

# Anthropological approaches to medical humanitarianism

Isabel Beshar and Darryl Stellmach

## Abstract

Despite broadly shared interest in the welfare of ‘precarious lives’, medical anthropology and medical humanitarianism are too often in tension. In this survey, we sketch a history of the two disciplines, then track three major patterns through which anthropologists approach the analysis of medical humanitarian efforts. Our three patterns frame medical anthropology as: 1) a critique of medical humanitarianism and its ties to colonialism and globalization, 2) a translation of medical humanitarianism and its associated lexicon, 3) and a reform of medical humanitarianism from the inside out. In highlighting the individual strengths of these three approaches, we argue for the value of medical anthropology – as both a mindset and a method – in health and humanitarian emergencies.

## Keywords

medical anthropology, medical humanitarianism, global health, applied anthropology, suffering slot

## Introduction

What possible form and effect does an anthropological presence have on medical humanitarian crises?<sup>1</sup> International medical actors, such as the World Health Organization (WHO) and Médecins Sans Frontières (MSF), have recognized a role for anthropologists in navigating responses to health emergencies, but this role has yet to be fully defined (Abramowitz et al. 2015, 330; Brown et al. 2015, 1). This is despite broadly shared concerns for engagement with human suffering and the pain of the human condition (Redfield 2013, 5–6; Ticktin 2014, 274–77), which can be characterized as a convergence of professional sentiments.

Anthropology and medical humanitarianism are both distinguished by internal heterogeneity, making for sometimes-awkward cross-disciplinary encounters; one can never quite be sure whether the other will share or reject one's own perspectives. The literature on the 'anthropological approach' to medical humanitarian crises is expansive and well theorized, yet for this reason it lacks a common, accessible narrative to pull together a diverse body of work. Such heterogeneity has been problematic for related fields as well. Historians Davey and Scriven (2015, 113), for example, state that '[w]riting on humanitarian history is a booming occupation' characterized by a 'depth, innovation and complexity' that refuses to cleave to ready patterns or overviews. While the diverse nature of humanitarianism and its scholarship is not easy to encompass with generalities, certain patterns emerge.

In an attempt to summarize anthropological approaches within and in relation to medical humanitarian agencies, this article asks two related questions: how have anthropologists

<sup>1</sup> Photographer's note (image included in online version): 'Three years after the beginning of the conflict, Leer and Mayendit counties are greatly affected by the ongoing violence and the longstanding clashes between governmental and opposition forces. Civilians are on the first line of the conflict and the ongoing violence has a very clear impact on the ability for the population to access basic and secondary medical care and other basic services. The population has been locally displaced multiple times; and many people had fled the area completely. In July, following clashes in Leer County, the population again had to flee and Médecins Sans Frontières (MSF) had to evacuate international teams from both Leer and Thonyor. In September MSF set up a decentralised basic healthcare programme to continue to reach the population and provide them with primary healthcare in their villages. Through a network of community health workers, community health promoters, and women health promoters, who live as part of the affected population, MSF teams have been able to continue to provide healthcare. These community health workers are trained in treating the most common morbidities, such as respiratory tract infections, malaria, water-borne diseases, etc. They stay with the community and are able to move with the communities if the population needs to move, thus continuing to provide healthcare. MSF resupplies them with medical supplies and provides ongoing supervision and training through supporting international teams.'

engaged with institutions and action in the context of medical humanitarianism, and how might such engagement look in the future? To develop our analysis, we undertook a survey of relevant materials in medical anthropology. Building on a recent review by Ticktin (2014), which surveys the growing field of the anthropology of humanitarianism, and the conclusions in Fassin's (2012) *Humanitarian Reason: A Moral History of the Present*, we evaluated works drawing from both anthropological and medical humanitarian sources, including but by no means limited to *Anthropological Theory*, *Annual Review of Anthropology*, *Medical Anthropology Quarterly*, *Somatosphere*, *Disasters*, *Health Affairs*, *Social Science and Medicine*, *Violence*, and *Politics and Humanitarian Action*. In doing so, we applied a working definition of 'medical humanitarianism' as proposed by Abramowitz and Panter-Brick (2015, 1) in their recent volume, *Medical Humanitarianism: Ethnographies of Practice*: 'the field of biomedical, public health, and epidemiologic initiatives undertaken to save lives and alleviate suffering in the conditions of crises born of conflict, neglect or disaster'. To this definition we added that medical humanitarianism is often a self-attributed label, a personal designation and category of action that responders may invoke, in part, as a moral appeal. In our understanding, humanitarianism places the human, and suffering as a human universal, as core concerns (Fassin 2012, 9; Redfield 2013, 39–42; Ticktin 2014, 273). This puts medical humanitarianism in sharp contrast to other forms of international health intervention that may seek, for example, to maximize the productive capacity of a population or buttress a health system against pathogenic threat (Lakoff 2010, 66; Elbe 2011, 849).

