MACQUARIE UNIVERSITY

ANTH 735 & 832: Global Health

Unit Guide

Semester 2, 2016

Faculty of Arts

Department of Anthropology

Unit Guide

Department of Anthropology
ANTH735 & 832: Global Health

Students in this unit should read this Unit Guide carefully. Although the unit convenor reserves the right to make minor alterations during the course of the semester, most essential information for this unit is in this guide. Please contact the convenor if you have any questions.

TEACHING STAFF

Unit convenor

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SEMINARS

Time: Wednesdays 6-8pm

Location: W6A, Room 708 (Anthropology Meeting Room)

Seminar Structure: The convener will first introduce concepts, provide background information or examples, or offer an overview of the key issues under discussion. The remainder of the seminar will be devoted to discussing the issues and readings.

Attendance: Seminar attendance and participation is compulsory. Students who miss more than one seminar without an authorized/approved excuse will risk receiving a lower mark or failing the unit. Attendance is vital.

UNIT DESCRIPTION

Global Health recognizes a holistic understanding of health that transcends borders and encompasses the links and transnational movements of people, materials and ideas. This seminar offers a framework for understanding the complex ways health and disease intersect within a range of global contexts, institutions and practices. The health challenges and quality of life within and between communities and nations are unequal. While gains have been made in global health over the past decades, the gap reflected in health and heath care disparities remains significant and, in some regions, is increasing. In order to affect change at the individual, community and global levels, we need to appreciate how human biology and health are shaped by the larger contexts in which they are embedded and the dynamic and uneven circulation of resources, technology, culture, values and people. In this class, we will examine the role of social, political-economic and environmental forces that shape patterns and the distribution of disease and health across communities and take a critical perspective when examining the underlying value systems in biomedical science, policy, health interventions, and global health practice.

Unit Learning Outcomes:
1. Synthesize the common anthropological, epidemiological, historical, policy, and political-economic approaches to major global health problems.

2. Discuss and evaluate the major issues confronting global health, including their trends, determinants, and effect on individuals and populations

3. Describe the global burden of disease, emerging global health problems, the causes and control of epidemics, and communicable and non-communicable diseases at the global level.

4. Identify the role of poverty, inequality, and structural violence in global health contexts and how health can be distributed unequally within and between populations.

5. Describe the particular health needs of vulnerable populations

6. Identify and evaluate the complex role and impact of policy, global institutions, non-governmental organizations, and major funders in global health.

Macquarie Learning Outcomes

All academic programmes at Macquarie seek to develop graduate capabilities. These are:

COGNITIVE CAPABILITIES

1. Discipline Specific Knowledge and Skills

Our graduates will take with them the intellectual development, depth and breadth of knowledge, scholarly understanding, and specific subject content in their chosen fields to make them competent and confident in their subject or profession. They will be able to demonstrate, where relevant, professional technical competence and meet professional standards. They will be able to articulate the structure of knowledge of their discipline, be able to adapt discipline-specific knowledge to novel situations, and be able to contribute from their discipline to inter-disciplinary solutions to problems.

2. Critical, Analytical and Integrative Thinking

We want our graduates to be capable of reasoning, questioning and analysing, and to integrate and synthesise learning and knowledge from a range of sources and environments; to be able to critique constraints, assumptions and limitations; to be able to think independently and systemically in relation to scholarly activity, in the workplace, and in the world. We want them to have a level of scientific and information technology literacy.

3. Problem Solving and Research Capability

Our graduates should be capable of researching; of analysing, and interpreting and assessing data and information in various forms; of drawing connections across fields of knowledge; and they should be able to relate their knowledge to complex situations at work or in the world, in order to diagnose and solve problems. We want them to have the confidence to take the initiative in doing so, within an awareness of their own limitations.

4. Creative and Innovative

Our graduates will also be capable of creative thinking and of creating knowledge. They will be imaginative and open to experience and capable of innovation at work and in the community. We want them to be engaged in applying their critical, creative thinking.

INTERPERSONAL OR SOCIAL CAPABILITIES

5. Effective Communication

We want to develop in our students the ability to communicate and convey their views in forms effective with different audiences. We want our graduates to take with them the capability to read, listen, question, gather and evaluate information resources in a variety of formats, assess, write clearly, speak effectively, and to use visual communication and communication technologies as appropriate.

6. Engaged and Ethical Local and Global citizens

As local citizens our graduates will be aware of indigenous perspectives and of the nation's historical context. They will be engaged with the challenges of contemporary society and with knowledge and ideas. We want our graduates to have respect for diversity, to be open-minded, sensitive to others and inclusive, and to be open to other cultures and perspectives: they should have a level of cultural literacy. Our graduates should be aware of disadvantage and social justice, and be willing to participate to help create a wiser and better society.

7. Socially and Environmentally Active and Responsible

We want our graduates to be aware of and have respect for self and others; to be able to work with others as a leader and a team player; to have a sense of connectedness with others and country; and to have a sense of mutual obligation. Our graduates should be informed and active participants in moving society towards sustainability.

PERSONAL CAPABILITIES

8. Capable of Professional and Personal Judgment and Initiative

We want our graduates to have emotional intelligence and sound interpersonal skills and to demonstrate discernment and common sense in their professional and personal judgement. They will exercise initiative as needed. They will be capable of risk assessment, and be able to handle ambiguity and complexity, enabling them to be adaptable in diverse and changing environments.

9. Commitment to Continuous Learning

Our graduates will have enquiring minds and a literate curiosity which will lead them to pursue knowledge for its own sake. They will continue to pursue learning in their careers and as they participate in the world. They will be capable of reflecting on their experiences and relationships with others and the environment, learning from them, and growing - personally, professionally and socially.

UNIT REQUIREMENTS AND EXPECTATIONS

Assessments at a glance

Task	Weight (%)	Due Date	Brief Description
Participation, Engagement, & Seminar Leadership	25	On-going	Active attendance and engagement with discussions. Leadership of one seminar discussion.
Essay Exam 1	20	Week 8	A take-home essay exam with pre-set questions that cover the key concepts from first half of the semester.
Essay Exam 2	20	Exam Week	A take-home essay exam with pre-set questions that cover the key concepts from second half of the semester.
Final Paper	35	Week 13	A final paper with a 10-15 minute class presentation.

