division of Nutritional Sciences 2012). At UCSF, graduate students in the Global Health Clinical Scholars Program "generally spend a minimum of one month in a resource-scarce country practicing clinical medicine, conducting a research project, or participating in program development" (UCSF Global Health Sciences 2012). And at Duke University's medical school, third-year medical students participating in the Global Health Study Program are linked with research opportunities at the university's various "global health international field sites," while medical residents are offered the chance to provide care in a "resource-constrained setting and conduct research at a partnering global health site" (Duke University School of Medicine 2012; Duke Global Health Institute 2012). All of these programs, as well as others like them, are enabled by the mobility of Northern researchers and students, who are both willing and

able to travel across continents to achieve certain kinds of experiences, training, and research opportunities. The value and authenticity of these global health experiences, in turn, is contingent upon the availability of certain kinds of bodies located in certain kinds of places. Southern patients and their ailments are envisioned as biological embodiments of settings alternately described as "resource-poor," "resource-scarce," and "resource-constrained," and working with them represents the chance to "do" global health. Thus, within academic global health in North America, the availability of patient bodies—lots of them—suffering from high levels of illness (especially infectious disease) and low levels of pharmaceutical, surgical, and other forms of treatment is both an inequality to be redressed and an opportunity to be taken advantage of.

Of course, patient bodies are not the only bodies to consider here. The bodies of North American students and faculty are highly mobile, and their ease of global travel contrasts sharply with the difficulties faced by many of their Southern peers, who despite their middle-class status face both financial and political barriers to international travel and learning. This is evident in Mushtaque Chowdury's complaint, cited earlier, about the visa troubles his Bangladeshi medical students experience when attempting to travel to the United States. It also arose in complaints voiced by Americans at the CUGH conference regarding the difficulty of establishing reciprocal exchanges with Southern institutions. For example, at the 2009 meeting, a representative from the University of Minnesota told me that his attempts to host foreign medical residents were thwarted by the university's teaching hospital, which "puts up so many hurdles that it's almost impossible," including forbidding foreign medical residents from seeing patients, even though they are brought over under the auspices of the medical school. This contrasts sharply with the ease with which even low-level undergraduate students from the United States are able to access the bodies of patients in the countries hosting them, as demonstrated in my opening vignette from Kampala (see also Brada 2011b; Wendland 2012).

A Resource in Refugees

The implicit linkage of bodies and places in global health is also visible in debates over what "counts" as a global health experience, and specifically

whether or not it is possible to "do" global health in the United States. This was an issue in the planning of Cornell University's undergraduate global health minor several years ago, where it was ultimately decided that the program would require an international internship. Other programs have gone the other way and chosen to include certain kinds of work within the United States under the rubric of global health. For example, students wanting to earn a master of science in global health from UCSF are permitted to conduct their required field experience with a "local underserved population." At the CUGH's 2009 annual meeting, the question of whether domestic work counted as global health was a topic of active discussion. Representatives of programs that recognized North American work as "global health" advocated the utility of the United States' diversity in this regard. One doctor from Oregon Health Sciences University promoted the usefulness of immigrant patients for medical student learning, noting, "We've found a resource in refugees," and advocated, "We need to invest in this population as a part of global health." A colleague from Boston University concurred, saying, "We're so diverse, global health is right outside our door."

Another example of this "refugees as resource" approach can be seen on the website of the University of Minnesota Medical School, which in 2010 promoted its International Medical Education and Research Program by touting the abundance of immigrant and refugee communities and their associated "tropical diseases" in Minnesota:

> Minnesota has become recognized as an epicenter in the field of Immigrant Health due to a major influx of immigrants in the 1980's and 90's from Southeast Asia, Latin America, and Africa. Indeed you don't have to leave Minnesota to see patients with "tropical diseases", such as malaria, strongyloidiasis, or buruli ulcer—even in January! Tuberculosis, which is declining in most states, has not abated in Minnesota, with over 75% of cases occurring among the foreign born. Over 400 immigrants with HIV/AIDS are cared for at clinics within the Twin Cities, which has become a microcosm of this devastating epidemic in their homeland (University of Minnesota Medical School 2010).

In a subsequent paragraph, readers were informed that the medical school had undertaken "major changes" in its curriculum to reflect the changing demographics of the state, including the development of a "Global Health Pathway" for entering medical students wanting to pursue work in international medicine.

