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## Scrambling for Africa

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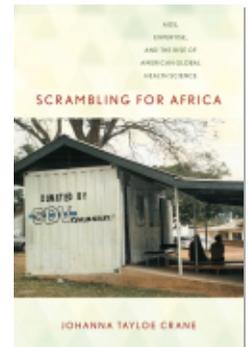
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## CONCLUSION

In 2011, the world marked the thirtieth anniversary of the June 5, 1981, CDC report documenting five unusual cases of *pneumocystis* pneumonia in young, previously healthy gay men in Los Angeles (CDC 1981). Traditionally, this report is viewed as the first official recognition of the disease that would come to be known as AIDS, and its publication has become a stand-in for the onset of the global epidemic. Other, less official forms of recognition came earlier—both in the United States, where gay men and their doctors started noticing inexplicable infections in the 1970s—and in central and east Africa, where doctors noticed a spike in illnesses during the late 1970s and early 1980s and people began referring to a new affliction called “slim” or “Juliana’s disease” (Ilfie 2006; Thornton 2008; Garrett 1994). This unofficial recognition, however, would remain just that: unpublished, “local” knowledge lacking the imprimatur of scientific expertise. In this way, the CDC’s 1981 publication marks another less recognized beginning, that of the hegemony of biomedical expertise—and American biomedical science in particular—in framing the epidemic.

Thirty years later, the AIDS epidemic and the global health science to which it gave birth are at a crossroads. In 2010, U.S. government funding for ARV programs via PEPFAR flatlined as the Obama administration's Global Health Initiative attempted to reorient the emphasis of U.S. global health funding towards maternal and child health (Sahoo 2010). In 2012, the Global Health Initiative's office closed and its work was shifted elsewhere (though the Office of the Global AIDS Coordinator, which oversees PEPFAR, remains in place; Donnelly 2012). Meanwhile, U.S. and other donations to the Global Fund to Fight AIDS, Tuberculosis and Malaria have declined, forcing the foundation to cease issuing new grants and spurring a \$750 million donation by the Bill and Melinda Gates Foundation to "shore up" the Fund (McNeil 2012). Although both PEPFAR and the Global Fund voice a commitment to continue supporting treatment for those already on ARVs, public funding to expand treatment access to new patients is becoming increasingly uncertain. Some have suggested that the scaling-up of ARV access and the "golden age" of global health funding have come to a close (Ingram 2012; Rushton and Williams 2011).

At the same time, the remarkable achievements of these programs in changing the global landscape of HIV treatment should not be overlooked. By 2010, the WHO estimated that over 6.6 million people in low- and middle-income countries were receiving antiretroviral treatment—a seventeen-fold increase since 2003. Of these 6.6 million, over 5 million were in sub-Saharan Africa (WHO, UNICEF, and UNAIDS 2011, 89–90). Furthermore, improvements in therapy mean that those taking ARVs are now capable of living normal, relatively healthy life spans in which their HIV infection may never progress to AIDS. This development, along with new scientific findings suggesting the protective effect of male circumcision and the utility of antiretroviral treatment in preventing new infections, led Secretary of State Hillary Clinton to declare the possibility of an "AIDS-free generation" in the near future (McNeil 2011b). While the possibility (and the meaning) of this pronouncement are subjects of debate, it should be noted that much of the research that made Clinton's declaration possible was conducted in southern and eastern Africa, providing further evidence that the locus, if not always the control, of some of the most prominent recent findings in AIDS science is now in Africa. Moreover, even as U.S. government funding for global health rests on unsteady ground, the number of global health programs at U.S. and Canadian universities tripled between

2006 and 2011, suggesting that the enthusiasm for global health within the North American academy continues unabated (Doughton 2011). There is further proof of this in Mbarara, where plans are underway to build an 18,000 square foot public health conference and education center aimed at strengthening global health research and education at the university and in the broader region. The construction of the center, which will be a part of MUST, is being managed by the global health program at Beale's academic medical center in the United States.