REQUIRED TEXT

All required readings will be available electronically on iLearn. There is no reader.

ASSESSMENT TASKS

1: Seminar Participation, Engagement, and Seminar Leadership

Weight: Participation 10%
Seminar Facilitation 15%

Due: Weekly

Details: Seminar attendance and participation are mandatory. ***Students are expected to be active participants and demonstrate that they have actively engaged the readings and material presented***. Participation also means contributing to a general atmosphere of scholarly enquiry, showing respect for the opinions of others. If you don't understand or agree with something someone says, ask them to clarify, or explain respectfully why you

disagree. Everyone should feel free to speak up. Please do not drown out quieter voices. If you are having trouble speaking up in class discussion, please come to speak with the course convenor and together we can strategize ways to facilitate your contribution.

An appropriate strategy would be to prepare summaries of sub-themes that you find especially compelling for each reading, and raise specific questions to clarify some aspect of those readings.

You are permitted to miss one seminar without an excuse. Do not submit a disruption of study request unless you have already used your one free absence. If you miss more than three seminars without a disruption of study (see Student Handbook) we will lower your mark. Attendance is vital. Remember that an essay question could be based on the week that you missed. For every unexcused absence beyond three, you will receive a 10% reduction in your final grade (4 absences = 10% reduction, 5 absences = 20% reduction, etc.). If you miss six or more seminars, you will fail.

Students will **lead one seminar** (either alone or in pairs) this semester. Seminar leadership entails facilitating a discussion centred on the issues and themes present in the readings. Additional relevant information, theories, or ideas related to the theme can also be presented to unpack or enhance the value of the readings and discussion. Do not prepare a lecture; rather, offer an engaging set of questions and relevant case studies or examples to discuss. The weekly descriptions below discuss the themes and offer questions to guide your efforts.

2: Essay Exam One
Weight: 20%

Due: Sunday, 2 October at 11:59

Details: Students will complete a set of short essays that cover the key concepts within the readings, lectures, and discussions from the first half of the semester. Success in this assignment necessitates seminar attendance, taking careful notes, and completing the readings. The questions will be provided well in advance of the deadline. Submit via Turnitin. More details will be provided later in the semester.

3: Essay Exam Two
Weight: 20%

Due: Monday, 21 November at 11:59pm

Details: Students will complete a set of short essays that cover the key concepts within the readings, lectures, and discussions from the second half of the semester. The structure and format will be similar to the first essay exam. Submit via Turnitin.

4: Essay: Global Health Issue
Weight: 35%

Due: Monday, 14 November at 11:59pm

Details: Select a global health problem of interest to you and write a review and analysis of the health problem. In your paper, include the following components:

1) A description of the health problem and people's experiences of it. Define the problem and consider the experience or "face" of the patient with the problem.

2) An introduction to the epidemiology of the health problem and/or why this is a significant global health issue. What are the causes of the problem? How have people studied or learned about the causes of the problem? What gaps exist in our knowledge of and prevention and treatment approaches to the problem?

3) A description of the approaches to the problem (policy, public/global health and anthropological). What are the ways in which such studies have led to increased understanding of the problem, or ways in which anthropologists and global health professionals/researchers have helped to improve public health education or interventions?

4) A critical evaluation of the historical or contemporary interventions and efforts; essentially, an evaluation of why some programs did not work or a critique of the assumptions enmeshed within programs. What programs are effective in preventing the problem? What types of interventions have been done to learn what works? What are the challenges and opportunities for closing the gap between science and practice? What ethical, social, or political issues exist?

5) A concluding section that suggests future directions for anthropologists, global health, and/or public health practitioners in addressing the problem at hand.

You are limited to ~3,000 words. Finally, you will offer a 10-15 minute presentation and discussion of your work in week 13. MRes students will be expected to attain a higher level of sophistication in their research and writing.

Global Health Topics Include (this is an indicative guide; variations are possible):

Abortion
Acute Respiratory Infections (ARI)
Breastfeeding
Cancers
Child Mortality
Cholera
Circumcision (Female and Male)
Community Health Workers
Community Health Promotion
Contraception/FP (many aspects of)
Diabetes
Diarrhea and ORT
Disease Control and Moral Regulation
Ethnomedicine and Traditional Healers
Family Planning and Birth Control
Gender Inequalities and Health/Care
Gender and Sexuality as Risk Variables
Guinea Worm
HIV/AIDS (many aspects of)
Household Production of Health
Immunization
Infant Care Practices and Infant Mortality
Infertility and New Reproductive Technologies
Malaria and Bednets
Maternal Morbidity and Mortality
Mental Health (many aspects of)
Nutrition and Malnutrition (many aspects of)
Pharmaceuticals
Pregnancy and Prenatal Screening
Prenatal Sex Selection and Feticide/Infanticide
Primary Health Care (many aspects of)
Schistosomiasis or other parasitic diseases
Sexually Transmitted Diseases
Smoking and Tobacco Use
Tuberculosis
War, Political Violence, and Refugee Health

UNIVERSITY POLICY ON GRADING

University Grading Policy
http://www.mq.edu.au/policy/docs/grading/policy.html

The grade a student receives will signify their overall performance in meeting the learning outcomes of a unit of study. Grades will not be awarded by reference to the achievement of other students nor allocated to fit a predetermined distribution. In determining a grade, due weight will be given to the learning outcomes and level of a unit (ie 100, 200, 300, 800 etc). Graded units will use the following grades:

HD	High Distinction	85-100
D	Distinction	75-84
Cr	Credit	65-74
P	Pass	50-64
F	Fail	0-49

Extensions, Penalties, and Special Consideration

Late submissions on any assignment will incur a penalty, unless the unit convenor has granted an extension due to certificated medical problems or to "unavoidable disruption" (see Undergraduate Student Handbook).

Exceeding the word limit
You will be deducted 1 percentage point for each 20 words you exceed the word limit. Please take the word limit very seriously and try to make your argument concisely and clearly. It is unfair to fellow students if one person has much more space to argue their case while another student sticks firmly to the length guidelines. The word limit is designed to level the essay-writing field, so to speak. You must provide a word count beneath the title when you submit your work. The word limit excludes end-of-text references but it includes footnotes and in-text citations.