This does not prevent a diverse array of actors from invoking humanitarian rhetoric – in other words, moral concern for human suffering – to justify actions that have motives quite distinct from saving life and reducing suffering. Thus, as others have noted, the 2003 military intervention in Iraq was characterized, in part, as a humanitarian campaign (Fassin 2012, 189–231; Gilman 2012, 173–74). This highlights overlaps in goals and means between medical humanitarianism and the arenas of geopolitics, global economics, global health, disaster management, and international development. Yet, because of the preeminent emphasis on human suffering, humanitarian responses to emergencies are not wholly convergent with other forms of response to health crises, and may differ with regards to timescales, moral stakes, and media visibility (Lakoff 2010, 66–70, 74–75). (For these reasons, our literature search was confined to 'medical humanitarianism' and excluded material on global health, disaster management, and international development, except where it used 'humanitarianism' as a keyword).

As a moral and political undertaking, humanitarianism recognizes the sanctity and dignity of human life, and the universality of both basic needs and suffering. Emerging in parallel with the rise of industrial capitalism, humanitarian action is the organized, collective practice of compassion. As a concept it began to take shape in the mid-eighteenth century but would come into its own in the nineteenth century (Barnett 2011, 49–50). In the rapid social and

technological transformation of industrializing Europe, the word came to be associated with a variety of compassionate societies and committees for the relief of human suffering (Barnett 2011, 50–60). During these early decades, the International Committee of the Red Cross (founded 1863) provided medical care and supplies to battlefield wounded (Barnett 2011, 76–81). For most of the nineteenth century the humanitarian designation was simultaneously applied to issues of prison reform, slavery, and employment conditions; it wasn't until the Geneva Conventions of 1864, 1929, and 1949 that a humanitarian 'sensibility' would be codified internationally and formally protected (Haskell 1985, 339). International humanitarian law attempted to regulate the conduct of war and provided a protected space – if imperfectly realized in practice – for civilian actors to assist those directly affected by conflict. In these spaces of exception, humanitarian actors were attributed political neutrality and immunity from military aggression (Abramowitz and Panter-Brick 2015, 9–10; Gordon 2015, 187–88).

Humanitarianism in its presently recognized form broadly means relief in times of crisis, particularly as prosecuted through transnational organizations and nongovernmental organizations (NGOs) in particular. For better or worse, medical humanitarianism views human crisis through the clinical gaze, framing human suffering as pathology amenable to medical intervention (Scott-Smith 2014, 23–25) and directly imprinted on body and psyche (Fassin 2000, 2005, 372; Ticktin 2011, 254). This has led to an anthropological critique of a tendency towards medicalization, and thus subordination, of lived experiences in the name of biomedicine, a politically fraught expression of compassion (Fassin 2012, 99–101).

There has historically been a breadth of anthropological literature on humanitarian action. In addition to large projects by professional historians (Barnett 2011; Davey and Scriven 2015; see also ODI 2015) and practitioners (Kent 1987; Terry 2002; Magone et al. 2011), anthropologists have written on the origins (both historical and ideational) of medical humanitarian action (de Waal 1997, 65–85; Fassin 2012, 1–17; Redfield 2013, 35–66; Ticktin 2014, 274–76). There is much work on the anthropological response to issues of famine, food security, and communicable diseases like HIV/AIDS, to name a few (see Oliver-Smith 1996, as well as Henry 2005, for comprehensive reviews). In the last decade, however, there has been a rise in the literature focused on the anthropological position, or approach, to the act and rhetoric of intervention itself. It is not *what* anthropology investigates in the humanitarian sphere but *how*. Ticktin (2014, 274, 281–82), for example, has broadly framed anthropologists as allies of humanitarian ambitions, critics of unintended consequences, and analysts of an amorphous social phenomenon; Abramowitz, Marten, and Panter-Brick (2015, 3–4) have gone even further, undertaking a poll to assess aggregate views of the perspectives of anthropologists working in medical humanitarian contexts. Both studies argue that anthropologists must actively engage individual humanitarian practitioners, agencies, and issues, regardless of whichever conceptual stance they adopt.