These developments raise questions about where American global health science is heading, and how and whether HIV/AIDS fits into its future. They suggest, as I have tried to illustrate in this book, that the outcomes of global health science are uneven. On one hand, the AIDS epidemic and subsequent rise of "global health" have led to greater engagement between universities and medical centers in the United States and in the global South, particularly in sub-Saharan Africa. This engagement, in turn, has brought new opportunities and resources to African institutions and experts, fostered greater collaboration between African and American colleagues, and pushed AIDS science to account for the global diversity of HIV. On the other hand, global health science has brought with it a host of new inequalities, many of which trouble the field's leaders' fervent espousal of an ethic of "partnership." Some of these inequalities are visible at the level of institutions: for example, the circumvention and undercutting of African public health and educational systems by American medical schools eager to avoid local bureaucracy, or the primacy of a few, U.S.-certified African laboratories in determining the landscape of global health knowledge-making. Others are more apparent on the micro-social level of human relations, such as the tensions that arose around the Wellness Clinic's database, or Dr. Balenzi's careful conversation with me about her medical staff's desire to be compensated for their interviews. What these ongoing disparities show us is that as the field of global health strives to reduce human suffering, it must not ignore the unequal social relations of science and medicine that it can engender.

Ethnography is one means of getting at these social relations, as its rigorous contextualization of human lives forces us to understand the actions of individuals as both socially and historically produced. By examining the everyday practices of U.S. and Ugandan global health researchers as both

emerging from and (sometimes) challenging a scientific landscape that is deeply geographically and economically stratified, this book represents an effort to push global health science to recognize and confront the inequalities that make it both possible and productive. For this reason, it seems appropriate to conclude by returning to ethnography to consider the question of global health's future. While I do not presume to be able to predict this future, two ethnographic vignettes from my research serve as cautionary tales.

### *Mbarara, 2009*

In the summer of 2009, I sat on a wooden bench in the hallway of the Immune Wellness Clinic waiting for a doctor who had agreed to be interviewed for my research. My seat happened to be directly across from one of the clinic's two pharmacies. I sat facing what staff called the "OI pharmacy," two small adjoining rooms where patients went to obtain the antibiotics, antifungals, and other drugs needed to treat any HIV-related opportunistic infections (OIs) they might be suffering from. (Antiretroviral drugs were dispensed from a separate pharmacy.) There was music coming from a radio inside and a pharmacist at work in there, as well as regular traffic in and out by clinicians and other staff. The rooms had windows that faced out onto the clinic hallway, and through them I could see inside to a wall of glass-fronted cabinets filled with bottles of prescription drugs: septrin, acyclovir, fluconazole. There were also stacked cardboard boxes of more drugs waiting to be unpacked. These were each hand-labeled in magic marker with the name of the clinic "stakeholder" that had paid for them: the Ugandan Ministry of Health, and two separate PEPFAR-funded programs.

What drew my attention most, however, was a memo that was posted on the pharmacy door. Dated October 2, 2008, it was addressed to "all staff" from "management." It read:

This is to inform all staff of this clinic and Hospital that all Drugs at the Immune Wellness Clinic are strictly for the patients Registered with the clinic. Therefore anyone who requires drugs should find a way of obtaining them elsewhere.

Later, Dr. Atuhaire and Dr. Balenzi explained the memo to me. Unlike the clinic's separate ARV pharmacy, which dispensed drugs useful only to patients with HIV, the OI pharmacy offered medicines for the treatment of all sorts of infections. Like ARVs, these drugs were purchased with monies from PEPFAR and the Global Fund (via the Ministry of Health) and provided to Wellness Clinic patients free of charge. To obtain their pills, patients simply had to hand their prescription through the window to a pharmacist and wait about five minutes for the medication to be dispensed. The pharmacist would then record the exchange on a spreadsheet called the "Drug Dispensing Sheet," which was entered into the clinic database at the end of each day.

At times, the doctors told me, patients who were not enrolled at the Wellness Clinic would attempt to obtain medications from the OI pharmacy. These were HIV-negative patients who had been seen at other clinics within the university hospital, but had been unable to fill their prescriptions at the hospital's outpatient pharmacy, which was frequently out of stock of all but the most basic drugs. Unable to afford to buy medication at the private pharmacies in town, patients who knew about the OI pharmacy would sometimes attempt to get their prescriptions filled there. This was a particularly difficult issue with "discordant" couples, Dr. Balenzi told me. "A wife with HIV may come in and get her treatment but her [HIV-negative] husband, who also needs something, can't get drugs."