While these statements promoting U.S.-based study may at first seem to contradict my assertion that global health depends upon certain kinds of "bodies in place," I would argue that the emphasis on refugees and immigrants suggests otherwise. Instead, within the global health imaginary, such patients are seen as biomedical embodiments of the "resource-poor" geographies from whence they came. In other words, they bring the "global" with them, and can thus be seen as representing an "Other" or "exotic within" the United States.[3] Given this, it will be interesting to see how global health programs evolve and whether or not work with impoverished U.S. populations—especially the U.S.-born—gains wide acceptance as a legitimate global health experience. This question is not merely semantic, as the explosion in global health–related funding puts projects and activities able to position themselves as within global health at a distinct advantage for support. More importantly, it has consequences for the bodily survival of patients who receive services through such programs.

Certainly within the field of HIV/AIDS, public and academic attention to the epidemic abroad (particularly in Africa), seems to currently exceed interest in HIV at home—a striking development, given that HIV in Africa received little attention from the United States during the first decade and a half of the epidemic. Now, in a remarkable shift, the African American community—one of the U.S. groups hardest hit by HIV—has begun comparing its HIV rates to those in Africa in an attempt to garner increased government attention and support. Here I refer to the 2008 report issued by the Los Angeles-based Black AIDS Institute with the noteworthy title, "Left Behind: Black America—A Neglected Priority in the Global AIDS Epidemic." The report includes a full-page silhouette image of the west African nation of Côte D'Ivoire accompanied by the statement, "If Black America was a country, its AIDS epidemic would be nearly the size of the AIDS epidemic in Côte D'Ivoire" (Wilson, Wright and Isbell 2008, 6). On the previous page, the report states, "the number of people living with HIV in Black America exceeds the HIV populations in 7 of the 15 focus countries of the U.S. government's PEPFAR initiative." Whether this advocacy organization succeeds in gaining recognition for African Americans with HIV as a "global health" population remains to be seen. However, it is worth

3. I borrow the phrase "exotic within" from Sindhu Revuluri.

noting that, following the publication of this report, the director of Columbia University's International Center for AIDS Care and Treatment Program, which works in thirteen African countries, authored an article in the *New England Journal of Medicine* decrying the "forgotten" epidemic in the United States, particularly among "poor black Americans" (El-Sadr, Mayer, and Hodder 2010).

Postcolonial Partnership

Global health envisions African patients not just as persons in need of treatment, but also as "bodies of knowledge" capable of yielding valuable scientific information. This, in itself, does not make them different from patients participating in medical research in the United States or elsewhere. Research subjects and research scientists everywhere must balance between the clinical imperative to heal and the scientific priority of data production. What makes global health research different is the radical inequality and geographic distance that underpin it, leaving the field haunted by a postcolonial power differential that it continually struggles against. In this context, the discourse of "partnership" between Northern and Southern institutions has emerged as a key strategy for confronting, at least rhetorically, the problem of inequality.

Aspiring academic global health researchers in the North are acutely aware of the dubious ethical conditions under which earlier international research was carried out. In the colonial and post-independence eras, American and European scientists often simply collected the data they wanted and left, with little accountability to Southern host communities, institutions, or researchers. In global health circles, this style of science is referred to as "parachute," "helicopter," or "safari" research, and looked upon disapprovingly. Instead, "partnership" with scientists and institutions in poor countries is advocated as an alternative, more equitable approach to conducting international research. Most often, this call to collaborate is aimed at African universities, which make up the bulk of global health partnership agreements with North American institutions (CSIS 2009).

Partnership between American and African institutions provides U.S. researchers with access to desirable patient populations, as well as African colleagues qualified to shepherd proposals through local IRB approval. At

the same time, partnership offers genuine benefits to African host institutions, including investment in infrastructure (such as laboratories, information technology, and buildings), job creation, and funded research opportunities for African investigators such as those in Mbarara, who might otherwise have little access to scientific grants. Many global health partnerships espouse an explicit commitment to "capacity-building" and offer training in research skills to African physicians, with the goal of fostering local expertise and leadership in global health science. Dr. Beale's International Scholars Initiative, which provided advanced research training and mentorship to Dr. Frederick Muyenje and other promising young investigators at MUST, is one example of such a benefit. Thus, "partnership" is not an empty promise, and there are many ways in which these alliances are mutually beneficial. At the same time, however, significant inequalities persist, and the promotion of global health by Northern stakeholders as a "win-win" example of genuine partnership risks obscuring this. As Rene Gerrets notes in his work on public-private partnerships in global health, "the notion of 'partnership' and its emphasis on equality and consensus, stands at odds with the diverse social realities and dynamics among the sites and actors that global health partnerships typically engage" (Gerrets 2010).

