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The field of medical anthropology in *Social Science & Medicine*

Catherine Panter-Brick, Mark Eggerman

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**Title: The field of Medical Anthropology in Social Science & Medicine**

**Authors: Catherine Panter-Brick and Mark Eggerman**

**Yale University**

*Social Science & Medicine* Anniversary Issue 2017

### **The field of Medical Anthropology in Social Science & Medicine**

#### **Abstract**

Conceptually and methodologically, medical anthropology is well-positioned to support a “big-tent” research agenda on health and society. It fosters approaches to social and structural models of health and wellbeing in ways that are critically reflective, cross-cultural, people-centered, and transdisciplinary. In this review article, we showcase these four main characteristics of the field, as featured in *Social Science & Medicine* over the last fifty years, highlighting their relevance for an international and interdisciplinary readership. First, the practice of critical inquiry in ethnographies of health offers a deep appreciation of sociocultural viewpoints when recording and interpreting lived experiences and contested social worlds. Second, medical anthropology champions cross-cultural breadth: it makes explicit local understandings of health experiences across different settings, using a fine-grained, comparative approach to develop a stronger global platform for the analysis of health-related concerns. Third, in offering people-centered views of the world, anthropology extends the reach of critical enquiry to the lived experiences of hard-to-reach population groups, their structural vulnerabilities, and social agency. Finally, in developing research at the nexus of cultures, societies, biologies, and health, medical anthropologists generate new, transdisciplinary conversations on the body, mind, person, community, environment, prevention, and therapy. As featured in this journal, scholarly contributions in medical anthropology seek to debate human health and wellbeing from many angles, pushing forward methodology, social theory, and health-related practice.

**Keywords:** Interdisciplinary; medical anthropology; theory; ethnography; biology; health.

### **A big-tent research agenda**

One of the most elegant characterizations of anthropology describes it as *the most scientific of the humanities, the most humanist of the sciences*. This phrase encapsulates the unique balancing act that anthropology, in espousing a holistic approach, plays in the generation of knowledge pertaining to human beings. Over 50 years ago, this memorable phrase was quoted by Eric Wolf to contend that anthropology is “less subject matter than a bond between subject matters. It is in part history, part literature; in part natural science, part social science” (Wolf 1964) (p.88). Wolf denounced the narrowness of scholarly endeavors that banished and brandished certain disciplinary perspectives as unworthy or worthy of scholarly attention.

However, disciplinary battles seldom die a good death in scholarly circles. They were drawn in 2010, for example, at the American Anthropological Association meetings with a controversy focused on the place of science within anthropology: strong views were expressed regarding whether the field should define itself as encompassing both evidence-based science and humanistic approaches, pitting scientific data against interpretive insights. Others fought for the banner of holism, advocating the return of a ‘big-tent’ anthropology (Antrosio 2011). As the controversy played out in scholarly publications, one Editor-in-Chief would argue that “journals should not serve a gatekeeping function in disciplinary debates” (Boellstroff 2011): they should publish the best scholarship relevant to the field, without expecting authors to strive for broader appeal beyond their sub-disciplines.

By contrast, *Social Science & Medicine* makes a conscious effort to encourage interdisciplinary appeal. It strives to nurture interdisciplinary engagement in health matters, knitting together health research with implications for policy and practice. This brings us to

medical anthropology *per se*, a field of knowledge explicitly represented in flagship international journals such as *Social Science & Medicine*, *Medical Anthropology*, *Medical Anthropology Quarterly*, *Anthropology & Medicine*, and *Culture, Medicine and Psychiatry*. Here we find that originality, quality, and depth of scholarship will serve to both advance social theory within the field and generate vigorous cross-disciplinary conversations. One of the founding editors of *Social Science & Medicine*, Charles Leslie, is remembered as a strategic “catalyzer” of scholarly contributions across disciplines (DeVecchio Good 2010). In his role as senior editor espousing a vision of medical anthropology with global and interdisciplinary significance, Leslie did not shy away from controversy. For example, in early work on the diversity of medical systems, he argued that “anthropologists cultivate an evenhanded view of medical pluralism, in contrast to the normative view that characterizes health professionals” (Leslie 1980) (p.191). An evenhanded view of medical systems is one that understands why diverse ways of framing healer-patient relationships co-exist, and how this is related to historical, social, and political contexts. And in his essay on *Scientific racism: reflections on peer review, science and ideology*, Leslie went further in his critique of categorical thinking and narrow conceptualizations of what matters in our research journey: he reflected on the controversial publication of a paper on AIDS epidemiology and racial variation, which he condemned as “transparent racist pseudo-science” (Leslie 1990) (p.891). At the time, Editor-in-Chief Peter McEwan defended the peer review process leading to this paper’s publication in *Social Science & Medicine*, with the principle that “there must be no sacred cows – all reasoned argument has the right to enter the general arena of discourse” (p.891). In moving forward our scholarship, especially on topics that are so central to science and politics such as race and racism, Charles Leslie struck a thoughtful note. His conviction was that “good judgment in the social sciences depends on moral knowledge and