No consideration for lost work
It is the student's responsibility to keep a copy (electronic or otherwise) of all written work submitted for each unit. No consideration will be given to claims of 'lost work', no matter what the circumstances.

Returning assignments
Student work will usually be marked and returned within two to three weeks of receipt. Students who hand their work in *before* the due date will not have it returned early.

Extensions and disruption of studies:
The University recognises that at times an event or set of circumstances may occur that:

- Could not have reasonably been anticipated, avoided or guarded against by the student
- AND
- Was beyond the student's control AND
- Caused substantial disruption to the student's capacity for effective study and/or

completion of required work AND
- Substantially interfered with the otherwise satisfactory fulfilment of unit or program requirements AND
- Was of at least three (3) consecutive days duration within a study period and/or prevented completion of a formal examination.

In such circumstances, students may apply for a Disruption of Studies. Disruption of Studies applications must be supported by evidence to demonstrate the severity of the circumstance(s) and that substantial disruption has been caused to the student's capacity for effective study.

Disruption of Studies applications must include specific details of how the unavoidable disruption affected previously satisfactory work by the student. The University has determined that some circumstances routinely encountered by students are not acceptable grounds for claiming Disruption of Studies. These grounds include, but are not limited, to:

- Routine demands of employment
- Routine family problems such as tension with or between parents, spouses, and other people closely involved with the student
- Difficulties adjusting to university life, to the self-discipline needed to study effectively, and the demands of academic work
- Stress or anxiety associated with examinations, required assignments or any aspect of academic work
- Routine need for financial support
- Routine demands of sport, clubs and social or extra-curricular activities

Conditions existing prior to commencing a unit of study are not grounds for Disruption of Studies. The student is responsible for managing their workload in light of any known or anticipated problems. The student is responsible for contacting Student Support Services if they have a chronic condition.

All Disruption to Studies notifications are to be made online via the University's Ask MQ system. The Student Enquiry Service will process your application and communicate it to your Unit Convenor.

For more information, see http://www.mq.edu.au/policy/docs/disruption_studies/policy.html

PLAGIARISM & ACADEMIC HONESTY

The University defines plagiarism in its rules: "Plagiarism involves using the work of another person and presenting it as one's own." Plagiarism is a serious breach of the University's rules and carries significant penalties. You must read the University's definition of plagiarism and its academic honesty policy. These can be found in the Handbook of Undergraduate studies or on the web at: http://www.mq.edu.au/policy/docs/academic_honesty/policy.html The policies and procedures explain what plagiarism is, how to avoid it, the procedures that will be taken in cases of suspected plagiarism, and the penalties if you are found guilty.

Please note that the availability of online materials has made plagiarism easier for students,

but it has also made discovery of plagiarism even easier for convenors of units. My best advice to you is to become familiar with the guidelines about plagiarism and then 'quarantine' the files that you are actually planning on turning in; that is, do *not* cut and paste materials directly into any work file that you plan to submit, because it is too easy to later on forget which is your original writing and which has come from other sources.
It's so easy to avoid plagiarism: all you have to do is make sure you (a) put in quotes any words taken from another source, and (b) scrupulously reference all quotes and all statements of fact. It is always better to cite than to use someone else's words without citation.

I use Turnitin to detect plagiarism and I take it very, very seriously. Plagiarism will result in a mark of zero for that assignment and, depending on the severity of the plagiarism, may result in failing the unit and/or referral to the University Discipline Committee.

Macquarie University students have a responsibility to be familiar with the **Student Code of Conduct**: https://students.mq.edu.au/support/student_conduct/

Academic honesty is an integral part of the core values and principles contained in the Macquarie University Ethics Statement: http://www.mq.edu.au/ethics/ethic-statement-final.html.

Its fundamental principle is that all staff and students act with integrity in the creation, development, application and use of ideas and information. This means that:

*All academic work claimed as original is the work of the author making the claim.
*All academic collaborations are acknowledged.
*Academic work is not falsified in any way
*When the ideas of others are used, these ideas are acknowledged appropriately.

The link below has more details about the policy, procedure and schedule of penalties that will apply to breaches of the Academic Honesty Policy which can be viewed at:
http://www.mq.edu.au/policy/docs/academic_honesty/policy.html

STUDENT SUPPORT SERVICES

Macquarie University provides a range of support services for students. For details, visit http://students.mq.edu.au/support/

Learning Skills
Learning Skills (http://mq.edu.au/learningskills) provides academic writing resources and study strategies to improve your marks and take control of your study. Services include Workshops; StudyWise; Academic Integrity Module for Students; Ask a Learning Adviser; and, Student Enquiry Service.

For all student enquiries, visit Student Connect at http://ask.mq.edu.au

Equity Support
Students with a disability are encouraged to contact the Disability Service who can provide appropriate help with any issues that arise during their studies.

IT Help
For help with University computer systems and technology, visit
http://informatics.mq.edu.au/help/

When using the University's IT, you must adhere to the Acceptable Use Policy. The policy applies to all who connect to the MQ network including students.

Results
Results shown in iLearn, or released directly by your Unit Convenor, are not confirmed as they are subject to final approval by the University. Once approved, final results will be sent to your student email address and will be made available in eStudent. For more information visit ask.mq.edu.au.

SEMINAR SCHEDULE AT A GLANCE AND KEY DATES

Week	Date	Seminar
1	3 Aug	Introduction: The Scope of Global Health
2	10 Aug	What We Know and How We Know It: Data, Theories, and Representations
3	17 Aug	Historical Emergence of Public Health: Sexualisation and Pathologisation of '3rd World'
4	24 Aug	Health For All? Values, Human Rights, and Health Care
5	31 Aug	Ethics, Clinical Trials, and the Pharmaceuticalization of Health
6	7 Sept	Healthcare Delivery, Systems, and Community Based Care
7	14 Sept	Maternal and Infant Health
8	5 Oct	Infectious Diseases
9	12 Oct	Tuberculosis and its Management
10	19 Oct	Chronic Diseases and the Locus of 'Responsibility'
11	26 Oct	Global Mental Health and the Challenges of Mental Illness
12	2 Nov	Global Politics of HIV Drug Treatment
13	9 Nov	Wrap-up and Student Presentations
		Exam Week

Seminar Readings and Outline

Please note that minor modifications to the readings might occur during the semester. Adequate warning will always precede these adjustments.