Our survey reveals three major strands of discourse on the intersection of anthropology and humanitarian action, which we term ‘critique’, ‘translation’, and ‘reform’. We argue medical anthropology has worked to critique humanitarian action, particularly how the field has become tied to capitalism, colonialism, and globalization. We suggest this approach has sometimes proved isolating, and we examine a second stream of anthropological work that works to translate and reframe medical humanitarian lexicons and ideologies. We finish by describing a third, emerging body of anthropological work that seeks to reform medical humanitarianism from inside out.

These categories are not exhaustive, nor are they discrete: as the survey reveals, they may intersect, cross-pollinate, and flow into one another depending on context and time. In that sense, our analysis offers a spectrum, rather than strict divisions. Our hope is that this discussion challenges a view that oftentimes seems to pit humanitarian practitioners and academic anthropologists against each other (Minn 2007; Ravelo 2015). Indeed, in observing exchanges between these streams, we believe that whatever distinctions remaining between the two are further blurred.

## The maturing of medical humanitarianism and medical anthropology

Tracing intersections and approaches of medical anthropology to humanitarianism requires knowledge of their complex histories, and how these have given rise to present-day institutional structures and politics. As the above histories reveal, medical humanitarianism, as contemporarily defined, had a violent birth, emerging in the nineteenth century out of military combat, disaster, and war to become an important social force of considerable size and scope (Bass 2008, 11–29). Today, the largest humanitarian agencies have annual operating budgets in the billions; for example, Save the Children’s budget in 2015 was more than US\$2 billion (Save the Children 2016). Such agencies frequently act as entrenched conglomerates (European Commission 2015, 1). They are fundamental to intra- and inter-country management not only of wars and disasters but also of diverse international crises that emerge, seemingly unanticipated, only to be handled with patterned regularity and predictable rhetoric (Calhoun 2004, 377–80). Indeed, the actions of self-declared medical humanitarian agencies cross boundaries of global health, human rights, international development, and political peacekeeping. Naturally, no single agency acts in all these sectors. The mix of activities demonstrates the heterogeneous and fundamentally contested nature of the humanitarian mantle; a wide variety of actors may claim humanitarian motives but undertake action in fundamentally different spheres.

In pace with this far-reaching growth, the field has become professionalized, developing frameworks to standardize humanitarian practice, support institution building, and supply scholarship and instruction. In the late 1980s, with the support of the European Commission for LifeLong Learning, European Union member states launched initiatives concerned with the quality and accountability of humanitarian work and established new postgraduate degrees and training in international humanitarian action (Brun and Attanapola 2014, 1; Walker et al. 2010, 2223–25). Initiatives like the Code of Conduct for NGOs and the Humanitarian Accountability Project attempted to standardize and professionalize humanitarian work (Walker 2005, 323–27). Yet, these developments remain entrenched in a Euro-American schema. According to Abramowitz and Panter-Brick (2015, 7), the professionalization of the medical humanitarian impulse has become a ‘substantial stand-alone industry’ distinct from volunteerism yet still embedded in a liberal ethic of ‘giving back’ and ‘doing good’. What remains to be seen is how this impulse survives its own explosive growth, given concerns that a shallow emphasis on ‘doing something’ may potentially lead to substandard delivery of care (Abramowitz and Panter-Brick 2015, 7). In the words of Dijkzeul and Wakenge (2010, 1141), the swell in the ‘role and number of humanitarian actors’ demands ‘scholarly attention’.

In conjunction with internal challenges to coherence that result from rapid growth, medical humanitarian action also faces external threats. Perhaps most pressing for practitioners is a perceived diminution of respect and recognition for the broad medical and humanitarian mission. While humanitarian ‘spaces of exception’ have been extensively theorized and often attributed with social and moral force (see, among others, Agier and Bouchet-Saulnier 2004, 303–04; Redfield 2005, 340–44; Fassin 2012, 151–54, 181–99), such spaces, when they exist at all, are difficult to establish and maintain in practice (Allié 2011, 1–5). Because while attacks against humanitarian and medical personnel in wartime are not new – humanitarian and medical impartiality have never guaranteed immunity despite the dictates of the Geneva Conventions, and the list of targeted attacks against health care facilities in the past century is long – recent events seem to indicate that humanitarian and health care activities are increasingly under threat as targets of war. From 2011 and onward, there has been a sharp jump in both the frequency and flagrancy of deliberate attacks against medical humanitarian facilities (Baker and Brown 2015, 4–7; WHO 2016, 4–5, 7). At the present moment, long-standing international norms, both of medical and humanitarian neutrality and the threat of international opprobrium, appear to have lost sway over many state and nonstate armed actors.