Within the context of the CUGH meetings, the term "partnership" played a prominent role, serving as a defining characteristic of the field of global health, a descriptor of the role played by Southern institutions and experts, and a qualifying condition for membership in the consortium. In addition, when meeting attendees described challenges or inequalities they had encountered in their global health work, "partnership" was often proposed as the remedy. For example, one U.S. university president speaking at the 2009 meeting noted the need for "humility" in the face of global health interventions that had been unsuccessful. Citing an instance in which donors had failed to realize that Sudanese recipients of insecticide-treated bed nets would want to wash the nets in order to remove the cooking smoke they collected (thus also removing the insecticide), he asked, "How will we do better in the future? By partnering with the people it impacts." In a different mode, at the same meeting, an NIH scientist described the reluctance of some U.S. institutions to participate in global health research out of fear of losing grant money to foreign collaborators. This anxiety could be assuaged, she said, by funding "partnerships" between domestic and foreign universities. In juxtaposing these two examples, we can see that the same concept of

"partnership" is being used to describe very different things: in the first case, a call for community-based public health intervention, and in the second, the creation of a transnational institutional structure for the purposes of administering research funds.

However, despite the frequent invocation of the idea of "partnership" in global health, the field has given little consideration to what partnership actually entails in practice or to the wide variety of relationships that currently exist between Northern and Southern entities. This lack of attention to the meanings and activities taking place in the name of partnership risks obscuring the diversity of arrangements and complex power dynamics at stake. Below, an examination of some of the administrative mechanisms behind global health partnership reveals ongoing tensions between Northern and Southern perspectives, and uncertainty over whether these partnerships benefit or deplete host institutions.

The (Indirect) Costs of Partnership

At the CUGH meetings, the priorities of partnership seemed different for the North American conference organizers and for the small group of Southern invitees. While panelists from Southern institutions tended to prioritize issues of equity and opportunity in their partnerships with North American schools—such as having a voice in research priorities, giving their students overseas learning opportunities, and building capacity at their home institutions—American panelists spent more time focused on the logistics of transnational academic collaboration, and particularly the navigation of complex bureaucracies of both U.S. and host institutions. Potentially controversial topics such as the efficient and legal movement of money, compensation rates for foreign employees, compliance with national tax laws abroad, intellectual property rights, and ethical approval for research were all discussed within the deceptively bland vocabulary of "enabling systems," "harmonization," and the establishment of a "common platform."

The value that Northern institutions placed on administrative streamlining was evident at the CUGH's inaugural meeting in 2008, where the unexpected star of the conference was not a high-profile researcher but a University of Washington administrator who was one of the very few

presenters without a graduate degree. The administrator wowed the audience of MDs and PhDs with her description of the administrative prowess of the UW's Global Support Project (GSP), which she had spearheaded in 2007 in order to coordinate and facilitate the university's increasing number of projects abroad by "optimiz[ing] the administrative processes that support global research and education" (University of Washington 2007, 1). She began her presentation to the CUGH with the assertion that "normal is defined differently everywhere," giving the example that what is normal in Seattle might not be considered normal in Ethiopia. She underscored this point by showing the audience a humorous photo depicting a group of people seated at an outdoor table, nonchalantly chatting and sipping beverages as several zebras drank from the swimming pool a few feet away—an apparently "normal" event in Kenya, where the photo was taken.