Week 1: 3 Aug

Introduction: The Scope of Global Health

Global health recognizes a holistic understanding of health that transcends borders and encompasses the links and transnational movements of people, materials, and ideas. Global health exists as a field of practice, research, and advocacy. The health challenges and quality of life within and between communities and nations are unequal. While gains have been made in global health over the past decades, the gap reflected in health and heath care disparities remains significant and, in some regions, is increasing. In this seminar, we will explore the scope and assumptions of global health. Why is global health becoming more popular? What is meant by the notion that global health is more of a collection of problems than a unified field of study? Since health solutions are context dependent, a goal of this seminar is to begin to develop the skills to think creatively about health problems and envision innovative ways of confronting health issues and identifying the benefits and consequences of interventions and their impact.

Required Readings

No required readings

References and Recommended Readings

Koplan, J., et al. (2009). "Towards a Common Definition of Global Health." The Lancet 373: 1993-95.

Cohen, J. (2006). "The New World of Global Health." Science 311(5758):162-167.

Biehl, J. and Petryna, A. (2013). "Critical Global Health." *In* When People Come First: Critical Studies in Global Health.

Feierman, S. and Kleinman, A. et al. (2010). "Anthropology, Knowledge-flows and Global Health." Global Public Health 5(2).

Janes, C. R. and Corbett, K. (2011). "Global Health." In *A Companion to Medical Anthropology*.

Adams, V., et al. (2014). "Slow Research: Thoughts for a Movement in Global Health." Medical Anthropology 33(3):179-197.

Week 2: 10 August

What We Know and How We Know It: Data, Theories, and Representations

A diverse range of data, theories, and interpretive frameworks inform the global health knowledge base. In this seminar, we will examine the common "ways of knowing" used by global health professionals. We will review a selection of the measures used to interpret the global burden of disease and further develop our toolkit for thinking about disease and health interventions. The gold standard in health care is the randomized controlled trial (RCT). RCTs and the rise of evidence-based medicine (EBM) is a result of a goal to create a stronger scientific foundation for clinical work and health interventions. What contributed to its rise? While yielding important health gains, EBM is

not perfect. What are some of the issues associated with EBM? In what ways does EBM (and, conversely, qualitative and ethnographic approaches) shape our research questions and interventions? In what ways has EBM and positivistic ways of knowing moved into other sectors such as NGO management? How best can measures of health, such as the DALY, be reconciled with local experience? Are there alternative ways to quantify and understanding morbidity and mortality? In the second half of the seminar, we will explore the social theories important in helping to explain why some global health initiatives succeed while others fail. Why is social theory important when talking about global health? How can social theories influence global health practice, and what are their limitations? How might one use the social theories we have learned to critique such a premium on evidence while still recognizing its value? Finally, we will emphasize the role that representations play in shaping health priorities and interventions. In preparing for this seminar, consider the theories or ways of framing issues that you are familiar with (such as the role of agency or social determinants of health) that can help better interpret global health efforts.

Required Readings

Hanna, B. and A. Kleinman. (2013). "Unpacking Global Health: Theory and Critique." *In* Reimagining Global Health: An Introduction. Pp: 15-32.

Adams, V. (2013) "Evidence-Based Global Public Health: Subjects, Profits, Erasures." *In* When People Come First: Critical Studies in Global Health. Pp. 54-90.

Murray, C. (2013). "Measuring the Global Burden of Disease." New England Journal of Medicine 369:448-57.

Birn, Anne-Emanuelle, Yogan Pillay, and Timothy H. Holtz. (2009). "What Do We Know, What Do We Need to Know, and Why it Matters: Data on Health." *In* Textbook of International Health: Global Health in a Dynamic World. Pp. 192-241.

Nichter, M. (2008). "Representations that Frame Health and Development Policy." *In* Global Health: Why Cultural Perceptions, Social Representations, and Biopolitics Matter. Pp: 107-118.

Recommended Readings

Kleinman, A. (2010). Four Theories for Global Health. Lancet 375:1518-1519.

Farmer, P. (2004). An Anthropology of Structural Violence. Current Anthropology 45(3), 305-325.

Stewart, K. A. (2010). Values and Moral Experience in Global Health: Bridging the Local and the Global. Global Public Health 5(2).

Benatar, S. R. et al. (2010). Values in Global Health Governance. Global Public Health 5(2).

Murray, C. (2013). Measuring the Global Burden of Disease. New England Journal of Medicine 369:448-57.

Meyrowitsch, D. W., et al. (2007). Global Burden of Disease: A Race Against Time. Danish Medical Bulletin 54(1):32.

McGahan, A. (2010). Economic Valuations in Global Health. Global Public Health 5(2).

Barrett, R., et al. (1998). Emerging and Re-emerging Infectious Diseases: The Third Epidemiologic Transition. Annual Review of Anthropology 27:247-271.

Week 3: 17 August
Historical Emergence of Public Health: Sexualisation and Pathologisation of "3rd World"

Global health emerged from 19th century trade and colonialism. Any exploration of global health would be incomplete without considering the history of health initiatives and the role of colonial legacies. As Green (2013) notes, the efforts to improve global health must navigate the historical wreckage of health programs (as well as the successes). Contemporary health interventions can learn a great deal from a critical examination of past programs and the consideration of the lingering effects of colonization. What has history taught us that we can apply to contemporary interventions? How did the medicalization of difference justify the colonial endeavour? As discussed in the Nichter reading last week, representations matter. How did the colonial representations of the other shape health interventions and the governance of colonized people? In what ways do the knowledge frameworks from colonial times persist? What can we learn if we applied similar critical forms of analysis to the assumptions behind contemporary representations of bodies, health, and illness in public health interventions? By examining the past, we can begin to see how global health must be understood as a product of on-going epidemiological, commercial, political, and technological change.

Required Readings

Greene, J. et al. (2013). "Colonial Medicine and Its Legacies." *In* Reimagining Global Health: An Introduction. Pp: 33-73.