sensibility as well as on the critical use of scientific reasoning” (p.897). He encouraged us “to speak from an informed heart” (p.904).

Now just over fifty-years old, the field of medical anthropology has developed a stance of engagement and critical intersections with allied fields (Inhorn and Wentzell 2012). It espouses wide-ranging interests, employs diverse tools of enquiry, and operates in many different contexts. The Society for Medical Anthropology (a section of the American Anthropological Association) characterizes the field as follows: “The discipline of medical anthropology draws upon many different theoretical approaches. It is as attentive to popular health culture as bioscientific epidemiology, and the social construction of knowledge and politics of science as scientific discovery and hypothesis testing. Medical anthropologists examine how the health of individuals, larger social formations, and the environment are affected by interrelationships between humans and other species; cultural norms and social institutions; micro and macro politics; and forces of globalization as each of these affects local worlds” (<http://www.medanthro.net/about/about-medical-anthropology>). The European Association of Social Anthropologists, for its part, specifically calls on its Medical Anthropology Network to engage with health professionals in medicine, nursing, public health, social work, therapy and administration (<http://www.easaonline.org/networks/medical>). What these statements indicate is that medical anthropology, in its theoretical approaches, empirical interests, and professional reach, is uniquely well-placed to lead the good fight against disciplinary imperialism: it thus frames conversations about health in terms of moral values, political power, social change, structural vulnerabilities, historical legacies, biological development, epidemiological importance, clinical care, and/or ecological relationships.

Let us now highlight some of the ways in which medical anthropology has defined disciplinary and interdisciplinary debates, through the lens of articles featured in *Social Science & Medicine*. One of the key ways in which this journal has encouraged scholarly debate has been through the production of targeted special issues. Taking several noteworthy articles and special issues guest-edited by medical anthropologists as select exemplars, we point to four main ways in which the field of medical anthropology fosters approaches to social and structural models of health and wellbeing: its contributions are critical, cross-cultural, people-centered, and transdisciplinary.

### **Critical enquiry: offering depth of interpretation**

In a foundational article for building the approach of critical medical anthropology, Hans Baer, Merrill Singer, and John Johnsen (Baer, Singer et al. 1986) saw it vital to provide a “critical analysis of socio-medical contexts,” one that explicitly recognized the political economy of health and illness: “A key component of health is struggle” (in power, determining access to and control over resources), while “the ultimate character of health care systems is determined outside the health sector” (p.95). Their hope was that critical medical anthropology would achieve deeper insights into the social, economic, bureaucratic, and political forces that impact health and healing. Indeed, the practice of critical enquiry is a hallmark of anthropology – one that has fostered multiple, contested bodies of work rather than a single, homogeneous approach to practices of reflective thinking (Fassin 2017). Diverse approaches in critical medical anthropology include, for example, anthropologists who might define their role as cultural brokers within clinical settings, and anthropologists who come to oppose the biomedicalization

of life or engage in a broader vision of “social medicine” (Scheper-Hughes 1990, Good, Fischer et al. 2010, Lock and Nguyen 2010).

One of these strands of critical enquiry is specific to the practice of ethnography, which deployed in narrative form, to convey depth of insight, achieves much more than a simple description or case study illustration. Critical ethnography focuses our attention on the world-views and practices of organizations (by studying-up) and the lives and cultural histories of people impacted by institutions (by studying-down). This engages us with issues of power, legitimacy, and discrimination, in revealing what risks to health are embedded in social structures, as well as with analyses of agency and social change. The special issue on *Ethnography of Health for Social Change* (Hansen, Holmes et al. 2013) provides a good exemplar of how such matters are debated and framed. Guest Editors Helena Hansen, Seth Holmes, and Danielle Lindemann (2013) focused on the following question: How can ethnography foster public engagement in health issues? In their words, ethnographic narratives to-date “have had a demonstrable impact on professional and organizational practices as well as our theoretical understandings of health and medicine” (p.116), but have not yet defined broader impacts in engaging with critical social issues of our times.

