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Author
Herr Harthorn, Barbara

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The Ethnography of Health Inequality:
Global Risk Society and Local Suffering

Barbara Herr Harthorn
UC Santa Barbara

The *delocalization* aspects of globalization are often cited as the most socially and economically destructive of its forces. In this paper, I want to discuss the possibilities for ethnography to *relocalize* the global. In particular, I argue that the assessment of risks attached to numerous aspects of global enterprises pleads for the kind of recontextualization that ethnography can provide through tracing the contours of local and translocal suffering and illness on the one hand and mobilization of agency and resistance on the other. My discussion will touch down on the SARS epidemic and the health of transnational immigrant workers in the California agricultural industry. They provide two different windows on the value of risk as a lens for examining the role of transnational forces in the social production of health inequality.

Globalization has frequently been discussed in terms of its **delocalizing** effects. Aspects of delocalization include fluid industrial location of production and its effects on workers, shifts in consumption to non-locally produced commodities and technologies, including mass media and popular culture, and increased vulnerability to the actions of global corporate actors who are far removed from local family, community, state, and nation (Heyman 1994; Inda and Rosaldo 2002). Delocalizing effects of globalization specific to health and healthcare include *spatial effects*, such as the loss of rural healthcare infrastructure, *political effects*, such as the increased power of global pharmaceutical companies to determine markets, availability, and pricing of critical pharmaceuticals, and the domination of modernist development-minded organizations such as WHO in directing from the center local practices and the infrastructure for health care in the periphery (Whiteford and Manderson 2000).

One of the most insidious *social effects* of delocalization is the kind of *forensic globalization* involved in judgments made about risk acceptability, for example when global corporate industries who effectively act as *risk makers* strategically relocate risk— environmental risks associated w/ production processes, occupational risks involved for their workers, or risks to the end-of-the-line consumers. A number of anthropologists and sociologists have argued that this idea of acceptable risk, which inevitably encodes racializing, gendered, and class-based agendas, only thinly veils the idea that there are expendable people, the actual *risk takers* who literally embody acute and long term health risks (Douglas 1992; Sobo 1995). In this paper I want to discuss the uses of ethnography, more specifically a critical medical ethnography, as a method for **relocalization** of these processes, and health and health inequality as an essential site for this kind of work.

First, to clarify my use of key terms, by talking about globalization as **delocalization,** I reference the processes that result in the loss of local power and control, especially through transnational corporate structures and practices, and also reference loss of meaning through dehumanization and depersonalization that accompanies these practices. I include as well their effects on local environmental and health degradation. By **forensic globalization**, I follow Douglas and others to represent a particular set of ideas and practices in the global arena that serve to redistribute "risk," often transnationally, and certainly across ethnic, gender, and class lines. In this case, I want to argue that increasingly well documented accelerating health inequalities, both between Third World and First, the South and the North, and within nations around the globe, can be directly linked to the normalization of forensic judgments about risk and risk acceptability.

By emphasizing the project of **relocalization** for an ethnography of health and health inequality I mean to imply a method of local and translocal analysis, inevitably multi-sited (cf. Marcus 1995) that embraces the following set of assumptions:

- an awareness of macro/global forces and actors, thus explicitly including the assumption that the local is not its own universe (cf. Marcus 1995; Gupta and Appadurai 1996);

- a post- theoretical framework, one that aims to make visible the invisible, the erased (Lipsitz 1994);

- an awareness of multiple temporalities as well as locations;

- a political agenda of witnessing, that includes mapping the "neoliberal politics of health" (Rylko-Bauer and Farmer 2002);

- and the idea that "flows" seen through this approach are better conceptualized as translocal movements of ideas, knowledge, funding, and people (Fisher 1997; Graeber 2002; Tsing 2002).

