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A Companion to Medical Anthropology

Edited by Merrill Singer,
Pamela I. Erickson,
and César E. Abadía-Barrero

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A Companion to Medical Anthropology

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We dedicate this book to our children,
who, each in their own way,
embody our hopes for a better,
more peaceful, and healthier world:

Jacob Singer, Elyse Singer, Jacob Wildwood,
Malena I. Abadia, and Laila G. Abadia

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Notes on Contributors

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Elise Andaya (PhD, New York University, 2007) is Associate Professor in Anthropology and Associate of the Center for the Elimination of Minority Health Disparities at the University at Albany (SUNY). She is a cultural medical anthropologist whose prize-winning research examines reproductive health, health-care policy and practice, and health disparities in the United States and Cuba. Her current research examines the race, health inequalities, and time (especially experiences of waiting) in the delivery of prenatal public health care in a New York City safety-net hospital.

Hans A. Baer is Principal Honorary Research Fellow in the School of Social Political Sciences at the University of Melbourne. He earned his PhD in Anthropology at the University of Utah in 1976. Baer taught at several US colleges and universities both on a regular and on a visiting basis. He was a Fulbright Lecturer at Humboldt University in East Berlin in 1988–1989. In 2004 Baer taught at the Australian National University and has been based at the University of Melbourne since 2006, as a regular academic until December 2013. He has published 25 books and some 220 book chapters and academic articles on a diversity of research topics, including Mormonism, African-American religion, sociopolitical life in East Germany before and after unification, critical health anthropology, medical pluralism in the United States, the United Kingdom, and Australia, the critical anthropology of climate change, Australian climate politics, mobility studies, and the political economy of higher education. Baer's most recent books include *Airplanes, the Environment, and the*

Human Condition (Routledge, 2020); *Grappling with Societies and Institutions in the Era of Socio-Ecological Crisis: Journey of a Radical Anthropologist* (Lexington Books, 2020), and *Climate Change and Capitalism in Australia: An Eco-Socialist Vision for the Future* (Routledge, 2022). He considers himself a scholar-activist and has been involved in a wide array of social movements, including the peace, labor, anti-apartheid, ethnic rights, environment, climate justice, and socialist movements.

Ron Barrett is Associate Professor of Anthropology at Macalester College. Conducting field research in India and North America, he has examined the ways that people come to terms with their mortality, ritual healing practices, and the social dynamics of infectious diseases. His dissertation research on mortality-informed stigma and the religious healing of leprosy is the topic of a book, *Aghor Medicine: Pollution, Death and Healing in Northern India* (University of California Press), which received the 2008 Welcome Medal from the Royal Anthropological Institute. Together with George Armelagos, he coauthored *An Unnatural History of Emerging Infections*, the second edition of which will be published in 2022 as *Emerging Infections: The Human Determinants of Pandemic Diseases from Prehistory to the Present* (Oxford University Press). Prior to his academic career, Barrett was a registered nurse with clinical experience in hospice, brain injury rehabilitation, and neurointensive care.

Charles L. Briggs is Professor of Anthropology, Co-Director of Medical Anthropology Program, Co-Director of Berkeley Center for Social Medicine, University of California, Berkeley, and the Alan Dundes Distinguished Professor in the Department of Anthropology of the University of California, Berkeley. His books include *The Wood Carvers of Córdova, New Mexico: Social Dimensions of an Artistic "Revival"*; *Learning How to Ask: A Sociolinguistic Appraisal of the Role of the Interview in Social Science Research; Voices of Modernity: Language Ideologies and the Politics of Inequality* (with Richard Bauman); *Competence in Performance: The Creativity of Tradition in Mexicano Verbal Art*; *Stories in the Time of Cholera: Racial Profiling during a Medical Nightmare* (with Clara Mantini-Briggs); *Making Health Public: How News Coverage Is Remaking Media, Medicine, and Contemporary Life* (with Daniel Hallin); *Tell Me Why My Children Died: Rabies, Indigenous Knowledge and Communicative Justice* (with Clara Mantini-Briggs); and *Unlearning: Rethinking Poetics, Pandemics, and the Politics of Knowledge*. He has received such honors as the James Mooney Award, the Chicago Folklore Prize, Edward Sapir Book Prize, the J. I. Staley Prize, the Américo Paredes Prize, the New Millennium Book Award, the Cultural Horizons Prize, the Robert B. Textor and Family Prize for Excellence in Anticipatory Anthropology, and fellowships from the John Simon Guggenheim Memorial Foundation, the National Endowment for the Humanities, the Lichtenberg-Kolleg, the Center for Advanced Studies in the Behavioral Sciences, the School for Advanced Research, and the Woodrow Wilson International Center for Scholars. He is currently President of the Society for Medical Anthropology.