The development of medical anthropology tracks a parallel timeline to medical humanitarianism. In the nineteenth and early twentieth centuries, studies of medicine by anthropologists were typically enveloped within broader studies of cultural and social traditions, at times confining medical anthropology to the study of the ways that the ‘other’

dealt with issues of sickness and health (Inhorn and Wentzell 2012, 2). But in the latter half of the twentieth century, medical anthropology carved its own niche. Medicine's intersection with issues of race, gender, and inequality, as well as the increased involvement of anthropologists in international health work and clinical settings in the name of soft diplomacy during the Cold War, energized the discipline (Inhorn and Wentzell 2012, 6–7). Anthropologists Strathern and Stewart (1999, 3) track what they call 'a circular migration' – 'from the jungle to the city, and back again' – such that medical anthropology became an investigation not only of other cultures and healing practices but also of their own. The development of critical medical anthropology in the 1990s, with its social constructionist understanding of disease and its political economy understanding of power, further popularized the discipline's approach. However, like medical humanitarianism, the effectiveness of the method posed its own threat: to date, anthropology has been criticized for taking 'healthy self-consciousness too far, inadvertently casting itself as a discipline suspicious of collaboration and cross-industry reciprocity' (Harragin 2012, 4).

Be that as it may, medical anthropology and humanitarianism continue to intersect. Both emerged from postcolonial concerns in a moment when neoliberalism, human rights, and democratic individualism were ascendant values. Both have thrived in a postnational, post-Cold War era characterized by the privileging of individual enterprise and cultural reductionism of the West. And both have embraced and continue to simultaneously embrace and criticize aspects of these values. Working in similar physical and discursive spaces, medical humanitarianism and anthropology have had interests, goals, and contexts that have at times met at points of complementarity and others at points of tension. Ultimately, it is this historical, material, and ideational relationship that enables, but also complicates, a survey of the literature of the two disciplines.

## Anthropology as critique

This bisecting history has helped produce three categories of disciplinary intersection. The dominant form of anthropological discourse on medical humanitarianism at present is that of critique. This approach calls on anthropologists to evaluate, interpret, and analyze NGOs and humanitarian actors as they would any other institution of power and influence. Rather than defer to appeals regarding the sanctity of human life and the moral imperative to aid people in distress (which leads to claims of humanitarian 'exceptionalism'), this work approaches these claims face on, problematizing the impact of morally motivated interventionism.

Numerous case studies track humanitarian missteps, in both practical and ideological arenas.<sup>2</sup> Ticktin (2014, 277–81) provides a thorough summary of work in this vein. Anthropologists have critiqued medical humanitarian projects for their unintended consequences, low standards of care, limited local input, weak oversight, and more (see, for example, Harrell-Bond 1986; Escobar 1995; Malkki 1995, 1996; de Waal 1997; Fisher 1997; Macrae 2002; Harragin 2012; Redfield 2013). Anthropologists have also criticized medical humanitarianism in broader swathes, particularly when it is conceptualized as a project with neoliberal, capitalist impulses. In part informed by work on the anthropology of development, which was influenced by Ferguson's (1990) work on aid in Lesotho, humanitarian action began to be reasoned 'in terms of an organized system of power and practice which has formed part of the colonial and neo-colonial domination of poor countries by the West' (Lewis 2005, 3).

Early examples of this framework are perhaps best represented by Pandolfi's (2000, 2003) work analyzing medical humanitarian agencies in postwar and postcommunist Albania and Kosovo. In her evaluation of the 'right to interfere' in the name of 'emergency', she describes the disappearing boundaries between medical and military intervention, at times referring to it as a mobile 'humanitarian-military apparatus' (Pandolfi 2003, 496–97). She characterizes humanitarianism by its state-like functions, identifying a new form of sovereignty at the intersection of biopolitics and 'bare life', ultimately resulting in the reduction of subjective individuality and the influx of diagnostic and numerical categories based on humanitarian management (Pandolfi 2003, 499).<sup>3</sup>

In subsequent years anthropologists published widely read critical studies: Redfield's (2005, 2013) retrospective ethnographies of MSF, Fassin's (2012, 1–2) critique of the humanitarian epistemology of 'moral sentiments' with regards to the status of immigrants in France, and Nguyen's (2010) commentary against the unintentional making of new markets and economies among both HIV/AIDS patients and their ART therapies on the part of the