In his contribution to this issue, Didier Fassin (2013) reminded us that critical ethnography has a propensity to unsettle, where it seeks to interpret and explain the “mystery” and complexity of noxious social phenomena. Focusing on the polemic surrounding the early years of the AIDS epidemic, Fassin (2013) situated his analysis within the political economy of the epidemic, rather than the cognitive and behavioral explanations of why the epidemic became so virulent amongst black South Africans. A political economy approach to health in anthropology has thus helped turn the tide against overly deterministic and superficial



explanations rooted in health beliefs and health practices, contesting the ahistorical, apolitical assumptions that equate a change in health beliefs with a change in health behaviors (Goodman and Leatherman 1998, Nichter and Lock 2002, Pool and Geissler 2005, Panter-Brick 2014).

In emphasizing the interpretive and political dimension of critical ethnography, Fassin is one among many scholars who persuasively argue for the ethnographic lens having multi-faceted significance. He shows that ethnography espouses a tradition of extensive fieldwork (an empirical contribution), a penchant for interpretive writing (a theoretical contribution), and an afterlife of knowledge transformation (a contribution of public engagement). Multi-layered ethnographies offer a good example of qualitative analysis that provides more than “a mere paraphrase of what the social agents know and tell, which is what it sometimes tends to be” (Fassin, 2013, p.122). This phrase rings a bell of caution for qualitative and mixed-methods research that contents itself with reproducing surface quotes from interview and focus group materials, lacking interpretive depth: such materials may reveal what people say, but not necessarily whether they will do as they say, given the many tradeoffs people must make in matters of health, health care, and decision-making. Even where presenting cultural viewpoints, a “responsiveness to multiple viewpoints and contested perspectives” is the *sine qua non* of critical reflexivity in the qualitative practice of ethnography (Pigg 2013). In practical terms, this means that anthropological research does not strive to describe cultural norms, in a reductionist and normative way; rather, seeks to showcase ambiguities, conflicts, and turning points that matter to people’s lives in society. Thus a notorious weakness of Knowledge, Attitudes, and Practices (KAP) surveys is to generate normative values about cultural beliefs that may prove of little value for understanding actual health-related decision-making. Even mixed-methods

studies, which might deploy ‘qual-quant-itative’ approaches, cannot sacrifice depth when claiming the virtue of breadth in data presentation.

Over the years, constructing social theory from ethnographic fieldwork, and highlighting both critical reflection and reflexivity in ethnographic study (Rubinstein 1991), has emerged as a powerful approach to record and interpret our lived experiences and contested social worlds. In *Social Science & Medicine*, we have seen a compelling body of work using ethnography and participant observation to analyze hospital care (van der Geest and Finkler 2004), ethnography and case studies to reflect upon and inform medical and public health practice (Harper 2007, Messac, Ciccaron et al. 2013), ethnography and textual analysis to investigate health communication (Briggs 2011, Hallin, Brandt et al. 2013, Prussing and Newbury 2016), and ethnography and structured interviews to reveal the world-views and practices of doctors, midwives, community health workers, patients, or families, and the contested practices of emergency care, routine vaccination, medicine use and medical technologies.

### **Global practices: championing cross-cultural breadth**

Scholarship in anthropology thus champions a deep appreciation of cultural knowledge - digging deep to find what habitually remains hidden from view. It also works hard to generate cross-cultural breadth in social analysis. Indeed, medical anthropologists take pains to demonstrate the complexities of social life and the everyday realities of human experience from the cradle to the grave – with powerful implications for normative assumptions about treatment and policy.

