

SMA 2020

3rd International Conference of the
Society for Medical Anthropology

American Anthropological Association



March 9-12, 2020

Havana, Cuba



Program at a glance (subject to change)

		9 -- 9:30	9:30 -- 10	10 -- 11	11 -- 11:30	11:30 -- 12	12 -- 12:30	12:30 -- 1	1 -- 2	2 -- 3:15	3:15 -- 4:30	4:30 -- 5
Tuesday March 10	Room 3	Anthropos inaugural conference	SMA opening	The social determination of health from epidemiology	The social determination of health from social medicine	The social determination of health from anthropology and other social sciences	LUNCH BREAK		The biosocial nexus: Rethinking health processes from a critical epidemiology perspective			
Wednesday March 11	Room 3	Structural vulnerability and health-disease-care-prevention processes in sexual and reproductive health in Latin America				Indigenous women's health and knowledge - Part 1 (Spanish)		Indigenous women's health and knowledge - Part 2 (Spanish)		Reproductive disruptions - Part 2		
	Room 8							Reproductive disruptions - Part 1		Attending indigenous politics, history, and trauma in healthcare		
	Room 10							Medical anthropologists take(s) on policy issues		Gender lens: Questions for responses from medical anthropology		
	Room 14							Blackness, health, medicine, and the sciences		The (queer) futures of anthropologies of quantification		
	Room 12							Clinical cultures / War zones, conflict, and trauma		Addiction / Nutrition, body weight, and culture		
Thursday March 12	Room 3	Intercultural health in Latin America			Indigenous traditions and teachings in intercultural healthcare - Part 1 (Spanish)			Social struggles and sexual moralities		Reproduction and obstetric violence		SMA closing
	Room 8				Policies and politics of maternal and infant health			Indigenous traditions and teachings in intercultural healthcare - Part 2		How social and political hierarchies affect intervention		
	Room 10				Shifting perspectives in medicine, medical anthropology and global health			Invisibilization		Indigenous traditions and teachings in intercultural healthcare - Part 3		
	Room 14				The ambiguous work of care			The First Garifuna Hospital in Honduras (film)		Medical anthropological research in Latin America (Spanish)		
	Room 12				Bio-eco-cultural perspectives			Global health 1		Global health 2		



SMA 2020 CONFERENCE PROGRAM AND ABSTRACTS

The 3rd International Conference of the Society for Medical Anthropology (SMA 2020) will take place at the Havana Convention Center, Havana, Cuba, on March 9-12, 2020, during Anthropos 2020—the anthropology conference organized by the University of Havana.

Prior to accessing the conference venue, registered and non-registered participants need to pick up their registration materials in the *Sala de Acreditación* of the Havana Convention Center between 9 am – 12 pm and 1 pm – 4:30 pm. Please note that you need to wear your conference badge to access the conference. We encourage everyone to get their registration materials on Monday, March 9th.

The conference opening and concert will take place Monday, March 9th, at 5:30 pm in Old Havana.

At the conference, we will focus on three topics:

- 1) Social determination of health from epidemiology, social medicine, and medical anthropology and other social sciences,
- 2) Sexual and reproductive health and rights, and
- 3) Indigenous movements and intercultural care in health.

Sessions in Room 3 will have simultaneous translation Spanish-English. Sessions in rooms 8, 10, or 14 will take place in either Spanish or English. Each session will have a chair who will contact participants in their session to set the time allotted for presentations and discussion. If using powerpoint, please bring your file to the *Sala de Medios Audiovisuales* prior to your session.

Other topics will be discussed in the gallery section in room 12. Presenters are expected to place their posters (maximum size is 120 cm height x 90 cm width) next to posters on the same theme on Wednesday morning and leave them until Thursday evening. The posters are structured around themes with a designated time during which the presenters will have 5 to 10 minutes to present their work, followed by discussion with other presenters and participants. Each topic will have a chair who will invite others in their group to get organized. Room 12 does not have audiovisual equipment.

SMA executive board: Officers: Charles Briggs (President), Arachu Castro (Past President), Jessica Mulligan (Treasurer), and Aida Benton (Secretary). Members at large: Elyse Andaya, Nolwazi Mkhwanazi, Erica Prussing, Eugene Raikhel, Matthew Wolf-Meyer, Danya Glabau, and Richard Powis.

SMA 2020 program committee: Arachu Castro (Conference President), Zoe Díaz Bernal, Elyse Andaya, Carolyn Smith-Morris, and Charles Briggs.

For the full program and additional information, please visit:
<http://www.medanthro.net/sma2020/>.



Opening day - Monday, March 9th

Registration

9:00 am – 12 pm and 1 pm – 4:30 pm

Oficina de Acreditación del Palacio de Convenciones de La Habana. Calle 9 and 146, Municipio Playa.

Conference opening and Concert in Homage to Dr. Antonio Julián Martínez Fuentes, President of Honor of Anthropos 2020 and President of the Cuban Society of Biological Anthropology

5:30 pm

Venue: Convento de San Francisco de Asís. Plaza San Francisco de Asís, Calle Oficios, Habana Vieja (Old Havana).

Day 1 - Tuesday, March 10th - MORNING

Welcome and opening remarks

9:30 am, Room 3 (plenary with translation)

- Arachu Castro, Universidad de Tulane, Estados Unidos.
- Eduardo Menéndez, Centro de Investigaciones y Estudios en Ciencias Sociales (CIESAS) Ciudad de México, México: *Algunas reflexiones sobre la antropología médica Latinoamericana / Some reflections about Latin American medical anthropology* (participación por video).

The social determination of health: Homage to Eduardo Menéndez

La determinación social de la salud: Homenaje a Eduardo Menéndez

10:00 am – 1:00 pm, Room 3 (plenary with translation)

Organizers: Arachu Castro (Universidad de Tulane, Estados Unidos), Zoe Díaz Bernal (Escuela Nacional de Salud Pública, Cuba), and Francisco Rojas Ochoa (Escuela Nacional de Salud Pública, Cuba).

La determinación social en salud desde la epidemiología

- Silvia Martínez, Sociedad Cubana de Salud Pública, Cuba
- Pedro Mas, Sociedad Cubana de Higiene y Epidemiología, Cuba
- Nivaldo Linares, BioCubaFarma, Cuba

La determinación social en salud desde la medicina social

- Francisco Rojas Ochoa, Escuela Nacional de Salud Pública, Cuba
- Ileana Castañeda, Escuela Nacional de Salud Pública, Cuba
- José Moya, Organización Panamericana de la Salud, Cuba

La determinación social en salud desde la antropología médica y otras ciencias sociales

- Leticia Artiles Visbal, Sociedad Cubana de Antropología Biológica, Cuba
- Mayra Espina Prieto, Cooperación Suiza y Facultad Latinoamericana de Ciencias Sociales (FLACSO), Cuba
- Luisa Íñiguez, Facultad Latinoamericana de Ciencias Sociales (FLACSO), Cuba
- Sandra del Pino, Organización Panamericana de la Salud, Estados Unidos



Day 1 - Tuesday, March 10th - AFTERNOON

The biosocial nexus: Rethinking health processes from a critical epidemiology perspective

El nexo biosocial: Repensando los procesos de salud desde la perspectiva de la epidemiología crítica

2 pm – 4:30 pm, Room 3 (plenary with translation)

Organizers: Sahra Gibbon (University College London, United Kingdom), Laura Montesi (CONACYT-CIESAS Pacífico Sur, Mexico) & Abril Saldaña Tejeda (Universidad de Guanajuato, Mexico).

Session abstract: Early exposure to environmental pollutants, intergenerational transmission of trauma, chronic stress, extended effects of childhood abuse, and long-term consequences of intrauterine undernourishment are only some of the phenomena that seem to be implicated in diverse disease conditions and health outcomes. Scientific advances in the field of epigenetics, neuroscience and microbiome research, among other emerging areas of biosocial science, are evidencing how environment and social determinants play a pivotal role in health processes. However, while most of the scientific production in this area adopts a multicausal approach it is nonetheless oriented towards proximate determinants. Given the opportunities that arise from emerging biosocial explanations to foreground the role of social context and environment, falling into the trap of (re)producing new forms of reductionism would be a grievous mistake. In this session, we invite medical anthropologists and sociologists and philosophers of medicine and science to explore how the conceptual tools of Critical Epidemiology might be used to open a dialogue with, question, reshape and/or contextualize what different fields of biosocial science are practicing and producing. We invite contributions that can consider and address how a critical perspective that includes social history (with its pathways of inequity and power) might be brought center stage in configuring new forms of biosocial science and identifying actions directed at well-being and living well. *Resumen de la sesión:* Exposición temprana a contaminantes ambientales, transmisión intergeneracional de traumas, estrés crónico, efectos prolongados del abuso sufrido en edad infantil, consecuencias de largo plazo de la desnutrición intrauterina, son sólo algunos de los fenómenos que parecen estar implicados en un sinnúmero de condiciones mórbidas y estados de salud. Los avances científicos en los campos de la epigenética, las neurociencias y las investigaciones sobre el microbioma humano, entre otras áreas de la ciencia biosocial, están poniendo en primer plano el rol que el ambiente y los determinantes sociales juegan en los procesos de salud y enfermedad. Sin embargo, aunque buena parte de la producción científica en estos ámbitos asume un enfoque multicausal, ésta sigue orientándose prevalentemente hacia los determinantes próximos. Dadas las áreas de oportunidad que se están abriendo a raíz de las emergentes explicaciones biosociales que visibilizan el rol de los contextos sociales y el ambiente, sería un error fatal terminar (re)produciendo nuevos reduccionismos. En esta sesión, invitamos a antropólogos médicos y sociólogos y filósofos de la medicina y la ciencia a que exploren cómo las herramientas conceptuales de la Epidemiología Crítica pueden ser ocupadas para dialogar, cuestionar, reformar y/o contextualizar lo que las ciencias biosociales están ejerciendo y produciendo. Invitamos contribuciones que consideran y abordan las maneras en que una perspectiva crítica que incluye a la historia social (con sus caminos de poder e inequidad) puede emplearse para reconfigurar a la ciencia biosocial e identificar acciones encaminadas hacia el bienestar y el buen vivir.

1. Melania Calestani (University of London, United Kingdom). **WASTE LANDS, TOXIC LEGACIES AND HEALTH INEQUALITIES: PERSPECTIVES FROM CRITICAL EPIDEMIOLOGY.** Based on multi-sited ethnographic research carried out for the Economic and Social Research Council (UK) project The Waste of the World, this paper critically examines the link between health inequalities and the ship breaking industry. As it emerged during fieldtrips in Europe and the USA, ship breaking facilities are often located in ‘waste lands’, places where it is quite difficult to determine if the contamination of the environment and the high percentage of cancer are due to the pollution created by the ship breaking industry or any other industry. With a particular focus on data collected in Brownsville-Matamoros (US/Mexican border) and Naples (Italy), the paper aims to critically deconstruct embodiments and social histories of toxicity taking into consideration a critical epidemiology lens. These places have been affected by illegal dumping of toxic waste and/or previous excessive industrial development, generating terrible consequences for the health of their inhabitants (for instance, anencephaly, leukaemia and cancer). Through these two case studies, the dialectic process of determination as



conceptualised in critical epidemiology will be the point of departure to shed light on the multidimensional power structure of the global economy and to reflect upon the undisclosed but powerful impact that commercial determinants of health can have on individuals' well-being. Moreover, it will discuss how this approach of commercial determinants becomes even more meaningful if connected with a critical epidemiological analysis. Finally, it will raise complex questions surrounding the rise of chronic non-communicable diseases in conjunction with the exposure to environmental toxins and the link with epigenetics.

2. Claudia Fonseca (Universidade Federal do Rio Grande do Sul, Porto Alegre, Brazil). **BODIES, COLLECTIVITIES AND FORMS OF KNOWLEDGE: HANSEN'S DISEASE THROUGH THE LENS OF CRITICAL EPIDEMIOLOGY.** The following reflection analyzes, through the lens of critical epidemiology, the practices surrounding the diagnosis, treatment and cure of a contagious disease... Hansen's Disease (leprosy) in Brazil. We take as starting point an as-yet unresolved controversy that divides the Brazilian and international medical community in two opposing blocks -- the proposal, launched by WHO (2016) and embraced by the Brazilian Ministry of Health to cut the duration of treatment by half, from 12 to 6 months. Our analysis of this debate highlights the agency of the bacillus itself in interaction with specific bodies, demonstrating that the "disease in motion" does not easily fit into the classificatory system of "evidence-based medicine". By tracing through body-biography trajectories, we are obliged to rethink the "ecologies of evidence" as to the efficacy of specific treatment regimens. Hence, we view the disease as a complex, multidimensional object that defies numerical projections, being better understood in terms of the dynamic and contextualized interaction of a heterogeneous series of bodies, collectivities and forms of knowledge.
3. Sahra Gibbon (University College London, United Kingdom). **GENEALOGIES OF THE BIOSOCIAL IN BIRTH COHORTS: ENGAGING AND SITUATING CRITICAL EPIDEMIOLOGY.** Longitudinal birth cohort studies that follow participants across the 'lifecourse' have been central to awareness of the social gradient in and social determinants of health. At the same time they are also now a vital resource for and tools of biosocial science, making them increasingly central to novel fields of scientific inquiry aimed at understandings how diverse social exposures and environments become embodied. Birth cohort studies are in this sense situated across a non-linear temporal terrain which reference shifts in understanding the relevance of the biological to questions of social inequality or adversity, even as such studies shape how those dynamics are examined and made relevant. This paper draws on planned and preliminary research in Brazil and the UK that has a broader aim of examining longitudinal birth cohort studies as an object of ethnographic inquiry and site of intervention. It considers how particular genealogies of the biosocial have shaped these type of studies and the ways that diverse articulations of social and political critique inform how they have come into being and are being sustained. A comparative perspective highlights the importance of reflecting on how the tools and technologies of biosocial science, such as birth cohort studies, are themselves products of social histories.
4. Tatiane Pereira Muniz (Universidade Federal do Rio Grande do Sul, Brazil). **RACIALIZATION OF HEALTH AND EPIGENETIC CONTROVERSIES.** Working on how race comes into being among geneticists, biomedical professionals, and black activists practices and narratives in Brazil, epigenetics arose on post-genomic explanations of some health conditions based on the exposure to environmental stressors. Exposure to toxic chemicals, psychological stress, malnutrition, among others, particularly in the embryonic phase, is supposed to result in intergenerational effects on individual health. The potential racialized explanation for genetic susceptibility or epigenetics effects on health would lead to mistakes and reductionist explanations when socioeconomic conditions are not adequately considered. Since exposure to environmental stressors such as unhealthy food, drugs, and smoking are considered avoidable, individual responsibility for self-care and caring for descendants takes a liberal interpretation in at least two ways. In the one hand, the moralization of risk exposure takes for granted that it is always possible to make healthy decision, not considering that they are unevenly distributed. On the other, an ontonorm (Mol) is imposed, suggesting that there are only specific ways to be healthy and living well. I aim to draw attention on how some narratives concerning race and genetics, especially on how black health conditions explanation has the potential to slip to epigenetics explanations since one advocates that race and health condition of the black population in Brazil is a result of racialization process and the stressful way of living in a racialized society.



5. Elizabeth F.S. Roberts (University of Michigan, USA). **A CRITICAL ENVIRONMENTAL APPROACH TO EPIGENETICS FROM LATIN AMERICA.** In this paper I argue for harnessing long-standing Latin American environmental models of bodily conditions to critically address the promises and pitfalls of epigenetics. I lay out these models by drawing 1) from my own work in Mexico and Ecuador on environmental health and reproductive medicine and 2) the historical, STS and medical anthropology literature on bio-scientific practice in Latin America, which demonstrates how bodily states are experienced as constantly shifting in relation to larger environments. This Latin American “environmentalism” contrasts with the twentieth century pendulum shifts between nature and nurture in the United States and Northern Europe, that sought to determine which “side” was more essential for producing the human condition. By focusing on organism/environment interactions, epigenetics, seemed to offer a détente in this battle. But instead, at least in the United States, epigenetics has been used to further essentialize and blame groups for their life circumstances. There is some indication, that the growing cadre of epigenetic scientists in Latin America have a more developmentalist and political understanding of bodily states and are better positioned to deploy epigenetics for understanding health inequalities. At the very least, by foregrounding long term Latin America environmentalism, I hope to counter the prevalent sense that, with epigenetics, the Global North has bequeathed Latin America with a radically new paradigm. Instead, let’s carefully examine the actual practice of epigenetic research in Latin America, as produced by researchers who were already likely to assume that bodies are produced in relation to shifting environments.

6. Abril Saldaña (Universidad de Guanajuato, Mexico) & Laura Montesi (CIESAS Pacífico Sur, Mexico). **EPIGENETICS AND DIABESITY IN MEXICO; INDIVIDUAL VS. SOCIAL RESPONSIBILITY.** This presentation analyses the tensions in epigenetic approaches to obesity and diabetes in the first National Strategy for the Prevention and Control of Overweight, Obesity and Diabetes launched by the Mexican Ministry of Health in 2013. By scrutinising two case studies –mothers of children treated at the child obesity clinic in Mexico City and indigenous people living in a community affected by high diabetes rates in Oaxaca—we will unveil the ways in which the National Strategy purports a reductionist, deterministic, hypermedicalised, and individualised approach to health problems. By contrast, the narratives of our research participants manifest some important interactions between large-scale social forces (i.e. structural inequalities, the effects of international trade agreements, migration, the loss of biodiversity and violence) and the experiences of obesity and diabetes within families and communities. The paper adopts Breilh’s concepts of modos de vida, social determination and interculturality to offer a critical and counter-hegemonic understanding of contemporary health issues and advise caution to epigenetic explanations founded upon strictly causalist frameworks.

7. Natali Valdez (Wellesley College, USA). **CONCEALING/REVEALING EXPOSURES FROM WITHIN.** Although scientific discourses focus mainly on how gestation and early development are critical periods for fetuses and infants, gestation is also a critical period for pregnant bodies. Maternal and surrogate bodies experience changes stimulated by the presence and interaction with fetal particulate matter. Recent studies find that fetal genomes can epigenetically stimulate changes to the production and development of placental tissue, which is associated with the progression of pre-eclampsia. Research suggests that surrogates are at risk of preeclampsia due to an epigenetic modification stimulated by fetal particular matter. How fetuses interact with the pregnant body to stimulate maternal health risks beyond gestation is an understudied field. This is partly due to a long standing and well-established framing of the maternal-fetal relationship as unidirectional – strictly from “mother to fetus.” Even with the re-emergence and further development of epigenetic theories, the traditional maternal-fetal relationship remains the consistent framework in reproductive healthcare. In my presentation I plan to discuss how epigenetics both reveals and conceals vulnerability to gene-environment modifications to certain imagined bodies and not others. This is a preliminary project, and as such the presentation will draw from primarily discursive material to explore how epigenetic recognition manifests unevenly across maternal fetal environments. Denying epigenetic recognition to pregnant bodies maintains political and material consequences for disease etiology and treatment. I suggest that the epigenetic recognition of pregnant bodies requires an acknowledgement of fetal particulate matter as exposure from within the maternal/surrogate environment.

8. Emily Vasquez (Columbia University, USA). **GDM PREDICT: NEW TECHNOLOGIES AND THE POLITICS OF DIABETES PREVENTION IN MEXICO.** In this paper I trace the social history, centered in Mexico, of a new



diagnostic test to detect genetic risk of gestational diabetes, GDMPredict. The logic behind GDMPredict is as follows: If tested when considering pregnancy or pregnant, a woman can take steps (with diet, exercise, or pharmaceuticals) to mitigate her risk of developing gestational diabetes. Doing so would not only limit her risk for gestational diabetes, but also her lifetime risk of developing type 2 diabetes. Preventing gestational diabetes would, in turn, lower her child's lifetime risk of developing type 2 diabetes, as well as a number of other immediate and longer-term risks linked to an adverse intrauterine environment. Hailed as a “proactive”, “anticipatory, and apparently twofold opportunity, with benefits for both mother and child, GDMPredict was developed by private biotech in close partnership with the Carlos Slim Foundation. The Foundation, a powerful health philanthropy operating in Mexico and across Latin America, is funded by Mexico's wealthiest entrepreneur and tech magnate, Carlos Slim, who is himself invested in the sale of the test, via private-sector investment. Importantly, GDMPredict is envisioned as a component of the Carlos Slim Foundation's MIDO Embarazo program, intended for large-scale implementation across Mexico through state and national governments, to improve birth outcomes and, most critically, to facilitate chronic disease prevention at the population level. Using GDMPredict and its relationship to the Carlos Slim Foundation as a lens through which to study the political economy driving technological innovation in chronic disease prevention, I examine how understanding of the drivers of diabetes risk are being re-imagined in this context and pose critical questions about the value of high-tech innovation for public health.

9. Francisco Vergara-Silva (Universidad Nacional Autónoma de México, Mexico). **NICHE CONSTRUCTION THEORY FOR 'SITUATED BIOLOGIES': DEVO-ECO-EVOLUTIONARY CONCEPTUAL RESOURCES FOR EPIGENETICS-ORIENTED EPIDEMIOLOGY AND MEDICAL ANTHROPOLOGY.** The concept of 'local biologies' (LBs) was originally introduced by medical anthropologist Margaret Lock to “conceptualize the mutual constitution of subjective bodily experience, language usage, and historical, social, political and medical contexts”. Aimed to critically review this idea, Jörg Niewöhner and Lock have recently proposed the notion of 'situated biologies' (SBs), to address criticisms related to LBs' potential reification of 'inherent' differences between human individuals/populations. Arguing in favor of LBs and SBs as important concepts in medical anthropology, Lock and colleagues usually link them to 'epigenetics'. Independently, historians, philosophers and sociologists of anthropology and biology interested in epigenetics have become increasingly aware of the importance of differentiating 'molecularized epigenetics' from a broader notion of epigenetics, linked more directly to Conrad Waddington's original definition of the term. In this paper, I delve into the meanings of 'epigenetics' used by Niewöhner and Lock, and critically review Waddington's developmental-evolutionary schemes and one of their most notable derivations in current evolutionary theory: 'niche construction theory' (NCT). I argue that SBs are congruent with models of 'human niche construction', derived from NCT —as developed by Greg Downey, Agustín Fuentes, Emily Schultz, and other 'integrative biological anthropologists'. In turn, I claim that Niewöhner and Lock's SBs could be incorporated into an even wider, framework of ecological, developmental and evolutionary multi-species interactions. Finally, I suggest that the resulting reconfiguration of models and theories of 'situated human bodies' could be useful to enrich current approaches in epigenetics-oriented critical medical epidemiology, with potential applications to empirical case studies.
10. Emily Yates-Doerr (University of Amsterdam, The Netherlands & Oregon State University, USA). **MATERIAL-SEMIOTIC INDETERMINACY: REWORKING THE SOCIAL DETERMINANTS OF HEALTH.** Public health experts and medical anthropologists are both concerned with how health is shaped by environmental forces. This creates an important alliance between the disciplines, yet crucial differences in how the two disciplines tend to value health remains. In this paper, I compare a public health framework known as the “social determinants of health” with anthropological interest in the sociality of health and illness. I draw on ethnographic fieldwork with global health planners and policy makers and in a community-based nutrition project in Guatemala to illustrate how attempts to redress inequality by improving “social determinants” exacerbated longstanding systems of hierarchy. Whereas health experts may strategically essentialize health to embolden social-justice oriented policies, I illustrate the benefits of an anthropologically-driven approach to valuation that doesn't know what health is – or who is healthy – ahead of doing research. If public health workers are serious about wanting to incorporate anthropological insights into their research methodologies, we must, together, rework the emphasis on “social determinants” to make space for health's material-semiotic indeterminacy.

Day 2 - Wednesday, March 11th - MORNING

Structural vulnerability and health-disease-care-prevention processes in sexual and reproductive health in Latin America

Vulnerabilidad estructural y procesos de salud-enfermedad-atención-prevención en la salud sexual y reproductiva en América Latina

9 am – 12:30 pm, Room 3 (plenary with translation)

Organizers: Paola Ma. Sesia (CIESAS-Pacífico Sur), Lina Rosa Berrío (CIESAS-Pacífico Sur) & Rubén Muñoz Martínez (CIESAS-CDMX).

Resumen de la sesión: El concepto de vulnerabilidad estructural (Quesada, Hart y Bourgois, 2011) es útil para entender desde la antropología médica crítica (AMC) cómo esta situación impacta--y constriñe las posibilidades y estrategias de respuesta--de manera diferencial a personas y/o colectivos sociales en la enfermedad, la atención y la desatención en la salud sexual y reproductiva en múltiples contextos latinoamericanos y lejos de perspectivas políticamente neutrales. En la mesa, se pretende analizar desde la etnografía y la AMC, cómo distintas problemáticas de la salud sexual y reproductiva--tales como la salud materna, el control de la reproducción, la salud sexual y reproductiva de adolescentes y el VIH-sida--se viven por individuos y grupos sociales en situaciones múltiples de vulnerabilidad estructural, en su encuentro/desencuentro con el sistema hegemónico de salud en Argentina, Chile, México, Perú, República Dominicana y, en general, América Latina.