<sup>2</sup> This is not to say that humanitarian actors and agencies themselves have not engaged in a tradition of self-critique. According to Davey and Scriven (2015, 115), medical humanitarianism 'cannot be accused of an unwillingness to reflect on its performance, be it through formal processes of research and evaluation or the collect decompression of a bar-side lament'. Examples can be found in the work of Vaux (2001), Terry (2002), and recent multilateral projects, including the United Nations Intellectual History Project and Global History of Humanitarian Action Project (Ralph Bunche Institute for International Studies 2011; ODI 2015).

<sup>3</sup> Although some authors contest this assertion – such as Dunn (2012, 1–2), who argues that the reach and nefarious nature of humanitarian ventures are dangerously overstated – the notion of humanitarianism as subversion through compassion has had influential effect.



humanitarian agency. In these contexts, the logics of what Fassin (2012) calls ‘humanitarian reason’ expose new vulnerabilities, mark new terrains, and gain control over new bodies.

More recently, this work has found itself intertwined with the field and politics of global health. In turn, anthropologists have articulated what they see as the ‘global health machine’ (Gaines 2011, 87) and an emerging ‘NGO industrial complex’ (Adams 2013, 76–79). Such machinery has been well-documented in a wide variety of phenomena, such as medical volunteerism, which Berry (2014, 347) has criticized for focusing more on the student résumé than the provision of medical care; pharmaceutical investment, which Parker and Allen (2014) suggest assumes tyranny over the monitoring and evaluation processes required of most humanitarian projects; the application of the ‘economic gaze’ to matters of health, wherein ‘the body is constructed as having little to no value outside of its role in the global economy’ (Sridhar 2011, 1909); and the default to a ‘one-size-fits-all model’ and erasure of local specificities in the ‘scale-up’ of global health interventions (Adams et al. 2014, 182–83).

This ‘anthropology as critique’ approach has deep historical roots in anthropology’s disciplinary preoccupations, as seen in the overwhelming amount of literature we found dedicated to this thread of discourse. It is well established that anthropological knowledge contributed to European colonial dominance, as is the fact that European power enabled anthropological practice, thoroughly influencing its methods, discourses, and central concerns (Asad 1991, 315). It is this problematic historical relationship with state power that makes many anthropologists justly skeptical of large-scale institutional influence, particularly when deployed among disenfranchised people. Fassin and Pandolfi (2010, 16, 20–22) imply that social scientists should resist being used as accomplices in larger humanitarian projects or agendas, especially when any form of intervention is anthropologically understood as a political play or implicit military action. Critical neutrality is both a role and a method in anthropology. But this stance can be taken too far: circumspection can become overwrought; fear of being used can become fear of being useful. This dynamic – perhaps best reflected in Kleinman’s (1982, 112) mock dilemma of an anthropologist constantly being asked ‘Whose interest does this professional stranger support?’ – is bound up in the critique approach to medical humanitarianism.

## Anthropology as translation

Anthropology’s role as external commentator can and has been perceived as isolationist and counterproductive (Abramowitz and Panter-Brick 2015, 8; Ticktin 2014, 283; Tol et al. 2012, 33; Harragin 2012, 3–5). Some anthropologists have rejected this viewpoint on the premise that it hampers collaboration and characterizes anthropologists as armchair spectators, trapping them in a ‘cul-de-sac of critique’ (Ticktin 2014, 283). According to Abramowitz and Panter-Brick (2015, 8), scholarly critiques of medical humanitarian reason are necessary but

sometimes ‘fail to convey the real-time exigencies of humanitarian experience and the range of internal debates within humanitarian networks’. Tol and colleagues (2012, 33) suggest that these criticisms appear to function as fodder for ‘academic debates without relevance for practice’.

A second stream of anthropological work has emerged out of this criticism. We argue that anthropology as translation favors an approach that investigates and privileges cross-disciplinary discussion between anthropological and humanitarian actors. With ‘translation’, we allude to Callon (1986) and Latour (1986), who conceptualize translation as a process through which meanings, claims, and contexts come to occupy new spaces and change foundational ground. Translation is not only interpretation from one language or discipline to another; rather, it is a process by which languages and disciplines are made to cohere, and in the process create new hybrids. In particular, we favor Latour’s (1986, 268) definition, in which translation results in a continuously infinite process of producing ‘something completely different’. In this definition, anthropological work on medical humanitarianism is not about interpreting the field for lay understanding but about producing a new discourse within which medical humanitarianism can be imagined in critical, creative, and diverse ways.