Heide Castañeda is Professor of Anthropology at the University of South Florida. Her research areas include political and legal anthropology, medical anthropology, borders, migration, migrant health, citizenship, and policing, focusing on the US/Mexico border, United States, Mexico, Germany, and Morocco. She is the author of *Borders of Belonging: Struggle and Solidarity in Mixed-Status Immigrant Families* (Stanford University Press, 2019) and co-editor of *Unequal Coverage: The Experience of Health Care Reform in the United States* (NYU Press, 2018). Her latest book is *Migration and Health: Critical Perspectives* (Routledge). Dr. Castañeda has also published dozens of research articles on

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Kitty Corbett is Professor Emerita in the Faculty of Health Sciences at Simon Fraser University, Burnaby/Vancouver, Canada. She has expertise in multimethod research, change theories, health communication, knowledge translation, cultural diversity, social marketing, and public health advocacy. She has contributed to public health projects and research addressing local to global health challenges of antibiotic resistance, appropriate pharmaceutical use, HIV and STI prevention, tobacco use, Chagas disease, cancer prevention, and promotion of local and traditional foods. With students, community partners, and colleagues, she has collaborated on and directed projects in the United States, Canada, Taiwan, Vietnam, Mongolia, Russia, Mexico, Guatemala, Peru, Argentina, and other countries. She has twice been a Fulbright Scholar, in Taiwan and Mexico.

William W. Dressler (PhD Connecticut, 1978) is Professor Emeritus of Anthropology at the University of Alabama. His research interests focus on cognitive culture theory, research methods, and especially the relationship between culture and the individual. Dressler and colleagues have examined these factors in settings as diverse as urban Great Britain, the Southeast United States, the West Indies, Mexico, and Brazil. His recent work emphasizes concepts and methods for examining the health effects of individual efforts to achieve culturally defined goals and aspirations. His research has been funded by both the National Institutes of Health and the National Science Foundation.

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Ruth Fitzgerald is Professor of Social Anthropology at the University of Otago, New Zealand. She researches in the field of medical anthropology with a focus on ideologies of health, the cultural significance of new medical technologies, and moral reasoning and genetic testing with a geographic focus on Aotearoa, New Zealand. She was awarded the Te Rangi Hiroa Medal by the Royal Society of New Zealand for her work in medical anthropology and is currently the general editor of *Sites: A Journal of Social Anthropology and Cultural Studies*. She continues to collaborate with Julie Park and Michael Legge on publications in the everyday ethics of reproductive decision-making and genetic testing and teaches across the graduate and postgraduate programs of Social Anthropology and the First Year Health Sciences program at Otago.

Alan Goodman, professor of biological anthropology at Hampshire College in Amherst, Massachusetts, teaches and writes on the health and nutritional consequences of political–economic processes including poverty, inequality, and racism. He received his BS and PhD from the University of Massachusetts/Amherst, and was a postdoctoral fellow in international nutrition at the National Institute of Nutrition, Mexico, and a research fellow in stress physiology at Karolinska Institute, Stockholm. He previously served as the Vice President for Academic Affairs, Dean of Faculty and Dean of Natural Sciences at Hampshire and is a past President of the American Anthropological Association (AAA). He codirects

the AAA's public education project on race (understandingrace.org). Goodman has written over one hundred articles and is the editor or author of eight books including *Building a New Biocultural Synthesis*, *Nutritional Anthropology*, and *Race: Are We So Different?* His forthcoming book is *Racism, Not Race: Answers to Frequently Asked Questions* (with Joseph Graves, 2021, Columbia).

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Clarence C. Gravlee is Associate Professor in the Department of Anthropology at the University of Florida, with affiliate appointments in African American Studies, the Center for Latin American Studies, and the Center for the Study of Race and Racism. His research aims to explain and address how systemic racism harms health and corrupts medical research and practice. He is former editor of *Medical Anthropology Quarterly*, co-founder (with M. Miaisha Mitchell) of the Health Equity Alliance of Tallahassee (HEAT), and co-editor (with H. Russell Bernard) of the *Handbook of Methods in Cultural Anthropology* (Rowman & Littlefield, 2015). His work has appeared in public-facing venues such as *Scientific American* and *Somatosphere*, and in a wide range of scholarly journals, including *American Anthropologist, American Journal of Public Health, Annual Review of Anthropology, American Journal of Human Biology, Culture, Medicine & Psychiatry*, and the *International Journal of Social Research Methodology*, and more.