1. Arachu Castro (Tulane University, USA). **VIOLENCIA OBSTÉTRICA EN AMÉRICA LATINA: PERSPECTIVAS DESDE LA ANTROPOLOGÍA MÉDICA CRÍTICA.** La violencia contra las mujeres durante el parto, que ocurre con frecuencia en América Latina, está situada dentro en un contexto más amplio de exclusión social y discriminación contra las mujeres. En esta presentación, establezco asociaciones entre las muertes maternas y los sistemas de atención médica caracterizados por la falta de atención continua, la falta de responsabilidad y de rendición de cuentas hacia las mujeres y la denegación de la atención. Sostengo que el personal clínico aprende a manejarse dentro de las limitaciones estructurales de los sistemas de atención en salud al no asumir la responsabilidad de la atención continua que cada mujer necesita, y que esta descarga de responsabilidad es un aspecto fundamental de cómo los profesionales de la salud pueden navegar, tolerar y perpetuar la estructura del sistema y, al hacerlo, crear el caldo de cultivo para que ocurra la violencia obstétrica. Por último, explico que aunque informar sobre el sufrimiento de las mujeres no evitará, por sí solo, la violencia obstétrica, aumentar su visibilidad a través de la investigación puede contribuir a promover los derechos humanos de las mujeres durante el embarazo, parto y postparto, al monitoreo de los derechos humanos y a la creación de medidas de rendición de cuentas dentro de los sistemas de salud para prevenir la violencia obstétrica.
2. Paola Sesia (CIESAS-Pacífico Sur, México) & Pedro Yáñez (Cátedra Conacyt/CIESAS-Pacífico Sur, México). **APRECIACIONES DE MUJERES INDÍGENAS OAXAQUEÑAS ACERCA DE LA ATENCIÓN MATERNA RECIBIDA: ENTRE LA VULNERABILIDAD ESTRUCTURAL Y LA VIOLENCIA SIMBÓLICA.** Las mujeres indígenas mexicanas que viven en áreas rurales de Oaxaca, consideradas de mayor rezago social, en la actualidad recurren en su gran mayoría a los servicios públicos de salud para la atención de sus embarazos y partos. Este proceso de búsqueda de atención se enfrenta a barreras importantes, asociadas a una calidad deficiente de los servicios disponibles y/o al maltrato, el abuso y la discriminación, por su condición étnica, a los que son sujetas muchas de ellas en instituciones públicas de salud. Estas barreras implican no sólo una mayor vulnerabilidad al enfrentar esta etapa de la maternidad sino, comúnmente, la vulneración de sus derechos. Objetivo: El trabajo explora y analiza las experiencias de interacción que tuvieron mujeres indígenas con el sistema de salud institucional durante su último parto. Método: A través de un extenso trabajo de campo en 2018-19, se entrevistaron a 188 mujeres en 21 municipios rurales e indígenas de la entidad, todos ellos con indicadores de profundo rezago social. Resultados y Conclusiones: Se encontró que, no obstante las múltiples fallas del sistema de salud, las percepciones expresadas por muchas mujeres tienden a valorar positivamente la atención recibida, utilizando criterios de calidad y trato que no coinciden con los empleados en el marco de los derechos humanos y que



discrepan de lo que el marco de la medicina basada en evidencia promueve en la atención obstétrica. La ponencia reporta acerca de estas percepciones diferenciales y proporciona posibles aproximaciones teóricas-- como la ocurrencia de un proceso de violencia simbólica interiorizada por las mujeres-- para explicar esas discrepancias.

3. Jennie Gamlin (University College London, United Kingdom). **THE SYMBOLIC VIOLENCE OF REPRODUCTIVE HEALTH AND SOCIAL DEVELOPMENT IN INDIGENOUS WIXÁRIKA COMMUNITIES, MEXICO.** Historically the delivery of health and social welfare in Wixárika communities, as is the case of all Mexican indigenous regions, has been closely tied with projects of national unity, (Spanish) literacy and cultural mestizaje. Under the veil of development and guise of wellbeing, decades of conditional social interventions and politically motivated donations have generated a dynamic of dependency and deservedness. These programmes have not been evenly distributed across the population but are instead largely targeted at women through the delivery of conditional cash transfers, reproductive and maternal health services, with a concomitant impact on gender, motherhood and local social and cultural practices relating to these. Objective: This paper will discuss utility of the concept of structural vulnerability for understanding the impact of reproductive health and welfare programmes in indigenous Wixárika communities, one of the regions with highest maternal and infant mortality rates in Mexico. Methods and Results: Using evidence from individual encounters with different levels of care and institutions, I explore why women make the choices they make during pregnancy and childbirth, and draw on Bourdieu's concept of symbolic violence to discuss the impacts of this on maternal health outcomes. Structural vulnerability describes a positionality that imposes physical or mental suffering on a population, suggesting that historical factors have undermined a group's ability to achieve their full potential. Offered as a more palatable and applied alternative to the concept of Structural Violence, I will conclude this paper by discussing the interplay between agency and vulnerability to explain the intersecting dynamics of Wixárika race and gender in relation reproductive and maternal health outcomes.
4. Rubén Muñoz (CIESAS CdMx, México). **LA EPIDEMIA DEL VIH EN LOS PUEBLOS INDÍGENAS DE OAXACA: INMUNIDADES ÉTNICAS Y PRÁCTICAS DE DETERMINACIÓN DE LA SALUD.** En la actualidad no existen cifras oficiales sobre el impacto del VIH en los pueblos indígenas de México y son muy escasos los estudios cuantitativos y cualitativos sobre este tema, debido al desinterés, desde diversos conjuntos sociales e ideologías dominantes, por conocer y abordar esta problemática y sus especificidades. Objetivos: Se describen y analizan prácticas socioculturales de determinación de la salud que impactan en la prevención, detección, atención del VIH y en la mortalidad por sida de esta población, de forma diferenciada respecto a la no indígena. Método: Se realizó una investigación etnográfica en un centro de atención del VIH (CAPASITs) en Oaxaca, el estado de México con mayor número de hablantes de lengua indígena, basada en observación participante y en 73 entrevistas en profundidad a personas indígenas con VIH, sus familiares cuidadores y personal de salud especializado, y se complementó con evidencias cuantitativas. Resultados y Conclusiones: Desde la antropología médica crítica, se proponen dos categorías de análisis: la inmunidad étnica como eje teórico conceptual que discute las narrativas y prácticas dominantes en la epidemiología, en la academia y en la sociedad civil respecto a esta problemática, basadas en la consideración de la etnicidad como un factor protector frente al VIH y las prácticas de determinación sociocultural de la salud como una propuesta que permite problematizar categorías como sujeto/estructura, cuidados-estrategias/afectación de la salud-determinación, a partir del análisis de las prácticas de actores y conjuntos sociales concretos en niveles políticos, económicos y culturales articulados entre sí y que analíticamente podemos diferenciar como macro, meso y micro.
5. Matias Stival (Universidad Nacional de Rosario, Argentina). **PUEBLOS ORIGINARIOS Y PROCESOS DE ATENCIÓN DE LA SALUD SEXUAL EN CONTEXTOS URBANOS DE ROSARIO, ARGENTINA.** Introducción y Objetivo: Con el propósito de aportar a los debates sobre las condiciones de acceso y utilización de los servicios de salud de los pueblos originarios en contextos urbanos, presentamos una investigación antropológica cuyo objetivo ha sido analizar los procesos de atención de la población qom de Rosario (Argentina) y su relación con los equipos de salud, poniendo énfasis en los "encuentros/desencuentros" vinculados a las problemáticas de la salud sexual. Método: Desde un enfoque etnográfico se aborda este campo relacional a partir de las trayectorias de atención de los grupos domésticos qom, y de las relaciones, las prácticas y los sentidos puestos en juego por el personal de salud. Resultados: A partir de la descripción de las trayectorias de atención qom se despliega un análisis de



las condiciones de vulnerabilidad estructural en donde emergen las tensiones y conflictos en la utilización de los servicios de salud, poniendo énfasis en los “encuentros/desencuentros” vinculados a las problemáticas de la salud sexual. Se sostiene que las problemáticas vinculadas a la salud sexual de estas poblaciones se instalan, se expresan y se reproducen en los núcleos de tensión de las relaciones inter e intra-étnicas, de las relaciones de género y generacionales. Se evidencia la necesidad de interpelar las nociones y las lógicas organizacionales de los servicios de salud. Conclusiones: Toda propuesta de salud dirigida a pueblos originarios, debe partir y contener a las representaciones y prácticas sociales, las definiciones locales, su modo de problematizar, definir y establecer cursos de acción, considerándolos desde una perspectiva histórica y política.

6. Lina Rosa Berrio Palomo (CIESAS-Pacífico Sur, México). **LA INVISIBILIDAD Y LA AUSENCIA DE DATOS COMO OTRA FORMA DE RACISMO. SALUD REPRODUCTIVA DE MUJERES AFROMEXICANAS.** El racismo es uno de los elementos incluidos en las conceptualizaciones sobre vulnerabilidad estructural como un eje de determinación social de la salud que tiene impactos concretos en las condiciones de atención y acceso enfrentadas por ciertos grupos sociales. En América Latina, los procesos de construcción de ordenes raciales presentan complejas particularidades en cada país y está atravesada por discusiones de larga data respecto a quienes son considerados como grupos mayoritarios (usualmente la población blanco-mestizas, que no necesitan autonombrarse) y las denominaciones de aquello que se reconoce en el marco de la alteridad, a menudo asociado a “lo indígena”, “lo afro” o “lo extranjero”, según cada país. Este reconocimiento de lo que merece ser nombrado de modo específico, tiene impactos en el tipo de datos oficiales que se producen en censos, encuestas y registros administrativos. En esta ponencia asumo que la salud hace parte de este campo de disputas por la visibilidad y el reconocimiento identitario. Analizo la ausencia de datos y registros administrativos en salud sobre población afrodescendiente en México, como una forma de invisibilización y racismo, que además dificulta la producción de diagnósticos y estrategias específicas de atención. La discusión metodológica sobre los tipos de fuentes y datos existentes en salud se complementa con los hallazgos respecto a algunos indicadores de salud reproductiva, construidos utilizando acercamiento proxys según municipios y localidades considerados mayoritariamente afro en Oaxaca y Guerrero; así como entrevistas a personal de salud y organizaciones afro sobre dicho tema. Interesa problematizar la ausencia de datos como un dato en sí y contrastarlo con los resultados en relación a ciertos ejes como embarazo adolescente, atención prenatal, tipo de partos, realización de cesáreas, acceso a anticonceptivos y acceso a servicios de salud, entre otros.

7. Michelle Sadler (Universidad Adolfo Ibáñez, Chile). **LO QUE ESCONDE LA LÓGICA DE LA ELECCIÓN EN LA ATENCIÓN INSTITUCIONAL DEL PARTO EN CHILE.** Chile cuenta con 10 años de políticas y programas que buscan transitar hacia una atención “personalizada” del nacimiento en instituciones de salud, las cuales buscan reducir intervenciones obstétricas de rutina y entregar una atención con respeto y dignidad. Dichos programas han demostrado tener muy poco impacto. Objetivos. Analizar las estrategias que permiten que se siga legitimando el modelo intervencionista de atención. Métodos. Los resultados provienen de dos estudios realizados entre los años 2013 y 2018: uno cualitativo basado en entrevistas a usuarias, matronas y obstetras (N= 54); y una encuesta on-line aplicada a mujeres cuyos partos fueron atendidos en Chile, de la cual se toman las experiencias de parto ocurridas entre 2014 y 2017 (N=5.697). Resultados y conclusiones. El modelo intervencionista de atención se apropia de un discurso más humanista pero sin cambiar su estructura de base, reproduciendo las mismas formas de violencia anteriores pero en formas menos evidentes. Con asidero en la lógica de la elección, que privilegia la autonomía personal, se responsabiliza a las usuarias de manejar adecuadamente el “riesgo obstétrico” y de elegir entre opciones disponibles para la atención de parto, transfiriendo la responsabilidad desde los equipos hacia la población usuaria. En este sentido, la apertura de opciones dentro de la atención institucional del nacimiento, en lugar de presentarse como una alternativa a la hegemonía tecnocrática y la subordinación de las mujeres al sistema médico, se puede utilizar para profundizar el alcance de estos procesos, exacerbando además las inequidades de ingreso al sistema de salud.

8. Ana Amuchástegui (UAM-Xochimilco, México). **LA DIMENSIÓN CONFLICTIVA DE LA MATERNIDAD EN LA EXPERIENCIA DEL VIH Y LA RESPUESTA A LA EPIDEMIA EN MÉXICO.** Si bien la epidemia de VIH en México está concentrada en las llamadas “poblaciones clave”, crece rápidamente en mujeres: la razón de masculinidad ha disminuido de 15 hombres por mujer en 1984, a 5 por una en 2016. Al mismo tiempo, aquéllas que logran acceder al tratamiento, son más proclives a abandonarlo que ellos. Aún así, la prevención vertical se ha



convertido en la estrategia principal de respuesta a la epidemia de mujeres, en línea con los objetivos de ONUSIDA, por lo que en los últimos años se han registrado más diagnósticos en mujeres que en hombres, al tiempo que muchas que no están embarazadas reciben un diagnóstico tardío. ¿Qué lógica de género opera dentro de esta forma de gobierno de la epidemia? Objetivo: El presente trabajo discute el papel que la maternidad -como puntal del orden de género- juega tanto en la experiencia de vivir con el virus como en las políticas de VIH. Método: Se lleva a cabo un análisis cualitativo del material etnográfico y narrativo de grupos de pares y entrevistas a usuarias y personal de tres clínicas especializadas, durante 5 años de colaboración con el proyecto de investigación-acción Yantzin: mujeres acompañantes pares en VIH en México. Resultados y Conclusiones: Los registros muestran una dimensión conflictiva entre la maternidad como deseo, derecho y/o obligación, en la interacción entre el impulso vital de las mujeres y la intervención biomédica de control de la epidemia, mismo que se ve mediado por el trabajo de las asesoras pares, quienes fungen como testigos corporales de que, a pesar del VIH, una maternidad deseada es posible.

9. Alexandra Obach (Universidad del Desarrollo, Chile) **ADOLESCENTES MIGRANTES EN CHILE: PROBLEMÁTICAS EN TORNO A SALUD SEXUAL Y REPRODUCTIVA.** La migración internacional ha aumentado en Chile, constituyendo cerca de un 5,5% de la población total del país. Del total de adolescente del país, alrededor de un 3% corresponde a personas extranjeras. Dado que la migración es un determinante social de la salud, se identifica la necesidad de indagar en la realidad de adolescentes inmigrantes, población invisibilizada tanto por ser menores de edad en una sociedad adultocéntrica, como por ser migrantes. Actualmente se entiende a este grupo como actores relevantes del proceso migratorio, que lo experimentan de manera particular en comparación a quienes no lo viven, entre ellos, salud sexual y reproductiva. Método: estudio cualitativo etnográfico, que indagó en la percepción de adolescentes migrantes hombres y mujeres de entre 15 y 18 años, equipos de salud, y profesores de tres escuelas, respecto a experiencias y necesidades en salud sexual y reproductiva. Se utilizaron las técnicas de investigación de observación no participante; entrevistas semi estructuradas y grupos de discusión con los actores involucrados. Resultados y conclusiones: se da cuenta de los principales resultados del estudio respecto a la construcción de identidad en adolescentes migrantes y las vulnerabilidad en materia de salud sexual y reproductiva a las que se ven expuestos/as, tanto en los ámbitos de acceso a salud al sistema de salud, como en la construcción de sus cuerpos. Se analizan elementos tales como sexualización de los cuerpos de adolescentes migrantes desde el sistema de salud y de educación, desde una perspectiva de género, en un marco de discriminación y xenofobia social estructural.
10. María Guadalupe García (Universidad de Buenos Aires, Argentina). **ETNOGRAFÍA DE LAS POLÍTICAS DE PREVENCIÓN DE LA TRANSMISIÓN PERINATAL DEL VIH-SIDA EN UN HOSPITAL DEL GRAN BUENOS AIRES.** La inclusión de las mujeres en el campo del VIH-Sida se centró en su rol de reproductoras y, por lo tanto, de vectores de la enfermedad para sus hijos. Desde 1994, la prevención de la transmisión perinatal se convirtió en un área prioritaria de intervención en las políticas del Sida globales y locales y la principal –cuando no única- estrategia orientada específicamente hacia las mujeres. Objetivo: El objetivo de esta ponencia es analizar la configuración local de las políticas de prevención de la transmisión perinatal del VIH a partir de un enfoque etnográfico centrado en los procesos de atención hospitalaria. Métodos: Se integraron estrategias metodológicas: relevamiento de fuentes secundarias, observación en espacios del hospital, entrevistas a profesionales y pacientes y acompañamiento a mujeres con VIH embarazadas, antes y después del parto. Resultados y Conclusiones: A partir de los dispositivos de atención y los itinerarios terapéuticos de las mujeres, se analiza la gestión de fondos globales de financiamiento en el hospital y la consecuente conformación de “islas asistenciales” que, en el marco de la precarización del sistema público de salud, establecen condiciones diferenciales de atención para las mujeres con VIH embarazadas. La perspectiva etnográfica posibilitó captar un proceso simultáneo de visibilización e invisibilización de las mujeres con VIH y sus embarazos. Estas mujeres son objetos de intervención en tanto sujetos de experimentación, y fuente de datos estadísticos y evidencia para estudios científicos globales. A la vez, sus necesidades y demandas son invisibles frente a otras prioridades del sistema de atención.
11. Rebecca Irons (University College London, United Kingdom). **THE PERUVIAN ENFORCED STERILISATIONS AND THEIR INSERTION INTO WIDER STRUCTURAL AND OBSTETRIC VIOLENCES.** The enforced-sterilisations of an estimated 300,000+ Peruvians in the 1990s are often framed as a focal event in the lives of the predominantly



poor and/or indigenous-Quechua women and their wider communities who were targeted at the time. Without necessarily disputing that, this paper questions the ‘unique’ significance of the violence of the sterilisations in a context where the entire population was emerging from a bloody civil-war, which also included other forms of violence towards women’s bodies through rape and violations in addition to horrific massacres on the part of the military against all considered a ‘terrorist’. Objectives: To query the significance of the sterilisations amongst Quechua people and interested stakeholders (activists, NGOs etc), in relation to the post-civil war and contemporary violences they have, and continue to, suffer. Methods: Twelve-months of ethnographic fieldwork in rural Ayacucho (a ‘red-zone’ during the Shining-path insurgency). 100 in-depth semi-structured interviews were also completed with Quechua men, women, and health-workers. Results: In a province where 153 forced-sterilisations are reported, yet thousands died and/or witnessed extreme violence during the 1980s onwards, these events insert themselves along a ‘continuum of violence’ in which violences, whether structural, war-related, sexual, or obstetric, are not necessarily separated out into distinctive events for those who suffered them. Conclusions: This discussion allows us to interrogate why the sterilisations are continuously privileged in feminist and human rights discourse, to the exclusion of any focus on contemporary structural and obstetric violences- which are less evocative and useful to forward a particular set of discourses.

12. Ells Natalia Galeano Gasca & Jairo Hernán Zapata (Gobernación de Antioquia, Colombia). **ADECUACIONES ÉTNICAS PARA LA RUTA DE ATENCIÓN INTEGRAL MATERNO PERINATAL EN EL DEPARTAMENTO DE ANTIOQUIA, COLOMBIA**. Resumen: En el año 2018 el gobierno colombiano expidió la Resolución 3280 que dispone los lineamientos técnicos para ser aplicados en los territorios departamentales y municipales por parte de los actores del Sistema General de Seguridad Social en Salud, a través de la ruta integral de atención en materno perinatal -RIAMP. En dicha norma se contemplan adecuaciones étnicas, que deben de ser adaptadas por los entes territoriales. Objetivo: En esta ponencia se expone cuál fue la metodología y los hallazgos que orientaron el proceso de implementación de dichas adecuaciones. Método: En principio, se realizó recolección de información con base en sistemas de información de la Secretaría de Salud de Antioquia, posteriormente se aplicaron entrevistas orientadas desde los puntos de intervención de la RIAMP, con la finalidad de reconocer qué hacía cada actor significativo en los eventos de salud-atención-prevención, esto es: sabedores ancestrales, promotores de salud, personal biomédico y autoatención de la comunidad. Resultados y conclusiones: a partir de esta información se propusieron adecuaciones interculturales que se condensan en dos grupos: oportunidad de la atención y aspectos socioculturales. En el primer grupo se condensan lineamientos en torno al transporte, casas de paso, brigadas extramurales para la atención y prevención en la zona rural dispersa y en las adecuaciones socioculturales, diálogos de saberes y disposición de traductores. No obstante, en los lineamientos quedan enunciadas las posibles dificultades para su aplicación, en tanto el financiamiento de las intervenciones dependen de un sistema de salud con graves deficiencias estructurales que redundan en la privación del derecho a la salud de las poblaciones más vulnerables.

13. Paula Santana Nazarit (Investigadora independiente, México). **ENTRE LA RESISTENCIA MÉDICA Y EL DESEO DE LAS MUJERES: ESTERILIZACIÓN QUIRÚRGICA COMO EXPRESIÓN DE DESIGUALDAD Y CONTROL DEL CUERPO EN CHILE**. El descenso global y nacional de la fecundidad responde a la masificación de métodos anticonceptivos por parte de las mujeres, entre ellos, la esterilización quirúrgica (EQ). Las políticas sobre esta materia han variado históricamente, expresando modelos de desarrollo y reproduciendo desigualdades sociales. En Chile, a pesar del cambio en la normativa de la esterilización que supone un mayor acceso y apego a los derechos humanos, su práctica reproduce inequidades afectando a las mujeres más vulnerables socialmente. Objetivo: Esta investigación doctoral buscó conocer en profundidad quiénes son las mujeres que escogen esterilizarse para regular su fertilidad, sus prácticas y representaciones acerca del género, sexualidad y reproducción, así como las del personal de salud que interviene en esta intervención. Método: El diseño es cualitativo, con un trabajo de campo de nueve meses distribuidos en los años 2015-2017, focalizado en dos establecimientos públicos de salud de Valparaíso, Chile. Resultados y Conclusiones: En el sistema público de salud se establecen mecanismos de priorización no formales, basados en construcciones tradicionales de género, quedando rezagadas las mujeres jóvenes o que no cumplen la paridad, impactando en su salud y proyecto de vida, al tener que asumir abortos o embarazos no deseados. Las mujeres esterilizadas padecen una serie de trastornos físicos y secuelas directas o indirectas de la operación que no son tomadas en cuenta por el sistema. Si bien el personal se resiste al método, para las mujeres la EQ es una vía para ganar autonomía y descansar de la reproducción.

14. Franklin Gerly Gil Hernández (Universidad Nacional de Colombia, Colombia). **RACISMO ESTRUCTURAL, INTERSECCIONALIDAD Y SALUD SEXUAL Y REPRODUCTIVA EN COLOMBIA.** La Encuesta Nacional de Demografía y Salud de Colombia 2010 incluyó una pregunta por la pertenencia étnico-racial en esta fuente estadística; siendo resultado del interés de incorporar una perspectiva de este tipo para entender los problemas de salud sexual y reproductiva, y a consecuencia de las presiones internacionales hacia su incorporación en la demografía oficial. Sin embargo, el balance de lo que ha pasado con este dato como un elemento para entender la SSR en Colombia es algo desalentador, quizá por fallas metodológicas, por ejemplo, problemas de representación estadística que a veces no permiten usar adecuadamente este dato, pero también por cuestiones teóricas y políticas que tienen que ver con la falta de consolidación en el campo de SSR de la raza y la etnicidad como categorías pertinentes. La persistencia de la sobrerrepresentación de poblaciones afrodescendientes e indígenas en indicadores como mortalidad materna son datos que llevan tradición en el campo, pero percibo que la falta de una perspectiva interseccional no ha permitido explorar formas explicativas al respecto. Trabajos que se ocupan de mortalidad materna dan pistas interesantes sobre racismo estructural, pero no son tratados como tales en esa literatura, sea por problemas epistemológicos (falta de pertinencia teórica para el campo), de conexión con los estudios feministas y los estudios sobre racismo, y/o de agenda política. Mi propuesta quiere mostrar la pertinencia de esta perspectiva relacional, identificar algunas dificultades teóricas, metodológicas y políticas, así como proponer pistas para emprender investigaciones en este sentido y ensayar posibilidades con los datos disponibles.