For example, Marcus (2010) argues that anthropology should engage all actors working in a medical crisis. In a nod to Scheper-Hughes’s (1995, 414–15) famous rejection of ‘anthropologists as spectators’, Marcus (2012, 362) calls on anthropologists to ‘modestly witness’ the conditions they are studying. For Marcus and Scheper-Hughes, anthropologists are not reporters but actors and negotiators.<sup>4</sup> This work places heavy emphasis on issues of communication and articulation. According to this literature, ‘anthropology as translation’ helps position human suffering in a way that avoids the norms of communication and engagement that ‘tend to make pain into abstraction’ (Marcus 2010, 371). This is not to evoke what has sometimes been termed and critiqued as the ‘suffering slot’: which, Robbins argues, situates vulnerability as a ‘privileged object of attention’ (2013, 450) with ‘a universalistic quality’ (ibid., 454) that anthropologists can categorize neatly to presume wider

<sup>4</sup> Marcus’s call for anthropologists to ‘witness’ has clear parallels to the humanitarian commitments of neutrality or *témoignage* (translated as ‘bearing witness’), as is typically invoked by MSF (2016; see also Redfield 2005 on MSF as ‘a less modest witness’). This is particularly the case because *témoignage* does not just imply watchful observation, but also the obligation and responsibility to speak on behalf of those in danger. In that sense, humanitarian actors, like anthropologists, are also negotiators: operating in a simultaneous cycle of creating – and then sacrificing – ‘neutral’ humanitarian spaces (Barnett 2011, 224). This interpretation of *témoignage* turns MSF’s own moniker (‘without borders’) on its head, positioning humanitarian actors precisely *at* the borders – between observation and action, outside and inside – not ‘without’ them.

understanding.<sup>5</sup> Rather, ‘anthropology as translation’ forces anthropologists to step out of imagined molds, enabling new forms that bypass norms or universality and instead celebrate distinctions and locality. In the words of Fassin (2012, 245), this work means ‘straddl[ing] the line between outside and inside . . . to be located “at the frontiers”’.

Translation work has, in part, been operationalized to reframe the narratives or linguistic and conceptual tropes that humanitarian actors may use. For instance, Redfield (2013, 14, 29–34) evaluates shaky underpinnings of the ‘states of emergency’ that legitimize a ‘crisis’; Harragin (2012, 3) interrogates the insufficiency of ‘short-term, humanitarian contracts’ in light of more long-term, existing infrastructural realities; and Feldman and Ticktin (2010, 1–5) interpret the practical implications of the humanitarian premise of ‘humanity’. ‘Sovereignty’ as a status of independent statehood or actorhood has been similarly unpacked, perhaps most notably by Pandolfi’s (2000) application of Appadurai’s (2003) ‘mobile sovereignty’ but also more recently by Abramowitz’s (2015) ethnography of MSF’s withdrawal in Liberia, Good and colleagues’ (2015) work on post-tsunami interventions in Indonesia, and Gordon’s (2015) analysis of the complexities and contradictions of medical medicine inherent to Iraq and Afghanistan.

The 2014–2016 Ebola outbreak in West Africa may be the most recent foregrounding of anthropology as translation. *Ebola’s Ecologies*, an interdisciplinary analysis edited by anthropologists Lakoff, Collier, and Kelty (2015), and the introductory chapter of Packard’s (2016) *A History of Global Health: Interventions into the Lives of Other Peoples* both examine how the Ebola outbreak forged new logics, practices, and rhetorics among its many and diverse actors. In *Ebola Ecologies*, the Ebola outbreak is seen as a product of failed ‘administrative imagination’ that neither categorized nor conceptualized of Ebola adequately; to Packard (2016, 2), the global North’s understanding of Ebola ‘represented examples of cultural modeling’ that ‘deflected attention from other, more fundamental causes of the event’. But both works acknowledge that the epidemic fostered new formulations in health systems management, pharmaceutical research, and multilateral engagement. Describing the process of Ebola vaccine trials instituted during and after the crisis, Nading (2015) comments on the ‘contingent, speculative, “chimeric” nature of contemporary global health’; while commenting on the Ebola ‘watchdog’ groups formed in communities where the infection had spread, Packard (2016, 331) discusses the local and foreign organizing that came together to privilege ‘capacities for self-help’ and ultimately slow the disease’s progress.