According to the administrator, the Global Support Program came about in response to the discovery that university scientists were running their global health projects out of personal bank accounts because the University of Washington (UW) did not offer the administrative structures they needed to manage international research. For example, UW did not have a mechanism for transferring more than $50,000 to a foreign country, even though administrative offices were getting requests for amounts in the range of $250,000 from principal investigators running studies overseas. As a result, projects were having serious problems getting cash to their local staff for hiring and operating expenses. The Global Support Project was designed to establish structures that could handle this kind of transnational fiscal administration, as well as issues like in-country subcontracting and human resources, tax compliance, information technology infrastructure, and risk and emergency management. Included in the GSP's services was assistance establishing "shell" nongovernmental organizations (NGOs) in host countries to act as fiscal and legal agents for global health projects, as the university was not permitted to register as a nonprofit abroad. In addition, as part of the Global Support Project, Seattle-based administrators were sent overseas to visit the university's international field sites—what the speaker described as "sending accountants on a road tour of Africa"—in order to give them a sense of "what goes on on the ground." Furthermore, as a state university, the GSP also worked locally to forge "relationships with people in the state capitol and get them on board," even succeeding in getting some state laws changed to facilitate their work.

Overall, the presenter painted a picture of a powerful, well-oiled administrative apparatus staffed by what she termed "fearless provocateurs" and dedicated to facilitating efficient and responsible international work. The motto of the GSP, she said, is "We Help People Who Change the World." Her presentation was very well received, and led to speaking invitations from other North American campuses seeking to replicate the Global Support Project, as well as an invitation to lead the meeting on "Enabling Platforms" at the CUGH again the following year. (At this subsequent meeting King Holmes, the chair of UW's Department of Global Health, would introduce her to the audience as "our savior.")

However, when North American meeting organizers asked representatives from Southern "partner" institutions whether it would be useful to share the GSP administrator's expertise with international staff, the response was more mixed. Jean William Pape, the Haitian researcher, agreed that it would indeed be "very useful." But Ugandan scholar Nelson Sewankambo disagreed, arguing that Northern universities were "undermining local capacity" by setting up separate administrative bodies in NGO form, rather than utilizing existing local administrative structures. The University of Washington NGO in Addis Ababa, Ethiopia, he argued, was undermining capacity at their partner institution, the University of Addis Ababa. Instead of establishing their own NGO to handle the grant money, he said, "They need to help the University of Addis Ababa manage the finances." Tom Quinn, the founding director of the Johns Hopkins Center for Global Health and a long-term collaborator of Sewankambo's, echoed this sentiment. "I agree that's happening a lot," he told the audience. International projects were building outside structures, he said, because local ones are "too difficult."[4]

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4. While government and university bureaucracies (both foreign and domestic) can certainly pose unwanted challenges and delays to eager researchers, the circumvention of African management and regulatory structures can also work to exclude and marginalize African experts from global health planning and governance. As Elise Carpenter has noted in her study of Botswana's national HIV treatment program (established through a government partnership with Harvard University and Merck Pharmaceuticals), "In most portrayals of Botswana's HIV [program] by international experts or donor organizations, barriers are called bureaucracy, success is called partnership. This effectively negates the contributions of [Botswanan] government bureaucrats" (Carpenter 2010).

This exchange reflects a much larger and ongoing debate in global health over whether Northern funding is helping to improve local health and education systems in Africa and elsewhere, or undermining them by setting up parallel, largely independent structures.[5] While most North American global health endeavors cite "capacity-building" at partner institutions as one of their goals, this is usually envisioned in the form of training opportunities for local researchers and clinicians and infrastructural improvements to buildings, laboratories, and information technology—not in terms of fiscal administration. However, global health projects are undoubtedly straining the fiscal capacities of partner institutions, which were not designed to administer huge scientific grants from the American government. During the 2008 CUGH meeting, one American researcher said to me in an aside that his university's program in Botswana had received "one grant that was bigger than the whole local university budget," which had, not surprisingly given its size, "no idea how to manage it." It's a real problem, he went on, because they "desperately want to be treated like equals" but are not able to handle large NIH grants.

The challenge of handling large sums of grant money is exacerbated by NIH regulations, which cap reimbursements for "indirect costs"—i.e., administrative and infrastructural overhead—at 8 percent for foreign institutions. By contrast, American institutions, which negotiate this rate with the NIH individually, are reimbursed for indirect costs at much higher rates: for example, the website for the Johns Hopkins School of Medicine lists a 62 percent reimbursement rate for federally funded research conducted on campus. In other words, if the medical school were to receive an NIH grant for $100,000, another $62,000 would be added on to this to cover "indirect" overhead costs. A foreign university receiving a grant of the same size