Indigenous women's health and knowledge – Part 1

12:30 pm – 1 pm, Room 3 (plenary with translation)

1. Catalina Alvarado Cañuta (Universidad del Bio Bio, Chile) & Paola María Sesia (Centro de Investigaciones y Estudios Superiores en Antropología Social Pacífico Sur, México). **PARIR COMO YO QUIERA: LAS MÚLTIPLES PARADOJAS DE LA POLÍTICA DE SALUD INTERCULTURAL EN LA ATENCIÓN DE SALUD MATERNA QUE PROMUEVE EL ESTADO CHILENO. EL CASO DEL HOSPITAL KALVU LLANKA DE CAÑETE, CHILE.** Introducción: Las políticas de salud en Chile promueven que las mujeres mapuche atiendan sus partos con parteras profesionales (matronas) en el sistema biomédico; políticas generalmente aceptadas por las mujeres. Desde 2006, se establecieron dos estrategias en estos contextos de atención: el Programa Especial de Salud y Pueblos Indígenas (PESPI) como una política que retoma aspectos médico-culturales de los saberes y prácticas mapuche; y la estrategia de humanización del parto, para disminuir su sobremedicalización hospitalaria. Objetivo: Analizar cómo se están implementando estas estrategias y cómo están siendo recibidas por las matrona/es que atienden en el Hospital Intercultural Kalvu Llanka, Comuna de Cañete, Arauco. Método: Se realizó trabajo de campo en 2015-16, con extensas observaciones al interior del área de atención obstétrica y entrevistas múltiples a las 12 matronas/es que trabajan en el hospital, además de los responsables del PESPI, la Dirección y otros funcionarios del hospital. Resultados y Conclusiones: El PESPI rescata algunos saberes y prácticas mapuche alrededor de la reproducción, pero de una manera descontextualizada y parcializada que termina por fortalecer el modelo médico hegemónico en la atención del parto. El PESPI y la humanización del parto son recibidos por parte de las matronas/es de manera diferencial, de acuerdo a sus distintas historias personales y profesionales y los años de ejercicio de la profesión. En general, las matronas expresan más apertura hacia la humanización del parto que hacia el PESPI; asimismo, tienden a concebir a este último como parte de la estrategia de humanización, sin lograr percibir sus finalidades distintas.
2. Ana Gabriela Cruz Martín (Universidad Nacional Autónoma de México, México), Daniela Flores Aguilar (Grupo GLADERPO, México), Ingris Peláez Ballestas (Hospital General de México “Eduardo Liceaga”, México), Adalberto Loyola Sánchez (Universidad de Alberta, Canadá). **INTERCULTURALIDAD COMO DISCURSO E INEQUIDAD Y VIOLENCIA ESTRUCTURAL COMO REALIDAD EN UNA COMUNIDAD MAYA YUCATECO.** Introducción: La interculturalidad entendida como una forma de relación de grupos de personas con formas diferentes de pensar y vivir que conviven y coexisten. Se plantea idealmente como una situación de horizontalidad y respeto, sin embargo en la práctica cotidiana esto no sucede. Objetivos: Describir y analizar la inequidad y violencia estructural vividos por personas mayas en su travesía por conseguir atención médica en los servicios de salud



locales y mostrar cómo las políticas interculturales del Estado no han funcionado para brindar una atención culturalmente sensible a esta población históricamente discriminada. Métodos: Estudio etnográfico. Narraciones obtenidas a través de entrevistas y observación participante. Trabajo de campo realizado entre los años 2016-2018. Resultados: Las narrativas muestran casos donde se observan: inaccesibilidad a la atención, así como las barreras idiomáticas, geográficas y culturales, lo que conllevan a la discriminación, al retraso en los diagnósticos y en la atención, a la discapacidad (física, laboral y social) y al empobrecimiento de la población. Conclusiones: La política intercultural aplicada por el Estado a los servicios de salud se ha quedado en un discurso y en el papel, y no se ve traducida en una atención a las personas mayas, esto porque las acciones continúan aplicándose de una manera vertical, de arriba hacia abajo, con una mirada homogeneizadora, sin tomar en cuenta la heterogeneidad de los pueblos originarios y sin realmente incluirlos en la elaboración de estas estrategias “interculturales”.

Day 2 - Wednesday, March 11th - AFTERNOON

Indigenous women's health and knowledge – Part 2

2 pm – 3:15 pm, Room 3 (with translation)

1. Liany Katherine Ariza Ruiz, Jorge Martín Rodríguez, Paula Vivas, Leidy Johana Gómez, Daniela Castro (Instituto de Salud Pública, Pontificia Universidad Javeriana de Bogotá, Colombia). **SISTEMATIZACIÓN DE EXPERIENCIAS DE INTERCAMBIO Y TRANSFERENCIA DE SABERES Y PRÁCTICAS ENTRE LA MEDICINA TRADICIONAL Y LA ALOPÁTICA PARA LA ATENCIÓN DEL EMBARAZO, PARTO Y PUERPERIO EN TRES DEPARTAMENTOS DE COLOMBIA.** Introducción: En Colombia mueren aproximadamente 400 mujeres/año por desigualdades asociadas a la pobreza, ruralidad, pertenencia étnica y desprotección sanitaria, siendo los departamentos del Chocó, La Guajira y Cesar tres de los más afectados. En los grupos étnicos y en las zonas rurales la medicina tradicional, incluyendo la partería, son respuestas sociales y culturales esenciales para plantear alternativas que reduzcan la mortalidad materna. Un grupo de investigadores presentamos al Departamento de Ciencia y Tecnología COLCIENCIAS un proyecto sobre intercambio y transferencia (IT) entre los conocimientos alopáticos y tradicionales para mejorar la salud materna y perinatal. Como parte del mismo se está realizando una sistematización de experiencias. Objetivos: Sistematizar experiencias de IT de saberes y prácticas en salud materna en Chocó, Cesar y Guajira. Identificar lecciones aprendidas a partir de estas experiencias. Reconocer aspectos a transformar en la atención de las gestantes en los departamentos de estudio a partir de estas experiencias. Métodos: La sistematización de experiencia es un tipo de investigación cualitativa, participativa y crítica que permite ordenar, analizar, interpretar y comunicar conocimientos y saberes emergentes de las prácticas. En el presente proyecto se sistematizarán tres experiencias (una por departamento) de IT de saberes y prácticas tradicionales y alopáticas para la atención del embarazo, parto y puerperio. Resultados: visibilizar avances y limitaciones de las experiencias de IT de saberes y prácticas en salud materna y perinatal en los departamentos de estudio. Conclusiones: Se orientarán a aportar evidencia sobre la necesidad de reconocer la medicina tradicional y de adelantar procesos que promuevan el dialogo y la interculturalidad para mejorar la salud de las gestantes y sus recién nacidos.
2. Adriana Ardila-Sierra, María Inés Sarmiento Medina, Myriam Beatriz Puerto de Amaya, Myriam Beatriz Puerto de Amaya, Claudia Marcela Velásquez Jiménez, Esteban Quintana, Sandra Vargas, Vilma Cenit Fandiño Osorio (Fundación Universitaria de Ciencias de la Salud / Universidad de Ciencias Aplicadas y Ambientales / Universidad El Bosque, Colombia). **INVESTIGACIÓN-ACCIÓN-PARTICIPATIVA INTERCULTURAL PARA FORTALECER EL LIDERAZGO FEMENINO, APLICADA A LA PREVENCIÓN DE CÁNCER DE CUELLO UTERINO, EN 5 ETNIAS.** Introducción. En Guainía, Colombia, mujeres indígenas preocupadas por mejorar la situación de salud femenina en sus resguardos, convocó a un grupo de docentes universitarias, para desarrollar un proyecto que a la vez las fortaleciera como lideresas, dado que el liderazgo del territorio es masculino. Objetivo. Diseñar una estrategia intercultural de atención primaria en salud, que involucre mujeres indígenas y aporte a su empoderamiento social y cultural para la autogestión y sostenibilidad de los programas de cuidado y conservación de la salud, aplicada a la prevención del cáncer de cuello uterino. Métodos. Investigación-acción-participativa en la cual el equipo de docentes universitarias ha transferido capacidades investigativas, para que mujeres de 5 etnias realicen el trabajo de campo en sus comunidades, indagando por las costumbres relacionadas con la salud sexual. Con los resultados, cada mujer identifica la estrategia de acción para su comunidad; las universidades apoyan el diseño y la implementación. Finalmente, se hará una brigada de citologías cervicouterinas que será analizada, con las comunidades, para identificar si fue culturalmente segura o cómo podría ajustarse. Resultados. Durante el trabajo de campo, el diálogo intercultural entre docentes y lideresas pasa por momentos de sintonía como de tensión. La comunicación a la distancia, por celulares, facilita unos procesos y dificulta otros. Las mujeres, cada vez más empoderadas, han elegido el formato de video multilingüe para desarrollar sus acciones. Conclusiones. La investigación-acción-participativa intercultural, aplicada a una temática específica de salud femenina, permite fortalecer el liderazgo indígena femenino y no solo la prevención de la enfermedad elegida.



3. Frank Hutchins (Bellarmine University, Estados Unidos). **MAMA ROSA: PLACE, HEALTH, AND FORM OF LIFE IN ECUADOR.** The critique of western medicine is extensive, and includes charges of dehumanization, expropriation by powerful health industries, and epistemological arrogance. Critiques reveal the limitations of reductionist science, harm due to structural vulnerability, and inequities caused by an immunological approach manifested both clinically and metaphorically. One result is indifference to a range of cultural, economic, and geographic factors that characterize diagnostic and prescriptive medicine. This paper uses geographical and anthropological discussions of “place” to look at an indigenous midwife and healer to reveal cultural and spatial gaps between vernacular and biological bodies. The former are productions of thick places filled with local meanings, affections, responsibilities, histories and conflicts; the latter are scrubbed of these unmeasurable realities in preparation for scientific assessment. This paper is based on ethnographic work in northern Ecuador. It explores the lived reality of Mama Rosa in her home community and in her healing practices. Beings, plants, and histories that inhabit and haunt these landscapes produce forms of life that contrast significantly with bare life as conjured up by western medicine. It is argued in conclusion that much falls into the gap between vernacular and biological bodies, including the potential for mutual respect and meaningful healing.

4. Silvia González Carías, Carmen Julia Fajardo, Mario Mejía (Universidad Nacional Autónoma de Honduras, Honduras). **CARACTERIZACIÓN DE PRÁCTICAS TERAPÉUTICAS Y ALIMENTARIAS TRADICIONALES EN COMUNIDADES LENCAS Y CHORTÍS: UN ENFOQUE INTERCULTURAL DE LA SALUD.** Este estudio fue el principal insumo para elaborar un módulo educativo dirigido al personal de La Secretaría de Salud de Honduras para su formación en interculturalidad. Se coordinó con el Programa Nacional de Etnias de la Secretaría de Salud y el Proyecto de Nutrición y Protección Social cuya estrategia de Atención Integral a la Niñez Comunitaria (AIN-C), funcionó como plataforma de contactos comunitarios para facilitar las relaciones con la comunidad en el desarrollo del estudio de campo. El objetivo general fue la caracterización de prácticas alimentarias y terapéuticas tradicionales en la atención a mujeres embarazadas, parturientas, puérperas, lactantes y niños y niñas recién nacidos y hasta los 5 años en comunidades lencas y chortís. Los objetivos específicos fueron caracterizar los sistemas tradicionales de atención a la salud e identificar las prácticas alimentarias. Para obtener la información se aplicó una metodología etnográfica en comunidades del centro y occidente de Honduras, incluyendo encuestas, entrevistas a profundidad y grupos focales, utilizando técnicas de investigación participativa y de los “Encuentros de Enriquecimiento Mutuo en Salud”. Se constató que los sistemas de salud tradicional continúan vigentes, los(as) especialistas tradicionales tienen credibilidad en la población, existe un sistema propio de clasificación y tipología según la causa de las enfermedades. La medicina tradicional es importante económicamente siendo el medio más barato y la única opción donde no hay otros centros de salud o su acceso es complicado.

5. Clara Mantini-Briggs (University of California Berkeley, USA). **MUJERES VENEZOLANAS Y SU RESILIENCIA: ¿DOS CASOS DE ESTUDIO DONDE LA GOBERNANZA DE LOS DERECHOS REPRODUCTIVOS SIGUEN FALLANDO?** Introducción: Se trata aquí de ejemplificar dos casos de estudios donde mujeres indígenas mueren por la discriminación facilitada por las erradas concepciones estereotipadas de culturalidad que niegan los derechos reproductivos de estas mujeres Warao a través de la puesta en práctica del concepto teórico de Imposibilidad Cultural Crónica propuesto por la autora en Mantini-Briggs, (2019) como un rezago marcado de la poscolonialidad en los profesionales de salud cuyos aprendizajes tienen efectos devastadores complicando y complejizando los derechos sociales y reproductivos femeninos en un estado que apunta a un proyecto de inclusión, participación y protagonismo de género e indigenidad en su políticas sociales. Método: explicación teórica de la Imposibilidad Cultural Crónica en las prácticas de la salud pública venezolana. Objetivo: presentación teórica de la práctica de la imposibilidad cultural crónica como obstáculo para alcanzar la garantía que debe brindar el estado venezolano en cuanto a los derechos reproductivos y sociales de la mujer indígena en una sociedad pluricultural. Conclusión: La visibilización y la comprensión del problema que significa La Imposibilidad Cultural Crónica puede significar el comienzo de un cambio no solo en la prácticas médicas y profesionales en general para combatir la discriminación de género y garantizar con responsabilidad institucional los derechos reproductivos promoviendo una sociedad mas inclusiva, participativa y protagónica



Reproductive disruptions - Part 1

2 pm – 3:15 pm, Room 8

1. Caroline Hodge (University of Pennsylvania, USA). **SIDE AFFECTS: EMBODIED EXPERIENCES OF THE PILL IN THE UNITED STATES.** Introduction: Changes in mood, in sense of self—what I call “side affects”—are remarkably common among users of the oral contraceptive pill, though they are conspicuously absent from dominant medical and pro-family planning feminist discourses of the Pill. Objectives: To 1) characterize the disjuncture between reported “side affects” and the medical “evidence base” about the Pill’s side effects and 2) to understand the strategies of improvisation that clinicians use in responding to reports of these experiences, for which clinical guidelines do not exist. Methods: Digital ethnography of online forums about contraception; participant observation of contraceptive counseling and semi-structured interviews with clinicians and patients in San Francisco, Philadelphia, and Kansas City (USA). Results: Physicians generally believe women who report feeling “crazy” or “like a stranger in my body” on the Pill, responding most often by switching the patient to another formulation or contraceptive method; this trial and error often repeats over months. This clinical improvisation appears to depend on the physician-patient relationship, as well as other social factors like race and education of the patient. Conclusions: Apprehending this clinical action as a form of improvisation pushes us to consider improvisation as an important feature of medical practice even in “well-resourced” settings. I argue that these improvisations form a politics of recognition which, though validating of a patient’s experience, nevertheless reinscribes existing evidentiary regimes, leaves unchallenged the status quo of knowledge production, and contributes to the continued dominance of a coterie of contraceptive technologies which are only just “good enough.”
2. Veronica Phifer, Rebecca Henderson, Sharon Y. Byun (University of Florida, USA). **THE REPERCUSSIONS OF CHANGING LEGISLATION REGARDING ABORTION IN THE U.S.** Introduction: Abortion is a controversial topic in American politics leaving the few abortion providers still in practice at a crossroads between verbal abuse, a medical career in secret, or opting against the career altogether. As a result, the U.S. is facing a critical shortage of abortion providers; they are forced to decide how to respond to laws designed to curtail abortion when they laws conflict with providers’ commitment to providing abortion care. Objectives: To identify how changes in politics have affected abortion providers throughout the U.S., as well as what strides providers will take in response to these changes. Methods: We used participant observation and open-ended interviews with current providers and medical students who attend Medical Students for Choice conferences. We investigated factors contributing to the decision to provide elective abortion. These interviews were done over the phone and were transcribed and analyzed using inductive coding with the assistance of MAXQDA. Results: Major themes included narratives about: how medical practitioners decide whether, and how, to include elective abortion in their medical practice; how abortion providers will address the illegalization of abortion, should this occur; and threats to providing these services for current providers. Conclusion: Abortion providers frame the decision to provide abortion as central to their personal, political and professional identities. Understanding their views against the backdrop of a rapidly changing legal landscape provides insight into the lengths to which medical personnel will go to ensure continued access to elective abortion care.
3. Alejandra Marks (Tulane University, USA). **INVISIBLE MEN: A STUDY ABOUT MALE ATTITUDES AND EMOTIONS TOWARDS ABORTION IN CUBA.** Anthropological and other research on abortion has focused primarily on the experiences of women, often to the exclusion of men’s experiences. In Cuba, investigation has centered predominantly on women’s motivations, wider economic considerations (Andaya, 2014), and the culturally uncommon view that abortion is a reasonable fertility control option by itself (Belanger et al., 2009). However, traditional renderings of abortion as a “women’s issue” are misguided because men often play a key role in reproductive decisions. In this paper, I focus on the abortion narratives of cis-gendered heterosexual Cuban men and women and what these stories tell us about their preoccupations and desires, as well as the conflicts that arise between partners with regard to reproduction. My analysis of men’s roles in abortion, in a country where nearly half of all pregnancies are terminated (Gonzalez, 2017), challenges the pervasive view that men’s involvement in women’s reproductive decisions is nearly always oppressive or coercive, both socially and politically. This paper takes seriously anthropologist Matthew Guttman’s assertion that the intersubjectivity crafted by men and women through daily interactions has a “culturally productive potential” (Gutmann, 2007).



An understanding of the anger, fear, frustration, grief, humor, and affection that couples share on an intimate level when faced with an unplanned pregnancy elucidates the genuine forces at play that are often obscured by the larger political discourse. Cubans' narratives reveal the complex nature of men's involvement in reproductive decisions and outcomes—including a common desire for more open and nuanced dialogue—implicating men in ways that are both more varied and more profound than an analysis of societal dynamics writ large might indicate. Much may be gained in both the social and political domains by attending to the interpersonal dynamics of abortion decisions and, in particular, men's roles within them. Lessons learned here, on the interpersonal level, could inform a more productive discussion based not on fixed ideologies but rather on individual experiences that reflect the complexity of the issue.

4. Emilia M. Guevara (University of Maryland, USA). **VIOLENCE IN A PEACEFUL PLACE: RURALITY AND RESISTANCE.** In Mexico, gendered violence is increasing with 66% of Mexican women facing emotional, physical, sexual, domestic, or economic violence in their lives. As women migrate from Mexico, they take with them the trauma of everyday violence and leave behind families that must contend with continued poverty, domestic violence, femicide, and encroaching drug and gang violence. The objective of this ethnographic study is to trace the everyday lives of chronically ill migrant women from rural Hidalgo, Mexico who work in the Maryland Crab industry in the United States. These women must manage their mental health and medical crises while coping with sexual and labor coercion from male migrants and employers. They also contend with U.S. state-sanctioned violence, discrimination, and symbolic oppression toward Mexicans and women in a rural Republican stronghold within the highly Democratic state of Maryland. As a qualitative, multi-sited ethnography, this study included participant-observation and 60 in-depth interviews which were audio recorded and transcribed. The data were analyzed using thematic coding and stored in NVivo. Results reveal that, while migration alongside traumatic events impact the severity of an individual's chronic illness, women are able to come to terms with the violence in their lives, allowing for individual agency and economic stability.

Medical anthropologists take(s) on policy issues

2 pm – 3:15 pm, Room 10

1. Alexa S. Dietrich (Wagner College and Social Science Research Council, USA). **ACCOUNTING FOR COMMUNITY-LEVEL RESILIENCE.** Introduction: Social science research on disasters suggests that being prepared for a disaster does not necessarily predict better post-disaster outcomes/resiliency. This work increasingly attends to social determinants of disasters following hazard events, but still focuses on individual-level variables. There has been little productive engagement by disaster researchers with the literature within medical anthropology on related issues, specifically community health. Objectives: Using data from research in New York City and Puerto Rico following Hurricanes Sandy and Maria, the paper will demonstrate the relevance of critical medical anthropology for disaster researchers. This analysis will be translatable into policy recommendations for more effective, community-relevant disaster preparedness. Methods: Data were gathered primarily through ethnographic methods, including participant observation, interviews, and review of journalistic and other scholarly sources. Data were analyzed qualitatively with a mainly inductive approach, looking for thematic patterns. Results: Analysis of materials shows that while there is general acknowledgement of the value of collective action in disaster literature, preparedness outreach materials from emergency management agencies typically emphasize individual and household-level preparedness. Well-established critical medical anthropological work speaks to similar fallacies in health promotion, offering by analogy rich empirical support for promoting community-level preparedness policies. Conclusions: Emergency managers and disaster researchers increasingly speak of a "whole community" approach to preparedness, including "creating cultures of preparedness," without drawing on the insights of critical medical anthropology to inform outreach programs. Comparative analysis of recent hurricanes suggests critical medical anthropology's emphasis on community-level and social determinants of health provides important lessons for disaster preparedness.
2. Kayla J. Torres Morales (Northern Arizona University, USA). **PUERTO RICO SE LEVANTA: HEALTH, DISASTER, AND RECOVERY AFTER HURRICANE MARIA.** Introduction. In anthropological literature, disaster is broadly defined as the failure of human systems to understand and address disturbances that produce a cultural shift in socio-



environmental relations and institutions. Accordingly, “natural” disasters are sustained as human events because the resulting emergency state and recovery period continues after the initial environmental destruction. The events in Puerto Rico (PR) following Hurricane Maria in 2017, provide an example of such a failure in disaster management. This ongoing disaster is further reflected in the Trump administration’s delayed relief response following Hurricane Maria. Objectives. In this paper, I explore the consequences of structural barriers, including the destruction of infrastructure and insufficient government aid following Hurricane Maria, and its effects on medical agency and access to healthcare among Puerto Ricans living with chronic illnesses. Methods. I examined the experiences of managing chronic illnesses during and after the hurricane through semi-structured interviews and surveys conducted among individuals who selfidentify as living with chronic illness in PR. I consider whether these individuals attributed their current state of health and well-being to the hurricane and the conditions thereafter. Results. In each of the 40 interviews, individuals associated Hurricane Maria with negative outcomes in their physical or mental health, regardless of illness type. Of 120 survey participants, emotional distress was four times more common than ongoing physiological impacts. Conclusions. A medical anthropological interpretation of the results of the ethnographic study suggest a need for a more humanistic response to natural disasters to avoid ongoing psychosocial distress in the lives of survivors.

3. Robin Mowson, Isabella Chan, Marcela Contreras, Martha Velandia (Pan American Health Organization, USA). **USING ANTHROPOLOGICAL INSIGHTS AND INNOVATIVE DATA COLLECTION TO UNDERSTAND AND ADDRESS IMMUNIZATION EQUITY AND DEMAND IN LATIN AMERICA AND THE CARIBBEAN.** International public health organizations working in immunization, such as the Pan American Health Organization (PAHO), are increasingly engaging with social sciences to understand the social determinants of health decision-making. This paper explores how the application of anthropological methods and perspectives are a valuable tool for addressing immunization coverage rates that globally have not reached the goal of 95% and are stagnating in some parts of LAC. The case studies and initiatives discussed in this presentation demonstrate how integrating anthropological theory and research methods with PAHO’s public health approach facilitate a holistic understanding of vaccination access, acceptance, and demand with the goal of increasing immunization equity in the Americas. Current work with global and national partners aims to integrate qualitative and quantitative methodologies, such as the use of innovative indicators and data points within electronic immunization registries (EIR) to identify susceptible populations, target underimmunized groups, and predict areas for outreach. Through the encouragement of qualitative methods and culturally relevant strategies to engage with the community as well as with available data, health staff is better equipped to take an adapted approach to understanding population motivations and needs. Within the global immunization community there is a growing confidence in and pursuit of anthropological knowledge to address equity challenges, and example of this being the case studies PAHO is developing to build a fuller understanding of local populations and how to reach them. There is a push to build programming with a more bottom-up approach including a focus on front line workers and the realities their communities face. The hope is to better contextualize administrative data to address inequities resultant from issues of access, acceptance and demand, encouraging data use to increase the success of immunization programs. Complementing quantitative understandings of high immunization coverage with qualitative insights can help target the “last mile” in immunization coverage by documenting successful strategies to address inequities at subnational levels and examining contextual determinants of health that may be masked by traditionally reported data. Using anthropological insights gives PAHO an opportunity to share achievements and lessons learned while supporting countries to reframe immunization strategies in an increasingly complex and interconnected world.
4. Yui Fujii, Rebecca Henderson (University of Florida, USA). **INFECTIOUS UNCERTAINTY: PREDICTIVE EPIDEMIOLOGICAL MODELING IN THE MIDST OF AN EPIDEMIC.** Introduction: Epidemiological models use mathematics and statistics to depict and predict the movement of infectious pathogens. Although modeling communities are aware of the inherent uncertainties that exists within models, ambiguity is often inadequately communicated to policymakers. This situation is compounded in cases of emerging pathogens or “new” diseases, where there is limited scientific knowledge available. Objectives: This study investigates the sources of uncertainty within epidemiological models of emerging epidemics, tracing the social and scientific forces that shape their creation. It also seeks to understand how uncertainty is addressed by modelers in publications and communication with policymakers. Methods: Participants were selected based on their creation of predictive



epidemiological models during the midst of the 2014-2015 West African Ebola epidemic, or the early movement of Zika through the Americas. Interviews were performed using a semi-structured interview script that focused on disease modeling practices, epidemiological thinking, and modeling communities. Interviews were analyzed thematically within MAX QDA. Simultaneously, an analysis of the modeling publications produced by interviewees was conducted. Results: Three distinct sources of uncertainty were discovered within the analysis: limitations within the model, lack of organized emergency modeling strategies, and political barriers. Modelers themselves understand the underlying uncertainties within models which is evident in their use of the mantra, “all models are wrong, but some are useful,” but due to the inherent uncertainty of models, modelers must better communicate this underlying issue to policymakers. Conclusions: As global health communities become increasingly concerned with epidemic response, an improved understanding of predictive epidemiological models is of crucial importance. The use of epidemiological models requires an improved understanding of the social forces which impact their creation, the multiple uncertainties they embed, and the partial transformation of models to policy.