I note this discussion assumes a relatively unproblematized use of "**ethnography**." I am not dismissing the many epistemological and ideological concerns anthropologists and others have raised about ethnographic research and the primarily textual products known as ethnographies (see Inda and Rosaldo 2002 for an excellent overview), but for the purposes of this discussion, I emphasize the work that anthropologists have shown ethnography, as distinct from other social science research methods, to be uniquely suited to accomplish. Thus, we can assert that ethnography can work to: argue against stereotypes fostered by anonymity by showing individuals (e.g., Desjarlais 1997; Beuf 1990), and, more broadly, resist universal categories (e.g., gender,

Baca Zinn and Dill 1999) and relativistic analyses; explore all the senses of experience

(Stoller 1997); show the complexities of the multivalent choices people make (Sobo

1995); trace how discourse weaves meaning and power in ritual performances (Csordas

2002); reveal the fragmented, fractured, and decentered aspects of everyday experience,

rather than just the normative; disrupt the trope of continuity and tradition/modernization

and rupture; show the effects of decision processes and moral dilemmas; and highlight

local ethnic and national identities that globalization discourse tends to overwrite. Even

more generally, I would argue that ethnography consistently reveals issues and problems

that surveys do not (e.g., in the context of managed care research, Rylko-Bauer and

Farmer 2002).

　　　While the examples above provide evidence for the particular strengths of

ethnography as a methodology, ethnography has had a much less visible role in the

literatures on health inequality. There is little doubt that health inequality is accelerating

globally, both within and between nations. This is linked with relative economic

inequality, as shown in Wilkinson's landmark book, *Unhealthy Societies: The Afflictions*

of Inequalities (1996). In general, the proponents of this approach to economic and health

inequality argue that inequality is demonstrably bad for our health (Daniels, Kennedy,

Kawachi 2000), and that justice is good for our health. More specifically, researchers like

Paul Farmer have argued that globalization-produced social inequalities have led to

economic inequality that has led, in turn, to the very inequitable distribution of risk and

vulnerability to infectious diseases like AIDS and TB, compounded by further inequities

in access to health care (Farmer 1996, 1997). Farmer's award-winning analysis of AIDS

vulnerability in Haiti (1992) laid the groundwork for this argument about the "structural

violence" of globalization and its impact on population health. This study alone provides a strong argument that close, ethnographic examination of socially-defined risk and its categories of acceptability can show how health inequalities are embodied, both among the healthy and ill.

The socially constructed aspects of illness are highlighted in this approach, in part because anthropologists have shown how the experience of illness necessarily involves moral suffering, because it always represents a transgression from the normative for the ill. Thus, an understanding of local moral worlds is always needed to understand suffering (Good 1994; Kleinman 1992). Global regimes of discipline and care and other messaging systems (e.g., global media) increasingly confront and disrupt local moral systems, in addition to their more direct negative impacts on health. The implications and causes of increased social suffering (i.e., health inequality) are arguably best analyzed in terms of a wide array of social, cultural, historical, political, and economic variables, and the methods of situated ethnography can contribute to this portrayal (Kleinman, Das, and Lock 1997; Castro and Marchand-Lucas 2000). I am suggesting that risk is a particularly fruitful "idiom of distress" for this kind of ethnographic analysis.

Giddens and Beck have provided the most prominent arguments about our global "risk society," in which late modernity or postmodernity is typified by eroding public trust in the state and its institutions for governance, in science and technology and their experts, and in global corporations. Lack of trust is expressed through increased feelings of fear, anxiety, and uncertainty, often expressed through risk talk. Risk has become a negatively valenced term for danger (Douglas 1992) that also encodes ideas of uncertainty (Lupton 1999; Luker 1975), and a number of researchers have shown that at

least in the English language its use has increased exponentially in the past decade (see
Lupton 1999:10). Ulrich Beck in particular has argued that the late 20th century saw the
emergence of a global risk society in which the globalized, less identifiable nature of
risks along with their increased potential for serious harm not just led to anxiety and
uncertainty but reflected a deep transformation in society as the 'failed promises' of
modernity's discourse of progress became widely recognized (Beck 1992; Giddens 1994;
Lupton 1999). Thus, this analysis of globalization predicts strong feelings of alienation
and negative affect among citizens in the industrialized West accompanying the erosion
of trust. Lupton has argued that risk meanings and strategies often have the paradoxical
effects of arising in order to stem uncertainty and anxiety while effectively producing
those same affects and cognitions (1999).

The forensic globalization argument allows us to focus the analysis of risk
particularly on the issues surrounding inequality. Defining risk is always an exercise of
power (Slovic 2000), and the social processes that construct and maintain risk as public
issues are at least as important as the physical and psychological dimensions of risk in
influencing perception of risk and acute risk events (Rogers 1997). For example, one
study has shown that lay inferences in the US about chemical exposure have 2
components, one about the mechanisms of exposure, and the other about the perceived
motives and purposes behind risk communication about chemical exposure (MacGregor,
Slovic & Malmfors 1999). It is into this field of health risk perception, linked to global
processes but grounded in local and trans-local ethnography, that I propose to venture
here by sketching the potential contributions of the ethnography of risk to the work of
relocalization.