Gilman, S. (1985). "Black Bodies, White Bodies: Towards and Iconography of Female Sexuality in Late 19th C Art, Medicine and Literature." Critical Inquiry 12(1): 204-242.

Comaroff, J. (1993). "The Diseased Heart of Africa: Medicine, Colonialism, and the Black Body." *In* Knowledge Power and Practice: The Anthropology of Medicine and Everyday Life. Pp: 305-329

Recommended Readings

Levine, P. (92000). "Orientalist Sociology and the Creation of Colonial Sexualities." Feminist Review 65.

Week 4: 24 August
Health For All? Values, Human Rights, and Healthcare

Is healthcare a human right? This week's readings begin with an overview of the past efforts and politics of global health efforts (1970s to 1990s). While leaders during this period made a commitment to healthcare for all people, the geopolitics and reality was far from their espoused values and vision. What political-economic forces played (and continue to play) a significant role in limiting healthcare for all? What role do neoliberalism and cost-effectiveness and other economic measures play in determining what forms of health

technology are available? Today, many people believe that health care is a basic human right; however, how can we put this ideal into practice? What types of care are essential and where do (or how do) international programs draw the line between essential and non-essential care? This seminar will engage the values and moral dimensions invoked in global health scholarship and decision-making. Each approach has is strengths and weaknesses (what are they?). What other moral frameworks or value systems could we consider? What do we gain by examining the moral frameworks that influence our work? Finally, what is Paul Farmer's position and recommendations on a human rights-based approach?

Required Readings

Basilico, M., et al. (2013). "Health for All? Competing Theories and Geopolitics." *In* Reimagining Global Health: An Introduction. Pp: 74-110.

Suri, A. et al. (2013). "Values and Global Health." *In* Reimagining Global Health: An Introduction. Pp: 245-286.

Farmer, P. (2010). "Rethinking Health and Human Rights: Time for a Paradigm Shift." *In* Partner to the Poor: A Paul Farmer Reader. Pp: 435-470.

Farmer, P (2010). "Making Human Rights Substantial." *In* Partner to the Poor: A Paul Farmer Reader. Pp: 545-559.

Recommended Readings

Boggio, A., et al. (2009). "Limitations on Human Rights: Are They Justifiable to Reduce the Burden of TB in the Era of MDR- and XDR-TB?" Health and Human Rights 10(2):121-126.

Amon, J., F. Girard, and S. Keshavjee (2009). "Limitations on Human Rights in the Context of Drug-Resistant Tuberculosis: A Reply to Boggio et al." Health and Human Rights, On-line Blog , Oct 7.

Week 5: 31 August

Ethics, Clinical Trials, and the Pharmaceuticalization of Health

How is pharmaceutical efficacy defined, and by whom? How do individuals experience these drugs and interpret their effects in the contexts of their lives? Whyte et al. stress that pharmaceutical treatments are "based on the principle that medicines have the same action in all patients: dosages are standardized … and the effects are considered to be universal. The underlying assumption is that biological bodies are the same in all settings, and that pharmacological action is located in the medical substance that is ingested." Schlosser and Ninnemann (2012) note that "a significant and growing body of research reveals that pharmaceutical efficacy is not such a one-dimensional phenomenon, but is linked to multilevel, interwoven dimensions ranging from individual biology to sociocultural dynamics." This week we will discuss the power of pharmaceuticals in the global context. Wellbeing is increasingly being associated with access to pharmaceuticals. The needs of pharmaceutical companies and the needs of public health do not always align. Petryna and Kleinman describe how the modern pharmaceutical industry got its start in the nineteenth century when several potent compounds were isolated and mass produced. After World War II, the industry used sophisticated marketing methods to transform from a commodity chemicals business to one heavily concentrated in several large firms and dependent on large

investments in research and marketing. Behind the pharmaceutical industry lies a morass of economic and moral paradoxes. Some therapeutic markets are launched while other no less urgently needed markets are ignored. The alarmingly slow development of the anti-HIV drug market in Africa has been attributed to the allegedly unreliable medical and economic behaviours of that continent's desperately poor HIV sufferers (2006:1-2). The production of knowledge about pharmaceuticals and other treatments occurs at the intersection of multiple interests, including researchers, clinicians, marketers, shareholders, and patient advocates. We will discuss these intersections. Second, the growth of pharmaceutical markets, testing, and the need for human subjects has resulted in increased demands for new populations being pursued as human subjects. What are the ethical issues behind the global spread of clinical trials? Why might pharmaceutical companies be interested in expanding their research to less developed contexts? Some might argue that clinical trials give people access to medication that would not otherwise have it. Considering the history of ethical violations of human subjects (such as the Tuskegee experiment), what is at stake in the international expansion of clinical trials and the proliferation of pharmaceuticals? Is there anything intrinsically wrong with medical researchers taking advantage of the disparity between a drug-wealthy healthful West and a med-famished global poor if patients consent (Shah 2006)?

Required Readings

Van der Geest, S. et al. (1996) "The Anthropology of Pharmaceuticals: A Biographical Approach." Annual Review of Anthropology 25:153-178.

Greene, J. (2010). "When did Medicines Become Essential?" Bulletin of the World Health Organization 88:483.

Petryna, Adriana (2005). "Ethical Variability: Drug Development and Globalizing Clinical Trials." American Ethnologist 32(2): 183-197.

Shah, S. (2007). "HIV and the Second Rate Solution." *In* The Body Hunters: Testing New Drugs on the World's Poorest Patients. Pp:77-99.

Recommended Readings

Petryna, Adriana and Arthur Kleinman (2006). "The Pharmaceutical Nexus." *In* Global Pharmaceuticals: Ethics, Markets, and Practices. Only Pp:1-22.

Petryna, Adriana (2007) "Clinical Trials Offshored: On Private Sector Science and Public Health." BioSocieties 2: 21-40.

Farmer, P (2006). "Rich World, Poor World: Medical Ethics and Global Inequality." *In* Partner to the Poor: A Paul Farmer Reader. Pp: 528-544.

Benatar, S.R. (2002)."Reflections and Recommendations on Research Ethics in Developing Countries." Social Science & Medicine 54: 1131–1141.

Nayyar, G., et al. (2012). "Poor-Quality Antimalarial Drugs in Southeast Asia and Sub-Saharan Africa." The Lancet Infectious Diseases 12(6):488-496.