Deven Gray is a PhD student in the Department of Anthropology at the University of South Florida. Gray is a medical anthropologist with a focus on infectious disease, especially concerning mosquito-borne infectious diseases such as Zika virus and dengue fever. He has multiple field seasons of experience in the country of Belize conducting mixed-methods ethnographic and Geographic Information Systems (GIS) research on epidemic and pandemic response efforts, researching policies and interventions that influence the management or health consequences of disease. Since 2018, Gray has served as an assistant editor for the applied anthropology journal *Human Organization*, and recently he has gotten involved with the University of South Florida's Center for the Advancement of Food Security and Healthy Communities (CAFSHC) to explore the effectiveness of food bank home delivery programs piloted in response to COVID-19.

David Himmelgreen is Professor in the Department of Anthropology and Director of the Center for the Advancement of Food Security & Healthy Communities at the University of South Florida. Himmelgreen is a biocultural nutritional anthropologist with expertise in maternal-child nutrition, growth and development, food security, dietary change and health, and community nutrition programming. He has conducted research in Costa Rica, Lesotho, India, Puerto Rico, and the United States. He served as Chair of the Department of Anthropology from 2014 to 2021. Since 2015, he has been involved in multiple projects addressing food insecurity in Tampa Bay. Himmelgreen is currently conducting research on a food prescription program, college student food insecurity, and diabetes self-management during COVID-19. He has over 100 publications and has received funding from NSF, USDA, Fulbright Commission, state agencies, and private and corporate foundations for research and programs aimed at reducing food insecurity and improving health.

Craig R. Janes is Professor and Director of the School of Public Health Sciences at the University of Waterloo in Ontario, Canada. His current work focuses on the intersections of anthropogenic environmental change and global health systems, including a country-wide study of the impact of climate change on the livelihoods and health of Mongolian pastoralists, assessments of the public health consequences of global resource extraction in Mongolia and Zambia, and a coupled social-ecological systems approach to identifying and mitigating the impacts of flooding regimes on the access to essential health services in western Zambia. He has also investigated the effects of globalized health systems reform programs on indigenous health systems, access to health services, and maternal health outcomes. In addition to his work in Mongolia and Zambia, he has conducted research in the United States, the Tibet Autonomous Region of China, Argentina, and Samoa. He is a past Board Chair and National Coordinator of the Canadian Coalition for Global Health Research, a Fellow of the Balsillie School for International Affairs in Waterloo, and with his colleagues in Zambia codirects the Zambezi Ecohealth Partnership.

Thomas Leatherman is Professor of Anthropology at the University of Massachusetts, Amherst. He is a biocultural anthropologist whose work adresses social change, inequalities, and health in Latin America and the U.S.. Work in the Yucatan of Mexico has focused on the social, nutritional and health impacts of the rapid growth of tourism-based economies, and the "coca-colonization" of diets in the Yucatan. Long term research in the southern Peruvian Andes focused on the co-constitutive nature of poverty, inequality and illness, and the links between structural violence and the political violence manifested in a 20 year civil war (1980-2000). Recent work and interests are on shifts in regional economies, food security and health in a post-conflict Peru. He co-edited *Medical Pluralism in the Andes* with Joan Koss and Christine Greenway (2004), and *Building a Biocultural Synthesis: Political Economic Perspectives in Biological Anthropology* (1998) with Alan Goodman; part of a long term theoretical interest in developing and expanding a more critical biocultural anthropology.

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J. Bryan Page is Professor of Anthropology at the University of Miami. He has secondary appointments in the Departments of Psychiatry and Sociology at that institution. He has conducted transdisciplinary research on the consequences of drug use for nearly 50 years. His focus on drug using behavior has relied on ethnographic, first-hand views in the users' natural habitats, whether on the streets of San Jose, Costa Rica, the shooting galleries of Miami and Valencia, or the villages of the Seminole reservations. The perspectives gained from this kind of research have made possible the designing of laboratory experiments to establish the parameters of decontamination for injection paraphernalia and the implementation of interventions for preventing the spread of HIV infection among injecting drug users.

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continues her collaboration with Ruth Fitzgerald and Michael Legge on publications on everyday ethics in the context of reproductive technologies and genetic conditions and with Judith Littleton on publications from their research on tuberculosis in New Zealand, the Cook Islands, and Tuvalu.

Marsha Quinlan is Medical Anthropologist in the Department of Anthropology at Washington State University. She concentrates on ethnomedicine and ethnobiology, including ethnozoology, ethnobotany, and health behavior in families. Prominent themes in her research are the cultural shaping of health and medicine (risks and treatment); cultural influence on individuals' contact with plants and animals; and, the effects of human–plant or human–animal interactions on health and medicine. She has worked in North and South America, East Africa, and has especially worked in the Caribbean country of Dominica since 1993. She also conducts cross-cultural ethnology on topics related to her fieldwork-based research.

