

<http://somatosphere.net/2011/04/global-health-complex-and-aids.html>

The global health complex and AIDS medication in East Africa

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By Eugene Raikhel

Recently two important journals have released special issues on closely related topics. A special issue of *Biosocieties* on "[The global health complex](#)" examines the "growing role of pharmaceutical corporations and philanthropic organizations in fight against 'diseases of the poor'; and a special issue of *Medical Anthropology* focuses on "[Global AIDS Medicines in East African Health Institutions](#)." One of these was mentioned in our recent "[In the journals...](#)" post but I thought it would be worth reproducing the titles and abstracts of both these issues in their entirety.

Biosocieties

[Volume 6, Issue 1 \(March 2011\)](#)

Linsey McGoey, Julian Reiss and Ayo Wahlberg, [Editors' Introduction: The global health complex](#)

In February 2009, Andrew Witty, the Chief Executive of GlaxoSmithKline (GSK) announced that GSK would slash the prices of its medicines in low-income countries, and, more surprisingly, raised the idea of a patent pool, where holders of intellectual property rights would share discoveries in order to stimulate neglected diseases research (Lancet, 2009; McNeil, 2010). The announcement generated cautious praise from non-governmental organizations (NGOs) such as the Médecins Sans Frontières (MSF) and the Drugs for Neglected Diseases Initiative, the latter suggesting that GSK has emerged as the 'most innovative' pharmaceutical company to tackle the persistent problem of how to encourage the private sector to pour R&D funding into diseases that have little market value, as most sufferers are unable to afford the cost of treatments.

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Behind the apparent selflessness of GSK's strategy lies much contestation and controversy over the economic motivations and unintended consequences of recent attempts to address disparities in access to medicines and health care. Using the complex matrix of global health initiatives as an anchor, contributors to this special

issue explore the underlying contention behind actions such as GSK's, examining how industry moves such as price-slashing in developing regions and calls for patent sharing relate to wider concerns about the tensions between private and public investment in health care; the nature of what Marcel Mauss once referred to as the 'in fact obligatory and interested' character of philanthropy and gift-giving; and the national security objectives embedded in bilateral and multilateral global health initiatives (Lakoff and Collier, 2008; Mauss, 1990).

Jeremy A Greene, [Making medicines essential: The emergent centrality of pharmaceuticals in global health](#)

Expanding access to pharmaceuticals has become one of the most visible aspects of twenty-first century global health practices, as evidenced by the moral urgency of antiretroviral rollout and the pressing call for new drugs for neglected diseases. However, the role of prescription drugs in public health was far less obvious to the framers of international health organizations only a half-century ago. This article examines the evolving role of pharmaceuticals in global health practices by charting the emergence of the category of 'essential medicines': initially a list of 186 drugs first defined by the World Health Organization (WHO) in 1977 to be 'basic, indispensable, and necessary for the health of the population', and subsequently expanded by actors beyond the WHO including NGOs, pharmaceutical companies and the broader financial community. This apparently simple act of list-making worked to transport a set of commodities from the private, commercial sphere into a public health commons, and sparked a series of methodological, logistical and political controversies over the winnowing of 'essential' from 'inessential' that collapsed evidentiary, regulatory, participatory and market terms into a single process. To ask 'what practices render a medicine essential?' is therefore to address the shifting ecology of knowledge governing global health today.

Donald W Light and Rebecca Warburton, [Demythologizing the high costs of pharmaceutical research](#)

It is widely claimed that research to discover and develop new pharmaceuticals entails high costs and high risks. High research and development (R&D) costs influence many decisions and policy discussions about how to reduce global health disparities, how much companies can afford to discount prices for lower- and

middle-income countries, and how to design innovative incentives to advance research on diseases of the poor. High estimated costs also affect strategies for getting new medicines to the world's poor, such as the advanced market commitment, which built high estimates into its inflated size and prices. This article takes apart the most detailed and authoritative study of R&D costs in order to show how high estimates have been constructed by industry-supported economists, and to show how much lower actual costs may be. Besides serving as an object lesson in the construction of 'facts', this analysis provides reason to believe that R&D costs need not be such an insuperable obstacle to the development of better medicines. The deeper problem is that current incentives reward companies to develop mainly new medicines of little advantage and compete for market share at high prices, rather than to develop clinically superior medicines with public funding so that prices could be much lower and risks to companies lower as well.