Thirty years ago, for example, there was a dramatic increase in medical anthropology work on the culture and politics of reproduction. Two special issues of *Social Science & Medicine* (Inhorn 1994, Jenkins and Inhorn 2003) drew attention to the “human drama

engendered by reproductive failure and its rising worldwide incidence” (Inhorn, 1994, p.459) and what the “emotionally charged contestations that take place in the everyday reproductive experiences of men and women around the world tell us about the subtleties of culture and power in everyday life” (Jenkins and Inhorn, 2003, p.1832). In generating cross-cutting themes, the special issue on *Reproduction Gone Awry* examined ways in which the concepts of normal and abnormal reproduction were problematized in countries such as Costa Rica, Egypt, France, Germany, Greece, India, Mexico, and the US. Papers made explicit the relevance of local understandings of agency and resistance to global reproductive practices, state policies, and policy-making pertaining to Safe Motherhood campaigns and New Reproductive Technologies. They focused attention on how, for example, immigrant women face true reproductive dilemmas and must be skilled negotiators of domestic and political climates (Sargent and Cordell 2003), how midwives have been demeaned by the biomedicalisation of birth with respect to their roles providing woman-centered care (Jenkins 2003), and how reproductive discourses regarding access to prenatal diagnostic technologies to screen against fetal anomaly are inflected by Germany’s political past (Erikson 2003).

Such issues continue to invigorate social analysis in many flagship journals and to engender forceful debates on sexuality, intersectionality, biopower, and health as a human right. Topics related to the human lifecycle, such as experiences of aging (Lock and Kaufert 2001) and conceptualizations of a good or bad death (Seale and van der Geest 2004), have come under similar cross-cultural scrutiny. Coming in the form of literature reviews, cross-cultural analyses of health issues can also be deeply insightful - examples include reviews of wellbeing, distress, and social positioning (Kaiser, Haroz et al. 2015), of mental health assessment tools (Haroz, Ritchey et al. 2017), and the social stigmatization of obesity (Brewis 2014). What *Social Science*

*& Medicine* strives for, in particular, is to bring scholarly research on health in conversation with practice and policy. One key element in this endeavor is to deepen and broaden disciplinary knowledge about health issues, presenting fine-grained data about specific issues in cross-cultural contexts, in order to foster global debates and comparative analyses of human existence, health, and wellbeing.

### **A people-centered approach to health**

Medical anthropology defines itself as offering a ‘people-centered’ view of the world when it comes to matters of health (Biehl and Petryna 2013, Farmer, Kim et al. 2013). Specifically, this is one of its defining contributions to global health, a field that has already gone through several conceptual ‘revolutions’ in advocating for access, quality, equity, and accountability in health. Putting forward people-centered analyses in global health signals a lifelong engagement with moral and political values: thus anthropology has generated powerful tropes and frameworks – such as *explanatory models of illness*, *social suffering*, *the mindful body*, *local biologies*, *local moral worlds*, *structural vulnerability*, *structural violence*, and *health syndemics* - to portray lived experiences, structural vulnerabilities, social agency, and biomedical practices (Kleinman, Eisenberg et al. 1978, Scheper-Hughes and Lock 1987, Kleinman, Das et al. 1997, Lock and Kaufert 2001, Farmer, Nizeye et al. 2006, Kleinman 2006, Lock and Nguyen 2010, Quesada, Hart et al. 2011, Suri, Weigel et al. 2013, Singer, Bulled et al. 2017).

In doing so, anthropology often extends the reach of critical enquiry to the lived experiences of hard-to-reach population groups. For example, in the *Social Science & Medicine* special issue on *Migration, ‘Illegality’, and Health* (Willen 2012), scholars examined the political and moral frames that portray those who fundamentally “have the right to have rights”

in opposition to those human beings who are fundamentally “other,” marginalized, undeserving and underserved. Compelling papers by scholars such as Heide Castañeda in Germany, Stéphanie Larchanché in France, Nora Gottlieb et al. in Israel, and Seth Holmes in the US examine the frames of exclusion and inclusion and the structural scaffolding of health care inequity (Castañeda 2012, Gottlieb, Filc et al. 2012, Holmes 2012, Larchanché 2012). In her introduction to the special issue, Sarah Willen framed three main goals of social enquiry; these well underscore the journal’s mission statement. One is to leverage interdisciplinary research to deploy a range of methods, both quantitative and qualitative, in diverse contexts, both lay and professional settings, in order to present multiple stakeholder perspectives. A second is to move to foster a robust enquiry on ideological environments, social discourses, and everyday practices, in order to illuminate what consequences specific ideologies and social practices have on health. The third is to link people to structures, debating important concepts and processes - such as how structural inequality becomes *embodied vulnerability*, stamped upon the body as well as stamped upon lived experiences. Such analyses reveal the force of exclusionary arguments about who merits attention in health care and investment. They go beyond the “simply acknowledging that normative understandings of who should have access to health care and the social determinants of good health and well-being often fail to map onto empirical assessments of who actually does have access” (p.809). As Willen emphasized (pp. 806-7), the concept of *deservingness* (perceived moral worth) is distinct from questions of entitlements (defined by law or policy) and/or mere access to good health or good health care.