<sup>5</sup> Trouillot ([1991] 2003, 18) was the first to coin the term ‘slot’ in reference to anthropological tropes, faulting anthropology for choosing as its disciplinary penchant ‘the savage, the primitive . . . the other’, arguing that the discipline’s survival depended on breaking past this limited niche and narrow object of inquiry.

Here, it is new imaginations, even some failed ones, that deserve anthropological investigation. As Biruk (2014, 7–8) writes, ‘anthropology [can] take objects in, reframe them, and re-generate knowledge in a new way that excavates the structures and logics that make them’.

## Anthropology as reform

A final stream of anthropological thought seeks not to criticize medical humanitarianism or translate its ideologies but instead to reform the discipline itself. As humanitarian agencies grow in size and complexity and engage with new actors and professionals, anthropologists have pushed for research that acts with, but not within, archetypical frameworks of humanitarian response. While the smallest of the three at present, this discourse promises to grow in the near future, as more anthropologists engage directly and more robustly with humanitarian agencies.

This third body of work demands anthropologists assume a more transformative role; in the words of Harragin (2004, 325), an anthropologist working in South Sudan, ‘It is time it [anthropology] realized that [excessive] introspection risks failing to engage with global forces that will sweep on with or without anthropological insights’. Ultimately, this literature pushes not for criticism nor for hybrid productions but for a ‘seat at the table’ for anthropologists engaging in humanitarian work (Abramowitz et al. 2015, 330). The focus on participation is key here. As Feierman and colleagues (2010, 123) assert in a piece on medical humanitarian programs, ‘Anthropologists . . . have the potential to play an important role in both mediating and studying flows of knowledge’. Abramowitz (2014) argues, in this same vein, that ‘many more anthropologists of West Africa are being invited to write *commentaries* on the current outbreak. But this does not go far enough’ (emphasis in original). This argument for practice is part of a broader demand for engaged anthropology (Fassin 2012; Eriksen 2006).

Anthropology as reform has the potential to establish a new discursive and professional space, one in which anthropology is not supplementary but a partner in its own right. Here, the focus is on how anthropology might help produce new norms or paradigms within and for humanitarian action. Adding nuance to Abramowitz’s ‘seat at the table’ offers a productive starting point: anthropology as reform is not a particular kind of temporal or professional role (in other words, follow-up commentary vs. contemporaneous original research) but rather a way of seeing that can alter how humanitarian crises are perceived and addressed. By virtue of method, anthropology works against the essentialism and reductionism that can be pernicious in humanitarian discourse, wherein people can be reduced to biology or statistics. The work of anthropology makes humans coherent within simultaneous contexts of individual, social, and ecological worlds; it unites empirical

experience, historical knowledge, and moral subjectivity, and holds these in productive tension (Latour 2014, 13–14). When practiced well, anthropology is an ‘evidence-based field science’ that is simultaneously relational, reflexive, and inclusive (Nyamnjoh 2015, 59–60). An anthropological lens on crisis can change the perception of causation, needs, and wants. By extension, this can change the nature of the humanitarian encounter itself.

While some examples of anthropology as reform may already be emerging in medical humanitarian organizations (see, for example, the recent ethnographies of Stellmach 2016 and Véran et al. 2017), this phenomenon is perhaps most evident in medical anthropological work on global health. Because anthropologies of global health exhibit considerable disciplinary and practical overlap with medical humanitarianism, a quick summary may indicate how an anthropology of medical humanitarianism can be an anthropology of reform.<sup>6</sup>

While the exact meaning of ‘global health’ is contested (Koplan et al. 2009; Lakoff 2010; Fassin 2012; Garrett 2013), we use the definition articulated recently by geographer Herrick (2016, 674): global health ‘involves the transfer of knowledge and resources [and] a variety of efforts to act on and reduce the global burden of disease, and a particular concern for and financial investment in the infectious disease triumvirate of HIV/AIDS, malaria, and tuberculosis’. Of course, as Herrick (2016, 674) herself acknowledges, this simple definition is complicated by the diverse and complicated assemblage of disciplines, actors, initiatives, and agendas working in the global health sphere.