5. Livia Garofalo (Northwestern University, USA). **WHITECOAT ACTIVISM: DISSENT AND DISILLUSIONMENT IN THE ARGENTINE HOSPITAL.** Introduction: In Argentina, doctors in public hospitals provide care for patients in conditions of infrastructural difficulty, resource scarcity, and - often - political tension. While the Argentine state provides free and universal healthcare, it is also viewed as inefficient, corrupt, and violent. It is in this context that my presentation examines how healthcare restructuring efforts affect the labor of doctors as state workers in public intensive care units. Following a series of budget cuts to healthcare throughout the presidency of Mauricio Macri, in 2018 physicians found themselves at the center of political tension. Methods: My presentation draws on ethnographic data from hospital marches, sit-ins, and other enactments of dissent in two public hospitals in Buenos Aires, Argentina. Through interviews and participant observation conducted between January 2018 and March 2019, I analyze the different strategies for opposition and the reasons for disillusionment towards hospital administration, national politics, and the future of “salud pública.” Results: Doctors differentially position themselves in response to political activism and daily infrastructural struggles to express their disagreement. While some decide to participate whole-heartedly, others support less evident strategies of resistance or expression of dissent. I argue that these forms of opposition can be termed as being a kind of “whitecoat activism” that builds on ideals of medical heroism. Conclusions: Argentina provides a poignant case to understand the relationship between care, the state, and its different publics at a time of renewed austerity and political unrest.

Blackness, health, medicine, and the sciences

2 pm – 3:15 pm, Room 14

Organizers: Ugo F. Edu (University of California, Los Angeles), Victoria Massie (University of California, Berkeley), Adeola Oni-Orisan (University of California, San Francisco), Yesmar Oyarzun (Rice University), Maryani Rasidjan (University of California, Berkeley)

Panel abstract: What can engagements with Black feminist thought/critical Black Studies reveal about the intersections of Blackness, health, medicine, and the sciences and the impacts on Black health, well-being, kinship, and reproduction? This panel seeks to draw upon insights from Black theorists to attend to the particularities of aesthetic and affective entanglements of Blackness with the medical and health sciences, globally. Recognizing that the construction of the medical sciences has developed alongside the popular perception of not only the construct of race but specifically the construct of Blackness then requires an attention and engagement of the two simultaneously. Each of the papers in this panel do so, whether explicitly or implicitly, expanding the critical intervention the emerging interdisciplinary field of Black Health Science Studies offers as a means to creating better understandings of health for Black communities and better interactions with the medical and health sciences. The panelists draw on ethnographic research carried out in Brazil, between the US and Cameroon, and within the US medical profession and structures of medical education residency. This panel will think with Black feminist scholars like Saidiya Hartman to anchor a critical rereading of topics in medical anthropology such as “repair” and “care.” Thinking with scholars like Toni Morrison, the panel also explores the operation of racialized aesthetics that underpin



definitions of “healthy” operating at the level of the racialized individual, the family or reproduction across multiple sites.

1. Yesmar Oyarzun (Rice University, USA). **TURF WARS”: BLACK PHYSICIANS AND MEDICAL STUDENTS NEGOTIATING PATIENT CARE FROM WITHIN THE MEDICAL PROFESSION.** Despite the growth of cultural competency discourses in medicine, who is allowed to be sufficiently culturally competent may continue to be contested. Focusing on the experiences of physicians and medical students of color in an urban setting in the United States, the objective of this paper is to demonstrate how physicians, medical students, and residents of color, in particular, have to negotiate with other doctors about patient care, but also about the patients’ and their own expertise. That expertise includes both medical and sociocultural expertise. This research was carried out over the summer of 2019. In a major US city, I used a snowball sampling method to interview physicians and medical students who identified as being interested in the issue of racism in medicine. In this presentation, I will use evidence selected from the qualitative interviews of two participants, a Black medical student and a Black physician. Participants stated they felt that they were challenged and/or distrusted more frequently on their medical opinions and with regard to their care of Black patients. Multiple stories emerged in which participants faced aggressive and/or isolating treatment from their colleagues and clinical superiors when they offered advice or assistance to patients outside of supervisors’/colleagues’ expectations. These cases may point to how the internal relations within the medical profession and the structures of medical education become spaces for “turf wars” in which medical professionalism, cultural competence, and social justice are situated as if in tension.
2. Adeola Oni-Orisan (University of California San Francisco, USA). **LEARNING TO SEE SICKNESS: BINARY TRIAGING IN MEDICAL EDUCATION.** Disparities in Black women’s health have recently caught the attention of mainstream media outlets with tennis star Serena Williams’ nearly fatal lung clot shortly after childbirth and model/actress Kim Porter’s sudden death the day after contacting her doctor to report that she was still not feeling better following weeks of flu-like symptoms. The fates of these celebrities highlight the disturbing realization that no level of financial security, educational attainment, or social status could mitigate the toxic effects of the intersecting systems of oppression, sexism and racism. While decades of health research have illuminated how even when socioeconomic differences are accounted for, the quality of health care one receives is determined by race, much less discussed is the fundamental role medical education plays in perpetuating these health disparities. How do doctors learn to discern who is sick, and thus deserving of urgent medical attention, and who is not sick? Drawing from 12 months of ethnographic research at a residency program based in a large county hospital in San Francisco, this paper explores binary triaging—a form of triage which relies on a vague set of often aesthetic criteria—in the hidden curriculum of medical education and its impact on disparities in the care patients receive. I use theoretical tools from medical anthropology and Black feminist theory to interrogate two scenes in clinical training. I argue that race is a determining factor in this process in ways that are rarely openly addressed, but that have deadly effects on Black women in particular.
3. Ugo F. Edu (University of California Los Angeles, USA). **PERCEPTIONS OF HEALTH: A CONFLUENCE OF AESTHETICS, RACE, AND RACISM.** Based on 16 months of ethnographic research in Salvador, Bahia, this paper points to the importance of an understanding and recognition of the aesthetic underpinnings of health and biomedical systems. Drawing on women’s reproductive experiences and navigations within a racialized gendered hierarchy, I draw attention to the role aesthetics play in the construction and perception of what constitutes healthy reproduction and reproductive practices. I point out how the processes and procedures related to the governance and measurements of reproduction and reproductive health shape the way Black women are navigating society and health systems. I focus in particular on Black women’s experiences of contraceptive use, attempts to acquire tubal ligations, and family construction. I analyze the way that values, sensibilities, and affect that have come to adhere to particular appearances and arrangements have also adhered to the perception and apprehension of reproductive decision-making (seen and un-seen), reproductive health, and family constructions. By demonstrating how aesthetic systems and their interactions with health and biomedical systems literally and figuratively color the movement and perception of movement of people through those systems, with implications for reproductive health, this paper highlights the “co-constitutive nature of medical science and popular perception, underscoring the need to engage them simultaneously.”



4. Victoria M. Massie (University of California Berkeley, USA). **RECONSTRUCTING GENETIC CAMEROONIAN ANCESTRY: RETURN AS CRITICAL FABULATION.** In the 21st century, genetic markers are viewed as things that both tell us who we are and how we relate to others across space and time. Genetic ancestry is one of the most popular examples, with over 26 million American consumers taking the test over the past two decades to learn what their alleged genetic racial identity has been and to find new ways to create identities and belonging accordingly. Science studies scholars have noted one disturbing problem with this: race is being reified as a biological fact under the guise of ancestry. This paper draws on Saidiya Hartman’s method of “critical fabulation” to grapple with how African Americans and Cameroonians reconstruct Cameroonian ancestry from the genetic traces that have been left behind. Rather than posing DNA as a source of repair, this paper asks how do African Americans and Cameroonians mutually constitute being with and to one another through genetic ancestry according to the material conditions of contemporary Cameroon? What does this offer to our understanding of genetic or biological citizenship, and an ethics of care that reckons with distinct, but no less related, histories of slavery and colonialism, without becoming reducible to those violence? How does genetic reconnection in Cameroon provide a critical rereading of DNA’s authority, and the conditions under which African ancestry is racialized to be particularly susceptible to biological essentialism?

5. Maryani Palupy Rasidjan (University of California Berkeley, USA). **BLACKNESS IN INDONESIA’S PERIPHERY: PAPUAN WOMEN’S REPRODUCTION, RACIALIZATION AND THE FIGHT FOR POLITICAL SOVEREIGNTY.** This paper examines the intersection between race, national identity and women’s reproductive health in Papua, Indonesia. I explore the ways in which a black Papuan self-identification has been both consolidated and contested in response to Indonesia’s national family planning program. Drawing on 10 months of ethnographic fieldwork in Papua, including archival and social media analysis, this project demonstrates that racialization and indigeneity, in a political context which claims to have no indigenous inhabitants, are mobilizing features of a pronatalist movement in the Papuan highlands. Through examining a pronatalist program, I show how this racialization, which sometimes oscillates between or is coupled with other forms of self-identification, is deeply entangled with ‘population’, and again centers on Papuan women’s bodies. Here ‘population’ emerges as the idiom of simultaneous anxieties—that is, charges of overpopulation by the state (thereby, requiring family planning) and depopulation (a clear indictment of family planning). I connect contemporary black Papuan self-identification to histories of early Papuan political invocations of a global black liberation in order to situate the assemblage of pressures and histories women contend with when confronting family planning structures.

Clinical cultures

2 pm – 3:15 pm, Room 12 (gallery with posters) – please see annex.

War zones, conflict, and trauma

2 pm – 3:15 pm, Room 12 (gallery with posters) – please see annex.

Reproductive disruptions - Part 2

3:15 – 4:30 pm, Room 3 (with translation)

1. Young-Gyuong Paik (Jeju National University, South Korea). **DECRIMINALIZING ABORTION, REPRODUCTIVE RIGHTS OF SEX WORKERS AND REPRODUCTIVE JUSTICE MOVEMENT IN SOUTH KOREA.** Introduction: On April 11, 2019, abortion was decriminalized in South Korea when it’s Constitutional Court ruled that the ban on abortion was unconstitutional. South Korea’s legislature must revise the 66-year-old anti-abortion law by 2020. This historic decision was made possible by the advocacy and activism of many feminist groups, doctors’ organizations, disability rights groups, youth activists, and religious groups, who collectively formed the Joint Action for Reproductive Justice in 2017. Although the anti-prostitution human rights group called E-Loom has been a part of this coalition, the members are concerned whether the idea of reproductive justice can be stretched to include the reality of sex workers. Objectives: To trace the emergent meaning of reproductive rights and justice through the voices of sex workers/activists. Methods: This work is based on the author’s long



involvement with the feminist movement and archival research on the history of South Korean population policy, and interviews with activists and sex workers. Results: While E-Loom welcomes the decriminalization of abortion and strongly supports the current reproductive justice movement, they express a sense of exclusion and marginalization from the mainstream of the movement. They fear even the reformed law might not address their concerns and wonder what the concept of reproductive rights could mean for them. Conclusions: The difficulties of addressing sex workers' concerns in reproductive justice movement have not only practical and strategical dimensions but also theoretical dimension. Sex workers' discomfort with the current movement asks for more discussion on the concept of reproduction, sex, and work.

2. Jess Marie Newman (Temple University, USA). **DANGEROUS SEX, TERRITORIALIZING RUMORS: NARRATING ABORTION IN MOROCCO.** In Morocco, abortion and extramarital sex are both criminalized, child abandonment is a punishable offense, and adoption has no legal standing. And yet, sex and abortion are “open secrets.” In this paper, I consider and how news and rumor solidified tenuous links between different kinds of illicit sexual activity in the minds of my interlocutors. The media intersects with flows of informal communication in ways that exacerbate everyday actors' senses that illicit sex is everywhere all at once. By pivoting between ethnographic material and the media, I negotiate the narrative landscape that characterized discussions about transgressive sex. I draw on two years of ethnographic fieldwork in Casablanca and Rabat, Morocco, during which time I worked with abortion seekers, single mothers, medical staff and activists. I focus on a public maternity hospital's Emergency Room to show that rumors and sensational media coverage of abortion and child abandonment had concrete impacts on how medical professionals did their jobs. Staff members consumed stories about abortion and child abandonment that colored their everyday experiences on the job. Their expectations for patient comportment or their concerns about their potential liability reflect concerns that extend far beyond triage and diagnosis, resulting in hybrid processes of medical and moral reasoning.
3. Whitney Arey (Brown University, USA). **EMBODIED EXPERIENCES OF ANTI-ABORTION RHETORIC.** This paper explores the embodied experience of anti-abortion protest speech on patients and their companions as they enter an abortion clinic. This paper is based on eighteen months of participant observation at two abortion clinics in North Carolina, U.S., each of which has a daily presence of anti-abortion protesters. I conducted a survey on affective experiences with protesters, interviews with people seeking abortion services, their accompanying friends, family members and romantic partners, and clinic staff and volunteers, as well as audio and video recorded interactions outside of the clinic for linguistic analysis. As people walk past protesters to enter the clinic, they experience targeted rhetoric about their personal bodies, relationships, mother or fatherhood status, religion, race, class, and gender in an attempt to convince them not to seek abortion services. This serves as a form of reproductive governance tailored to individual bodies, where social readings of their individual bodies are utilized by protesters to personalize speech about what actions their bodies are taking, should be taking, and might experience as a result of abortion. While this experience is often fleeting, it has impacts on people's appointments, on the care they receive, and on how they think and talk about their experience weeks later. I show how patients come to resist these narratives about their bodies through the construction of their abortion experience, as well as how these sometimes verbally abusive negative constructions of the body can be embodied as a part of subjective experiences of abortion.
4. Elyse Singer (University of Oklahoma, USA). **“FRAUGHT CARE”: PROVOCATIONS ON CARE AND VIOLENCE IN MEXICO CITY'S PUBLIC ABORTION PROGRAM.** Mexican obstetrics has come under scrutiny in recent years by feminist scholars, midwives, and social activists alike (Dixon 2015; Smith-Oka 2015). Reports from Mexico document the prevalence, in public and to a lesser extent private contexts, of “obstetric violence”— hostile doctor-patient interactions that collude with wider social inequities to threaten women's reproductive rights and assault their personhood (Castro and Erviti 2015, D'Gregorio 2010; Smith-Oka 2015; Dixon 2015). My long-time research in Mexico City's public abortion program (the ILE program) has led me to consider the analytical limitations of “violence” in capturing the moral and affective registers of caring engagements that unfold there. This paper thus begins with a set of Provocations: what is lost in scholarly accounts that overdetermine “violence” in interactions between providers and their obstetric patients? How can we account for troubling acts of harm in reproductive healthcare while also attending to the caring dispositions that motivate most clinicians to practice medicine? I argue that harm and care coincide in the ILE clinic, tangling into each other so as to become indistinguishable. Regaño [scolding] forms a regular part of ILE care, as ILE personnel dispense a



moral curriculum about responsible patienthood, proper reproduction, and good citizenship. These providers coax and cajole their patients as intimate expressions of concern for the health of women and the vitality of the Mexican social whole. Mexican abortion providers envision their labor as part of a social duty to preserve the Mexican family and the public health of Mexican society.

5. Silvia del Zordo (Ramón y Cajal, University of Barcelona, Spain), Joanna Mishtal University of Central Florida, USA), Giulia Zanini (Queen Mary University of London), Ann-Kathrin Ziegler (University of Barcelona), Caitlin Gerdts (Ibis Reproductive Health, USA), Camille Garnsey (Ibis Reproductive Health, USA) & the ERC BAR2LEGAB project. **'BUT LISTEN, MADAM, YOU'VE EXCEEDED': GESTATIONAL AGE LIMITS IN ABORTION CARE AND CROSS BORDER ABORTION TRAVEL IN EUROPE.** Research about abortion travel in Europe has focused on women who travel from countries with highly restrictive abortion laws, but limited existing data suggest that cross-border travel to access abortion care is a necessity even for women from countries with relatively liberal abortion laws, including France, Germany, and Italy. This paper explores the experiences of women who travel to the UK, the Netherlands, and Spain for abortion care from countries with relatively liberal abortion laws. Our research is a European Research Council-funded mixed-methods study, which combines anthropology and epidemiology. Drawing on data collected with 204 women, we show that the majority of women traveled because they exceeded the legal gestational age limits, making it too late to have an abortion in their home country. Reasons for delays varied. Some found out they were pregnant in the end of/beyond the first trimester because of irregular periods, lack of clear pregnancy signs, distressful life circumstances, and/or misinformation by physicians. Some were delayed by lack of information or abortion providers. This study is significant because it calls attention to serious barriers to abortion care even when the laws are perceived to be relatively liberal, as in Italy and France. These barriers compel women to travel abroad to seek abortion services. The time and cost associated with abortion travel are substantial, and represent a significant burden to women who are able to make the journeys. Therefore, this study highlights the stratification of access to reproductive health care and raises questions about abortion regulation.

Attending indigenous politics, history, and trauma in healthcare

3:15 – 4:30 pm, Room 8

1. Eugenia Rainey (Tulane University, USA). **FROM CULTURAL COMPETENCY TO CULTURAL HUMILITY: HOW SANTERÍA HELPED SHAPE MEDICAL TRAINING IN SOUTH FLORIDA.** In this paper I examine how the influx of Cuban exiles to the US during the 1980 Mariel Boatlift facilitated the development of cultural competency (training healthcare providers in cross-cultural narratives) in south Florida, and motivated biomedical practitioners to learn more about La Regla de Ochá (Santería) which was widely practiced by this population. The groundbreaking work in cultural competency done by the University of Miami was motivated in part by the need to address the medical and psychological issues faced by this population. La Regla de Ochá proved to be a central focus of this training. What can we gather from the early years of cultural competency regarding the initial subjectivity of these patients and how has their subjectivity changed over the last few decades? This research uses participant observation and semi-structured interviews with some of the scholars who shaped the initial paradigm, medical educators utilizing the current “cultural humility” paradigm (focusing on self-reflection and sincere relationship building) and patients who are practitioners of the religion. The paper addresses how the delivery of the paradigm has evolved over the years and how it has impacted the medical encounter. Ultimately, the research illustrates that biomedical practitioners are uncomfortable with religion and spirituality. They are far more inclined to focus on secular aspects of life, like diet and family structure, making it difficult to maintain a robust paradigm to address the social determinants of health in all their nuances and complexities.
2. Lauren Sealy Krishnamurti (University of Pittsburgh, USA). **CARING WITH ALOHA: SUICIDE PREVENTION AND WATCHFUL CARE IN HAWAII.** A growing number of people report high rates of suicidal ideation in Hawaii, reportedly doubling between 2007 and 2012. Concern surrounding the potentiality of a suicide crisis resulted in a proliferation of community responses to reducing suicide in the state. My fieldwork (2014–2019) follows the efforts of suicide prevention care workers in Honolulu, Hawaii. Based on interviews with prevention workers, I



show that a majority of those involved in this (predominantly unpaid) work share affective connections to the cause, with many having personally lost a loved one to suicide. My fieldwork shows that those administering a type of “watchful” care in Hawaii present an alternative to what Lisa Stevenson terms to be the “anonymous care” of U.S. suicide prevention strategies, which she reveals are depersonalizing in their overreliance on cold institutional protocols. In Hawaii, suicide care with aloha maintains the centrality of those in need of care—their identity, their experiences, their mo’olelo or story—rather than addressing suicide in what Stevenson shows is a detached model, one that declares life’s unique value to no one in particular. Prevention workers in Hawaii, as the narratives I present illustrate, explicitly aim to do the opposite—though they cannot always succeed. In this way, I also contend with the reality that care in suicide prevention, even in its most idealized form as articulate with aloha, can often still be inadequate.

3. Carolyn Smith-Morris, Sylvia Rodriguez, Rose Soto, Morningstar Spencer, Luigi Meneghini (Southern Methodist University, USA). **DECOLONIZING DIAGNOSIS: RECOGNIZING CULTURE AND FAMILY AT THE MOMENT OF DIAGNOSIS.** Introduction: The moment when a new diagnosis is first delivered to a patient is critical to future response and prevention, and a time when cultural and family factors have important, long-lasting influence. Given the continuing rise of diabetes prevalence globally, recent calls have been made for more tailored approaches to the delivery of a diagnosis. Objectives: The purpose of this research was to document and understand person-specific differences in culture, ideology, and attitudes at or near the moment of diagnosis with diabetes or a major diabetes-related complication. Methods: Research was a collaborative (Indigenous and non-Indigenous), clinic-based observational and interview-based study spanning 6 months. In-depth analysis was made of the recorded, transcribed, and narratively coded responses in 15 adult, Native American patients to receipt of an initial diagnosis of diabetes or a major diabetes-related complication (i.e., the need for insulin, the need for dialysis, initial peripheral neuropathy diagnosis, initial cardiovascular diagnosis). Results: Findings suggest that lessons learned from family about diabetes were often trauma-informed and fear-inducing, and that Native American heritage in urban U.S. inter-tribal settings does not reflect the Indigenous identity of all patients equally. Conclusion: Medical anthropology engaged in collaborative clinical settings has the potential to influence clinical best practice in ways that promote better recognition and response to cultural, historical, and family factors in care.
4. Michael Stoop, Yasmin Hamzah, Rebecca Henderson (University of Florida, USA). **WHAT IT MEANS TO PARTICIPATE: A CRITICAL ANALYSIS OF HEALTH COMMUNITY-BASED PARTICIPATORY RESEARCH IN INDIGENOUS COMMUNITIES.** Introduction: Community-based Participatory Research (CBPR) has become increasingly popular in health research with indigenous communities. Despite its widespread use, there has not been a critical examination of the use and meaning of CBPR, and the assumptions it embeds. Objectives: We seek to systematically examine the plurality of ways “community” and “participation” have been deployed within CBPR. This critical analysis reveals unspoken assumptions about the meaning of health, collaboration and indigenous communities. Methods: A systematic literature review was conducted using core social science and health databases. Articles with a primary focus on indigenous communities, health, and CBPR methodology were selected. A coding schema was developed, and articles were coded for variables and themes by the first two authors. Results: Articles reporting CBPR varied in their descriptions of key components of the research process, including definitions of community, amount and type of collaboration, and key assumptions about indigenous peoples. A comparison of the use of CBPR across health disciplines showed significant heterogeneity both within and across disciplinary boundaries. Significantly, while CBPR purports to provide an alternative to hierarchical structures, some CBPR replicates colonialist and neo-liberal assumptions. Conclusion: CBPR continues to be deployed uncritically, replicating assumptions and undermining true indigenous participation. For CBPR to fulfill its promise of inclusive, meaningful research, health researchers across disciplines need a more critical set of best practices which avoid replicating assumptions and truly engage with indigenous communities.
5. Randall C. Burson (University of Pennsylvania, USA). **MONOCULTURE IN AN INTERCULTURAL LANDSCAPE: MENTAL HEALTH CARE AND FORESTRY CONFLICT IN WALL MAPU/LA ARAUCANÍA, CHILE.** The region of La Araucanía has the highest rate of mental illness and lowest measures of economic development in Chile. Indigenous Mapuche peoples—who comprise 30% of the region’s population—are disproportionately and



unjustly represented in these statistics. To address these disparities, the Chilean government built a network of indigenous-biomedical health clinics, essentially partitioning medical care from the context in which these disparities arose. Namely, La Araucanía has been the epicenter of a longstanding conflict between militarized Chilean police and Mapuche communities seeking to reclaim their ancestral territory from multinational forestry companies. Incorporating the “structural determinants of health” offers a lens to see how this politico-economic context complicates mental illness as a purely bio-individual phenomenon requiring biomedical care. In this paper, I first analyze how psychosocial problems like grief and anxiety are comorbid with the Chilean-Mapuche territorial conflict, and then trace how care becomes intertwined with efforts to seek justice. I draw on interviews and participant observations of mental health teams, intercultural health facilitators, and Mapuche healers, as well as emblematic cases of conflict between Mapuche leaders and forestry companies in Southern Chile. Attending to the ruptures generated by extractive logging practices and state violence, I demonstrate the (im)possibility of separating the acts of care offered in intercultural clinics from acts of justice-seeking for the lands on which these clinics are built. By analyzing how biomedical and Mapuche healers make sense of comorbid human and environmental distress, I show how intercultural care and justice have become co-constitutive in La Araucanía.

Gender lens: Questions for responses from medical anthropology

3:15 – 4:30 pm, Room 10

1. Mai-Lei Woo Kinshella (University of British Columbia, Canada). **BEYOND REPRODUCTION: THE FIRST 1,000 DAYS APPROACH TO NUTRITION THROUGH A GENDERED-BASED LENS.** Introduction: The First 1000 Days approach has been highly influential in mobilizing policy attention and resources to improving nutrition from a woman’s conception to a child’s second birthday for good development and growth throughout the child’s life and potentially onto their own offspring. Objectives: The purpose is to critically review the theory and consider it within a gendered human rights lens. Methods: The gender responsiveness of the theory is evaluated with the WHO Gender Responsive Assessment Scale (GRAS) and processes of systematic neglect explored through Bourdieu’s theories of how social structures are reproduced. Results: A critical examination of the First 1,000 Days approach to nutrition reveals a conceptualization of motherhood as a site of intervention. Though the need to empower women is highlighted, theoretical underpinnings implicitly reflects and reproduces gender biases by conceptualizing women within a limited scope of reproduction and childcare. The scope of women within the First 1,000 Days is both limited to their roles in reproduction and childcare but also limiting in that it seems natural to all parties involved to see women within this sphere. Conclusion: Building on the works of Bourdieu and others on how social structures are constantly being reproduced, the power of research as a part of social justice mobilization lies in its ability to expand the limited scope and bear witness to the realities that people experience. For the First 1,000 Days approach, this means accountability to the empowerment of women and girls in a genuinely gender transformative way.
2. Mika Kadono (University of South Florida, USA). **“IT WAS A CALCULATED RISK I WAS WILLING TO TAKE”: THE EXPERIENCE OF VACCINE HESITANT MOTHERS IN SOUTHERN CALIFORNIA.** Introduction: While vaccines are well-established as a safe and effective preventive intervention, they have become a polarizing issue, once again. Many countries, including the United States, are experiencing a rise in vaccine hesitancy, or the delay or refusal of vaccinations despite their availability. In-depth examination is required to understand and address this highly vaccine- and context- specific phenomenon. Objectives: This exploratory study sought to identify underlying factors that impacted vaccine-related decisions and behaviors and understand the experience of vaccine hesitant parents. Methods: In-depth, qualitative interviews were conducted with 14 parents living in Los Angeles County, California who had at least one child of pre-school age (12 months to 5 years old). Interviews were recorded, transcribed verbatim, and coded for themes. Results: Using political economic theory through a feminist lens, several themes impacting vaccine hesitancy were identified, including (1) neoliberal mothering, which prioritized individual responsibility, risk assessment, and risk management, (2) trends toward de-medicalization, characterized by the rejection of biomedical interventions, including vaccines, and (3) the gendered nature of vaccine hesitancy. Conclusion: These results illustrate the complex, gendered experience of vaccine hesitancy. Most of the vaccine hesitant mothers in this study reported feeling responsible for making individualized vaccine-



related decisions for their children, while facing scrutiny and judgment for doing so. This paradoxical experience highlights the tension between individualized healthcare and community-based public health interventions. Efforts aimed at addressing falling vaccination rates among this population must consider multiple socioecological levels, including interpersonal, societal, and policy.