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5. With its vertical administrative structure and heavy usage of U.S. subcontractors for supply chain management, PEPFAR has been particularly controversial in this regard. At the Immune Wellness Clinic, the PEPFAR-run antiretroviral programs are undoubtedly more reliable and successful than programs run through the Ugandan Ministry of Health, which suffer from interruptions in drug supply, less optimal drug choices, and less availability of CD4 and viral load testing. This has served to increase confidence in foreign-funded projects and fueled existing discontent with the efficiency and reliability of government programs in Uganda. Of course, PEPFAR is also much better funded. The question at stake is whether investing U.S. funds in Ministry of Health systems instead of creating the largely independent PEPFAR program could result in successful government-run treatment programs.

would only be given $8,000 to cover administrative expenses. This 8 percent reimbursement is actually an improvement over NIH regulations in the 1980s, which did not allow any indirect cost reimbursements for foreign institutions—a product of negative Reagan-era sentiments toward foreign aid. The rule changed in the 1990s, when fears of "emerging diseases" made the climate for international health funding more favorable. Officials at the National Institutes of Allergy and Infectious Disease successfully lobbied for an increase to 8 percent, the same amount that the NIH offers recipients of its training grants, but found that any amount greater than this was politically untenable (John McGowan and Gray Handley, personal communication). The consequence is that universities in low-income countries in Africa and elsewhere are being asked to manage large scientific grants from the U.S. government, but are offered insufficient reimbursement for the administrative costs of doing so—a recipe that sets them up for failure. I witnessed this in my own research, where the NGO established to serve as the Ugandan fiscal agent for Dr. Beale's research suffered a financial meltdown as U.S. interest in conducting research at the site grew and the number of projects it was expected to administer ballooned beyond its capacity.

This problem did not go unrecognized at the CUGH meeting, where one American scientist noted that the low reimbursement rate was simply not enough for foreign universities to build the infrastructure needed to support international partnership. An 8 percent reimbursement rate, he said, was simply "not very partner-like." This challenges the public promotion of global health partnerships as inherently mutually beneficial, and raises an important question: does the language of partnership serve as an obfuscation, turning our attention away from the inequalities that are produced when North American global health programs seek to streamline access to the bodies of Southern patients?

Valuable Inequalities

Given the ongoing context of global socioeconomic inequality, how might these emerging disparities within global health programs and practice be ameliorated? Clearly, efforts to define the meaning, scope, and mission of global health need to be more inclusive of perspectives from low-income nations—otherwise, claims of partnership are likely to remain strictly

aspirational rather than actual. To do this, scholars from poor and middle-income countries need to be included in larger numbers and at higher levels in organizations like the CUGH, lest such groups become de facto clubs of North American academic power brokers. At the CUGH meetings, there was some awareness of this problem among North American participants. In a discussion toward the closing of the 2009 meeting concerning the membership status of Southern "partner" institutions, one CUGH board member noted that "there is lots of discussion about how low- and middle-income partners should participate, but there are no representatives *from* a partner institution in the room." The 2010 meeting in Seattle, which had both greater overall attendance and more international participants, showed some improvement on this front, perhaps due to its more open attendance policy.

However, the challenges to equity within global health go beyond issues of definition and representation. In addition to making global health more inclusive, North American universities must come to terms with the fact that the very poverty and inequality they aspire to remedy is also what makes their global health programs both possible and popular. In other words, in the world of academic global health, inequality is a valuable opportunity. In her work on the globalization of clinical trials research, Adriana Petryna has shown how the for-profit research sector is exploiting this opportunity by seeking out lower-income countries as locations for pharmaceutical testing. Countries like Brazil and Poland, she writes, allow trials to be conducted more cheaply and efficiently than is possible in the United States, due to their large numbers of untreated patients and variable ethical requirements (Petryna 2009). The global health activities I have described here bear both important similarities and differences to the private-sector research described by Petryna. A key difference is that academic global health research is largely federally funded and aimed at producing scientific and public health knowledge useful and applicable primarily in the South, not the North, where different standards of care preclude the testing of many interventions designed for impoverished settings (Crane 2010, Wendland 2008). In addition, unlike the international science studied by Petryna, academic global health is not limited to research, as it also encompasses clinical training activities for health professionals and students from both sponsor and host nations.