At present, writings on global health seem to be the most conducive to an anthropology of reform. Abramowitz (2014) has taken perhaps the most practical approach, writing of ten tangible actions that anthropology can undertake in public health emergencies, including detecting and identifying latent local capabilities, generating innovative ways of communicating among new and diverse actors, and pushing for funding from government bodies. Emphasized here are the tools and avenues through which anthropology provokes a departure from normalcy. Others (Guyer et al. 2010; Erikson 2012; Sangaramoorthy 2012) recognize the ways that anthropology can participate in traditional approaches to monitoring and evaluation in order to ‘provide various levels of accountability for activities or policies’ (WHO 2004, 4). According to Biruk (2014, 348), institutionally necessary data, while expected to be ‘clean, accurate, precise’, and a fixed representation of a problem at hand, is

<sup>6</sup> Anthropologies of global health are one example among many. For example, applied anthropologists and anthropologists of development have also contributed key insights into how anthropologists can work within global institutions. See Mosse 2013.

in fact complex, messy, and uncertain – full of a kind of ‘noise’ that Abramowitz (2014) argues is uniquely suited for anthropological analysis.

Perhaps most accessible to the reader is the approach taken by Adams and colleagues (2014, 179–80), who borrow from the ‘slow food movement’ to emphasize the need for ‘slow research’ in global health. Like the organic slow food movement, Adams and colleagues argue for a combination of long-term anthropological research on local particularities with the ‘fast’ qualities of emergency relief and information acquisition characteristic of contemporary global health. They urge caution against ‘anticipatory modes of engagement’ – the quickening of assumptions and conclusions – calling instead for a ‘pause before eating’ and ‘a moment to contemplate’ what is before or ahead (Adams et al. 2014, 187–88). The authors conclude: ‘Slow research is not necessarily opposed to “fast” research, but it is opposed to what might be identified as a new normal. Slow research is a response, addition, and possible alternative to the newest normative trends’ (Adams et al. 2014, 180). This also suggests how anthropologists might react to the speed and ethical complexity of medical humanitarian crises: not to lose one’s method in the rush of emergency, but rather to double down on method, adapting the technique to the context (Stellmach 2016). Resident in institutions that simultaneously comfort and oppress (as so many institutions of modernity do), anthropologists’ awareness of power dynamics, both institutional and interpersonal, can help us negotiate a path between co-option and refusal to participate for fear of co-option.

It is worth reiterating that anthropology as reform is not about fitting anthropology into an existing global health or humanitarian apparatus. As anthropologist and sociologist Pigg (2013, 127) argues, ‘in the face of intensifying demands on ethnographers to subsume their insights to ever narrower, utilitarian goals . . . it is important to recognize . . . the unique character of ethnographic praxis’. In other words, anthropology as reform pushes for new sources of evidence that are not constrained by standardized regulations and historical form. Ultimately, as Pigg (2013, 133) argues, the hope is to position anthropology ‘in the very midst of the making of global health as it – whatever “it” is – unfolds’.

## Conclusion

In this survey, we have argued that three anthropological approaches – critique, translation, and reform – have typically framed the intersection of anthropology and medical humanitarian action. To do so, we detailed the overlapping values and histories of medical anthropology and humanitarianism, highlighting how disciplinary origins feed into contemporary norms of engagement. We have also examined the typologies of anthropological participation, suggesting that ethnography can offer a unique framework by which to understand health and medical issues in the context of humanitarianism.

We do not wish to privilege or prioritize one approach over others, but instead to identify and further extrapolate three axes upon which humanitarian action can be evaluated. Each category has an appropriate time and place, and individual anthropologists may switch between each of the three modes as circumstances merit. Medical humanitarianism will continue to shift in direction and purpose, and whether by critique, translation, or reform, anthropologists should take care to purposively entangle – and disentangle – these threads of action. Only then will anthropological ways of knowing continue to grow in value.

## About the authors

Isabel Beshar is a medical student at Stanford University School of Medicine. She received her MPhil in medical anthropology from the University of Oxford, where she studied as a 2014 American Rhodes Scholar. She previously worked as a consultant at Global Health Strategies, where she helped coordinate emergency response management of vector-borne diseases and women's health.

Darryl Stellmach divides time between academic and applied roles, as a postdoctoral researcher at the University of Sydney and as anthropology implementer for the London office of the aid group Médecins Sans Frontières (MSF). A former field manager for MSF, Darryl assists with the integration of anthropologists and anthropological research techniques into the agency's field teams. A Commonwealth doctoral scholar, Darryl's 2016 dissertation undertook an ethnography that followed MSF aid practitioners in South Sudan as they responded to that country's emergent civil war and subsequent nutritional crisis. The work is available at the Oxford research archives ([www.ora.ox.ac.uk/](http://www.ora.ox.ac.uk/)).

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