3. Peter J. Brown (Emory University, USA). **THE ANTHROPOLOGY OF MALE LONGEVITY DISADVANTAGE: BIOPSYCHOSOCIAL DETERMINANTS OF LIFE SPAN.** In nearly all human societies, the life expectancy of males is shorter than that of females. Demographers often label this phenomenon as “Female Longevity Advantage” (FLA), but this paper focuses on the male disadvantage (MLD)— why men die earlier than women. The presentation first summarizes cross-cultural and historical data that generally show that FLA/MLD varies with political-economic conditions. Extant demographic and medical data are utilized. Understanding the gender gap requires a holistic biopsychosocial approach within a cultural context. Important biological differences (e.g. genetic, endocrinological, neurological) are described in the context of evolutionary life history theory. Behavioral differences affecting MLD (e.g. dangerous activities, health-seeking patterns, exposure to violence) have both psychological and cultural aspects; these are learned within social contexts. Gender patterns of behavior interact with proximate biology (testosterone exposure) and differences in modal personalities (impulsivity and aggression). FLA/MLD differences decrease when healthy life expectancy (HALE) are included. The question is which is better – a longer life with more chronic morbidity in old age or a shorter life with less morbidity? Anthropology helps our understanding of why “women get sicker but men die quicker.”
4. Katherine Careaga (Rutgers University and New Jersey City University, USA). **TEACHING “GLOBAL HEALTH” IN U.S.-BASED PROGRAMS.** Introduction: This study examines a hegemonic global health textbook from a critically applied medical anthropology of science perspective. Objectives: The objective is to understand how structural and schematic factors shape approaches to teaching and global health workforce capacity-building in the United States, within the context of higher education restructuring in order to lay the foundation for a comparative discussion of critical medical anthropologists’ role(s) in the teaching of “global health” and bridging of social medicine understandings from the global South with hegemonic definitions of “global health” in the global North. Methods: The study analyzes discourses on health disparities and particular social determinants of health-- “culture” and “gender”--in Richard Skolnik’s Global Health 101. The author draws on her participant observation experiences in academies of the global South and in U.S.-based programs within the U.S. and abroad, gray literature review and archival data as a framework for (con)textual analysis of the book (chapters). Results: Information on cultural/ethnic and gender disparities and determinants is atheoretical, reductive, sparse, misrepresented, critically uninformed, compartmentalized, and presented without input from medical anthropologists in general. The “Culture and Health” chapter consists of anthropologically uninformed and individual-focused behavior change models. The book is not inclusive, conflates “gender” with “Women’s Health”. Until the 3rd edition, there was no mention of LGBTQI health beyond as an HIV/AIDS risk group, nor exploration of the cultural construction of “gender”. Conclusions: The book represents the glaring need for mainstreaming of anthropological perspectives in global health curriculum.

The (queer) futures of anthropologies of quantification

3:15 – 4:30 pm, Room 14

Organizers: Cal Biruk (McMaster University, Canada) & Matthew Thomann (University of Memphis, USA)

Session abstract: Amid the rise of big data and audit culture, medical anthropologists have taken critical interest in the practices, technologies, and politics of quantification in global health. Finding themselves both complicit with and critical of quantification’s ambitions and projects, anthropologists have been overwhelmingly expected to provide correctives to what numbers get wrong, overlook, or conceal, a charge that relies on assumed contrasts between anthropology and numbers in a data-driven world: small anthropology/big data and slow research/high velocity, for example. Yet, anthropological theory and method in their focus on careful tracking of emergent phenomena, carry much more potential than merely illuminating the shortcomings and reductionism of numbers in global health and other projects centered on knowing and improving bodies, behaviors, and health phenomena. This is particularly true for anthropological approaches that queer the supposed limits and constraints of the particular



metric-centric moment, instead asking how disciplinary cultures and regimes are confronted by individuals, communities, and indeed anthropologists themselves. This panel curates a set of papers that reflect on the pasts, presents, and futures of critical approaches to numbers in the subfield of medical anthropology and asks what a queer lens that recognizes the disciplinary power of such regimes while giving credence to how social actors (privileged and subjugated; centered and erased; etc.) engage these emergent regimes in ways that help us to think about alternative futures of global health. The papers engage, especially, how ethnographic approaches to tracking quantitative data's vitalities and social lives might helpfully denaturalize concepts at the very core of medical anthropology: health, healing, bodies, gender, race, and sexuality, for example. The panelists model anthropologies of quantification across diverse geographical contexts (Malawi, USA, Ivory Coast, Kenya, and X). Importantly, all of the papers move away from merely arbitrating the accuracy or efficacy of metrics, technologies of counting, indicators, or numbers, instead seeking to rethink quantification as an inherently queer practice whose internal slippages and aporias produce unlikely queer projects, resistances, and redirections. Rob Lorway's paper, for example, uses a series of graphics protesting biometrics in surveillance science and WhatsApp group practices within and HIV testing project to examine how queer bodies and beings move "toward, around, and against" objects of global health. Kathryn Hicks, meanwhile, explores the implications of acknowledged and unacknowledged uncertainty in Institute of Medicine (IOM) recommendations for maternal weight gain for social justice projects. Cal Biruk mobilizes 'queer metrics' to consider how indicators and counting practices in performance based aid economies in Malawi become unlikely queer resources for self-fashioning and material accumulation. Finally, Matthew Thomann's paper examines how Ivorian sexual and gender minorities act with and upon epidemiological categories of risk to highlight the ways in which individuals and communities complicate the assumed homogenizing forces of global health. Taken together, these papers highlight the critical pasts, presents, and future of critical approach to logics of quantification through a "queering" of not only disciplinary regimes in global health, but how individuals and communities engage, adapt, and subvert them.

1. Rob Lorway (University of Manitoba, Canada). **QUEER ORIENTATIONS IN GLOBAL HEALTH: OBJECTS, MATERIALITIES, AND NAVIGATIONS.** Introduction: Critical scholars have problematized the emergence of global health regimes in the era of 'virtuous capital'. Their critiques expose global health as working various improvement schemes across unequal registers of (primarily) western-based expertise and influence—via evidentiary regimes, cultures of measurement, relations of accountability, opportunistic financing, student exchange programs, medical training, and so on. Objectives: Horizons of global HIV prevention and care appear similarly crowded. New technologies, prevention and demonstration trials, enumerations and targets seem to overwhelm possibilities for imaging global health lifeworlds beyond the confines of population health logics. Herein lies my point of departure. Drawing upon Sara Ahmed's theorizations of alterity in 'queer phenomenology' I ask: how do sexual dissidents in Kenya (re)orient themselves to objects of global health? Methods: By examining a series of graphics to protest biometric surveillance and WhatsApp group practices during an HIV self-testing project, I consider how queer dissidents craft and realize political, social and economic priorities in relation to material culture (including new technologies and their own bodies) and the nearness and farness of global health others. Results: The transnational circulation of visual depictions of technologies not only intensifies affective dispositions of repulsion and anxiety but also of attachment and pleasure in ways that stir connections between bodies, technologies and social justice projects. Conclusions: As beings-in-the-world of global health, sexual dissidents are continually moving toward, around and against these new objects of intervention—dissolving the boundaries between beings and materialities while igniting the socially productive forces that animate global health practices.
2. Cal Biruk (McMaster University, Canada). **QUEER METRICS: CITATION, EMERGENCE, AND TECHNOLOGIES OF QUANTIFICATION IN NGO WORLDS IN MALAWI.** Introduction: This paper draws on ethnographic work with an LGBTI-rights NGO in Malawi that has seen a recent influx of resources directed toward reducing risk and prevalence of STIs including HIV among men who have sex with men (MSM). Global Fund and other monies also carry performance expectations measured through metrics and indicators. Objectives: The paper moves beyond representational critiques of technologies of quantification (wherein anthropologists call for "queerer" metrics isomorphic with queer identities), emphasizing instead how the failure of metrics to provide accurate counts or comprehensive pictures of queer people in NGO worlds enables queer cooptation, play, and performativity. Method: I draw on long-term work as a collaborator with NGO projects. In addition to capturing how people



make metrics work for them (as sites of material or social accumulation), the paper experiments with an analytic I propose elsewhere—queer metrics—as mode of theory for anthropologies of quantification. The paper brings together queer theory and critical data studies. Results: Taking the category MSM and instruments that seek to measure ‘yields’ and ‘outcomes’ of projects implemented in Malawi as entry points, queer metrics illuminates how quantification, beyond merely getting things wrong, constitutes a performative site of citation and re-citation that produces diverse kinds of value for diverse actors. Conclusions: The paper provocatively conjugates queer and metrics, modeling potential in bringing queer theoretical perspectives into conversation with critical data studies as undertaken by medical anthropologists of global health and beyond.

3. Kathryn Hicks (University of Memphis, USA). **THE ROLE OF UNCERTAINTY IN THE DEVELOPMENT OF GESTATIONAL WEIGHT GAIN RECOMMENDATIONS.** Introduction: A 2009 Institute of Medicine (IOM) report reassessed recommendations for maternal weight gain, based on concerns that women gain more weight than recommended and that this predicts pregnancy-related complications and compromised child health. The report has fueled research and guidelines for clinical practice, but also explicitly raises questions and points of uncertainty, including about causality in the relationship between weight gain and outcomes for women and children. Objectives: I explore expressions of relative uncertainty in the IOM report, and the degree to which these are addressed or acknowledged in 1) the recommendations contained in the report and 2) academic research and guidelines for clinical practice. I particularly examine the role of uncertainty in determinations of how to intervene with high risk populations including women classified as overweight or obese. Methods: I conduct a systematic analysis the IOM report, public health studies based on the IOM recommendations and materials designed either for clinicians or pregnant women to guide health behavior and weight gain within prescribed limits. Results: I find that the IOM report does pose a number of questions for discussion and investigation, but that the weight-gain recommendations based on BMI category are expressed with relative certainty, and citations of the report refer disproportionately, and often straightforwardly, to these. Conclusions: Both unacknowledged and acknowledged uncertainty in weight gain recommendations during pregnancy have important implications for social justice. I explore this, for example, with regard to the recommendation that mothers’ weight-change over the course of pregnancy be recorded on birth certificates.
4. Matthew Thomann (University of Memphis, USA). **PUTTING AFRICAN ‘MSM’ TO WORK: QUEERING METRICS IN GLOBAL HEALTH PROGRAMMING.** Introduction: This paper draws on nine years of ethnographic research on sexual and gender minority-led HIV organizing in Côte d’Ivoire. I explore how U.S. donor-driven metrics and performance-based pay systems seeking to document intervention coverage of men who have sex with men – or ‘MSM’ – have led to new social practices and subjectivities. I argue that these practices and subjectivities ‘queer’ both global health axioms and anthropological engagement with them. Objectives: The paper builds on recent important discussions in critical medical anthropology about what epidemiological categories such as ‘MSM’ obscure by focusing instead on the ways in which individuals and communities mobilize such categories in their daily work and lives. Methods: This paper draws on participant observation and semi-structured interviews with Ivorian sexual and gender minority HIV peer educators and activists, as well as archival research from donor organizations to add context to the shifting metrics to which these communities have been held. Results: HIV peer educators and activists adopt and bend metric-centric agendas in order to achieve locally relevant goals, simultaneously picking up circulating ideas about sexuality, personhood, and health and imbuing them with novel meanings that suite the local context. Conclusions: While metric-centric regimes may sometimes constrain what imagined possibilities in global health, anthropology’s recent concern with what such approaches obscure fails to engage how such categories are taken up and acted upon.
5. Thurka Sangaramoorthy (University of Maryland, USA). Discussant.

Addiction

3:15 – 4:30 pm, Room 12 (gallery with posters) – please see annex.

Nutrition, body weight, and culture

3:15 – 4:30 pm, Room 12 (gallery with posters) – please see annex.

Day 3 - Thursday, March 12th - MORNING

Intercultural health in Latin America / Salud intercultural en América Latina

9 am – 11:30 am, Room 3 (plenary with translation)

Organizer: Roberto Campos Navarro (Universidad Nacional Autónoma de México, México)

Resumen de la sesión: En la década de los cincuenta del siglo pasado, en América latina se inician los esfuerzos por incorporar cambios e innovaciones en la salud de los pueblos originarios. En este contexto resultó relevante el texto denominado “Los programas de salud en la situación intercultural” (1955), del médico y antropólogo mexicano Gonzalo Aguirre Beltrán, en el cual expuso las bases fundamentales de la atención sanitaria con enfoque intercultural, orientadas a mejorar las condiciones de salud de los pueblos indígenas y afrodescendientes de México. Serían los Centros Coordinadores del Instituto Nacional Indigenista (INI), establecidos en las más importantes regiones indígenas del país (Chiapas, Michoacán, Oaxaca, Yucatán, etc.), quienes pondrían en marcha algunos de los postulados del Dr. Aguirre Beltrán, con escaso empleo por parte de los funcionarios de la Secretaría de Salud y Asistencia (SSA) en zonas rurales no indígenas. En Chile surgirían programas interculturales desde 1994 con la creación de las oficinas de orientación intercultural (denominadas Amuldungún) en las regiones indígenas mapuches al sur chileno, que luego se extendería –con reconocibles alcances– al resto del país. Con desiguales resultados, se implantarían oficinas semejantes en Bolivia (Willaqkuna en Potosí), en el Perú (Ayacucho) y sobre todo, con demostrada eficacia en Venezuela durante el gobierno del presidente Hugo Chávez. Otros países que han establecido programas de salud intercultural serían Colombia, Guatemala, Costa Rica y Panamá. A poco más de 60 años del inicio de prácticas sanitarias en pueblos originarios, afrodescendientes y comunidades rurales, consideramos conveniente hacer un balance de las fortalezas y debilidades detectadas con estas políticas gubernamentales relacionadas con la salud intercultural. **Objetivos:** 1. Brindar los antecedentes históricos regionales sobre las acciones de salud intercultural desarrolladas en América latina en la segunda mitad del siglo XX y el presente. 2. Describir y analizar –de manera crítica– las políticas públicas sobre salud intercultural que se han generado por los gobiernos de la Región. 3. Presentar los recientes avances, estancamientos y retrocesos en proyectos de investigación, programas docentes y actividades sanitarias relacionadas con la salud intercultural en América Latina, centrados en los pueblos originarios y afrodescendientes.

1. Miguel Güémez (Universidad Autónoma de Yucatán, México). **SALUD, ENFERMEDAD Y ALIMENTACIÓN DURANTE EL EMBARAZO EN EL CONTEXTO INTERCULTURAL: UN ESTUDIO DE CASO CON MUJERES MAYAS DEL ORIENTE DE YUCATÁN.** Este trabajo presenta los resultados preliminares del proyecto colectivo "Alimentación, salud y enfermedad durante el embarazo en el contexto intercultural: el caso de mujeres mayas con sobrepeso y obesidad en Yaxcaba, Yucatán (2018-2020)" que se desarrolla con una metodología de acción participativa, y cuyo propósito es construir, a partir de un diagnóstico, un Programa de Intervención Alimentaria con enfoque intercultural e interdisciplinario para el mejoramiento cualitativo de la nutrición en el Primer Nivel de Atención durante el embarazo-puerperio que coadyuve a la prevención de enfermedades y complicaciones asociadas: abortos, partos prematuros, preeclampsia, enfermedades crónico degenerativas. Este Programa prevé una alimentación y nutrición sustentable, intercultural y participativa que articule elementos de la biomedicina y de las tradiciones, saberes y productos locales. Estará basado de guías de acompañamiento diseñadas con la información surgida en los diálogos (grupos focales) entre las mujeres, las parteras/os locales y el personal del Centro de Salud, y en general, de los resultados y productos obtenidos en el proyecto. En este contexto nos hemos propuesto: 1) Propiciar un proceso de interacción donde el conocimiento académico se articule con los saberes locales del pueblo maya y del personal médico. 2) Facilitar y crear las condiciones en que esa colaboración e interacción debería darse u ocurrir. 3) Delimitar las aportaciones de los académicos (antropólogos, estudiantes y profesores de ciencias de la salud); los compromisos de los representantes del sector salud, así como las aportaciones de los representantes del pueblo maya; 4) Identificar, en el proceso, las fortalezas, dificultades y limitaciones del llamado enfoque intercultural y el diálogo de saberes. Finalmente, el proyecto busca que este diálogo de saberes sea un paradigma colaborativo para el ejercicio de una interculturalidad adecuada y pueda resolver problemas de alimentación en el campo de la salud reproductiva.



2. Gina Carrioni (Universidad de los Andes, Colombia). **¿SALUD INTERCULTURAL, SERVICIOS DE SALUD ADECUADOS SOCIOCULTURALMENTE, MODELOS O SISTEMAS DE SALUD PROPIOS E INTERCULTURALES? LA EXPERIENCIA EN LA FORMULACIÓN DE UNA POLÍTICA PÚBLICA EN SALUD PARA LOS PUEBLOS INDÍGENAS DE COLOMBIA.** Análisis de la normatividad –nacional e internacional- y políticas públicas que posibilitan en Colombia la estructuración de un Sistema de Salud Propio e Intercultural de manera participativa con y para los pueblos indígenas. Situación de salud de los pueblos indígenas –desde los datos oficiales y desde las problemáticas identificadas por los pueblos indígenas- que justifica la estructuración de un sistema de salud diferente para los pueblos indígenas. Concepciones frente a la salud intercultural, salud propia, medicina tradicional o ancestral, adecuación sociocultural, modelos de salud, sistema de salud propio e intercultural – principios rectores, componentes, actores-, participación, consulta y concertación en salud, promoción y prevención en salud, acciones individuales y colectivas, entre otros, desde la perspectiva institucional – gubernamental nacional y local, de las ONG y organismos internacionales- y desde la de los pueblos indígenas y sus organizaciones. Cómo surge la iniciativa de un sistema de salud propio e intercultural para los pueblos indígenas y su relación o articulación con el Sistema de Salud colombiano, cómo se ha venido estructurando, sus avances, estancamientos, retrocesos y retos, quiénes han participado en su elaboración y cómo se ha dado esa participación, roles y responsabilidades de los actores participantes del proceso y de los demás sectores que inciden en la salud –intersectorialidad-, cómo se propone operativizar en el territorio.

3. Noly Fernández (Universidad de las Ciencias de la Salud Hugo Chávez Frías, Venezuela). **A 15 AÑOS DE INTERCULTURALIDAD EN SALUD EN VENEZUELA.** De acuerdo con el marco jurídico vigente que a partir del año 2004 se crea en el Ministerio del Poder Popular para la Salud la Coordinación de Salud Indígena (hoy Dirección General de Salud Intercultural) con la misión de formular y evaluar políticas en salud en el marco de un enfoque intercultural con pueblos y comunidades indígenas, a fin de contribuir a transversalizar el enfoque intercultural, generando respuestas oportunas, pertinentes, sostenibles y potentes al imperativo ético-político de las necesidades sociales de pueblos y comunidades indígenas que el Estado venezolano está comprometido a desarrollar. Estas series de acciones y las respuestas de apoyos a los hospitales, personal de salud y las comunidades indígenas permitieron el crecimiento y la extensión de los Servicios de Atención y Orientación al Indígena (SAOI) en las distintas regiones del país con presencia indígena; estrategia que permitió implementar otros proyectos de gran éxito como el Plan de Salud Yanomami (PSY), Proyecto Cacique Nigale (PCN), Programa de Apoyo a las Poblaciones Warao del Delta del Orinoco (Prowarao), Plan Apure (PSA), Programas de Formación y Sensibilización en Interculturalidad en Salud, entre otros. Tomando en cuenta lo anteriormente expuesto esta dirección ejecuta sus acciones desde hace aproximadamente 15 años a nivel nacional. Dentro de las limitaciones del sistema de salud, el MPPS ha enfrentado una serie de dificultades históricas, económicas, sociales, culturales y políticas que han sido obstáculos para el fortalecimiento del Sistema Público de Salud con enfoque intercultural. Aún cuando se ha impulsado diferentes estrategias para fortalecer los servicios públicos de salud, los esfuerzos no han logrado su objetivo. Si bien hay una escasez importante de recursos financieros, también existen otros problemas como la forma en que se comprende la salud-enfermedad, como fortalecer la medicina tradicional indígena, la forma en que se organiza la atención, la formación y gestión del personal de salud, la generación de información y conocimiento, y la administración de otros recursos.

4. María Teresa Mosquera Saravia (Universidad de San Carlos de Guatemala, Guatemala). **INTERCULTURALIDAD DE LA SALUD EN GUATEMALA.** La interculturalidad de la salud es un tema que se ha implementado muy lentamente en Guatemala, las ONG's han sido las instituciones pioneras de la implementación de programas interculturales de la salud en algunos territorios que han logrado disminuir tanto la mortalidad materna como infantil, estas instituciones son: La Asociación Médicos Descalzos en el municipio de Chinique y El Instituto de Salud Incluyente ISIS en el distrito Guineales y en el municipio de San Juan Ostuntalco. Otras ONG's, han realizados acciones muy concretas, de poco impacto en el tema de la interculturalidad de la salud como lo son Pies de Occidente y Asindi Rex We. Debido al impacto en la disminución de la mortalidad materna e infantil que ha tenido, la implementación de dos programas mencionados anteriormente, se presentarán muy brevemente. El Ministerio de Salud Pública y Asistencia Social –MSPAS-, se ha preocupado de implementar algunas políticas, entre ellas: el parto vertical, el uso de los idiomas mayas, ceremonias mayas, construcciones de temazcales o tuj, etc. Sin embargo, durante un año, el equipo de trabajo que estuvo al mando del MSPAS, logró implementar el Modelo Incluyente de Salud –MIS-, este programa de la atención primaria en salud se ocupaba de 4 ejes:

género, medio ambiente, interculturalidad y derecho a la salud. Su propuesta de atención a la salud primaria no pudo prolongarse en el tiempo, debido a diversos problemas. En una sociedad como la guatemalteca la falta de formación en el tema de la cosmovisión es lo que provoca un atropello, una falta de comprensión y de entendimiento del otro, razón por la que el tema de la interculturalidad de la salud es un factor indispensable en la recuperación de la salud del paciente y en la creación de una política con pertinencia cultural.

5. Romano González (Ministerio de Salud, Costa Rica). **AVANCES Y RETROCESOS EN LA POLÍTICA SANITARIA PARA PUEBLOS INDÍGENAS EN COSTA RICA: ¿SOBREVIVIRÁ EL MODELO DE SALUD INDÍGENA?** Costa Rica tuvo sobre todo durante la década de 1970 avances sobresalientes en sus indicadores de salud. Sin embargo, en el Censo de Población del año 2000 la pirámide de población para los Pueblos Indígenas (que son un 2,4% de la población total, era la de la Costa Rica de 1970, es decir, había un rezago de 30 años para la población indígena, solo explicable por las diferencias culturales entre éstos y la “cultura” del Estado, que no supieron manejarse para respetar las primeras y en términos generales, se procuraron borrar las diferencias imponiendo el modelo occidental de prevención y atención de la enfermedad. Pese a ello, sobrevive en muchos territorios indígenas (son 24 en el país) un fuerte arraigo cultural, incluyendo la presencia de “médicos” indígenas. El cambio cultural sin embargo es rápido y ubicuo. Las instituciones prestadoras de servicios en salud han procurado ajustes. El más temprano fue el de la formación de Asistentes Técnicos de Atención Primaria en Salud procedentes de Territorios Indígenas, pero en el marco de la medicina occidental. En 2003 se desarrolló una dinámica particular y surgió la 1° Política en Salud para Pueblos Indígenas. En 2006 se conformó el Consejo Nacional de Salud de Pueblos Indígenas para dar seguimiento a la estrategia. Recientemente se han integrado profesionales indígenas en medicina graduados en Cuba al sistema de salud. Por razones burocráticas no se cuenta con un Plan Nacional de Salud para Pueblos Indígenas. En todo esto...¿está sobreviviendo el modelo de salud indígena? El cambio cultural es rápido y ubicuo y las acciones estatales puntuales y lentas. Apenas en 2015 se incorpora a la Constitución Política de la República el reconocimiento de su carácter multiétnico y pluricultural. Si se trata de sumar lo mejor de las culturas occidental e indígena para la prevención, promoción y atención de la enfermedad y de que sobreviva el modelo de salud indígena (alimentos, agricultura, plantas medicinales, curadores, espiritualidad), el futuro no es muy halagüeño. Sin embargo, como muestra de las capacidades institucionales, en 2018 se oficializa el 1° Plan Nacional de Salud para Afrodescendientes.