This body of work speaks to debates on structural vulnerability and the embodiment of risk (Quesada 2012), analyses of health with a lens on social justice (Castro and Singer 2004), and tangible assessments of social history to help address health disparities in clinical care

(Bourgois, Holmes et al. 2017). As shown in this special issue and argued elsewhere (Petryna, Kleinman et al. 2006, Ticktin 2011), medical anthropologists shed light on how discourses of moral worth, entitlement, and exclusion reinforce structural restrictions on health and bolster popular, institutional, humanitarian, and clinical practices leading to neglect and maltreatment. They also help provide a people-centered, empirically-grounded analysis of health risks and health-related behaviors: some compelling examples include the therapeutic use of harmful chemicals for self-treatment (Ramdas 2012), the practice of healthy-disordered eating (Musolino, Warin et al. 2015), caregiving priorities and child developmental risks (Worthman, Tomlinson et al. 2016), the vulnerabilities of injecting drug users (Rhodes, Singer et al. 2005), threats to masculinity leading to suicide (Adinkrah 2012), attacks of anger among traumatized refugees (Hinton, Rasmussen et al. 2009), the silencing of emotional suffering and medicalization of distress in war-affected children (Akello, Reis et al. 2010), and resilience among survivors of genocide-rape (Zrally and Nyirazinyoye 2010).

### **Transdisciplinary innovation**

Lastly, in pursuing a big-tent research agenda, medical anthropology embraces conceptual and methodological versatility, which in turn fosters transdisciplinary innovation on issues relevant to wellbeing of the body, the mind, the person, the community, and the environment. In developing and expanding research at the nexus of cultures, societies, biologies, and health, medical anthropologists are well-placed to help crystallize interdisciplinary knowledge and catalyze new interdisciplinary conversations. Some of the special issues in *Social Science & Medicine*, led by anthropologists, explicitly include contributions from many disciplines in order to debate health from many critical angles. One good example of transdisciplinary reach is the

study of *Sleep, Culture and Health: Reflections on the Other Third of Life* (Henry, Knutson et al. 2013). Twin goals for this issue were to provide a “collective benchmark” for social science study, given that the field of sleep and sleep disorders lacked conceptual coherence, and to stimulate future social research, across the lifecycle, of value to public health, medical and therapeutic advice, and social and technical enquiry. Papers in this special issue offered methodological, empirical and theoretical innovations, as championed by medical anthropology and allied disciplines. Thus to develop a comparative sleep ecology, medical anthropologists took to the systematic direct observation of both night-time co-sleeping patterns in the laboratory (Volpe, Ball et al. 2013) and day-time napping patterns within the household (Worthman and Brown 2013). Some have challenged the public health initiatives focused on Sudden Infant Death Syndrome and the strongly-held views about infant care and safe sleeping locations in contemporary Western societies, showing them to be evolutionarily peculiar and socially counter-effective to sustained breast-feeding practices (Volpe and Ball 2013). They have examined what sleep means in diverse populations and why sleep matters to health, with a lens on the body, the mind, the adolescent at school, the person in a co-sleeping partnership, the lay and professional discourses of risk, and the strategies deployed for sleep disorder prevention and therapy. Medical anthropologists are here framing new questions about the biological and sociopolitical significance of sleep for human health, and also calling for transdisciplinary insights and collaboration.

To generate transdisciplinary conversations often leads one to transform one’s toolkits, concepts, and partnerships. To nurture collaborations and long-term partnerships across academic and professional institutions is a very generative endeavor, one that is not generally thought to pertain to anthropology, given its roots in ‘deep ethnography’ in far-away locales. Yet