Alex Broadbent, [Defining neglected disease](#)

In this article I seek to say what it is for something to count as a neglected disease. I argue that neglect should be defined in terms of efforts at prevention, mitigation and cure, and not solely in terms of research dollars per disability-adjusted life-year. I further argue that the trend towards multifactorialism and risk factor thinking in modern epidemiology has lent credibility to the erroneous view that the primary problem with neglected diseases is a lack of research. A more restrictive contrastive model of disease is endorsed as better suited to the definition of neglected disease.

Ann H Kelly and Uli Beisel, [Neglected malarials: The frontlines and back alleys of global health](#)

Among the public health community, 'all except malaria' is often shorthand for neglected tropical diseases. The Bill and Melinda Gates Foundation's cause célèbre, malaria receives a tremendous amount of funding, as well as scientific and policy attention. Malaria has, however, divergent biological, behavioural and socio-political guises; it is multiply implicated in the environments we inhabit and in the ways in which we inhabit them. The malaria that focuses our attention crops up in the back alleys of Dar es Salaam, brought into being by local labour and municipal governance – a version of malaria that, we argue, is increasingly excluded in current eradication campaigns. This article considers

the cycles of public health amnesia, memory and neglect that construe the parasitological exchange between man and mosquito. It begins by exploring the political concerns and technical capacities that have transformed malaria into a global enemy. Combining these historical accounts with ethnographic material, we suggest how malaria is disentangled from or conflated with particular places. Ultimately, our aim is to reflect upon the relationship between scale of malaria control and its social consequence, attending to the actors and relations that fall outside of contemporary global public health policy.

Paul Kadetz, [Assumptions of global beneficence: Health-care disparity, the WHO and the outcomes of integrative health-care policy at local levels in the Philippines](#)

Traditional, complementary and alternative medicine (or heterodox health care) functions as the primary source of health care for a majority of populations in low-income countries. The World Health Organization has promoted the integration of heterodox health-care practices and practitioners into formal state and local biomedical health-care systems. Heretofore, the literature has assumed the beneficence of this policy in reducing health-care disparity, without assessing the outcomes of this policy's implementation. This research examines the impact of health-care integration policy on local health care in communities in four municipalities in the Philippines. Communities in two municipalities that implemented health-care integration (top-down and bottom-up) were compared with two municipalities that did not implement health-care integration. A qualitative design of data collection was utilised. Convenience samples (n=500) of community members, community leaders, health-care providers and key policy actors participated in semi-structured interviews and focus groups to assess the changes in community health-care systems and in community health-care access following health-care integration. The assumptions of beneficence of health-care integration are not supported by this research. Furthermore, this research suggests that health-care integration may not be beneficial to communities if implemented in a manner that ignores the particular needs of a given local context.

Anne Pollock, [Transforming the critique of Big Pharma](#)

Intersecting fields of scholarship have accounted for pharmaceutical companies' extraordinary success in promoting

and profiting from their wares. This article instead tracks resistances and failures in the terrain of Big Pharma amid economic, epistemological and political challenges to their business models. Pfizer has been a key player in the rise of Big Pharma, and its fortunes since 2006 provide windows into the industry's stagnation – the failure of Pfizer's would-be blockbuster torcetrapib, the closing of its heart disease research unit, its free drug program for newly unemployed Americans. These illustrate transformations in 'least neglected diseases' and in pricing structures, and can be understood in the contexts of both biotech and Global South critique. Biotech companies have remained profitable by creating biologics for niche subsets of rich populations with a high willingness to pay (including lucrative treatments I call 'drugs for short lives'). At the same time, dominant global capitalists/philanthropists have brought unprecedented funding to making treatment for AIDS and TB available to the poor and tackling long-neglected diseases like malaria. Now that pharmaceutical profits and markets seem less than infinite in their expansion and philanthropy has been pharmaceuticalized, the stakes of demands like 'medicine for people not for profit' are changing. STS critique of pharmaceuticals should take these transformations into account as it deepens its systemic critique of global inequality.