6. Lucy Orellana de Piscocoya, María Luisa León Mendoza y Melchora Ávalos Mamani (Universidad Nacional de San Cristóbal de Huamanga, Perú). **PARTO VERTICAL QUECHUA: FUNDAMENTOS DE LA LÓGICA CIENTÍFICA EN COMUNIDADES ANDINAS ACOCRO Y PAMPAMARCA DE AYACUCHO 2013.** El Parto Vertical Andino Quechua acuna saberes y prácticas ancestrales, actualmente es de uso cotidiano en comunidades andinas de Perú. La legitimidad social y seguridad cultural hacen persistir en tiempo y espacio demostrando lógica y coherencia basado en fundamentos científicos que otorgan validez desde ámbitos: Históricos a través de iconografías, idioma quechua que patrocina comunicación en el proceso y descripción de la toponimia en la estructura anatómica y fisiología del parto. Culturales: es parte de la medicina tradicional basada en la cosmovisión andina, que otorga presupuestos tangibles y no tangibles lógicos para la atención. Filosóficos: evidencia saberes y prácticas asociadas a principios andinos de “reciprocidad”, “relacionalidad”, “armonía” y “complementariedad” en comportamientos de la partera, parturienta, familiares. Endocrinológicos: valora aspectos de la voluntad y el accionar instintivo de la mujer; “neocortex” en reposo no admite miedo, las estructuras primitivas hipotálamo e hipófisis desencadenan mayor secreción oxitócica por ambiente seguro, con acompañamiento, sin bulla, libertad de la mujer para elegir posición y dirigir su parto, situaciones que atenúan la activación del cerebro de la racionalidad. Físico: reconoce puntos de apoyo, alimentación, masajes manejo de frío/calor, uso de fitoterapia. Psicológico/espiritual: prioridad en el mundo andino, uso del “ritual” como medio para alcanzar y valorar el equilibrio psicosomático. Conclusión: Existe Lógica y coherencia en los saberes y prácticas de la atención del parto vertical quechua y los fundamentos descritos que otorgan argumento y validez científica. Estudio cualitativo alcanzado con la participación de parteras, parejas y familias de la comunidad de Pampamarca en Ayacucho Perú.

7. Margarita Sáez Salgado (Universidad de Chile, Chile). **EL PUENTE ROTO DE LA SALUD INTERCULTURAL EN CHILE.** Muchos se han preguntado por qué Chile tiene una historia que compartir en salud y pueblos indígenas bajo el concepto de la controvertida interculturalidad en salud, el supuesto básico es que constituyen un bajo

porcentaje de la población. Porqué tienen más de 20 años de trabajo con presupuesto asignado al Programa Nacional de Salud y Pueblos Indígenas y tantas experiencias conocidas en otros países. Tratar de responder estas y muchas otras preguntas es el objetivo de esta ponencia. Desde una mirada al contexto, primero reflexionar sobre el proceso de construcción de una política de salud indígena en el sector salud considerando un Estado cooptado por el neoliberalismo en los gobiernos de la posdictadura, cómo fue posible hacerlo con participación y en el escenario de una Ley Indígena que no menciona a salud y que no habla de pueblos. Principalmente, aportar una aproximación al papel de los antropólogos en este complejo proceso, ilustrar los acuerdos y desacuerdos sobre interculturalidad, modelos de atención complementarios, reconocimiento de los sistemas de salud de los pueblos, formación y capacitación de recursos humanos, conceptos de salud-enfermedad-muerte, epidemiología sociocultural. Al finalizar, compartir cómo se implementó el proceso Nacional de Consulta y Participación del Reglamento para el Artículo 7 de la Ley de Derechos y Deberes en Atención de Salud, sobre Interculturalidad en la Red de Servicios, realizado bajo los principios del Convenio 169 de la OIT, el que duró al menos tres años y su estado actual.

8. Roberto Campos Navarro (Universidad Nacional Autónoma de México, México). **TREINTA AÑOS DE SALUD INTERCULTURAL EN POBLACIONES INDÍGENAS DE MÉXICO: UN PROCESO INCOMPLETO E INACABADO.** A finales de la década de los ochenta, el gobierno mexicano firmó y ratificó el Convenio 169 de la Organización Internacional del Trabajo, cuyo artículo 25 versa sobre el reconocimiento de la medicina tradicional y la participación de los pueblos indígenas en la planificación de los servicios de salud en sus comunidades. El Instituto Nacional Indigenista –durante el periodo 1990-1996– cumplió un papel apreciable al relacionarse de manera muy cercana con las organizaciones de médicos indígenas de todo el país, incorporando una organización al interior del único hospital administrado por la institución y creando la primera biblioteca sobre la medicina tradicional con quince tomos que describen el estado de sus recursos humanos, materiales y simbólicos. El Instituto Mexicano del Seguro Social –en su versión rural– consolida su programa de interrelación con la medicina indígena en las áreas donde tiene presencia institucional, pero no fue sino hasta inicios del presente siglo, que la Secretaría de Salud inicia una política de salud intercultural a nivel nacional, con un limitado ejercicio normativo, una notable precariedad de actividades operativas y un reducido apoyo presupuestal. Todo ello se refleja en una atención de la red hospitalaria (en regiones indígenas) carente de una verdadera funcionalidad en términos interculturales.

Indigenous traditions and teachings in intercultural healthcare - Part 1

11:30 am – 1:00 pm, Room 3 (with translation)

1. Charles Briggs (Universidad de California Berkeley, USA). **MÁS ALLÁ DEL SUMAK KAWSAY-ISMO: REPENSANDO CÓMO LA MEDICINA SOCIAL Y LA EPIDEMIOLOGÍA CRÍTICA SE RELACIONAN CON LAS PERSPECTIVAS INDÍGENAS.** Introducción: El concepto de sumak kawsay juega un papel clave en las constituciones de Bolivia y Ecuador y en esfuerzos por parte de políticos, practicantes e investigadores/investigadoras indígenas en desafiar las perspectivas eurocéntricas en salud. Por esto, los profesionales de la medicina social y la epidemiología crítica han adoptado sumak kawsay como un mecanismo conceptual para incorporar perspectivas indígenas en sus modelos. Métodos: Este papel yuxtapone esas dos disciplinas con las perspectivas de la antropología médica y la antropología lingüística, además de décadas de trabajo del autor en sectores indígenas en el noreste de Venezuela. Resultados: Se examina aquí los procesos que estructuran como sumak kawsay y otros conceptos han sido extraídos de las lenguas, discursos y géneros literarios indígenas e insertados en modelos preexistentes. Objetivos: Se proponen alternativas a base de la distinción entre interculturalidad funcional e interculturalidad crítica propuesta por Catherine Walsh en crear un proceso para la transformación de modelos analíticos de salud. Conclusión: Diálogos más democráticos, dialecticos y creativos con filósofos, activistas y practicantes indígenas de la salud constituyen una fuente clave para avances en la medicina social y la epidemiología crítica, y la antropología médica puede servir con un puente para profundizar los aspectos teóricos de dichas conversaciones.
2. María da Paz Feitosa de Sousa & Zoe Díaz Bernal (Escuela Nacional de Salud Pública, Cuba). **PERTINENCIA INTERCULTURAL DE LAS ACTIVIDADES DE LOS EQUIPOS DE SALUD EN EL ENTORNO RURAL DE TAMBORIL,**



CEARÁ, BRASIL. Introducción: La interculturalidad en salud es la práctica y el proceso relacional que se establecen entre el personal de salud y los pacientes, pertenecientes a sistemas culturales diferentes, donde se requiere de un recíproco entendimiento para que los resultados del contacto sean satisfactorios para las dos partes. Objetivo: Explicar la pertinencia cultural de las prácticas de los equipos de salud en el entorno rural de Tamboril, a través de las percepciones de actores clave del proceso salud- enfermedad- atención. Método: Estudio fenomenológico, sobre las percepciones acerca de la pertinencia de las prácticas de los equipos de salud. La investigación tuvo lugar entre septiembre de 2018 y septiembre de 2019. Participaron tres grupos de sujetos muestrales y la información obtenida fue sometida a un proceso de categorización abierta. Resultados: Se obtuvieron dos categorías analíticas: entorno socio- económico y cultural en el que se desarrollan las actividades de los equipos de salud de Tamboril y prácticas de salud en la zona rural de Tamboril, las que fueron argumentadas con los discursos de las personas participantes. Conclusiones: La pertinencia cultural de las prácticas de los equipos de salud en el entorno rural de Tamboril es cuestionable, toda vez que la población beneficiaria de esta la descalifica, mientras que quienes prestan atención a dichas comunidades reconocen la necesidad de incluir nuevas, más ajustadas al entorno.

3. Anahí Viladrich (City University of New York, USA). **“PLANTAS CON VIDA” (LIVING PLANTS) BOTÁNICAS AS INTERCULTURAL HEALING CENTERS IN NEW YORK CITY.** Introduction: This paper examines the role of “botánicas” (religious-healing dispensaries) as intercultural healing centers that welcome a growing Latin American and Caribbean population in New York City (NYC). Products and services from different ethno-medical traditions merge at the botánicas, where providers (i.e., guías espirituales) offer much-needed products and services to vulnerable groups (e.g., undocumented immigrants). Objectives: This study aimed to analyze botánicas’ inter-cultural healing practices by exploring the confluence of diverse ethno-medical systems. The project’s specific objective focused on providers’ prescription of particular herbs and plants having bioactive and spiritual properties. Methods: An ethnographic study of botánicas was conducted between 2014–2018 in NYC. The first stage of the project involved mapping the location of botánicas, mostly in Queens and Brooklyn. This was followed by participant observation in 37 botánicas and in-depth interviews with 28 botánica providers. Results: Most botánica counselors prescribe leafy greens, flowering plants and roots based on both their alleged medicinal properties and religious-healing power (e.g., despojos & ofrendas). Two specimens were identified as the most popular among botánica providers: Rue for reproductive conditions and for protection against envy; and sábila (aloe vera) for healthy skin, to ameliorate inflammation and cleanse the social environment from negative energies. Conclusions: The study findings speak to the intercultural use of specific plants among Latino groups and other immigrant communities in NYC, many of which embrace Afro-Caribbean beliefs and practices. These implications suggest the need to expand the biomedical approach towards addressing the cultural and religious use of plants and herbs.
4. Anaxsuell Fernando da Silva (Universidad Federal de Integración Latinoamericana, Brasil). **SALUD MENTAL, ADICCIONES Y DISCURSO RELIGIOSO: NOTAS DE UNA INVESTIGACIÓN EN EL CONTEXTO DE LA FRONTERA LATINOAMERICANA.** En esta ponencia pretendemos discutir las posibles relaciones entre las experiencias religiosas y la salud mental en un contexto fronterizo latinoamericano. Con este fin, presentaremos, una descripción teórico-analítica de los principales temas expresados en la literatura especializada sobre el tema propuesto, articulándolos con el contexto religioso en la región de la triple frontera latinoamericana (Brasil / Paraguay / Argentina). Luego compartiremos las preguntas iniciales en torno a una investigación empírica que tiene lugar en la interfaz entre la antropología y la salud. En este punto, enfatizaremos los discursos religiosos sobre temas de salud mental, la forma en que la religión engendra experiencias colectivas de salud. La reflexión permitirá explicar los siguientes ejes de análisis: la dimensión religiosa como factor desencadenante y explicativo de las formas de salud mental y enfermedad y, en consecuencia, una apreciación de los espacios religiosos destinados a hacer frente a la enfermedad mental y sus implicaciones sociopolíticas, especialmente en lo que concierne Derechos humanos.
5. Ailet Pérez Cabrera (Instituto Superior de Ciencias Pedagógicas “Enrique José Varona” e Instituto Superior de Ciencias de las Religiones “Rafael Cepeda Clemente”, Cuba). **LAS PRÁCTICAS ETNOMEDICINALES DENTRO DEL COMPLEJO DE LA REGLA DE OCHA-IFÁ COMO EXPRESIÓN DE SALUD INTERCULTURAL.** Las concepciones sobre la salud y la enfermedad en el ser humano varían de un contexto cultural a otro. Cada grupo social construye



sistemas terapéuticos dentro de sus propios paradigmas, constituyendo prácticas etnomedicinales. Ellas se consideran expresiones de salud intercultural por la imbricación de estos sistemas alternativos, junto a las terapias que ofrece la medicina científica. Dado los escasos estudios sobre procesos interculturales asociados a los modos curativos en Cuba, se propone una contribución al centrarse sobre las prácticas religiosas a la vez que terapéuticas. Esta investigación valora la significación de las prácticas de sanación que se realizan dentro del complejo Regla de Ocha-Ifá. Las terapias etnomedicinales como consagraciones, recibimientos de deidades, baños lustrales con líquidos sacralizados, ofrendas y rezos, poseen un componente simbólico insoslayable por su vinculación con entidades supraterrrenales para el desarrollo de los rituales con fines curativos. La teoría basada en la Antropología Médica, el trabajo de campo con entrevistas y observaciones realizadas; arrojaron que esta expresión religiosa conceptualiza el cuerpo humano singularmente: de forma integral, así como también distingue cada miembro u órgano del cuerpo en relación con sus deidades y prácticas rituales, las cuales ostentan una finalidad sanadora. Las génesis patológicas se asocian a la cosmovisión religiosa. En los resultados se resume la interpretación sobre las funciones curativas o profilácticas de las etnoterapias descritas. Como conclusión se determinó que las prácticas etnomedicinales son expresiones interculturales debido a su íntima relación con la identidad cultural de los individuos, empleando las etnomedicinas en interacción a otros sistemas terapéuticos.

6. Catalina González-Urbe, Mónica Pinilla-Roncancio, Jorge Rodríguez Hernández, Amparo Hernández Bello, Liany Katherine Ariza Ruiz, María Alexandra Matallana Gómez, Paola Niño Rincón, Angélica Romero Daza, Yamasáin Yuseth Romero Sánchez, Silvia Quiroz Mena, Ledy Manuela Mosquera, Mariluz Uribe, Shirlys Najera (Universidad de los Andes, Colombia). **TRANSFERENCIA DE CONOCIMIENTOS Y PRÁCTICAS ENTRE SABERES TRADICIONALES Y FORMALES EN COLOMBIA, EL CASO DE SALUD MATERNO-PERINATAL EN UN ESTUDIO PILOTO.** Colombia, para el año 2015 no logró el cumplimiento de los Objetivos de Desarrollo del Milenio relacionados a salud materna y perinatal; esta situación es más complicada para las mujeres y recién nacidos en zonas rurales, con mayores niveles de pobres y en áreas dispersas, donde vive un mayor porcentaje de población indígena, afrodescendiente o campesina. Este resumen hace parte de un megaproyecto, en el cual se busca contribuir al estudio de cómo se implementan procesos de intercambio y transferencia de experiencias, conocimientos y prácticas entre los saberes formales, profesionales y técnicos, y los tradicionales y comunitarios, cuyo propósito es mejorar la salud materna y perinatal. Basados en los resultados de la sistematización de experiencias en tres regiones de Colombia (Guajira, Cesar y Choco) y en el análisis de oferta institucional en salud materna y perinatal (formal y tradicional) se diseñará una estrategia piloto que busque solucionar los problemas reconocidos dentro de la comunidad en el proceso de implementación de estrategias de transferencia de conocimientos y saberes para mejorar la salud materna y perinatal de una población determinada. Bajo un enfoque intercultural y diferencial, esta estrategia piloto se basará en los resultados de un proceso participativo que involucre saberes tradicionales y formales en una zona de Colombia. Se espera que los resultados de la implementación de esta estrategia piloto brinden información de como la implementación de procesos participativos entre saberes tradicionales y formales, pueden mejorar las estrategias ya implementadas, pueden contribuir a su sostenibilidad y mejorar la salud materno-perinatal.

Policies and politics of maternal and infant health

11:30 am – 1:00 pm, Room 8

1. Brooke Bocast (Montana State University, USA). **THE INVENTION OF PREPREGNANCY IN SOWETO, SOUTH AFRICA.** This article considers the concept of “pregnancy” as deployed in a World Health Organization childhood obesity intervention in Soweto, South Africa. Prepregnancy – also known as “preconception” – refers to the time period in a woman’s life prior to commencement of unprotected sexual relations that could lead to conception. Or, more simply, the time between menarche and conception. In what has been characterized as a “paradigm shift,” preconception is now central to global health efforts to reduce in vitro risk factors for childhood obesity and non-communicable disease. I draw from recent work on temporality and personhood in medical anthropology to investigate the implications of this paradigm shift for state policy and programming in South Africa. First, I trace the intervention design mechanisms that produce prepregnancy as a new life stage for women. Second, I examine the power relations that prioritize potential life and metabolic relationships over



existing lives and metabolisms. Third, I ask what happens when the language of intervention becomes the language of policy in conditions of political-economic precarity. I close with some thoughts on the relationship between the chronicity of prepregnancy interventions and Hannah Arendt's notion of "natality," thereby suggesting directions for future theorizing around birth, lifecourse, and reproduction.

2. Holly Horan (University of Alabama Tuscaloosa, USA). **"NO TE AHOGES EN UN VASO DE AGUA": THE LOCAL BIOLOGIES OF MATERNAL STRESS IN PUERTO RICO.** Introduction: Puerto Rico's rate of preterm birth (PTB), a delivery that occurs before 37 weeks of pregnancy, has declined over the last decade but remains persistently and inexplicably high. Maternal stress is an etiological factor in half of the PTBs that occur in the US, however, scholars of perinatal stress argue that any study of the association between maternal stress and birth outcomes requires a more holistic understanding of the ways maternal stress is experienced within unique and highly dynamic individual, socio-historical, political-economic, and biological contexts. Objective: The purpose of this study was to contextualize prenatal maternal stress in Puerto Rico during the childbearing year. Methods: This research includes 16 months of ethnographic research in community-based and private-maternity care settings and 25 semi-structured interviews with pregnant and recently postpartum Puerto Rican women. Results: Maternal narratives illustrate the embodied, interwoven nature of individual versus structural stressors of pregnancy in Puerto Rico, as well as the social expectations that are shaped by colonial, neoliberal perceptions of motherhood. These results are shaped by the framework of local biologies to argue that existing models for understanding health disparities unique to Puerto Ricans are not the result of biological or genetic determinism but, lie at the intersection of political-economic and health systems inequities. Conclusions: Maternal narratives highlight the unique facets of maternal stress in Puerto Rico that are related to the infrastructural oppression of a US colony; identifying the multiple manifestations of political-economic precarity as a primary contributor of prenatal stress and PTB.

3. Hope Bastian (Brown University, USA). **EXCLUSIVE BREASTFEEDING INCIDENCE AND LACTATION SUPPORT IN HAVANA 2019: EXPERIENCES OF PARENTS OF CHILDREN IN THE FIRST YEAR.** The World Health Organization recommends exclusive breastfeeding up to 6 months of age and continued breastfeeding along with appropriate complementary foods up to two years of age and beyond. In Cuba, despite social policies aimed to support parents' ability to breastfeed throughout the first year of life, such as generous parental leave, data from the 2014 MICS 5 showed that only 33% of Cuban infants under 6 months are exclusively breastfed. A 2018 article in a Cuban journal for health administrators put out a call to the scientific community and health administrators for further research to understand exclusive breastfeeding practice in Cuba and identify gaps in order to modify and strengthen the national breastfeeding program. To answer this call our project is designed to understand infant feeding practices and beliefs surrounding exclusive breastfeeding in the Cuban capital from the perspective of first time gestational parents of children under one year of age in the municipalities of Marianao, Habana del Este and Plaza de la Revolución to understand why they feed their infants the way they do. What support do they receive from formal and informal channels to learn how to breastfeed and in dealing with lactation problems when they arise? What factors contribute to decisions to wean or to supplement with other liquids before their baby reaches 6 months of age? In conclusion the research suggests interventions that might help increase exclusive breastfeeding rates in the Cuban capital.

4. Alice Larotonda (Brown University, USA). **PODEROZAS: BREASTMILK, POWER, AND EMPOWERMENT.** Introduction: Breastmilk and power have historically been deeply intertwined. While unequal dynamics of gender, race, and class still weigh on breastfeeding and breastmilk sharing, some women find power in producing and feeding breastmilk, a substance considered critical to young infants' lives. In Cabo Verde, women can voluntarily donate their excess breastmilk to infants in intensive care through a Human Milk Bank. This hospital service aims to reduce neonatal mortality, support breastfeeding women, and advocate for the protection of breastfeeding as part of a large international network of Human Milk Banks. Within this network, breastmilk donation is presented as "empowering" based on its capacity to save and foster lives. Objectives: This presentation investigates how donors, clinical staff, and institutional actors within this network understand the relation between breastmilk and power. How might feeding and donating breastmilk "empower" women? Whom does this discourse leave behind? Methods: This 18-month research used participant observation and in-depth ethnographic interviewing to collect data in Human Milk Banks in Cabo Verde and Brazil. Results:



Institutional and clinical actors describe breastfeeding and breastmilk donation as practices that “empower” women. Donors did not adopt the same language of “power”. However, they reported these practices made them feel fulfilled in their roles as mothers and adult community members. Conclusions: While the language of empowerment may accurately describe the experiences of some donors and breastfeeding women, a critical analysis of what “empowerment” means is necessary to shed light on the relation between breastmilk and power.

5. Ilyas Manakkadavan (Indian Institute of Technology Bombay, India). **“ASSISTANCE” IN ASSISTED REPRODUCTIVE TECHNOLOGY (ART); IT’S IDEA, PRACTICE AND NORMALIZATION: ON THE SOCIO-RELIGIOUS ENGAGEMENTS WITH ART IN KERALA.** Developments in reproductive biology and reproductive technology have posed ambivalences and question over institutions and technologies of procreations which also has opened negotiations within/between reproductive biology, techno-science, socio-religious institutions and their practice and beliefs. Thus, the objective of this paper is to understand the idea and practice of “assistance” in assisting infertile persons looking into the negotiations within and between religion (Islam), technology and medical science. Through the ethnographic and semi-archival methods done in Kerala, a south-western state in India, focusing on reproductive clinics, practitioners, infertile couples, and Islamic jurisprudence, this paper finds the nature of “reproductive assistance” as plurality of magico-medical/religio-medical idea, practice and cultures. It also finds the negotiations and practice within and between religion and new reproductive technologies as centred on the dichotomy of “possibility v/s permissibility” having its underpinning on the ideology, reasoning and practice of jurisprudence, technologies of normalization and relatedness, vernacular texts and ritual traditions of fertility/infertility. It concludes by describing how techno-scientific assistance in conception, being an assistance in configurations and re-configurations in relatedness, operate through the already existing culture and technologies of normalization such as kinship, print, electronic media and consumer culture, but in new ways.

Shifting perspectives in medicine, medical anthropology, and global health

11:30 am – 1:00 pm, Room 10

1. Sara Rubin (University of California San Francisco, USA). **PAIN’S SUBJECTIVITIES: THE IMPLICATIONS OF NEUROSCIENTIZATION IN THE CLINIC.** Introduction: Throughout much of clinical history, those working within the arena of pain medicine have conceptualized pain as a musculoskeletal problem. Clinicians adhered to biomechanical explanatory models of pain, seeking out an underlying corporeal source and targeting the body as a site of intervention. Recently, however, some pain specialists have begun to promote the notion that pain is an output of the brain, rather than an input of the tissue. In this paper, I trace the ways in which pain is being newly biomedicalized, or neuroscientized, as a result of both the opioid crisis and the neurocognitive turn. Objective: I sought to understand the ways in which neural and plasticity discourses are taken up in clinical settings under this emerging logic of pain as a brain disease. Methods: This analysis draws upon semi-structured interviews with 30 pain clinicians and/or scientists, as well as 75 hours of ethnographic observations within 3 clinical pain groups intended to train chronic pain patients in brain-based, self-management techniques. Data were analyzed using grounded theory methods and coded in Atlas.ti. Results: I argue that these neural understandings of pain are shaping notions of patienthood by invoking a simultaneous opportunity for optimization and obligation for self-regulation. Conclusions: These neural techniques invariably carry with them notions of plasticity, wherein patients are encouraged to think of themselves as malleable, capable of transformation and enhancement. These discourses, then, are situational and the distribution of their benefits stratified, as some techniques necessitate patients who are already engaged and activated.
2. Rosalynn A. Vega (University of Texas Rio Grande Valley, USA). **SOCIAL EPIGENETICS: UNCOVERING THE SOCIAL DETERMINANTS OF GENETIC EXPRESSION.** Introduction: This critical medical anthropology analysis examines emerging research on epigenetics, the microbiome, and the central role of bioconsumption in the future of health. Medical anthropologists have referred to epigenetic phenomena for nearly three decades, long before epigenetics emerged as a field of study. Thus, I analyze the downstream effects of genomic technologies on bioconsumers. Objectives: The presentation explores the implications of living in the genomics era for human



health. The research analyzes how recent findings regarding the effect of the microbiome on our genes and even our personalities shifts our relationship with bacteria, thus transforming our understanding of good/bad, inside/outside, and Self/Other. Furthermore, the research uncovers socioeconomic inequality ignored by “experts” and bioconsumers who argue that conscientiousness and healthy choices (e.g. consuming only non-GMO, organic food) are the key to a healthy microbiome and optimal gene expression. Methods: The research combines both ethnographic and digital medical humanities research methods. Results: Rapidly increasing accessibility of direct-to-consumer genetic testing signals a paradigm shift from public preparedness to P4 medicine: medicine that is personalized, precise, predictive, and participatory. Genomic medicine is a tool for transitioning from diagnosis to prognosis. The future of medicine will use “big data,” artificial intelligence, and systems biology to give new meaning to “patient-centered” medicine. Conclusions: By excluding indigenous and other ethnic people from profit chains, functional medicine is yet another example of how genomic technologies can reinscribe racial inequality. The right to health includes access to resources that facilitate health, not just those that manage disease.