Although such patients would occasionally come to the OI pharmacy in person asking for medication, more often they tried to enlist the help of a friend or relative who worked at the clinic. The memo on the door was thus intended to remind staff that providing drugs to patients not receiving HIV care was forbidden. The Wellness Clinic could not afford to provide free drugs to patients without HIV, Dr. Atuhaire told me, "because we have to give accountabilities at the end of the month. We know the number of patients we are providing care for, so we are able to make accountabilities [to donors] that we received this number of tins of septrin and we have dispensed it as follows." Nonetheless, he was sympathetic with the inequality inherent within the situation, telling me: "Two patients come to the hospital, one goes to the hospital outpatient clinic, sees a doctor, and all the medications that have been written have to be bought. The one who has gone to the same hospital but to the HIV clinic gets a prescription, and all the drugs written are provided. For free."

## *Seattle, 2012*

In the summer of 2012, residents of and visitors to the city of Seattle were invited to have a global health experience without ever leaving the city. The “Global Health Experience” exhibit, housed just a few hundred yards from the city’s iconic Space Needle, was just one of several events comprising “Global Health Month” in Seattle. The month was organized by the “Global Health Nexus,” a consortium of academic, medical, philanthropic, and private research institutions in Washington state “dedicated to branding our region internationally as the nexus for global health discovery, development, and delivery” (Puget Sound Regional Council 2012). It was conceived as one of many events comprising “The Next Fifty”—a six-month celebration commemorating the fiftieth anniversary of the Seattle World’s Fair. Held at the Seattle Center, an urban event space originally built to house the 1962 fair, “The Next Fifty” was intended not only to celebrate Seattle’s past but also to foster “a dialogue about our future” (Seattle Center Foundation 2011). Given that it is home to the Bill and Melinda Gates Foundation,<sup>1</sup> the nonprofit Program for Appropriate Technology in Health (PATH), and the University of Washington’s Department of Global Health, it is perhaps not surprising that Seattle’s business and political leaders would promote it as a “curative global city” (Sparke 2011).

Visitors to the Global Health Experience entered the exhibit’s warehouse-like space through a large doorway emblazoned with photographs of African children captioned “4 lives, 4 countries, 4 challenges to survival.” Additional text promised “hands on activities—free and for the whole family.” Upon entering, visitors could wind their way through four different “life lanes” each focused on a different global health challenge—cancer, diabetes, maternal health, and malaria—and profiling the ways in which Washington-based organizations and companies were working to ameliorate it.

The exhibit spaces were designed as life-size dioramas aimed at transporting visitors to impoverished settings in the global South: for example, in

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1. Both the Global Health Nexus and Global Health Month were heavily supported by the Gates Foundation, which is headquartered across the street from the Seattle Center. The foundation is the world’s largest philanthropic organization, and global health is its largest grant-making area.

the “cancer lane,” set in Uganda, visitors walked through a room with “mud” walls (constructed out of plastic), filled with holes and blackened by smoke from a charcoal stove. The “malaria lane,” set in Tanzania, featured a room with corrugated tin walls and furnished with a single, uncovered foam mat lying on the floor. In both cases, these stark conditions and the bare survival they evoked were juxtaposed with photos and text that detailed the efforts of Seattle area organizations to diagnose, treat, or prevent such diseases. The Ugandan cancer exhibit, for example, described “*careHPV*™,” a technology “co-developed by PATH” and aimed at diagnosing the human papilloma virus, which is linked to cervical cancer. (The test’s other developer, a multinational medical diagnostics corporation called Quiagen, was not mentioned in the exhibit.) The diabetes exhibit, in turn, promoted the “HumanPen Memoir™,” an insulin-delivery device designed to help patients remember their injections. The device was developed by the pharmaceutical firm Eli Lilly and the research and development organization Battelle, which has major offices in western Washington state.