Shah, Sonia (2007). The Body Hunters: Testing New Drugs on the World's Poorest Patients. New York: The New Press.

Week 6: 7 September
Healthcare Delivery, Systems, and Community Based Care
What works in healthcare delivery in low- and middle-income contexts (or, for that matter, developed, high-income settings)? How can we design an effective health system capable of delivering care in settings of poverty and disruption? How can care be provided and address the structural barriers that prevent good health? The readings this week will explore some possibilities for patient-centred, community-based care. This week we welcome Seng Raw Lahpai as a guest lecturer. Seng Raw, an ethnic Kachin woman, is a Yangon University graduate. Between 1990 and 1997, she worked with the Representative Office for Kachin Affairs in Thailand where she was in charge of humanitarian and development initiatives. Her main focus in this position was the welfare of women, youth and children. Among different activities, she established income generation programmes and Kindergartens along the Sino-Burma border and placed young people in vocational training schools in Thailand and India. Following ceasefires between the military government and various nationality groups in Myanmar in the 1990s, there was an urgent need for recovery and trust-building measures after decades of armed conflict in the ethnic borderlands. Seng Raw therefore returned to Myanmar in 1997 with the purpose of assisting refugees and internally-displaced populations in rebuilding long-divided and suffering communities. To support these objectives, she established and directed the Metta Development Foundation. Metta has since become one of the most recognised non-governmental organisations in Myanmar, working in collaboration with different stakeholders and community-based groups in conflict and natural disaster-affected areas across the country. After fourteen years of leading Metta, Seng Raw stepped down from the directorship in September 2011 but has remained committed to addressing the underlying issues of conflict and poverty in Myanmar. In 2013 she was presented with the Ramon Magsaysay Award. With the US$ 50,000 prize, she founded a new initiative, Airavati, with the goal of supporting local initiatives that are dedicated to building peaceful social relations and environmental sustainability.

Required Readings
Mills, A. (2014). "Health Care Systems in Low- and Middle-Income Countries." The New England Journal of Medicine 370:552-7.

Drobac, P., et al. (2013). "Building an Effective Rural Health Delivery Model in Haiti and Rwanda" *In* Reimagining Global Health: An Introduction. Pp: 133-183.

Behforouz, Heidi L., Paul E. Farmer, and Joia S. Mukherjee (2004). "From Directly Observed Therapy to Accompagnateurs: Enhancing AIDS Treatment Outcomes in Haiti and in Boston." Clinical Infectious Diseases 38 suppl 5:S429-S436.

Recommended Readings
Frenk, J. (2010) The Global Health System: Strengthening National Health Systems as the Next Step for Global Progress. PLoS Med 7(1).

Denzter, S. (2009). The Devilish Details of Delivering on Global Health. Health Affairs 28:946-947.

World Health Organization (2008). Everybody's Business: Strengthening Health Systems to Improve Health Outcomes. Read Pp ii-30.

Week 7: 14 September
Maternal and Infant Health
Child and maternal health and mortality rates are often the best indicators of development. Mothers and children are often the most vulnerable during periods of social unrest, famine, and war. Those that live in rural areas and the poor are most vulnerable. This week, we examine the factors that influence material and infant mortality. What are the significant risk factors? How are these risk factors addressed? What might be some of the unintended consequences of or difficulties associated with material health programs? We will also explore the disjuncture between the globally circulated notions of maternal risk and local perceptions of risk. Paramount in local conceptions of risk is the relationship between biomedical hegemony and material perceptions, choice, and cultural context. Special attention will be paid to the intersection between global infant and maternal health messages and experiences of mothers in these contexts.

Required Readings
Horton, R. (2010). "The Continuing Invisibility of Women and Children." The Lancet 9730:1941-1943.

Ronsmans C., et al. (2006). "Maternal Mortality: Who, When, Where, and Why." The Lancet 368:1189-1200.

Smith-Oka, V. (2012). "They Don't Know Anything: How Medical Authority Constructs Perceptions of Reproductive Risk among Low-Income Mothers in Mexico." *In* Risk, Reproduction, and Narratives of Experience. Pp:103-122.

Young, A. (2012). "Negotiating Risk and the Politics of Responsibility: Mothers and Young Child Health among Datoga Pastoralists in Northern Tanzania." *In* Risk, Reproduction, and Narratives of Experience. Pp:157-172.

Davis-Floyd, R. et al. (2009). Introduction. In *Birth Models that Work*.

Recommended Readings
Gerein, N., et al. (2009). Health System Impacts on Maternal and Child Health. In *Maternal and Child Health*, Pp 83-97.

Khan K., et al. (2006). WHO Analysis of Causes of Maternal Death: A Systematic Review. Lancet 367:1066-1074.

Denham, A. (2012). Shifting Maternal Responsibilities and the Trajectory of Blame in Northern Ghana. In Risk, Reproduction, and Narratives of Experience. Pp 173-189.

Semester Break 19 September to 3 October

Week 8: 5 October
Infectious Diseases
Infectious diseases remain one of the most important disease burdens in poor regions. Why are diseases that are nearly absent in developed contexts remain in poor areas? What are the factors that contribute to the spread of infectious diseases? What are some successful

interventions or prevention models? The answers are not as simple as, for example, offering vaccinations only. Brown (2011) notes how the cultural notions of contagion, fear, and stigma have an impact on the experience of the disease, the accessibility of care, and the disease course and consequences. Hence, in what ways do the domains of culture, poverty, and the disease intersect? The readings this week emphasize how an ecological approach (cultural ecology and political ecology) underlines the complexity of infectious diseases and their treatment and how infectious diseases need to be examined from multiple levels. What are these levels and what do they tell us? Emerging and re-emerging infectious diseases are a significant global health issue. In our discussion, we will consider the cases of the Ebola and Zika viruses and the conceptual frames, discourses surrounding, and the applied efforts to address the outbreaks.

Required Readings

Brown, P. J., et al. (2011). "Humans in a World of Microbes: The Anthropology of Infectious Disease." *In* A Companion to Medical Anthropology.

Farmer, P. (1999). "Rethinking Emerging Infectious Diseases." *In* Infection and Inequalities: The Modern Plagues. Pp.: 37-58.