Gilbert Quintero is Professor in the School of Public and Community Health Sciences at the University of Montana. His research foci include examination of sociocultural aspects of drug use in several different populations in the United States, including American Indians, Hispanics, and young adult college students. His current interests include the integration of information and communication technologies into social interactions and drug-use practices among young adults in collegiate environments and the nonmedical use of pharmaceuticals.

Nancy Romero-Daza is Professor in the Department of Anthropology at the University of South Florida. As a medical anthropologist she has extensive experience conducting community-based research, designing and evaluating health-related interventions, and overseeing the delivery of social services to diverse populations. She has conducted research and program evaluation on HIV/AIDS, harm reduction, drug use, chronic disease management, food security, and health of minority populations. Other areas of interest include sexual and reproductive health and ethics of research. She has worked in the United States, Puerto Rico, Haiti, Costa Rica, and Lesotho.

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Eleanor Shoreman-Ouimet is Assistant Professor of Human and Environment Interactions at the University of Connecticut whose research and teaching focuses on human–environment interactions, environmental justice, cross-cultural conservation practices, community response to natural hazards and the effects of climate change, and the links between culture, history, environmental ethics, and resource management. Shoreman-Ouimet's recent publications have addressed anthropological approaches to the study of environmental repair, the influence of anthropocentrism in the social sciences, and facilitating cooperative efforts between anthropologists and conservation groups. In addition to teaching and researching

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Sandy Smith-Nonini, PhD, is a research assistant professor of Anthropology at the University of North Carolina at Chapel Hill. Her work has focused on the intersection of medical anthropology and political economy – including projects on health systems, resurgent infectious disease epidemics, working conditions of US migrant labor, and the relationship of oil dependence and debt to energy poverty. She authored Healing the Body Politic: El Salvador's Popular Struggle for Health Rights – From Civil War to Neoliberal Peace, (Rutgers University Press, 2010), aided by a Richard Carley Hunt Award from the Wenner Gren Foundation. Sandy recently produced *Dis.em.POWER.ed: Puerto Rico's Perfect Storm*, a film on the "fossil colonial" origins of the longest US blackout: www.disempoweredfilm.com.

Merrill Singer is Emeritus Professor of Anthropology at the University of Connecticut. Dr. Singer's work has focused on infectious disease (including COVID-19), syndemics, and environmental health. He is the author of 34 books, and over 220 peer-reviewed articles. Social justice, the social determinants of health, climate change, and critical medical anthropology have been enduring themes of his research and applied work. His most recent books are titled *Climate Change and Social Inequality: The Health and Social Costs of Global Warming* (Routledge, 2018) and *EcoCrises Interaction: Human Health and the Changing Environment* (Wiley, 2021).

Elisa (E. J.) Sobo is Professor and Chair of Anthropology at San Diego State University. Recent projects concern the intersection between health and education, vaccination choice, cannabis use for children with intractable epilepsy, and conspiratorial thinking. Sobo is currently part of the CommuniVax coalition, a nationwide participatory action research initiative focused on community-based capacity building for an equitable and effective COVID-19 vaccination rollout. Past president of the Society for Medical Anthropology, and current Section Assembly Convener for the American Anthropological Association, Sobo has published numerous peer-reviewed journal articles and has authored, coauthored, and coedited 13 books—including second editions of both *Dynamics of Human Biocultural Diversity: A Unified Approach* and *The Cultural Context of Health, Illness, and Medicine*. Her work has been featured on NPR's *All Things Considered* and by *The New York Times*, *The Washington Post*, and other news outlets.

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Robert T. Trotter, II, began publishing applied oriented cross-cultural research in the fields of culturally competent health-care delivery and culturally sensitive approaches to substance use and misuse and in the Lower Rio Grande Valley of Texas in 1976, based on

research on culturally influenced communication on patient interactions and substance abuse prevention processes (including information from traditional healers on the US Mexico border), as well as cross-cultural comparisons of alcohol use among Hispanic and Anglo college students. In the 1980s his research focus included institutionally oriented research on migrant health and cross-cultural health-care systems, and in the 1990s evolved into research on the confluence of substance abuse and the pandemic spread of HIV, with a focus on prevention research in a multicultural context, including a special focus on social structure, social determinants of health, and cultural applicability design for institutional change, including institutional change in corporate cultures. Subsequent research, in the 2000s to present, has focused on both domestic and international research associated with NIH, the Surgeon General's office (RARE: Rapid Assessment, Response and Evaluation), CDC (I-RARE), and WHO (International Classification of Disabilities). Dr. Trotter's current applied research includes prevention and intervention–oriented research focused on the confluence of criminal justice conditions, converging comorbidities, and substance abuse, and on the interaction of the social determinants of health and infectious disease transmission (including sociocultural approaches combined with cutting-edge genomic studies), in both general populations and in institutional (hospital) populations. Dr. Trotter's applied oriented research includes involvement as P.I. on NIH RO1s, U01s, T-32s, as well as other roles (Co-PI, mPI, Investigator, Evaluator) on NIH U54s, R01s, U01s, as well as funding for CDC and WHO projects. Dr. Trotter has served as an ad hoc and regular member of NIH study sections for NIDA, NIMHD, NIMH, and CDC. Dr. Trotter currently serves as Lead Core Director for the Research Infrastructure Core (RIC) for the NAU Southwest Health Equities Research Collaborative (SHERC) (NIMHD U54MD012388), as well as a Senior Scientist for the NAU Center for Health Equity Research (CHER). Both roles are focused on mentoring early career investigators in relation to both qualitative and quantitative methods, technology, and research design.