In addition to the four disease-specific “life lanes,” the Global Health Experience also devoted a large area to clean water and sanitation efforts—featuring water-purification and latrine technologies developed by Seattle-area groups—and an additional section simply titled “Other Cool Technologies.” This area displayed inventions ranging from “Partopants,” a low-tech birth simulator designed to train birth attendants in the management of obstetric emergencies (designed at the University of Washington), to “Ultra Rice,” a manufactured “grain” made from rice flour and fortified with micronutrients developed by PATH and the private U.S. company Bon Dente International. As visitors left the exhibit space, they were encouraged to visit the “Pathways to Global Health” exhibition in a neighboring building, where they could learn about local education and career options in global health.

### **“We Are Somewhere”**

It is easy to see the ways in which the spaces in these two vignettes are divergent. Located half a world away from one another, Mbarara’s Immune Wellness Clinic and Seattle’s Global Health Experience not only occupy separate continents but also serve separate purposes, one curative and one

promotional. More importantly, they differ profoundly in their access to resources and proximity to bodily suffering. Yet I would argue that these sites actually have quite a bit to say to one another.

First, both places raise questions about the role of HIV/AIDS in global health. The notice on the door of the Wellness Clinic's OI pharmacy is a mundane yet profound marker of how HIV/AIDS has dominated global health funding and actions, often at the expense of other, less spectacular but equally lethal illnesses. The result, as many critics have noted, is an "AIDS exceptionalism" within global health that offers state-of-the-art care to those suffering from HIV (and to some extent, TB and malaria), but leaves other diseases and broader public health concerns unaddressed (Ingram 2012; Biehl 2007; Garrett 2007).<sup>2</sup> Global health research has mirrored this uneven attention, focusing primarily on the "big three" of AIDS, TB, and malaria. For this reason, the absence of HIV/AIDS from the Global Health Experience exhibit is noteworthy. The exhibit's limited attention to infectious disease and its highlighting of chronic illnesses (cancer, diabetes) often thought of as "first-world" diseases suggests a broadening of the scope of global health and a growing recognition of illnesses and concerns other than HIV. While the story of the Wellness Clinic pharmacy exemplifies what happens to medical care when global health is limited to a "pharmaceuticalized" response to AIDS, the Seattle exhibit suggests a technology-driven response to global health in which HIV/AIDS is no longer a primary concern.

Secondly, these sites are similar in their demonstration of an oft-noted and worrisome trend in global health: the turn away from public health. In Mbarara, a visit to the public hospital's outpatient pharmacy—stocked by the Ministry of Health—confirmed what Dr. Atuhaire had described. Although the pharmacy was able to provide patients with "basic" drugs like antimalarials, some antibiotics, and Panadol (acetaminophen), the pharmacist on duty told me that the drug supply varied from month to month, and that they regularly suffered from stock-outs. For "complicated" drugs "like Keflex" (a branded antibiotic), patients were often sent to private pharmacies in town, where they had to purchase the medications themselves.

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2. Exceptionalism shaped domestic responses to the AIDS epidemic within the United States as well (Bayer 1999; Casarett and Lantos 1998; Crane, Quirk, and Van der Straten 2002).

Hypertension and diabetes patients were particularly difficult to treat, he said, as insulin and blood pressure medications were not available through the Ministry and often too expensive for patients to buy in town. No wonder, then, that hospital patients would sometimes find their way to the well-stocked, internationally-funded OI pharmacy at the Wellness Clinic in hopes that they might find what they needed.

If African public health has been hollowed out in Mbarara it is nonetheless still visible in the form of the doctors, nurses, and pharmacists who continue to treat patients under the hospital's conditions of "normal emergency" (Feierman 2011). But in the "Global Health Experience" offered up to visitors in Seattle, African government health systems have been almost completely erased. Instead, global health is framed as a series of technical problems offering new market niches for American ingenuity and public-private product development. Scholars have rightly criticized this "private turn" in global health governance as marginalizing state systems and traditional international bodies such as the WHO while promoting a technical approach to global health that sidelines basic public health (Rushton and Williams 2011; Benatar 2005; Lakoff 2010).<sup>3</sup> This is not to say that there is no room for useful technology development in global health; ARVs have proven as much. But when a patented insulin-delivery pen is promoted as an adherence-enhancing device for diabetics in places where insulin is not available via the public sector, it is difficult not to view this action as predatory.