Stolnik, R. (2008). "Communicable Diseases." *In Essentials of Global Health* (scan as a reference to gain overview).

Zika

A Forum on the Zika Virus (collection of posts on Somatosphere)
http://somatosphere.net/2016/02/a-forum-on-the-zika-virus.html

Roberts, J. (2016). "Web Roundup: Zika Virus and the Politics of Public Health responses." In Somatosphere Blog. http://somatosphere.net/2016/01/web-roundup-zika-virus-and-the-politics-of-public-health-responses.html

Lowy, L. (2016). "Zika and Microcephaly: Can We Learn from History?" *In* Anthropology Now. http://anthronow.com/online-articles/zika-and-microcephaly

Ebola

Street, A. (2014). "Rethinking Infrastructures for Global Health: A View from West Africa and Papua New Guinea." Somatosphere, December 11.

Farmer, P (2014). "Diary." London Review of Books 36(20).

Abramowitz, S. (2014). "Ten Things that Anthropologists Can Do to Fight the West African Ebola Epidemic." Somatosphere. http://somatosphere.net/2014/09/ten-things-that-anthropologists-can-do-to-fight-the-west-african-ebola-epidemic.html

Recommended Readings

Lederberg, J. (2000). "Infectious History." Science 288: 287-293.

Morens, D.M., et al. (2004). The Challenge of Emerging and Re-emerging Infectious Diseases. Nature 430:242-249.

Brown, H. et al. (2014). Material Proximities and Hotspots: Toward an Anthropology of Viral Hemorrhagic Fevers. Medical Anthropology Quarterly 28(2): 280-303.

MacPhail, T. (2015). "Global Health Doesn't Exist." Limm 5(1). http://limn.it/global-health-doesnt-exist/

Farmer, P. (1996). "Social Inequalities and Emerging Infectious Diseases. *Emerging Infectious Diseases,* 2(4):259-269.

NPR Staff (2014). "The Experts The Ebola Response May Need: Anthropologists."

Week 9: 12 October
Tuberculosis and its Management
Despite the widespread availability of effective treatment, tuberculosis (TB) remains the second leading cause of death from infectious disease worldwide (Mason et al. 2015). More concerning is the spread of drug resistant strains of TB. This week we welcome Dr Paul Mason. Paul will provide an overview of perspectives on TB, review prevention and treatment paradigms, and discuss his field research experiences.

Required Readings
Farmer, P. (1997). "Social Scientists and the New Tuberculosis." Social Science and Medicine 44(4):347-358.

Mason, P., et al. (2015). "Social, Historical, and Culture Dimensions of Tuberculosis." Journal of Biosocial Science 1-27.

Seeberg, J. (2014). "The Death of Shankar: Social Exclusion and Tuberculosis in a Poor Neighborhood in Bhubaneswar, Odisha." *In* Navigating Social Exclusion and Inclusion in Contemporary India and Beyond.

Recommended Readings
Seeberg, J. (2014). The Event of DOTS and the Transformation of the Tuberculosis Syndemic in India. Cambridge Anthropology 32(1):95-113.

Farmer, P (2000). The Consumption and the Poor: Tuberculosis in the Twenty-First Century. *In* Partner to the Poor: A Paul Farmer Reader.

Keshavjee, S. (2015). How Unromantic It Is To Die Of Tuberculosis In The 21st Century. National Public Radio. http://www.npr.org/sections/goatsandsoda/2015/03/22/393860586/how-unromantic-it-is-to-die-of-tuberculosis-in-the-21st-century

Week 10: 19 October
Noncommunicable Diseases and the Locus of "Responsibility"
Noncommunicable (or chronic) diseases (NCDs) are now the leading cause of death globally. The majority of NCD deaths now occur in low- and middle-income countries and are often compounded by high infectious disease burdens. Health professionals believe that the majority of these diseases can be prevented. NCDs are a result of not only personal or

lifestyle choices (use of alcohol and tobacco, unhealthy diet, and low physical activity), but pervasive underlying socioeconomic determinants and the consequences of rapid urbanization. Notably, among the poor, a vicious cycle may ensue: "poverty exposes people to behavioural risk factors for NCDs and, in turn, the resulting NCDs may become an important driver to the downward spiral that leads families towards poverty" (WHO 2011:vii). How can effective NCD programs be designed and implemented, particularly among poor countries? In developing these programs, what role does responsibility (or blame) play? The treatment for NCDs (and the phenomena of non-adherence or non-compliance) reveal deep tensions around notions of the responsibility for the disease and treatment. Where responsibility is assigned often has powerful consequences for how diseases become stigmatized and managed. Finally, how might the challenges be met across the range of diverse non-communicable conditions—cancer, mental health, heart disease, diabetes, and tobacco related diseases?

Required Readings:

WHO (2011). "Global Status Report on Noncommunicable Diseases 2010." Read Executive Summary pp 1-8.

Gostin, L. (2014). Healthy Living Needs Global Governance. Nature 511:147-9.

Whitmarsh, I. (2013). "The Ascetic Subject of Compliance" *In* When People Come First: Critical Studies in Global Health. Pp: 302-324.

Capewell, Simon, and Hilary Graham (2010). "Will Cardiovascular Disease Prevention Widen Health Inequalities?" PLoS Medicine 7:1-5.

Brownell, K. et al (2010). "Personal Responsibility and Obesity: A Constructive Approach to a Controversial Issue." Health Affairs 29: 379-387.

Recommended Readings:

Knowles, John H. (1977). "The Responsibility of the Individual." Daedalus 106: 57-80.

Garrett, Laurie (2007). "The Challenge of Global Health." Foreign Affairs 86: 14-38.

Whyte, S. (2012). "Chronicity and Control: Framing 'Noncommunicable Diseases' in Africa." Anthropology and Medicine 19(1):63-74.

Setel, P. (2003). "Non-Communicable Diseases, Political Economy, and Culture in Africa: Anthropological Applications in an Emerging Pandemic." Ethnicity & Disease 13.

Aikins, A. et al. (2010). "Tackling Africa's Chronic Disease Burden: From the Local to the Global." Globalization and Health 6(5).

Sawyer, S. et al. (2012). "Adolescence: A Foundation for Future Health." The Lancet 379.