But there are other ways in which global health enthusiasts in the academy resemble their colleagues in the private sector, most notably in the way in which they benefit from the opportunities afforded by global inequalities. Petryna describes how lack of oversight of international clinical trials, combined with health system inadequacies in lower- and middle-income countries, permit a kind of "experimentality" in which "experiments draw from public resources and are coined as social goods" (Petryna 2009, 30). Similarly, American students seeking a global health experience in Africa or elsewhere in the "developing" world are engaged in a kind of learning experiment, in which easy access to patient bodies allows them the opportunity to test and refine their nascent clinical skills under the auspices of providing medical aid. As others have already noted, the primary beneficiaries of these short-term encounters may be North American "clinical tourists" (Wendland 2012), who find their knowledge and resumes enhanced, and not patients, who may suffer as a result of foreign students' inexperience (Crump and Sugarman 2008). In addition, like private-sector science, academic global health research benefits from the surfeit of untreated or "treatment-naïve" patients in low-income countries, which provide research subjects in numbers that cannot be duplicated in the global North. The premium placed on "baseline" blood samples by the University of California researchers described in chapter 3 is one example of this.

However, academic global health training and research are not typically profit-driven, and this remains an important difference between the kind of work undertaken by members of the CUGH and the contract research organizations described by Petryna. This leaves us with another question: if not profit, what drives these students and researchers to pursue "global health"? In my own experience, they are moved both by a sincere humanitarian desire to address suffering, and by intellectual curiosity and the opportunity to learn or produce new knowledge. These motivations, while well intentioned, should be considered in light of the long history of Northern efforts to "cure the ills" of Africans and other residents of the Southern Hemisphere through scientific medicine (Vaughan 1991). At a 2010 conference in honor of historian of Africa Steven Feierman, Nancy Rose Hunt described "extraction" and "salvation" as the two main historical modes of Northern intervention in Africa (Conference on Social Health in the New Millennium, University of Pennsylvania, April 24). I am concerned that

vestiges of these colonial-era motivations may persist, albeit in attenuated forms, in today's global health involvement on the continent.

In academic global health, extraction comes in the form of scientific data production and clinical experimentality, while salvation is manifest in seemingly miraculous biomedical interventions able to snatch patients away from the jaws of death (a phenomenon most visible in HIV treatment). These twin themes are apparent in *Saving Lives: Universities Transforming Global Health*, the glossy, multipage brochure commissioned by CUGH for distribution to the U.S. Congress, where images of African women and children—the "saved"—are paired with text touting the importance of scientific inquiry and learning (Consortium of Universities for Global Health 2009). The cover of the ten-page booklet exemplifies this by featuring a large photo of an African mother holding her ailing baby, underneath the banner "Saving Lives." On the following page there is a caption describing this photo, as well as a suggestion as to how the suffering it depicts might be remedied. "A mother holds her 8-month old daughter at Hospital LeDantec in Dakar, Senegal," we are told. "The child, whose lips are blue from lack of oxygen, had pneumonia." Then, the next sentence offers up a solution: "Research conducted by Boston University investigators will lead to earlier interventions for severe pneumonia, cutting down the number of cases such as this one and saving lives." No one would dispute the need to invest global health dollars into fighting pneumonia, which kills more children worldwide than any other disease, or the need for public health research that could contribute to better treatment and prevention (UNICEF 2006). It is the positioning of North American scientists as saviors of Africans—there is no mention of Senegalese scientists in the caption—and the erasure of the power relations that structure scientific knowledge production in global health that are troubling here.

The legacy of colonial-era inequalities is an uncomfortable topic in global health, and one that the field seeks to avoid reproducing through the invocation of an ethic of "partnership." However, as I hope I have shown, the espousal of partnership—while a noble aspiration—runs the risk of obfuscating both the enduring and novel forms of inequality that shape the transnational relations of global health. This includes the dependence of Northern global health programs on easy access to the bodies of undertreated patients in (or, in the case of refugees, from) the global South, and the difficulty in envisioning how Southern clinicians and researchers might

learn or practice global health. This complicated and paradoxical relationship to inequality is not usually addressed by North American actors and institutions within the field, who tend to position their activities as straightforwardly beneficial for both wealthy sponsor nations and lower-income host countries. To be fair, these programs do bring benefits to institutions in poor countries, and their presence is most often quite welcome. However, if global health wishes to truly make strides toward its ethic of equitable partnership, the field must make a more genuine effort to grapple with the unequal terrain on which it operates and which, ultimately, serves as its condition of possibility.