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water-related diseases. Dr. Whiteford's research has been funded by the National Science Foundation, and she consults for the World Bank and The US Agency for International Development. Significant publications include *Primary Health Care in Cuba: The Other Revolution*; *Anthropological Ethics for Research and Practice*; *Globalization, Water and Health: Resources in Times of Scarcity*; and *Global Health in Times of Violence*.

Introduction

Merrill Singer, Pamela I. Erickson, and César Abadía-Barrero

Medical Anthropology is a "baby boomer" of sorts. It came into being alongside the unprecedented interest in the health and wellbeing of Third World peoples in the aftermath of WWII when the world was full of the hope and possibility that science, in this case biomedicine, could alleviate human suffering due to infectious disease and malnutrition, and then help eliminate or control many of the world's major health problems. Many anthropologists of that era worked with the international health community (WHO, USAID, UNICEF, etc.) to bring biomedicine to the world. The presumption guiding this effort was that shown the effectiveness of biomedicine and modern public health methods (e.g., the health value of boiling water before drinking it), while addressing contextual and cultural barriers to change, people would readily adopt new ways and the threat of many diseases would begin to diminish. Seven decades later, a large proportion of the morbidity and mortality in our world is still due to the same tenacious problems of malnutrition, pregnancy-related complications, infectious diseases, and lack of access to high-quality health care. Although some of the diseases, like HIV/AIDS, are new, one old disease but only one, smallpox, has been eliminated. With economic development, the so-called Third World was re-branded in terms of the size of each country's economy as low- or middle-income countries. With more "development," these countries started to experience a mixed epidemiologic profile: "diseases of poverty," on the one hand (Farmer 2003), and chronic conditions such as cancer, diabetes, and cardiovascular disease, on the other. The raising awareness of the world interconnectedness demonstrated how health profiles depended on key social determinants of global health such as living and working conditions; level of education; neighborhood characteristics; and access to water, sanitation, and health care services which are exacerbated by escalating levels of poverty, inequalities, war, genocide, and greed (Singer and Erickson 2013).

A Companion to Medical Anthropology, Second Edition. Edited by Merrill Singer, Pamela I. Erickson, and César E. Abadía-Barrero.

The political economic systems that have resulted from unconstrained capitalism and global free market policies married to a scientific positivism whose advocates thought they would save the world have become systems of structural violence (Galtung 1969) that are especially damaging to the poor and marginalized peoples of the planet. As Farmer (2003:1) indicates, structural violence refers to "a host of offenses against human dignity [including]: extreme and relative poverty, social inequalities ranging from racism to gender inequality, and the more spectacular forms of violence that are uncontested human rights abuses…." Medical anthropologists waver between people-centered approaches that include individual experiences and collective realities of lived marginalization and "social suffering" (Biehl and Petryna 2013; Kleinman et al. 1997), and infrastructures of violence, historical trauma, and systems of oppression. As Langer (1996:53) asserts, "We need a special kind of portraiture [and a special language] to sketch the anguish of people who have no agency in their fate because their enemy is not a discernible antagonist, but a ruthless racial ideology, an uncontrollable virus, or, more recently, a shell from a distant hillside exploding amid unsuspecting victims in a hospital or market square."