it is the hallmark of much research in biological anthropology, human ecology, and cross-cultural psychiatry, all sub-fields that dovetail and overlap with the sub-field of medical anthropology. Thus many anthropologists have worked to develop ambitious, multi-method and multi-country collaborative projects. Craig Hadley and colleagues, for example, have focused on issues of food insecurity and water insecurity in resource-poor settings, examining their impacts on lived experiences, nutrition, and population health across generations. In their analysis of precarious households in Ethiopia, for example, Hadley et al. analyzed a large population dataset to test whether household level measures of food insecurity predicted adolescent experiences of food insecurity, and whether this was patterned by gender (Hadley, Lindstrom et al. 2008). Broadening and thus innovating on studies of water shortages and uncertainty, Stevenson et al. examined the cultural, lifestyle, and wellbeing aspects of water insecurity, taking research and policy concerns beyond mere distributive notions of access and adequacy (Stevenson, Greene et al. 2008). Here mixed-methods approaches advance new understandings of the impacts of insecurity, as opposed to outright scarcity, contributing to a body of knowledge on how households and communities must leverage precarious resources to navigate the real tension between sustaining lives and sustaining livelihoods (Hampshire, Panter-Brick et al. 2009, Hadley, Stevenson et al. 2012). Importantly, such research is predicated on building long-term collaborations and institutional partnerships to advance research endeavors.

Many other health domains have similarly benefited from an explicit cross-cultural, interdisciplinary, and collaborative research agenda. As published in *Social Science & Medicine*, examples include special issues on the ethics of medical research in Africa (Molyneux, Peshu et al. 2004, Molyneux and Geissler 2008), research at the intersections of violence and global health (Panter-Brick 2010, Lee, Leckman et al. 2015), research and practice in humanitarian



settings (Good, Delvecchio Good et al. 2014), and analyses of health and financial crises (Basu, Carney et al. 2017). Biocultural research teams have investigated, for example, the links between prestige-based or dominance-based social rank and nutritional status in the Bolivian Amazon (Reyes-Garcia, Molina et al. 2009), the impacts of rapid modernization and changing social stratification on immune or hormonal responses in Samoa (James, Baker et al. 1987, McDade 2001), and possible intergenerational impacts of ethnic discrimination in New Zealand (Thayer and Kuzawa 2015). Historical and spatial analyses of colonial and present-day administrative and clinical data have converged with qualitative interviews and case-control studies to help explain the origin and persistence of neglected diseases (de Silva, Albert et al. 2017).]

In medical anthropology, we find that writing for interdisciplinary audiences serves an important purpose: it builds upon careful analyses of ‘culture’ and health (Dressler 2012, Singer, Dressler et al. 2016), seriously engages with global diversity (Manderson, Cartwright et al. 2016), and fights the necessary fight against the grave shortcomings of cultural explanations that are often deployed in the health literature (Viruell-Fuentes, Miranda et al. 2012). Culture is all too often conflated with context – indeed, it is often equated with society, religion, or ethnicity, boxing together large swaths of individuals into tidy analytical categories in multi-country surveys, and often relegated, as with race or gender, to the role of a single predicting variable. Anthropology advocates a fine-grained approach to culture, one helpful to understand processes and change in ways that can be amenable to quantification for useful and meaningful biocultural research. For example, Dressler and colleagues in Brazil were able to connect individual-level analysis to social norms and structures, through cultural consonance analysis of stress physiology, depression, and genetic markers (Dressler 2012). Anthropology also calls for

investigating health over the lifecourse, paying attention to which measures are useful for appraising biological outcomes or developmental pathways. For instance, demographers, epidemiologists, and anthropologists have engaged in back-and-forth debates on how to define and measure 'stress' across 'social context' in order to reach a multidimensional understanding of health and allostatic load (Gresten 2008, Loucks, Juster et al. 2008, McDade 2008).

Integrated biocultural analyses of health and wellbeing, while challenging, are needed to advance paradigms of medicine and public health (Worthman and Kohrt 2005). Anthropologists are also open to applying theoretical frames originating in other disciplines, to provide innovative understandings of health issues - such as using signalling theory to analyze how patients decide whom and what treatment to trust (Hampshire, Hamill et al. 2017).

One of the earliest, most-cited contributions in *Social Science & Medicine* was written by Arthur Kleinman, a medical anthropologist and a psychiatrist, to advance a "new cross-cultural psychiatry" (Kleinman 1977). This paper demonstrated the pitfalls of category fallacy in relying on data on illness categories as if they were culture-free, as "defined and therefore seen" by a Western cultural model (p.4). Thus was launched an early battle for the relevance of cultural analyses in global mental health, a battle that is now largely won. The field of global mental health is now a diverse and engaged field of research and practice (White, Sumeet et al. 2017). It advocates the representation of diverse communities and underlines the impacts of poverty, inequality, and violence on wellbeing. In settings of violence and marginalization, global mental health research now goes beyond a narrow interest in trauma-focused epidemiology and therapy (Miller, Kulkarni et al. 2006, Pedersen, Tremblay et al. 2008, Miller and Rasmussen 2010), and also goes beyond analyses of social suffering and distress to give voice to experiences of

everyday resilience, resistance, agency, or hope (Wexler, DiFluvio et al. 2009, Eggerman and Panter-Brick 2010, Barber, McNeely et al. 2016).