It is not only African public health that is absent from the "Global Health Experience"—it is also African expertise. This brings me to my final point: in order to truly enact the ethic of partnership it espouses, global health science must account for the social relations of knowledge production it engenders. Moreover, it must strive to make these social relations of science more equitable just as it aims to make health more equal. My concluding ethnographic snapshots reveal very different paths in this regard. Other than a brief mention of the Uganda Cancer Institute (which has a

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3. The Gates Foundation, which has been criticized for its emphasis on top-down technology development and quantifiable outcomes over qualitative and collaborative improvements in basic public health, has been particularly influential in promoting technology-driven approaches to global health due to its vast wealth and substantial scientific and political influence (Birn 2005; McCoy et al. 2009).

partnership with the Fred Hutchison Center for Cancer Research in Seattle), the Seattle exhibit's displays say very little about knowledge production by African (or Asian, or Latin American) researchers. Rather, the primary representation of the global South is one of destitution and often ignorance. Africa is once again a place in need of salvation by Western intervention. The life-size dioramas of mud shacks and threadbare existence are in many ways a return to the "dirty water and mud roads" imagery of Africa that dominated the debates over global ARV access that I described in chapter 1, a key difference being that now these impoverished conditions are envisioned not as a barrier to high-tech medicine, but as a market niche for (Western-developed) technologies designed specifically for "low-resource settings." This brings us full circle: underdevelopment has been transformed from a barrier to treatment into a medical technologies market opportunity. But the social relations of science, in which "authorities in rich countries [debate] what is to be done for (or to) the poor" have remained the same (Feierman 2011, 190).

By contrast, the Wellness Clinic, despite its ongoing inequalities, provides an important counter to the Seattle exhibit's vision of global health science. At the clinic, Ugandan doctors and researchers are indispensable to the production of scientific knowledge about HIV and AIDS. Dr. Beale's research endeavors have been very successful, both in the scientific findings they have produced and in the resources they have brought to the clinic, and his career has advanced substantially as a result. None of this would have been possible without collaborators like Dr. Atuhaire, whose methodical clinical record keeping served as the foundation upon which the transnational scientific collaboration could be built. Moreover, it was Atuhaire's colleagues at the Wellness Clinic who ultimately enabled its transformation from a "local" clinic into a "global" research site by—sometimes reluctantly—serving as gatherers of clinical data on the patients under their care. As I hope this book has shown, the outcomes of this transformation—and others like it across Africa—have been uneven. Without a doubt, the transnational scientific communities being forged in Mbarara and elsewhere have yielded important scientific insight into HIV/AIDS and other health problems facing poor countries, as well as valuable intellectual and professional opportunities for the aspiring Ugandan researchers with the good fortune to become, in the words of Dr. Katabira, "attached to someone" like Dr. Beale. At the same time, the tensions over the meaning and

purpose of the Wellness Clinic database and other research conducted on the premises (including my own) should remind us that the symbiotic relationship this work suggests is at best a lopsided one.

The spaces of global health science are spaces of “friction,” where the work of studying and redressing global health inequalities often generates new forms of inclusion and exclusion. At the Wellness Clinic, these frictions—although challenging—were also productive in that they forced difficult but important conversations about who benefits from international research, and the unequal relationships of power and economics that underlie collaborations between U.S. and African scientists. In contrast to the abject picture of Africa presented in the Seattle exhibit, the work being done by the international community of doctors and researchers at the Wellness Clinic and medical school repudiates the imaginary of Africa as “down to the dogs” by affirming, as one Mbarara doctor insisted, that “we are somewhere.” Their stories also highlight the hard work involved in working towards “true partnership” across steep inequalities, and reveal the uncomfortable mix of preventable suffering and scientific productivity that characterize global health. However uncomfortable, this recognition should serve as a critique, but not a condemnation, of global health. It is only through confronting the ways in which global health values inequality that we can work towards building a more equal global health science.