If this were not enough, health problems have become more severe and widespread due to globalization (e.g. with the alteration of food supplies or migrants facing a range of aggressions in the host countries) (Castañeda 2019; Horton 2016; Perro and Adams 2017) global warming (with higher rates of heat stroke and other heat-related problems) (Baer and Singer 2018, Singer 2019), and environmental restructuring and degradation (with more pollutants and chemicals in the air, soil, water, and everyday use items), all of which interface with each other to effect syndemics (Singer 2009a), ecosyndemics (Singer 2009b), and ecocrises interactions (Baer and Singer 2018; Singer 2009c, 2010, 2019, 2021). Indeed, at least in the United States, life expectancy is declining and, at the same time, a myriad of mental health problems, metabolic and immune conditions, drug overdose, and gun violence are reaching "epidemic" proportions and affecting younger and younger generations (Perro and Adams 2017). We are in a situation in which health improvements and innovations coexist with longstanding inequalities and even worsening health indicators. The ever increasing costs of care given the for-profit characteristics of the pharmaceutical, biotechnology, and health delivery industries continue with minimal national or global regulations (Sunder Rajan 2017). The push for insurance-based privatization policies has been globally enforced in the Sustainable Development Goals as "Universal Health Coverage" (Abadía-Barrero and Bugbee 2019). As health care financing and metrics take over health decisions (Adams 2016; Metzl and Kirkland 2010; Mol 2008; Mulligan 2014), the most fundamental health care interventions, such as child and maternal health or immunizations, continue to receive funding and health technologies in the form of vertical programs, adding to the historical disregard of comprehensive primary health care and inter-sectorial approaches. Within this scenario, medical anthropologists are effectively conducting research that bridges the local with the global to ask questions such as why certain indicators and not others count in global health? whose agenda is considered more important behind national and global decisions? what sets of problems, contradictions, and obfuscations are evident as people are funded to improve certain indicators but are required to disregard other health frameworks that they might deem as important? how are power, bureaucracy, technologies and health delivery interconnected and how these shape the experiences of patients and health care personnel? how are diseases shaped and changed historically, biologically, politically and socioculturally? By asking such questions, medical anthropology's biocultural approach opens dialogues and debates with public policy,

clinical medicine, political economy, public health, and health care systems and management, among other fields of research and intervention.

It is estimated 700,000 people died from AIDS-related illnesses in 2020, most of them in developing countries. Over 4 million people have died of COVID-19 and over 3 million more died from tuberculosis and malaria. Infectious disease accounts for about 29% of under-age-five child deaths in developing countries, and malnutrition plays a role in about half of these deaths (WHO 2005). When these diseases interact – HIV, for example, interacts adversely with tuberculosis, malaria, and malnutrition (Abu-Raddad et al. 2006; Gandy and Zumla 2003; Gillespie and Kadiyala 2005; Herrero et al. 2007) – the consequences are multiplied exponentially. Moreover, maternal mortality takes one in 74 women each year away from their families (World Health Organization 2004). Syndemic infection during pregnancy adds a significant additional level of risk to what is already a risky situation for most women in the Third World (Ayisi et al. 2003). Other less attended to and "neglected diseases" kill millions more people each year 2008. Sometimes called tropical diseases, they are, as Nichter (2008:151) stresses, "diseases of poverty, development, and political ecology – not climatic happenstance." Notably, they, too, tend to occur in overlapping geographic zones and to involve polyparasitism or other comorbidities and harmful disease interactions (Hotez et al. 2006). COVID-19 also interacts synergistically with various non-communicable diseases or conditions—including diabetes, obesity, severe asthma, respiratory, and cardiovascular diseases—with serious health consequences.

As Nichter's comment suggests, our world is one of great health disparities and inequalities in health status, access, and treatment that closely mirror social disparities and prevailing structures of non-egalitarian social relationship. Because health is the foundation of civil society, it has tremendous impact on political stability. The heightened anxiety surrounding the 2003 SARS, 2009 "swine flu" (H1N1 influenza), and our current 2020–2021 COVID-19 pandemic scares represented global expressions of a fragile perceived susceptibility in our new and dangerous twenty-first century world. While certainly there are areas in which health has improved, such as access to clean water in some locales, improvements in sanitation in many places, and progress in antenatal care, all of which are reflected in declining rates of child mortality, as the World Health Organization (2008:6) observes, the progress that has been made in health in recent years has been deeply unequal, with convergence toward improved health in a large part of the world, but at the same time, with a considerable number of countries increasingly lagging behind or losing ground. Furthermore, there is now ample documentation of considerable and often growing health inequalities within countries.

From its beginning medical anthropology was defined as "…the cross-cultural study of medical systems and … the bioecological and sociocultural factors that influence the incidence of health and disease now and throughout human history" (Foster and Anderson 1978:1). Thus, it has long had a broad mandate to understand and interpret human beings – their behavior, their diseases and illnesses, their medical systems and the place of each of these in the encompassing sociocultural system (Erickson 2003). Medical anthropology was professionalized as a subfield within the discipline in the 1960s. At 60 years of age, it has a history of both venerated founders (George Foster, Cecil Helman, Arthur Kleinman, Charles Leslie, Hazel Weidman, Charles Hughes, Benjamin Paul, Pertti and Gretel Pelto, Arthur Rubel, among many others) and contested theoretical paradigms that have followed broader theoretical shifts in the discipline. There are now a range of medical anthropology

journals and programs around the world, some hosted within anthropology departments, and others in interdisciplinary fields, such as global health.