This is a time when the global reach of infectious disease is prominently in the public eye, most immediately by the SARS (Severe Acute Respiratory Syndrome) epidemic, and with HIV/AIDS and multi-drug resistant TB much more broadly. The global public health arena is one particular case in which to interrogate the development project of the West. Like the days following 9-11 in the US, the SARS epidemic shows vividly how global regimes of care and disease control intersect with global, national, and local political and moral agendas. In the case of HIV/AIDS the spread of infections is clearly along "fault lines" caused by structures of inequality (see Parker 2000). It is too soon for the postmortem on SARS, but the differential assessment of the degree of risk (by nation, class, location), appropriate interventions, media coverage, dedication of resources, and so on by different national and international actors provide an unusually high degree of visibility to the social processes through which risk is constructed and communicated. The following sets of questions indicate the starting points for an ethnography of infectious disease risk in this case:

Affect: US newspaper accounts quoted Chinese public saying that "if SARS doesn't kill you, fear will" to indicate the panic and outrage associated with the conflicting typifications of risks, the political suppression of epidemiological data, and the quarantine processes. How did the media work to both create and control public panic and fear, and how did the public perceive them?

Social control of health risk: Jobs have already been lost over risk communication strategies chosen, and civic choice versus state control over limiting exposure and transmission possibilities is debated internationally. How has the process of quarantine, which historically has always carried stigma, worked in these situations—how enduring

or transitory are risk assumptions? And how to different regimes operate? For example a recent NPR story in the US detailed the complete lack of preparedness of the US to implement quarantine interventions such as those put in place Toronto, should it be necessary.

Social and self protection: Who had access to protective equipment and who didn't? Who had the economic means to carry out self protection and who had to depend on socially provided care? What social categories got what kind of care, and how was this rationalized?

The at-risk label: Who was seen as being at risk? How are gender, race, and class implicated epidemiologically and in terms of social identification? How do persons of differing social locations form judgments about their own risk vulnerability and the motives and agendas of those pursuing them? Do previous health status, nutritional status, gender, age, ethnicity, social marginality, access to care, and other factors we know to lead to vulnerability to infection elsewhere play out in this epidemic? How do those assumptions inform behavior? What does this kind of outbreak do to the cultural constructions placed on global mobility and travel? What kinds of local meanings do social actors place on their susceptibility to or escape from infection? How do new technologies (of health care, of communication) play a role in the construction of a global epidemic? What processes seem linked to these particular global judgments about risk, given the relatively low numbers of people afflicted with the disease and its effects? A multi-sited ethnography of this could follow Emily Martin's lead in her award-winning study, *Flexible Bodies,* to trace the construction of the SARS virus and the judgments about risks associated with it through different sites—the laboratories where it was

identified, the hospitals where it traveled, turning numerous care-givers into deathly ill patients, to the airports and planes that provide transportation to microbes along w/ human passengers, to the media who cover the event, to the public fascination with and aversion to these processes, to the different national regulatory processes that responded so distinctively to this disease, and to the afflicted—the quarantined and the sick and the dead.

A recent analysis of 'the politics and anti-politics of NGOs' has shown vividly the irony of WHO and World Bank-mandated, bottom-up development through NGOS of such moral and political agendas as family health, infant care, women's reproductive health, and food preparation (Whiteford and Manderson 2000; Fisher 1997). This critique shows how moral and political agendas in globalization can be disguised within deceptively simple generalizations. Whiteford and Manderson (2000) in particular have shown how the global playing field for public health is not just rife with inequalities but also dependent in its logic on maintaining the illusion of a level playing field. Two classic examples that depict this are the changing world of WHO wisdom about infant bottle-feeding, wherein breast feeding was for decades actively suppressed under racist and sexist colonial regimes of 'care' while milk corporations exported and heavily marketed expensive and nutritionally inferior infant formula with a result in declining breast-feeding rates worldwide. The relocalized ethnography of WHO-mandated NGO family health care today shows remedial instruction of breast feeding techniques to the next generation of women around the globe and the proliferation of new medicalizing expertise (such as lactation consultants) in those same societies (Manderson 1982; Ram and Jolly 1997; Castro and Marchand-Lucas 2000; Whiteford and Manderson 2000).