3. Shana Harris (University of Central Florida, USA). **TRIPPING AND TRAVELING: MEDICAL TRAVEL AND THE USE OF PSYCHEDELICS FOR DRUG TREATMENT IN MEXICO.** Introduction: The therapeutic use of psychedelics has increased rapidly in recent decades. One psychedelic that has become popular is ibogaine, which is utilized to treat addiction because of its detoxification properties and ability to stimulate self-reflection. Ibogaine, however, is illegal in several countries, including the United States. As a result, people who use drugs travel to Mexico, where ibogaine is unregulated, to receive treatment at centers that cater to a U.S. population looking for this alternative addiction care. Objectives: This presentation will show the important role that medical travel plays in the pursuit and provision of this psychedelic-based drug treatment in Mexico. Specifically, it examines how cross-border travel affects both the therapeutic experience and treatment delivery. Methods: This presentation is based on 16 months of ethnographic fieldwork at ibogaine treatment centers in Baja California, Mexico, between 2015 and 2019. Results: The decision to travel to Mexico as well as the provision of ibogaine is influenced by multiple social and structural factors. Namely, prohibitive policies and limited drug treatment modalities in the United States restrict healthcare options for addicted populations and necessitate seeking care abroad. Medical travel offers them opportunities when they run out of treatment options or face obstacles to care at home. However, who can access these therapeutic opportunities and under what conditions in Mexico are also influenced by social and structural factors. Conclusions: This research offers novel insight into the role that alternative drug treatments play in addiction care, an increasingly important issue as cross-border healthcare diversifies globally.

4. Carla Braga (University Eduardo Mondlane, Mozambique). **THE SOCIAL LIFE OF CD4: OF CELLS, GOD AND THE SPIRITS IN CENTRAL MOZAMBIQUE.** Clinical criteria to initiate people living with HIV/AIDS into Antiretroviral Treatment (ART) in Mozambique follows World Health Organization’s public health approach, on which CD4 cell lab exams play a crucial role. Based on ongoing ethnographic research since 2007 in central Mozambique (where in a neoliberal context, AIDS treatment is being provided through institutional arrangements comprising the state, aid agencies, and international NGO’s and funded mainly through PEPFAR (USA President’s Emergency Plan for AIDS Relief), this paper suggests that: a) CD4 cells parlance became ubiquitous and part of everyday life of most persons in ART even in rural areas and among illiterate women and men; b) CD4 counts are associated with moral values and become a measure of patients’ worth and “good behaviour” in terms of sexual practices and attitudes towards risk, thus becoming a disciplinary technique; c) CD4 cells are represented and experienced as having a life of their own, endowed with some kind of “agency”; d) God and the Spirits are thought of as influencing CD4 counts. Both religion and biomedical technologies influence the way human beings think of and experience themselves in a post-colonial context. The quantification of CD4 cells as selection criteria to have access to HIV/AIDS treatment speaks to Mozambican official discourses on “modernity” associated with science, biomedicine and laboratories.



The ambiguous work of care

11:30 am – 1:00 pm, Room 14

1. Lynn Kwiatkowski (Colorado State University, USA). **DOMESTIC VIOLENCE AND THE AMBIGUITY OF CARE IN NORTHERN VIETNAM.** This paper analyzes forms of care provided to women who experience domestic violence in northern Vietnam, and the ways in which care can be experienced as ambiguous and contradictory by care providers and women abused by their husbands seeking care. Vietnamese health care personnel, government officials and mass organization leaders, civil society organization personnel, and family and community members, as well as international organizations administer care to abused women. Care is shaped and offered in a context of emergent globally influenced innovation in the provision of care to abused women, state openness to this creative movement, as well as economic constraints and persistent gender and other social inequalities that in many cases limit the potential for effective care. This paper assesses the complicated processes that make accessing care for abused women and providing effective care to abused women uncertain endeavors. This analysis is based on ethnographic fieldwork conducted in northern Vietnam, involving participant observation and interviews with abused women, health care personnel, government officials and leaders, civil society organization personnel, international organization personnel, and other community members. While globally informed care options for abused women have been expanding in Vietnam, addressing their injuries, emotional distress, suffering, social difficulties, and needs for protection, ambiguities surrounding the production and provision care, and social and economic inequalities in the women's local communities, make their effectiveness uncertain.

2. Xinyan Peng (Shandong University, China). **REPRODUCTIVE CHOICE AS INTERGENERATIONAL PROJECT IN URBAN CHINA.** The demographic crisis in today's China is perceived to be an aging population among the elderly and declining fertility rates among the young, the latter of which has persisted despite the state's efforts, such as the two-child-per-family policy, to encourage young women to reproduce. Other policy efforts to reverse the fertility decline include reducing gender-based discriminatory practices in the workplace and improving childcare and education facilities, all of which presume that individual young women (and men) are the sole decision makers when it comes to reproductive choice. The role of the elderly in the decision-making process of reproduction is often portrayed as pressuring young couples to reproduce for sustaining family lines and fulfilling filial obligations. Nevertheless, my ethnographic fieldwork in urban China demonstrates that not only is childrearing an intergenerational project of everyday care, but the decision to have a child (or a second child) can result from deliberation, negotiation, and collaboration across generations. This paper first shows how an intergenerational division of labor gets established in urban middle-class Chinese families: young parents, especially mothers, are responsible for disciplining and educating children, while grandparents undertake traditional forms of domestic labor such as cooking, feeding, and cleaning. Young couples who are deciding whether to have a (or a second) child take into account the availability of such intergenerational division of domestic labor, although conflict can arise between different generations. I argue that reproductive choice is an intergenerational project, connecting the two seemingly separate dimensions of demographic crisis in today's East Asia.

3. Adrienne Strong (University of Florida, USA). **INVOKING KINSHIP TO CARE FOR CARE: WOMEN AND BIRTH COMPANIONS IN KIGOMA, TANZANIA.** Introduction: The World Health Organization recommends birth companion programs as one way to reduce obstetric violence and improve quality of maternal healthcare in low-resource settings. There has been little research about how pregnant women and these companions interact in the context of these programs. Objectives: To demonstrate how the presence of birth companions changes the social dynamics on the maternity ward of a health center in Kigoma, Tanzania and provide the example of women who call the on-call companions kin names, such as mother, sister, and grandmother, to invoke a caring relationship while in labor and giving birth. Methods: The data presented are based on six months of participant observation on the maternity ward, as well as interviews with companions, women, and healthcare workers. Results: Women in labor invoked kinship terms when afraid or struggling to give birth. They often addressed the on-call birth companions as "mama" or sister in an effort to establish a familial relationship that would obligate the companion to help her. The on-call birth companions sometimes responded to these pleas but, at others, ignored the women, and even rebuked them via physical or verbal sanctions when they did



not wish to help. Conclusion: Family relations obligate care in many settings in Tanzania. For women in labor, establishing temporary familial ties created a new intersubjective relationship in which the companion, an NGO employee, was obligated to provide care befitting a family member or, alternatively, reject the woman's pleas for care, becoming more like health facility nurses.

4. Adrienne Pine (American University, USA). **NURSES V. EMPIRE: THE HONDURAN FIGHT FOR PATIENT CARE AND AGAINST NARCO-DICTATORSHIP.** For decades in Honduras, assistant nurses—and more recently, professional nurses and physicians—have fought against IMF/USAID-led healthcare privatization in their country. Since the 2009 U.S.-supported coup that set the stage for today's neoliberal fascist narco-dictatorship, nurses have taken on increasingly important and dangerous activist roles. They are among the lead voices articulating the violent, embodied impacts of militarized neoliberalism, and have placed their own bodies on the line in their hospitals and on the streets to protect their patients and their people. In this paper, I will outline some of the direct impacts of U.S. imperialism on Honduran health since the coup, exploring examples ranging from the impacts on patients of the replacement of nurses and medications with USAID-funded panoptic worker-control technology to the side-effects of teargas capitalism. Based on years of ethnographic research with a specific focus on data gathered during in August 2019 and at the trial of Tony Hernández in New York City in October 2019, I argue (following my interlocutors and compañerxs) that the healthcare worker-led fight to oust the dictator Juan Orlando Hernández, and to build a new model of healthcare based on a gendered moral commitment to healthcare as a human right, is a powerful rejection of U.S. imperialism and necropolitics. I argue that the struggle of Honduran nurses—carried out amidst deadly repression—requires a new, heightened, somatic solidarity from anthropologists and others who likewise understand the links between the fight against neoliberal fascism and human and planetary survival.
5. Lauren Whitmer (University of Michigan, USA). **¿QUÉ DIRÁN? GOSSIP AS A BARRIER TO SUPPORTIVE SERVICES FOR VICTIMS OF INTIMATE PARTNER VIOLENCE IN LAMBAYEQUE, PERU.** Over 69% of women in Lambayeque, Peru self-report experiencing Intimate Partner Violence, but few access formal supportive services. My research, drawing on ethnographic interviews, life history interviews, and participant-observation with mujeres abusadas (abused women), suggests that a fear of gossip and el que dirán (what people will say) influences and often deters formal and informal help-seeking. In this small town where everyone seemingly knows everyone, connectedness in kinship and social networks is necessary for individuals' economic and social survival. Help-seeking, which makes "personal" issues public, is treated by many as a deviant act. Gossip and shame are expertly wielded by "regular folks" as tools of social control to protect or tarnish individuals' and families' reputations and to maintain local socio-political structures, including patriarchal gender norms. Formal service providers, who are gatekeepers to services and resources, also figure in these networks and participate in gossip and victim-blaming. Service providers regularly offer or deny support based on victims' and abusers' positionalities in socio-political networks, and some ask victims and abusers for bribes to "tip the scales." Supportive friends try to counter these pressures, telling mujeres abusadas, "you don't live off of what others say." Mujeres abusadas have sophisticated understandings of the potential consequences of gossip. They gauge their positionalities against others' and engage in rational readings of the social terrains they must navigate, often making calculated decisions to not seek help despite wanting access to support and resources. Correspondingly, gossip hinders new state initiatives designed to serve mujeres abusadas and reduce violence.
6. Derrick M. Gordon (Yale University, USA). **US URBAN, MINORITY MEN AND REPRODUCTIVE HEALTH: OFTEN NEGLECTED, BUT CRITICALLY IMPORTANT.** Health disparities research in the U.S. focused on men highlights how social, economic, and individual factors coalesce, resulting in adverse outcomes in overall health and wellbeing for men, in general, and minority men in particular. How these disparities impact men's reproductive health care needs as they receive preventive care from health serving institutions remains unexamined. This paper presents the findings of a quantitative research project where respondents, men, and women, in an urban community setting, were asked about their reproductive health intentions, experiences, and needs. Respondents' commented on whether they believed their desired reproductive health agendas, expectations, and needs were integrated into their preventive health care screenings and check-ups offered during their primary care visits. The paper analyses the differences and similarities between women and men around primary care discussions that extend beyond STI care and prevention. This research addresses the need for



medical institutions to develop more robust strategies to engage men in developing reproductive health plans. Analytically, this research highlights the benefits and rewards of an intersectional approach, which addresses the interrelationships between men and their partners in addressing the reproductive health care needs of men.

Bio-eco-cultural perspectives

11:30 am – 1:00 pm, Room 12 (gallery with posters) – please see annex.

Day 3 - Thursday, March 12th - AFTERNOON

Social struggles and sexual moralities

2 – 3:15 pm, Room 3 (with translation)

1. Erin Moore (Columbia University, USA). **NATIONALISM, MORAL PANICS, AND UGANDA'S NEW NATIONAL SEXUALITY EDUCATION POLICY.** Introduction: This presentation examines nationalist rhetoric in recent moral panics over sex education in Uganda, a country with among the highest rates of HIV and teenage pregnancy in the world. Public outcry over comprehensive sexuality education erupted in 2016 over claims that children were being taught “homosexuality” and “masturbation” by a set of Scandinavian textbooks. In response, Uganda’s Parliament formally requested the drafting of the National Sexuality Education Framework, released by the Ministry of Education in 2018. Objectives: This talk will analyze the public debates surrounding the framework and the cultural, health, and religious discourses found within it. Methods: This talk draws upon analyses of national media and policy as well as from fieldwork conducted over thirty-four months in Uganda (2009-2019). Results: Religio-nationalist rhetoric in Uganda’s new sexuality education policy positions appropriate psychosexual development as a process of “cultural socialization.” While the policy would appear to appease detractors by guaranteeing to teach purity and virginity among other religious values governing sexuality, it has nonetheless been widely rejected by Christian and Muslim religious leaders, who claimed the framework would “ruin the lives of children.” Conclusions: Moral panics over sexuality education, which swung between the rights of young people to sexual health information and the religiously-inflected “African” cultural value of leaving matters related to children’s sexuality to parents and kin, were carefully crafted and consciously deployed by the global Right. Paradoxically, nationalist concerns over unemployment and economic sustainability also provided a language justifying sex education as a matter of population control.
2. Lydia Z. Dixon (California State University Channel Islands, USA). **“NO SE CUIDAN (THEY DON’T TAKE CARE OF THEMSELVES)”. RESPONSIBILIZATION, MORALITY AND CONTRACEPTIVE PERSUASION IN A MEXICAN PUBLIC HOSPITAL.** Introduction: Mexico, like much of Latin America, has a complicated history when it comes to contraception. Until recent years, long term or permanent forms of contraception were coercively implemented in many Mexican clinics, their use enforced through quotas. Providers had to comply or risk their employment. Malthusian concerns about population growth shaped decades-long national imperatives to reduce fertility by pushing contraception - especially on Mexico’s rural, poor and indigenous. Objectives: Building on 15 years of research on reproductive health in Mexico - first with midwives, and more recently with doctors - I examine how contraception is being mobilized within a neoliberal regime of responsabilization. Methods: I conducted participant observations and provider interviews in a Mexican public hospital labor ward in 2019. Results: While ostensibly no longer utilizing outright coercion, providers continue employ persistent pressure, urging women to choose long term or permanent contraception and expressing deep disappointment when they do not. Conclusions: I argue that providers may view this persistence as a form of caring and a moral responsibility, as they simultaneously cast women as immoral for what they see as their inability or refusal to “cuidarse (care for themselves)”. Such refusals are framed by providers as symptoms of a host of national concerns, from poverty to education levels to machismo (women’s genuine desires to have more children are rarely seriously considered). I ask: how do such moral regimes of responsabilization shape women’s interactions with providers, as well as their choices, experiences and health outcomes?
3. Hannelore van Bavel (University of London, United Kingdom). **CUT OUT TO BE A ‘GOOD WOMAN’: THE SHIFTING ROLE OF FEMALE CIRCUMCISION IN CONSTRUCTING WOMANHOOD AMONG KENYAN MAASAI.** Introduction: Anthropologists have described how female circumcision creates ethnic and gendered bodies. Among the Maasai of Kenya, female circumcision initiates girls into womanhood and licenses them to become wives and mothers. Uncircumcised women, regardless of age, are regarded as ‘girls’, unfit to be married or to give birth. However, with increasing access to formal education, exposure to urban lifestyles, and the formation of a middle class, the role of female circumcision in creating proper womanhood is shifting. Objectives: I aim to show that among the Maasai of southern Kenya female circumcision as marker of ‘good womanhood’ is being



contested by an upcoming middle class of formally educated, urban, and protestant Maasai. Methods: I draw from participant observation and in-depth interviews conducted among the Maasai community of the Loita Hills in southern Kenya. Results: My research shows that notions of what constitutes a ‘good woman’ and who can marry and give birth are being contested. Formally educated, urban, and protestant Maasai increasingly believe that female circumcision constitutes a barrier to, rather than requirement of, ‘proper womanhood’ because of the constraints they believe circumcision places on couples’ sexual experience and the risk it involves for childbirth. In the eyes of this growing middle class, formal education and, in some cases, church membership are more important elements for being ‘good women’. Conclusions: The role of female circumcision in constituting ‘good womanhood’ is shifting, and formal education and church membership are increasingly considered to be important characteristics of ‘good women.’

4. Chiara Pussetti (University of Lisbon, Portugal). **THE BEAUTY AND THE BLEACH: THE COSMETIC CONSTRUCTION OF WHITENESS.** Inspired by the anthropology of the body, critical medical anthropology, and gender and colonial/post-colonial studies, in this paper I seek to analyze the relationship between normative notions of beauty in Portugal, new paradigms of body (re)shaping, and aspirations of social integration among immigrant populations in the Greater Lisbon area. Combining quantitative and qualitative methods and focusing on what people say a perfect or ‘flawless’ beauty should look like, in the first place I investigate local beauty standards, aspirations and cosmetic practices designed to shape an ‘ideal European body’, as a specific form of bio-investment aimed at producing socially valued bodies in order to climb the social ladder or to boost chances of success. Secondly, considering beauty as a project steadily ‘under construction’, I explore specifically the aesthetic labour of immigrants and ‘non-white’ Portuguese as a way of adaptation to local and global circuits of representation. As beauty is about creating difference through artifice and shaping valuable bodies in a classed, aged, sexualized, gendered and racialized way, I seek to highlight that white bodies are also racialized, even if this racialization is not admitted and interpreted politically. The final purpose of this paper - addressing “skin” as a social signifier, a device of inequality production, and a field of intervention - is to highlight how beauty and cosmetic procedures are not only deeply ‘gendered’ and ‘classed’, but also ‘racialized’ and ‘racializing’, reproducing and reinforcing both symbolic boundaries and social inequalities.
5. Risa Cromer (Purdue University, USA). **FINDING “HOMES” FOR EMBRYOS: RELIGION AS REPRODUCTIVE GOVERNANCE IN US CHRISTIAN ADOPTION.** Introduction: At the turn of the twenty-first century, the fates of hundreds of thousands of human embryos left over from in vitro fertilization procedures and frozen in fertility clinics across the United States became the focus of evangelical Christian activism. The same year biologists in a University of Wisconsin lab established the first human embryonic stem cell line from a donated leftover embryo, a group of white evangelical Christians initiated the world’s first “embryo adoption” program designed to “save” embryos from “frozen orphanages” by returning them to where they allegedly belong: uteruses. Embryo adoption is a Christian practice that uses uteruses to resolve the “incomplete destinies” of frozen embryos and assert God’s authority as the prime assister of reproduction. Objectives: Bridging medical anthropology of reproduction and Christianity, this paper traces how religious discourses function as a form of reproductive governance within embryo adoption. Methods: This paper draws from twenty-seven non-consecutive months of ethnographic research conducted from 2008-2018 within US Christian “embryo adoption” programs; 111 semi-structured qualitative interviews with “embryo adoption” professionals, recipients, and donors; and textual analysis of program materials. Results: Narratives from embryo adoption program staff, donors, and recipients show how uterine “homes” are gendered as sites of nurturance and protection in which women’s bodies provide passive care for transferred embryos. Uteruses also become disembodied “vessels” in which women’s bodily labor is obscured and outsourced to God, who is treated as reigning authority working within wombs to complete each embryo’s destiny. Gendering uteruses in these ways diminishes women’s reproductive role in assisted conception and strengthens religious claims about God’s responsibility and authority in reproductive outcomes. Examining how Christianity serves as a form of reproductive governance in US embryo adoption encourages further analysis of the sociopolitical implications of intersecting religious and reproductive politics.



Indigenous traditions and teachings in intercultural healthcare - Part 2

2 pm – 3:15 pm, Room 8

1. Rebecca Shannon (Roanoke College, USA). **PALAUAN CHILDREN'S ATTITUDES TOWARDS FOOD AS INTERPRETED BY PARENTS AND TEACHERS.** The Republic of Palau has experienced high prevalence of nutrition-based non-communicable disease (obesity, diabetes, heart disease) owing to Westernization and likely genetic predisposition to fat storage. Roanoke College has been working with the Palauan Ministries of Health and Education and other community partners since 2010 to assess community assets, barriers, and ideas associated with healthy eating. In 2017, the Palauan legislature mandated that the Ministries of Health and Education work together to create a set of school health and nutrition standards for the nation. To provide background for this effort, Roanoke researchers were asked to examine the opinions of those involved in the school system, parents, teachers, and students and what they would recommend to improve nutrition at schools. As part of this work we conducted focus groups about child nutrition, eating habits, and attitudes towards food with parents and teachers in eight schools. This presentation will discuss the results of the focus groups and will highlight educational materials created after analysis for the focus group findings. Key findings from the research include the role of peer pressure in child food consumption, varied definitions of healthy foods, and differing expectations regarding appropriate portion size. The presentation will also briefly discuss means of strong inclusion of undergraduate researchers in longitudinal and applied global health work.

2. Kristin Hedges (Grand Valley State University, USA) & Joseph Ole Kipila (Olosho Initiatives, Kenya). **INDIGENOUS MEDICINE: A COMMUNITY-BASED RESEARCH APPROACH TO PRESERVE TRADITIONAL MAASAI MEDICINE.** Introduction: Medicinal plants play a crucial role as 'first aid' in the health care of indigenous communities throughout the world. In East Africa, the Maasai traditional medicinal knowledge (TMK) of local herbs has supplied many of the healing properties needed for typical household health concerns. However, this component of health care is currently threatened. Objectives: This community-based project has the objective of documenting and preserving local traditional medicinal knowledge. The project framework uses a Participatory Action Research (PAR) approach. Members of the study population have worked to design and direct the project for their own local needs. Methods: Plant identification walks were conducted with local identified knowledgeable people. Descriptions of the medicinal usage of the plants were audio recorded. To date, 30 plant descriptions have been documented. Household interviews were conducted to conduct consensus analysis of the use of each plant and understand household decisions making for accessing health care. To date, 30 interviews have been conducted, transcribed, and analyzed. Results: The results demonstrate that there is a generational gap in TMK among this Maasai community. Both the elders and younger generation are well aware of the gap and articulated a concern for this knowledge being lost in the community. Due to the increase of western style education and spread of urbanization, younger Maasai are no longer living full time in their homelands which limits in-situ learning opportunities impacting knowledge transition. Conclusion: The presentation concludes with future steps of the project to conserve and protect this valuable cultural resource.

3. Saquib A Usman (University of Michigan, USA). **REMEDIATING BLINDNESS: A NONSECLAR CRITICAL MEDICAL ANTHROPOLOGY OF BIOMEDICAL ENCOUNTER IN THE REMOTE MAURITANIAN "VILLAGE OF THE BLIND."** How do practices and discourses of western biomedicine go beyond desires of material intervention to craft secular political subjects and define social structures? By critiquing latent assumptions of medicine's secularity, and religion's conscription to an ideological domain disjoint from materiality, scholars drawing from critical medical anthropology and post-secularism have begun calling for deeper inquiries into the specific ways that medical practices have relied on religious frameworks to craft secular political subjects in various configurations, and how religious commitments themselves draw upon particular spiritual, political, material, and medical understandings. To explore these questions, this proposed presentation draws upon my ethnographic fieldwork amongst the Ummar in Dali Gimba, a remote village in the southwest Sahara renowned not only for its overwhelming hereditary blindness over the past nine generations, but also for their miraculous capacities understood to be granted through a divine spiritual compensation. For the first time in 2017, a team of Mauritanian researchers supported by national and international institutions painstakingly discovered the "defective" gene causing their eye ophthalmologic surgery, began to passionately advocate for a possible surgical intervention. To their incense, however, Dali Gimba has remained unconvinced and disappointed with



the whole affair. This presentation seeks to understand this encounter as something more than just secular medicine clashing with religious traditions by exploring the religious commitments and material considerations that frame both sides. It will also examine how various representational practices in the encounter effectively remediated “blindness” itself and recast social relationships across various spatial scales.

4. Sarah Staub (University of Florida, USA). **PERCEPTIONS AND PRACTICES SURROUNDING MALARIA AMONG TRADITIONAL MEDICAL PRACTITIONERS (TMPs) IN SOUTHERN GHANA.** Introduction: Malaria places an enormous economic and health burden on people and countries affected. 80% of people use traditional medicine (TM) when they get malaria. Objective: The aim of this study was to understand the perceptions and practices which traditional medical practitioners (TMPs) in Southern Ghana have surrounding malaria. Methods: Semi-structured interviews were done with 25 TMPs who had registered for an herbal medicine training. All interviews were recorded, transcribed and coded using an inductive approach for key themes and recurring responses into MAXQDA and Excel. Data analysis was carried out using MAXQDA and Excel. Results: TMPs listed 31 ailments commonly treated, with malaria being the most cited (52%). While 84% of participants identified mosquitoes as causing malaria, various other causes, such as food and diet (64%) were also cited. 28% of respondents discussed drug and parasite resistance, the need for multiple treatments, and the need to confirm cases of malaria with rapid diagnostic tests (RDT) (16%). Respondents largely diagnosed patients with malaria through consultation (52%) and RDT tests (24%). Conclusions: TMPs play a large role in the management of malaria. TMPs reported various symptoms for uncomplicated and severe malaria, although various identifiable symptoms of severe malaria, such as seizures and coma were not mentioned. This may have negative implications for diagnosing malaria and result in treatment seeking delays. Respondents indicated a desire to learn and share knowledge, so education trainings and the integration of TM with biomedical practices would likely be well received.