Academic medical anthropology in the twenty-first century encompasses the domains of individual experience, discourse, knowledge, practice, and meaning; the social, political, and economic relations of health and illness; the nature of interactions between biology and culture; the ecology of health and illness; the cross-cultural study of ethnomedical systems and healing practices; and the interpretation of human suffering and health concerns in space and time (Baer et al. 2003; Erickson 2008; Joralemon 1999; Lock and Scheper-Hughes 1996; McElroy and Townsend 2009; Nichter 1992; Sargent and Johnson 1996; Scheper-Hughes and Lock 1987; Singer and Baer 2007). Applied medical anthropology takes on the responsibility of making research useful for clinical or health educational applications, for influencing health policy, or for effecting social justice (Erickson 2003; Rylko-Bauer et al. 2006; Singer and Baer 2007), continuing the founding theme of bettering the public health. Despite our different interests, "our great strength is our diversity of theory and method, our holistic approach, our willingness to cross disciplinary boundaries, and our insistence on social justice" (Erickson 2003:4).

Companion to Medical Anthropology is meant not to serve as a full history of the subdiscipline (although many components of the field's history are discussed), or as an encyclopedia (although essays on many key topics are included), nor as an annual review of medical anthropology. Rather, we have identified scholars who we believe have something important to say about some of the major topics and themes in medical anthropology. For this second edition, we asked authors, some from the first edition and some new, to write an original or significantly updated chapter that addresses current issues, controversies, and state of the field for their particular area of expertise from their own perspectives, and to hypothesize about the future trends and directions in their areas of expertise: where we are, what the major and emerging issues currently appear to be, and what might lie ahead.

The book is designed to address students, scholars, and practitioners alike. Unavoidably, there are many more thematic and topical areas than could be included in this volume. Thus, Companion is not exhaustive and was not meant to be. We believe, however, that what you find in these pages will engage your interest, passion, and commitment to ensure that medical anthropology continues to matter in a world of enormous health challenges.

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PART I Theories, Applications, and Methods

CHAPTER 1

Re/inventing Medical Anthropology: Definitional Struggles and Key Debates (Or: Answering the *Cri Du Coeur*)

Elisa J. Sobo

Introduction

The distinct subfield called "medical anthropology" emerged in the 1970s as the outcome of many lines of intertwined inquiry. Interest in diverse health practices and understandings goes back centuries, pre-dating anthropology's establishment as an academic discipline. However, after World War II, a notable subset within the field began to consider health a topic worthy of focused specialization. Anglophone anthropology's participation in post-World War II international and public health efforts fueled this impulse: Data collected in earlier times for simple descriptive purposes proved invaluable as these scholars worked to help said health programs succeed. That is, medical anthropology's concretized emergence was driven by ethnology's newly valuable, directly "technical" (Scotch 1963) relevance. Indeed, the first review of the nascent field, William Caudill's "Applied Anthropology in Medicine" (1953), emphasized its practical utility.

The shorter phrase "medical anthropology" seems first to have been used by P.T. Regester (1956) and then by Khwaja Hasan and B.G. Prasad (1959), while an article by James Roney carried the phrase in its title (1959). But what did this label describe? What tensions did it encompass? Did these tensions exhibit different characteristics in different global settings?

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Building on previous historical reviews (including Anderson 2018; Browner 1997; Claudill 1953; Colson and Selby 1974; Fabrega 1971; Foster 1974; Foster and Anderson 1978; Good 1994; Hasan 1975; Lock and Nichter 2002; McElroy 1986; Polgar 1962; Scotch 1963; Sobo 2004; Todd and Ruffini 1979; Weidman 1986), I examine medical anthology's rise as a named subfield. This process unfolded initially in the USA, where the great majority of medical anthropologists were, and still are, concentrated. However, anthropology is an international discipline: The subfield's emergence depended on inputs from anthropologists of a variety of nationalities, as well as from related disciplines. Global variation and concerns that emerged as the subdiscipline matured also are key to the story. To foreshadow: In medical anthropology's early days as a distinct subfield, debate centered on the applied–theoretical divide, the generalist–specialist distinction, and the contrast between physical (now "biological") and cultural perspectives. Later developments related to the evolving definition of culture, the influence of various instantiations of critical theory, the role of extra-disciplinary interaction, and concern for social justice and for decolonizing the field.

Medical Anthropology Takes Shape

Application or Theory?