Medical Anthropology: Cross-Cultural Studies in Health and Illness
[Volume 30, Issue 2, 2011](#)

Anita Hardon; Hansjörg Dilger, [Introduction: Global AIDS Medicines in East African Health Institutions](#)

In this introduction to the special issue, we follow the journey of global AIDS medicines into diverse health facilities in East Africa, which for decades have been subjected to neoliberal reform processes and increasing fragmentation. The introduction explores the multifaceted and multidirectional connections between global processes and their manifold articulations and experiences "on the ground." We sketch how individuals, families, and communities dealt with HIV/AIDS-related illness and death before the scale-up of life-prolonging antiretroviral therapy programs, and describe the global policy processes that led to an influx of large volumes of donor support for AIDS treatment programs. We argue that global AIDS medicines have caused dramatic changes in institutional set-ups and care practices. The pharmaceutical medicines travel to the local health care settings with "baggage": protocols and guidelines on who to treat and why, with strict guidelines on how to

ensure adherence; and new notions of responsible and therapeutic citizens. This special issue elucidates the frictions, negotiations, and ambiguities that have shaped the incorporation of global AIDS medicines in local healthcare settings.

Dominik Mattes, [“We Are Just Supposed to Be Quiet”: The Production of Adherence to Antiretroviral Treatment in Urban Tanzania](#)

This article investigates the implementation of antiretroviral therapy (ART) in urban Tanga, Tanzania. First, the enrollment procedures of the national treatment program and medical professionals’ techniques to produce adherent patients are examined. Second, exemplary case studies of patients and their families are explored to depict varying responses to the increasing medicalization of everyday lives through the therapy’s rigid treatment regime. I argue that the observed disciplinary power exerted on users of antiretroviral medicines throughout treatment preparation and surveillance contrasts with the emergence of ‘therapeutic citizens’ as described in the wake of ART introduction in other African settings. There are also frictions between propagated biomedical truths and ‘rational’ lifestyles, on the one hand, and patient reasoning on the other; the latter being strongly influenced by perceived gender roles, economic constraints, and the struggle to maintain mostly kinship-based support networks.

Anita Hardon; Emmy Kageha; John Kinsman; David Kyaddondo; Rhoda Wanyenze; Carla Makhoul Obermeyer, [Dynamics of Care, Situations of Choice: HIV Tests in Times of ART](#)

In the 1990s, African AIDS programs followed a voluntary counseling and testing (VCT) approach to HIV testing. In the wake of large scale AIDS treatment programs, policymakers opted for routine provider-initiated testing (PITC) with less emphasis on counseling, which led to concerns about the ethical conduct of HIV testing. Inspired by Annemarie Mol, we ask if PITC can be framed as good care, rather than as medical domination that threatens to violate patients’ rights. Based on fieldwork in Ugandan and Kenyan health facilities, we reveal that situations of choice vary: patients in hospital wards, are given time to decide whether they want a test, while in antenatal care testing women find it very hard to opt-out. We argue that the medical context inherent in PITC provides an attractive moral space for people to undergo HIV tests.

Noelle Sullivan, [Mediating Abundance and Scarcity: Implementing an HIV/AIDS-Targeted Project Within a Government Hospital in Tanzania](#)

While free antiretroviral therapy (ART) in Tanzania has undeniably increased accessibility of services, the effects of ART programs as they are brought into existing health facilities are more ambiguous. As transnational nongovernmental organizations (NGOs) establish clinics within government hospitals, we see a telling example of how NGOs are providing services from within the state. The conditions of NGO-operated clinics within government health facilities act as a daily reminder of the failures of the government to provide health workers with that to which they feel entitled: adequate pay, access to sophisticated technology, upgraded training, extra-duty allowances, and a professional working environment. At the same time, health personnel compete to position themselves in such a way to be able to make claims on the state through these NGO clinics, which is the only means available for them to access the very resources to which they feel entitled by their profession.

Oliver Human, [The Rings Around Jonathan's Eyes: HIV/AIDS Medicine at the Margins of Administration](#)

In this article I explore how a medical protocol is encountered by a doctor practicing in a South African setting. I examine how the attempt at standardizing medical services is simultaneously challenged and upheld within medical practice by illustrating the cognitivist assumptions upon which standardizing medical decision making is based, and showing how this is a product of a particular history of thought. This is challenged by the practice of medicine. I then explore the ethical implications of standardization. The case studies demonstrate that relationships between doctors and patients do not fit necessarily into the pre-established categories created by protocols.

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