In this respect, medical anthropology in conversation with allied disciplines has been successful in shaping the research and practice agenda in global mental health, explicitly supporting a framework attuned to political ecology and social ecology to advocate better strategies to support the under-served (Kohrt 2010, Kohrt, Rasmussen et al. 2014, Pedersen 2017). It has also been singularly successful in invigorating research on plural medical systems (Rubel and Sargent 1979, Helman 2006), the scientific agenda on infectious diseases and health syndemics (Singer, Bulled et al. 2017, Willen, Knipper et al. 2017), and debates on race and racism (Dressler, Oths et al. 2005, Gravlee 2009), to give further examples of cross-disciplinary knowledge production.

### **Ongoing challenges**

Yet often times anthropologists face more than an uphill battle in spearheading social engagement, political change, or policy improvement in matters of health. Responses to the West Africa Ebola outbreak between 2014 and 2016 are a case in point: social sciences expertise on ‘culture’ and community-level social mobilization was sidelined by medical responses to contain the epidemic. Those anthropologists who made ethical, practical, and logistical recommendations to improve crisis management (Calain and Poncin 2015, Abramowitz 2017) saw major gaps in the integration of social sciences during global health crises, but remained “distant from the centre of decision-making and resource prioritization” (Abramowitz, Bardosh et al. 2015) (p.330). The nature and relevance of anthropological enquiry has also been strongly contested in the arena of neglected tropical diseases, where global and financial rhetoric

concerning mass drug treatment have led stakeholders to willfully set aside local, biological and social evidence undermining claims to a successful public health campaign (Parker and Allen 2014). In part, this is because medical anthropologists have brought to light data that will unsettle the humanitarian and human rights imperative of global health policies – by highlighting their unintended consequences, their ethical shortcomings, or community-level resistance to biomedical interventions. At times, the so-called ‘small data’ about actual people, generated from close observation, are at odds with the ‘big data’ analytics about patterns and trends, based on analyzing statistical associations at the population level. Integrating ‘small data,’ which often reveal tensions and dissent, with ‘big data,’ which capture associations, is often a challenge for public health decision-making.

There are still many ‘translational gaps’ undermining effective collaboration between scholars and policy-makers in the fields of humanitarian, clinical, and global health care. Some of these gaps rest upon what is thought to constitute compelling evidence (Adams 2013). In terms of data presentation, social sciences analyses can span the single case study (Zenker 2010) to more than a thousand interviews (Eggerman and Panter-Brick 2010). In cross-methodological collaboration, they carve up spaces “to document context, process and meaning” within quantitative or clinical research (Messac, Ciccaron et al. 2013) (p.2). Other gaps rest upon the disjunctures between critical social theory, epidemiological models, and activist research, where researchers often speak past one another, with little appetite to integrate methods, theory, or practice. Such gaps truly matter for health and wellbeing – and are thus of fundamental importance.

## **Conclusion**

Medical anthropology is poised at the intersection of the humanities, social sciences, and biological sciences, seeking to transform our understanding of “what matters” for people in terms of health and wellbeing. Embracing far-ranging interests, it generates in-depth knowledge about the ways people understand health and frame health-related decisions. It also provides a cross-cultural, historical, and developmental lens on health in relation to the body and society.

Scholars often ask which journal would be best suit their particular paper, and this is sometimes hard to determine (although perusal of one’s cited references usually suffices to provide a canny indication of intended readership). While the primary role of all editors is to assess quality and originality of scholarly work, we editors at *Social Science & Medicine* strive to encourage depth and interdisciplinary breadth of knowledge regarding pathways to health and wellbeing. As we reflect on the body of work published in this journal over the last fifty years, we find a strong, rich record of medical anthropology scholarship, one that pushes forward methodology, social theory, and health-related practice. An ongoing challenge is to bring conceptually and methodologically diverse bodies of work to bear on health practice and policy in a timely and effective manner.

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