When medical anthropology coalesced in the 1960s, it was as a "practice discipline" (Good 1994, p. 4) dedicated to the service of improving public health in economically poor nations. Indeed, initial effort at organizing a medical anthropology interest group in the USA – diligently fostered by Hazel Weidman – resulted in a 1968 invitation from the Society for Applied Anthropology (SfAA) to affiliate (Weidman 1986). The fledgling community, then called the Group for Medical Anthropology (GMA), accepted this invitation as a practical solution to the challenges of maintaining cohesion, but it was "something of an embarrassment" to many (Good 1994, p. 4). Even George Foster, a key founding figure, reported having to work through ambivalences: "We were trained to despise applied anthropology" (Foster 2000, quoted in Kemper 2006).

As Scotch reported, at the time many felt that because of its practical bent "the quality of literature in [medical anthropology] is not always impressive… It is superficial, impressionistic, and nontheoretical" (1963, p. 32): wholly *infra dig*. Some felt that its practitioners were "less rigorous than their more traditional-minded contemporaries" (p. 33) and denigrated them as mere "technicians" (p. 42). In the UK, this stigma was worse (Kaufert and Kaufert 1978): a British Medical Anthropology Society did form in 1976, but it served mostly medical doctors (Dingwall 1980).

Generalists or Specialists?

Anthropologists who did consider assembling worried whether formally organizing as medical anthropologists would reinforce an "artificial area of study"; in support of this claim some pointed to "the lack of systematic growth and the failure to produce a body of theory" (Scotch 1963). Some feared that formal organizing might "prove detrimental to the development of theory in anthropology" as it would force the fragmentation of the field (Browner 1997, p. 62), a growing concern at that time.

The American Anthropological Association (AAA) was itself then in "organizational disarray," according to the Committee on Organization, which noted that while anthropologists in general desired to "retain an integrated professional identity" the profession also

faced strong "fissiparous tendencies" (*Anthropology Newsletter* 9[7], as cited in Weidman 1986, p. 116). Some US medical anthropologists felt, accordingly, that simply maintaining a newsletter would be better than assembling as if a faction (Weidman 1986, p. 119). Alan Harwood was one who had, in the late 1960s, tried to put his "finger in the dike… of specialization" (Harwood 2019). Although Harwood eventually came round, taking over the editorship of the group's renamed newsletter in 1985 when it finally became the journal *Medical Anthropology Quarterly*, others held out. Arthur Rubel, for instance, "would not be pigeonholed as a medical anthropologist [ever]… for he always saw health/medical phenomena as human behavior to be understood as anthropologists understood other forms of human behavior" (Cancian et al. 2001).

An Uneasy Resolution

Partially to better demonstrate ties to the parent discipline the GMA continued to push the AAA (which at that time did not have "sections") to create a mechanism for its affiliation with AAA as a subgroup. Eventually, largely due to the GMA's own organizing efforts, this came to pass (see Weidman 1986, pp. 121, 124): the group adopted a "constitution" in 1970, incorporated, and in 1972 became an official AAA "affiliate" (Society for Medical Anthropology 1975). This move firmly anchored the group – now the Society for Medical Anthropology (SMA) – within academic anthropology, although many members remained SfAA members also. Additionally, partly because anthropologists eschewing applied work tended not to join SMA née GMA (cf. Good 1994, p. 4), the influence of applied perspectives remained strong. Many SMA members were employed in schools of medicine, nursing, or public health or in the international and public health fields. The authority of biomedical clinical culture, where curative work and saving lives takes precedence, was manifest (Singer 1992a).

To counter accusations of over-specialization, a statement issued by the SMA in 1981 defining medical anthropology asserted unambiguously: "Medical anthropology is not a discipline separate from anthropology" (Society for Medical Anthropology 1981, p. 8). This did not offset objections related to the narrow technical definition of the term "medical," noted, for instance, at the GMA's 1968 organizational meeting. Not only did "medical" leave out nurses and members of the allied health professions; it suggested (and still does) a biomedical gold standard. Other concerns have been the implied focus on pathology and the implicit devaluation of interpretive ethnographic methods.

Nursing theorist Madeline Leininger suggested instead "health anthropology" – which an increasing number prefer today as well (e.g., Baer et al. 2016), perhaps most commonly in Europe, where the preference has deep roots (Hsu 2012). The appellation is perhaps least commonly heard in the Global South, where medical utility often is emphasized (Mishra 2007). At the 1968 meeting, however, although the proposal to rebrand instigated "lively discussion" it did not triumph (Weidman 1986, p. 119).

Cultural Interests Assume the Lead

For better or worse, the subfield moved forward as "medical anthropology." This was accompanied by a number of "What is Medical Anthropology?" essays. Howard Stein in 1980 recognized this "*cri du coeur* […as] a recurrent, quasi-ritualized annual event" (p. 18). While in its initial phase, generalist–specialist and applied–theoretical tensions had prominence, now the tension between cultural and biological priorities took precedence.