Xiao, S. (2008). "Anthropology in China's health promotion and tobacco." The Lancet 372.

Livingston, J. (2012). Chapter 1 and Chapter 2. In *Improvising Medicine,* Pp 1-51.

Week 11: 26 October
Global Mental Health and the Challenges of Mental Illness

Mental illness is a major component of the global burden of disease. Mental health needs are routinely under-resourced, both globally and in Australia. In this seminar, we will briefly review mental illness cross-culturally and discuss the globalization of "Western" forms or categories of mental illness. What is a mental disorder and how does culture influence how we define mental disorders? We will examine the "failure" of global mental health, what Kleinman means when he states that the fundamental truth of global mental health is moral, and consider the new global mental health strategies. Importantly, we will closely engage the debate between those that believe that universal forms of mental illness and treatment approaches exist (Patel) and those that consider it risky and a form of Western neo-colonialism (Summerfield). Mental illness is generally treatable and multiple opportunities exist for enhancing access to care, but what solutions are the best? Are people's fears surrounding the global mental health movement (one that is largely shaped by access to pharmaceuticals) grounded in people's experience (see Good)? Perhaps one way we can frame the issues at hand are to ask what are the barriers to mental health care and what are the strategies to overcome these.

Required Readings:

Kleinman, A. (2009). "Global Mental Health: A Failure to Humanity?" The Lancet 374(9690): 603-604.

Collins, P., et al. (2011). "Grand Challenges in Global Mental Health." *Nature* 475(27): 27-30.

Patel, V. (2011). "A Renewed Agenda for Global Mental Health." The Lancet 378(9801):1441-1442.

Summerfield, D. (2008). "How Scientifically Valid is the Knowledge Base of Global Mental Health?" British Medical Journal 336(7651):992-994.

Patel, V. (2014). "Why Mental Health Matters to Global Health." Transcultural Psychiatry 51(6):777-789.

Kirmayer, L. (2014). "Toward a New Architecture for Global Mental Health." Transcultural Psychiatry. 51(6):759-776.

Good, B. (2010). "The Complexities of Psychopharmaceutical Hegemonies in Indonesia." *In* Pharmaceutical Self: The Global Shaping of Experience in an Age of Psychopharmacolog. Pp:117-144.

Miller, Greg (2012). "Who Needs Psychiatrists?" Science 335: pp. 1294-1298

Recommended Readings:

Patel, V. et al. (2012). "Putting Evidence into Practice: The PLoS Medicine Series on Global Mental Health Practice." PLoS Medicine 9(5).

Patel, V. et al. (2014). “Transforming Lives, Enhancing Communities—Innovations in Global Mental Health.” New England Journal of Medicine 370.6: 498-501.

Summerfield, D (2012). Afterward: Against “Global Mental Health.” Transcultural Psychiatry 49(3):519-530.

Miller, G. (2006). “The Unseen: Mental Illness’s Global Toll.” Science 311: 458-461.

Jacob, K.S. et al. (2014). “Classification of Mental Disorders: A Global Mental Health Perspective.” Lancet 383:1433-35.

Bemme, D. (2014). “Global Mental Health and its Discontents: An inquiry into the Making of Global and Local Scale.” Transcultural Psychiatry 51(6):850-874.

Kleinman, A. (1988). “Do Psychiatric Disorders Differ in Different Cultures?” *In* Rethinking Psychiatry: From Cultural Category to Personal Experience. Pp. 18–33.

Watters, E. (2010). “The Americanization of Mental Illness.” *New York Times*

Week 12: 2 November
Global Politics of HIV Drug Treatment

In many parts of the world, HIV/AIDS has moved from a deadly disease to a manageable chronic disease. Significant gains have been made in the past two decades of HIV treatment, yet several barriers remain. What are these barriers? This week we will examine the historical and contemporary forces that shape access to treatment and the challenges associated with the transformation of HIV into a chronic disease. Care of those infected with HIV involves much more than the provision of anti-retroviral medications. How can we apply what we learned this semester to the provision of quality HIV care? How does the shift from a “plague” model to that of a chronic disease transform how people think about and manage the disease? What about the influence of the social realities associated with HIV? How do the media and contemporary discourse influence public perceptions and the accessibility of care for those with HIV?

Required Readings

Messac, L. et al. (2013). “Redefining the Possible: The Global AIDS Response.” *In* Reimagining Global Health: An Introduction. Pp: 111-132.

Reynolds-Whyte, S. et al. (2004). “Treating AIDS: Dilemmas of Unequal Access in Uganda.” Journal of Social Aspects of HIV/AIDS Research Alliance 1(1):14-26.

McGrath, J. et al. (2014). “Challenging the Paradigm: Anthropological Perspectives on HIV as a Chronic Disease.” Medical Anthropology: 33(4):303-317.

Vanwesenbeeck, I. (2011). “High Roads and Low Roads in HIV/AIDS Programming: Plea for a Diversification of Itinerary.” Critical Public Health, 21:289-96.

Recommended Readings

Mattes, D (2014) Caught in Transition: The Struggle to Live a ‘Normal’ Life with HIV in Tanzania, Medical Anthropology: 33:4, 270-287.

Comaroff, J. (2007). Beyond Bare Life: AIDS, (Bio)Politics, and the Neoliberal Order, Public Culture 19: 1

Nguyen, V-K. (2005). "Anti-RetroViral Globalism, Biopolitics, and Therapeutic Citizenship," in Collier, S. and Ong A. (eds) *Global Assemblages* Routledge.

MacGregor, H. (2009). "Mapping the Body: tracing the personal and political dimensions of HIV/AIDS in Khayelitsha, South Africa." Anthropology and Medicine 16(1): 85-95.

Moyer E, & Hardon A (2014) "A Disease unlike Any Other? Why HIV Remains Exceptional in the Age of Treatment." Medical Anthropology: 33:4: 263-269.

Lyttleton C. (2008). AIDS and Civil Belonging: Disease management and political change in Thailand and Laos, in Maj-Lis Follér & Håkan Thörn (eds.). *The Politics of AIDS, Globalization, the State and Civil Society*, Palgrave Press

Week 13: 9 November
Wrap-up and Student Presentations