Ethnographic analysis shows the conflict for women between these globally constructed mandates and agendas to urge women to breast-feed and local contradictions as the realities of the changed working world make breast feeding impractical (Gottschang 2000).

The marketing of tobacco in the Third World is another notorious case. In this instance, tobacco companies who are being actively prosecuted in the US, Canada, and Australia over the risky product they push and the health consequences of its use for millions of people, nonetheless continue to expand their markets in low-income countries that are often also, not coincidentally, the tobacco-producing countries who are most dependent on the market (Unwin et al. 1998; Whiteford and Manderson 2000). Critical ethnographies have been key in showing the multiple effects of such global corporate practices on health and behavior, and the interrogation and interpolation of managerial discourses of risk and embodied risk, across boundaries of gender, age, status, nation and region can be particularly illuminating.

I would like to move my discussion now to one final example to trace the possibilities of ethnography for relocalizing globalization through an examination of risk. This case involves transnational migration and global agribusiness by looking at Mexican-origin immigrants working in California agriculture. A relocalized ethnography of health and health inequality among the women and men who do farmwork entails a multisited analysis of risk discourse and embodied risk, exposures and resistances, over time, within a large, vertically integrated, corporatized agricultural industry, a struggling rural health care system, and racially segregated, poverty-stricken communities with few collective resources. The analysis needs to include attention to processes of migration

and a close analysis of the living and working conditions experienced by women and men farmworkers and their families (Harthorn 2003). The multiple and conflicting constructions of risks to from exposure to agricultural chemicals by numerous federal, state and local government agencies, by their scientists and those in industry and the academy, the powerful lobby of agribusiness in Sacramento and its effects in political control of risk judgments produced from these locations, and the growers who put farmworkers on the frontline for experiencing pesticide exposures but also experience exposure themselves—a full ethnography will include the views of risk from these different social locations and the practices that ensue from them.

Farmworkers' judgments about risk can be shown to vary by migration history and experience, age, gender, years of work in farmwork, crop- and grower-specific experience, direct personal experience of illnesses and injuries, by family factors, by relative economic conditions. Anxiety about finding and keeping work, INS capture and deportation, financial survival, and multiple experiences of racist derogation are the most salient 'risks' in farmworkers' reported concerns about their lives—longer term health risks from chemical exposures have lower immediacy and salience. Access to healthcare is a luxury most cannot afford, and through a paradoxical cycle that more Americans are sure to experience in the future, the sick and the injured find that if they cannot work, they also lose access to the healthcare they need to recover their health. The bodily burden of agribusiness's practices carries long past the time when growers see any responsibility for providing care to their workers.

Yet another thread in this fabric of work and health and life in the US is constituted by the Anglo communities whose suburban homes, carefully segregated from

those of the lower income Latina/o community, steadily encroach into agricultural land and who, once there, find themselves confronted with smelly and possibly dangerous exposures. Their anxious, clamoring voices are both heard and disabled by the politically dominated, regulatory processes that use the language of science to oppose conflict and to protect powerful agribusiness concerns in a state that depends on them for economic success. However, like many risk communication failures, this process does not account for public perceptions of health risk, their suspicions about the political and economic agendas of those declaring their air and their food to be "safe" or, even more problematic, "safe enough." Meanwhile 'the public' in question simultaneously erases the voices and concerns of those who most clearly embody these risks, the Latina/o farmworkers in the fields and their families.

This is only a sketch of how a situated ethnography of risk and health inequality can work to provide a contextualized view of the lived experiences of workers in a global industry, without instantiating a local that is self-contained, unchanging, univocal or even single sited. The kind of ethnography called for by these conditions is rather one that captures the global transformations responsible for living and working conditions of specific individuals and groups, follows the threads of those relations through layers of control and care, examines the political, historical, and cultural constructions of health and of suffering and illness, and shows how differing social locations profoundly affect experience, affect, and embodiment of risk. How women and men complicate global corporate agendas and medicalizing forces by having knowledge and agendas of their own and acting on them in overt and covert ways gets to the heart of the relocalization project described here (see also Lock and Kaufert 1998). Ethnography, in spite of the

many issues surrounding its practices, offers a unique possibility for participating in the

critique of globalization, witnessing its effects, and fighting for social justice.

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Notes