5. William E. Hartmann (University of Washington-Bothell, USA). **A CHALLENGE FOR INTERCULTURAL CARE IN BEHAVIORAL HEALTH: INSIGHTS FROM A CLINICAL ETHNOGRAPHY IN URBAN AMERICAN INDIAN BEHAVIORAL HEALTH.** Introduction. Concepts of culture maintain an extended history of being taken up by diverse groups and ascribed different meanings to serve distinct agendas. This is true of American Indian behavioral health (BH) where popular culture concepts have been problematized yet continue to inform clinical practice (e.g., culture as group orientation). An afterthought in most BH settings in the U.S., culture and its role in American Indian health and wellness is of primary concern for Indian Health Service (IHS)-sponsored BH clinics. Yet, despite engaging in culturally-prescriptive practices of psychotherapy, little is known about how clinicians navigate culture and clinical practice in these settings. Objectives. To better understand these issues, I partnered with an IHS-sponsored BH clinic in a Midwestern city for a clinical ethnography. Methods. Data collection extended throughout all settings within the clinic except client encounters for 19 weeks. Results. Although clinicians talked about clinical practice in abstract as departing from clinical practice norms to facilitate a therapeutic process of cultural re-connection, they described and demonstrated clinical practice as reflecting standard BH services re-packaged as culturally different to facilitate a therapeutic process of cultural re-imagination. Conclusions. This disjunction reflects a major predicament for intercultural care in BH as engagement with diverse cultural traditions stands at odds with modern American cultural sensibilities embedded in clinical training. Rather than immersion into a life-world familiar to indigenous ancestors ala cultural re-connection, clinicians used representations of culture in therapy to assist clients in fashioning positive modern identities to buttress against devaluation in modern America.

Invisibilization

2 pm – 3:15 pm, Room 10

1. Rachael Galbraith (University of Winnipeg, Canada). **NARRATIVES OF DELAY: THE CLINICAL INVISIBILITY OF ENDOMETRIOSIS.** The average diagnostic delay for individuals with endometriosis is seven years. This autoethnographic thesis aimed to uncover both the underlying causality and human outcome of this delay, using a critical medical anthropology framework to confront the social determinants of women’s reproductive pain dismissal. This project focused on a corpus of survey data taken from 56 Canadian participants with



endometriosis, as well as the author's own experience with diagnostically delayed endometriosis. Methodologically, a mix of narrative synthesis and statistical analyses reveal the narratives common to diagnostic delay: the normalization and/or dismissal of women's reproductive pain, the deterioration of trust between patients and biomedical professionals, and the development of self-advocacy and self-directed research skills. Diagnostic delays are shown to decrease the quality of life in individuals with endometriosis and continue to negatively affect their interactions with the biomedical system after diagnosis. Based on the priorities of my participants, narrative medicine was introduced as a possible part in the solution to diagnostic delay: this methodology would subvert the current clinical invisibility of endometriosis by reestablishing lived experience as valid diagnostic data and by fostering genuine dialogue between patient and professional.

2. Laura A. Meek (University of Hong Kong, Hong Kong). **THE GRAMMAR OF LEPROSY: TEMPORAL POLITICS & AN IMPOSSIBLE SUBJECT.** In this talk, I will critically interrogate the World Health Organization's commitment to the elimination of leprosy. I will argue that leprosy has been portrayed (for nearly a century) as something from the past, recalcitrantly lingering on into the present, but surely about to be gone—a temporal framing which I call the 'grammar of leprosy'. First, I will analyze a series of correspondences published by scientists in the *Lancet: Infectious Diseases* in which researchers working for Novartis (the supplier of antibiotics for leprosy) continue pushing for an always-immanent "elimination", while field researchers in Brazil repeatedly caution about the potential problems of this approach. Next, I will discuss how some of these issues congealed in the experience of Luka, one of my interlocuters in Tanzania, whose existence became a problem for his doctors, one that they ultimately resolved by fabricating negative test results in order to record what they already knew: leprosy has been eliminated. Finally, I reveal how the grammar of leprosy operates through a complex set of converging and diverging temporal politics, pulling into its orbit and being enabled by multiple interwoven temporalities. I conclude that—due to this grammar, the impossible subjects it produces, and the temporal politics through which it operates—leprosy elimination campaigns may have dire consequences for the lives of people with leprosy today, impeding rather than enabling the disappearance of the disease.

3. H. Tankut Atuk (University of Minnesota Twin Cities, USA). **EPIDEMIOLOGY OF CONSERVATISM: POLITICS OF HIV, PREVENTION, AND SEXUALITY IN TURKEY.** Introduction: According to the recent data provided by the World Health Organization, the number of HIV diagnoses in Turkey has increased by 450% since 2007. Nevertheless, the Turkish State refuses to undertake public health interventions necessary to control the world's fastest-growing HIV epidemic. Although treatment is provided at no cost, preventive measures such as sex education, HIV awareness-raising, and condom use are prohibited, for they are believed to encourage sexual activities. The Ministry of Health publicly offers monogamy as the only medical and moral way to cope with the epidemic. Objectives: I will answer: (1) What does the refusal to recognize and prevent the national HIV epidemic reveals about the Turkish State's understanding of sex, sexuality, and sexually transmitted infections (STIs)? (2) In terms of biopolitics, what does it mean for a state to provide treatment but not prevention to its citizens, therefore, let infect and be infected? (3) How does the absence of the Turkish State in the field of HIV allow global pharmaceutical companies and local HIV organizations pursue their own political and economic agenda in the name of public health? Methods: This presentation will be based on, what I call, viral (auto)ethnography, carried out by an HIV+ Turkish gay researcher in Istanbul and Ankara. So far, I interviewed forty respondents, who are health providers, government officials, activists, NGO workers, and pharmaceutical employees. Results: The presentation will conclude that not only the Turkish State but also the local HIV organizations and global pharmaceutical giants contribute to the conservative ethics of HIV in Turkey. Therefore, from the perspective of critical social epidemiology, they bear the responsibility of the current epidemic. Conclusions: My impetus here is to understand and mitigate the reasons and impacts of the state withdrawal on HIV+ persons and those who are put at risk due to the absence of a caring State. By caring, I refer both to "caring about" and "taking care of."

4. Helena Fietz (Universidade Federal do Rio Grande do Sul, Brazil). **"IT STAYS THE SAME": THE INFANTILIZING OF ADULTS WITH DEVELOPMENTAL DISABILITIES IN SOUTH BRAZIL.** Life expectancy for people with developmental disabilities has increased in Brazil in the past few years. Still, adult disabled people are frequently rendered invisible with most of the services and policies targeting school-aged children. Also, parents and professionals often refer to people with developmental disabilities as children, regardless of their age. In this presentation, I aim to analyze how medical and familial discourses and practices contribute to the infantilizing of people with



developmental disabilities. Drawing from ethnographic research conducted from May 2017 to August 2018 with families of disabled adults in the city of Porto Alegre, Brazil, I propose a reflection on the transitioning aspects that emerge when both mothers and children grow older. With my research, I have found that the experience of developmental disability challenges legal and bureaucratic markers that establish different life stages in a very particular way. Mostly due to the centrality of cognitive patterns in defining what is considered to be "normal." Thus, there is a common-sense perception that people with developmental disabilities never reach adulthood. A belief strongly influenced by medical statements about one's "mental age." Finally, I propose that this process is better understood when analyzed through the lens of systemic ableism, which is inherently present on the social and individual expectations and legal markers regarding being an adult. Markers and expectations that do not encompass diverse ways of inhabiting the world.

5. Svetlana Borodina (Rice University, United States). **IS THERE A PROBLEM? BLINDNESS AND WELLBEING IN POSTSOCIALIST RUSSIA.** What problems cluster around the well-meaning postsocialist imperative to medically cure blindness? To answer this question, I draw on publicly accessible media materials and semi-structured interviews with eight blind adults from a large urban area in Russia who refused the enthusiasm associated with sight restoration and instead pushed forward ideas about wellbeing that are not predicated on curing blindness. I critically examine my interlocutors' arguments against the overmedicalization of blindness and the paternalistic care patterns to which Russian society routinely subjects blind people. I view public media, NGO and governmental actors, medical spokespersons as well as unsupported blind persons as complicit in producing structural and individual helplessness among blind people in Russia. This contribution concludes with a brief discussion of possible alternatives to the overmedicalization of blindness and the acknowledgment of alternative conceptualizations of blindness that fuel individual and collective wellbeing.

The first Garifuna hospital in Honduras: Articulating Garifuna healthcare and territorial sovereignty

2 – 3:15 pm, Room 14

Organizers: Beth Geglia (American University), Rony Castillo (University of Texas, Austin), Luther Castillo (Harvard University), Jesse Freeston. Film with discussion.

Since 2005, Garifuna doctors and community members on Honduras' northern coast have organized to create The First Garifuna Hospital of Honduras and provide free healthcare services to surrounding communities. Garifuna doctors, trained in Cuba, integrate the preventative and bio-psycho-social approach characteristic of Cuban medicine with Garifuna cultural knowledge and medicinal practices. In doing so, the hospital has not only been able to treat some of the region's most prevalent pathologies but has identified the structural causes of health disparities in afro-indigenous Garifuna communities and integrated healthcare practices into a broader movement for Garifuna territorial autonomy. This session will first feature the documentary film *Revolutionary Medicine: A Story of the First Garifuna Hospital* (40 mins, co-directed by Beth Geglia), a film that narrates the hospital's history, approach to intercultural health, relationship to the Honduran state, and relevance to social movement processes. A panel discussion will follow the film featuring Luther Harry Castillo, ELAM graduate and co-founder of the First Garifuna Hospital and Fundación Luago Hatuadi Waduhenu, and Dr. Rony Castillo, who's scholarly work focuses on models of Garifuna autonomy and institution building. The panel will expand on the types of health interventions Garifuna doctors have implemented in the region as well as current challenges in providing intercultural care. Finally, the panel will also discuss the social life of healthcare in Garifuna communities, how it is both shaped by and generative of political and territorial contexts and realities.

Global health 1

2 pm – 3:15 pm, Room 12 (gallery with posters) – please see annex.



Reproduction and obstetric violence

3:15 – 4:30 pm, Room 3 (with translation)

1. Isabella Schultz and Adrienne Strong (University of Florida, USA). **PATHWAYS TO MATERNAL DEATH IN THE HOSPITAL: CASE-COMPARISON DATA FROM RUKWA, TANZANIA.** Introduction: Maternal mortality results from complex factors. Even when women access biomedical facilities, chronic shortages, social and organizational dynamics, and delays can derail their care, ultimately leading to death. Objectives: To use medical records from a regional referral hospital's maternity ward in Rukwa, Tanzania to examine non-clinical issues and their contribution to maternal deaths in low-resource settings. Issues of interest included: time of admittance, delays in receiving care, availability of prescribed medications, continuity of care, and duration of stay before death. Methods: We analysed 34 matched case-comparison sets of medical files, comprised of files from one woman who died and an average of two admitted with the same complication but who survived. We used Chi-squared and t-tests to analyze three categories of non-clinical information: 1) institutional/organizational problems, 2) structural problems related to Tanzania's health sector, and 3) social interactions at the hospital. We also conducted more general qualitative comparisons of the cases to examine differences in sequences of events, context or the intensity of the women's condition. Results: We identified general pathways used to treat different obstetric emergencies (and deviations from them), revealing systemic weaknesses that sometimes resulted in a woman's death. Key variables included personnel, time of arrival, supply availability, and time to initiation of treatment. Conclusion: Examining near miss cases reveals always-present systemic shortages but may only become visible in the event of an obstetric crisis. Combining these findings with ethnographic data provides insight into how hospitals can rethink routine care procedures and their potential weaknesses.

2. Ruth Iguñiz-Romero (Universidad Peruana Cayetano Heredia, Peru). **ACKNOWLEDGING OBSTETRIC VIOLENCE. HOW DO HEALTH PROFESSIONALS UNDERSTAND AND EXERCISE MEDICAL INTERVENTIONS DURING PREGNANCY AND LABOR.** Introduction: In Peru, by 2018 93,6% of deliveries were assisted by qualified health personnel; and c-sections procedures have increased from 26.5% in 2013 to 34.5% in 2018. Currently, the Plan against Gender Violence (2016-2021) recognizes OV as "a specific modality of institutional violence exerted by the health system...as a form of domination and control over the body and the autonomy of women". However, few medical professionals acknowledged their personal and medical practices as violent or avoidable therefore become unable to discuss and/or modify them. Objective: Identify contexts and practices that health professionals recognize as OV and acknowledge as personal/medical avoidable or unavoidable decisions consequences of "standard medical procedures", health system characteristics, or individual discriminatory standards. Methods: exploratory study combining phenomenological and health systems approaches and anthropological methods, to conduct and analyze semi-structured interviews with midwives (11) and OB/GYN (9); male (5) and female (15). Study had approval from Ethics Committee. Results: Ob/gyn acknowledge that having scheduled c-sections "is nicer and very practical, because you know the patient beforehand, it's a more friendly situation" than in an emergency context. Midwives on hospital deliveries work on overcrowded "emergency obstetric wards" structured to respond to stressful and life-threatening situations affecting their relationships with women and OB/GYN. Conceptions about how women should deliver, varied from those willing to use epidural or c-section to mitigate pain to accept pain as necessary to ensure maternal-child bonding. Conclusions: It's key for change to promote health professionals' awareness of their own habitus and practices to begin dialogue with women experiencing OV.

3. Vanessa Kathryn Voller (University of Minnesota, USA). **INTERROGATING (IN)ACCESS TO COMPREHENSIVE SEXUALITY EDUCATION (CSE) AND REPRODUCTIVE HEALTH SERVICES.** Introduction: Maternal mortality is the leading cause of death for adolescent girls in Latin America. While it is known that sexual and reproductive health (SRH) education and healthcare services hold life or death consequences for adolescents, access is inequitably distributed. To combat this inequity, health and education ministries across Latin America signed a ministerial declaration which mandated the provision of SRH education and healthcare services in 2008. However, signatory countries developed vastly different interventions. For example, while the Bolivian government relies upon international development agencies to implement CSE in public schools and provide adolescent SRH services, Costa Rica began a state-run campaign to provide such services. Currently, there is a dearth of comparative research on this topic in Latin America. Objectives / Methods: This comparative research



aims to (1) understand why Bolivia and Costa Rica developed different interventions; (2) document how the interventions manifest locally; (3) identify issues of (in)access that uniquely exist for rural adolescents and, specifically, pregnant adolescent girls. Methods employed include: (1) critical discourse analysis of policies affecting the provision of CSE and SRH healthcare services; (2) observations of CSE classrooms and clinics providing SRH healthcare services; (3) participatory photovoice with adolescents to capture their experiences (in)accessing these services. Preliminary Results / Conclusion: Preliminary results suggest that interventions in both countries (1) fail rural adolescents and (2) are seeped in a neo/liberal ideology that unfairly over-responsibilizes adolescents with the safeguarding of their SRH and negate the material conditions affecting an adolescent's SRH choices.

4. Michelle Potiaumpai (University of London, United Kingdom). **PAIN AS A CONSTANT COMPANION: A THEMATIC ANALYSIS OF WOMEN'S PAIN EXPERIENCES WITH ENDOMETRIOSIS.** Introduction: Endometriosis is a chronic condition where tissue normally found along the inner lining of the uterus, is found in other areas of the body such as the pelvis, bowels, and other reproductive organs. Symptomatology includes severe chronic pain, fatigue, and infertility. Although 1 in 10 women of reproductive age are affected by endometriosis, it is still widely misunderstood by the medical community leading to delayed diagnosis and mistreatment of symptoms. Objectives: The objective of this qualitative study was to explore how women experience endometriosis pain and how this pain impacted their physical, emotional, and psychosocial well-being. Methods: Twenty-two women, aged 18-38 years, responded to open ended interview questions. Inductive thematic analysis was used to analyze responses. Results: Four major themes emerged: (1) pain as a constant companion, (2) effects of normalization of pain in seeking medical care, (3) struggle for diagnosis, and (4) reasoning after diagnosis. Participants conveyed that living with endometriosis pain was a daily battle, from maintaining their social and work lives to struggling to prove their pain to physicians. Women felt ignored by the medical community which heightened their reluctance to seek further medical care. A positive diagnosis led to a variety of emotions such as hopelessness, validation, and empowerment. Conclusions: This study's findings have important implications for health professionals, including improved awareness of endometriosis and better strategies to address pain concerns. There is an urgent need to take women's symptoms more seriously at the point of consultation to ensure effective treatment and increased patient welfare.

How social and political hierarchies affect intervention

3:15 – 4:30 pm, Room 8

1. Nicola Manghi (University of Turin, Italy). **THE LEGAL PRODUCTION OF SELF-HARM IN TURIN'S CENTER FOR THE DETENTION OF UNDOCUMENTED MIGRANTS.** Italian centers for the detention of undocumented migrants (CPR) find themselves in a legal grey zone. Their functioning is not regulated by any specific legal provision, which makes them quite a literal example of the "camp" analyzed by Giorgio Agamben. Our research looks at how self-harm, which is unanimously acknowledged as a frequent phenomenon in CPR, is legally produced by precise institutional dynamics in Turin's CPR "Brunelleschi". As police can't guard the hospitalized detainees (since they are not convicted criminals), hospitalization is turned into a possible easy way out from detention. As a consequence, patients from the CPR are immediately suspected of deploying agency finalized to flee the center. The methods employed for our research include unstructured interviews with nursing and medical staff both at Turin's CPR and at the nearest hospital, religious personnel who regularly visit the center, and lawyers whose clients have been detained in the CPR and have gone through severe health issues, as well as a legally and philosophically informed history of detention centers for migrants in Italy. The results of our research show how the institutional dynamic above sketched puts patients coming from the CPR in the position of being constantly suspected of making up symptoms, therefore jeopardizing the quality of healthcare available to them. In conclusion, looking at self-harm allows us to have a grasp of the political life of these "total institutions", and the unexpected intertwining between agencies, bodies, and rights that takes place there.
2. Mariane Ferme (University of California Berkeley, USA) & Raphael Frankfurter (University of California San Francisco and Berkeley, USA). **PARAMOUNT CHIEFS AND THE EBOLA RESPONSE IN SIERRA LEONE.** Introduction: This paper addresses the role of Paramount Chiefs--the highest "traditional" political authority in rural Sierra



Leone--in responding to the West African Ebola Virus Disease (EVD) outbreak of 2013-16. These authorities were responsible for implementing public health regulations but were caught in time lags between their responses and constantly changing medical understanding of EVD transmission. Objectives: To analyze the missed opportunities and politics of an epidemic response in relation to a particular socio-political institution, and to contribute to a critical epidemiology of the West African Ebola outbreak attentive to the role of this institution. Methods: Ethnographic research in rural Sierra Leone before, during and after the Ebola outbreak. Results: 1) Communities and leaders experimented with protective measures with available models and materials. Contrary to assumptions that affected populations would resist public health interventions, people sought new solutions to a new disease and were not trapped in cultural practices linked to heightened health risks. 2) When national authorities with British military support intervened to contain EVD, Paramount Chiefs found themselves caught in relations modeled on colonial regimes of Indirect Rule. This may have contributed to an efficient distribution of resources, but also led to siloed regional efforts and ambivalent attitudes towards outbreak responses. Conclusions: Historical particularities of local institutions tasked with managing an outbreak response must be understood in order to predict the ways in which an epidemic might unfold, and to anticipate the limits of control efforts.

3. Cassandra L. Workman (University of North Carolina Greensboro, USA) & Maryann R. Cairns (Southern Methodist University, USA). **GLOBAL WASH INSECURITY: SOCIAL SCIENCE CONTRIBUTIONS AND FUTURE DIRECTIONS.** Introduction: Anthropological research on WaSH has historically focused more on water than on sanitation or hygiene. WASH-specific research on sanitation and hygiene primarily includes critiques of development and development policy. Drawing from several sub-disciplines within anthropology, geography, and public health, anthropologists outline how illness and disease are driven by poverty and exclusion. Moreover, in addition to biological outcomes, there is attention to how inequity in WASH can result in increased psycho-emotional burden and social conflict. Objectives: We assert that anthropologists and social scientists can contribute to a comprehensive understanding of WaSH as a multi-dimensional phenomenon, one that is yet sufficiently operationalized. Ensuring WaSH security requires comprehensively identifying biological risk profiles but also attention to how sanitation is integrated into households and communities and how it is lived by individuals. Methods: The authors' respective original empirical research on sanitation informs this article, providing experiences from Bolivia, Tanzania, and other sites for consideration alongside a wider critique of the state of the state in this field. Results: In contrast to viewing culture as a "barrier" to uptake, social scientists see sanitation systems as embedded within culture. As evidenced by the results from the recent WASH Benefits and SHINE trials there is a need for qualitative/local perspectives and a more comprehensive understanding of what WASH entails. Conclusions: Over fifty years of development initiatives indicate the need for sophisticated, integrated approaches to improving human health.

4. Glauca Maricato (Federal University of Rio Grande do Sul, Brazil). **LARGE NUMBERS: UNCOUNTED EFFECTS OF LEPROSY STATISTICS.** In 2000, the World Health Organization (WHO) announced the global elimination of leprosy as a public health problem. Since the introduction of multidrug therapy (MDT) in the 1980s, the number of cases registered globally has decreased from over 5 million to about 200,000 cases. However, although it has been taken for granted that leprosy can be cured after some months of treatment, the MDT regimen does not necessarily lead to the end of the disease. It kills the *Mycobacterium leprae* and, doing so, breaks the transmission chain, but the disease goes beyond the infection. According to some estimates, between the years 2000 and 2020 as many as 4 million cases of leprosy will be overlooked worldwide. Some scholars suggest that the announcement of global elimination of leprosy have caused campaigns of active surveillance to be discontinued, and a progressive loss of expertise in diagnosis and treatment. Drawing on literature from STS and Medical Anthropology and based on seven years of ethnographic research, I will delineate how both the "ontological politics" of cure performed by the MDT and the manner in which global statistical data is produced together take part in the evidence-making process of the global truth about leprosy epidemiology. In other words, aside from the underdiagnosed cases and the drop of expertise, I argue that we need to analyze where and how the global epidemiological reality is enacted and what are its effects.



Indigenous traditions and teachings in intercultural healthcare - Part 3

3:15 – 4:30 pm, Room 10

1. Patricia Hudelson (Geneva University Hospital, Switzerland). **INTEGRATING MEDICAL ANTHROPOLOGY INTO MEDICAL EDUCATION: GENEVA, SWITZERLAND.** Introduction: Working with socially, culturally and linguistically diverse patients can be challenging. Difficulties arise from the diversity of patients' health beliefs, values, preferences and behaviors, and from providers' inability to communicate effectively across language and cultural differences. Communication barriers complicate the task of identifying, understanding and incorporating patients' diverse beliefs, behaviors and preferences in the provision of health care. While it is widely accepted that in order to ensure quality and equity in health care for diverse populations, physicians need to acquire specific knowledge, attitudes and skills, variously referred to as (inter /trans/cross) cultural competence, early efforts reflected an essentialist approach to culture, focusing on patients as "other" and contributing to stereotyping. More recently, it has been proposed that medical students and physicians turn an "anthropological gaze" towards the customs, languages, and beliefs systems that are shared by physicians. From this perspective, cultural competence is developed through a greater understanding of medicine as a cultural system, and through becoming astute "ethnographers" of their patients. Objectives: This presentation will describe how medical anthropology concepts and methods are integrated into medical training at the University of Geneva, the teaching approaches used, and the challenges that remain in establishing medical anthropology as an essential element of medical training. Results: Concepts and methods of medical anthropology have been successfully incorporated into all 5 years of medical education. However, a number of challenges remain. Conclusions: In order for medical anthropology to become an integral part of medical training, a number of strategies are proposed.

2. Xiuyuan Liu (KU Leuven, China). **MAKING CHINESE MEDICINE THROUGH TRANSLOCAL PRACTICE: AN ETHNOGRAPHY OF CHINESE MEDICINE OVERSEAS.** The paper is an ethnography focusing on the practice of Chinese medicine under a translocal frame. It unveils how the dynamic forms of Chinese medicine practice are embodied through encounters and entanglements in a non-local society. Setting ethnography in Basel, a Swiss city famous for its pharmaceutical industries as well as a highly modernized city, the contrast of practicing Chinese medicine in a biomedicine-based society is underlined to examine why patients in a modern society even choose Chinese medicine. Through interviews and participant observation, it involves multiple forces such as practitioners, patients, pharmaceutical workers, and even popular media, all of which become the active actors that build up the making of Chinese medicine. It suggests that the making of Chinese medicine is an active and ongoing process and an interacted complex between ontology and practice. The Chinese medicine in Basel is on the one hand practiced by practitioners in the form of acupuncture, massage, or cup therapies, which are commonly regarded as traditional Chinese medicine therapeutic methods; on the other hand, however, it is shaped by various actors and its ontological system is transformed by the practical interaction. In conclusion, it suggests that Chinese medicine as a living tradition is in enduring transformation of shaping and being shaped through ontological and practical interaction within the embodiment of localized characters.

3. Annikki Herranen-Tabibi (Harvard University, USA). **CARING STATE CONTRA HEALTHY (SÁMI) SOCIETY? STATE-MAKING AND INDIGENOUS RESURGENCE IN DEANULEAHKI (DEATNU RIVER VALLEY), SÁPMI.** Introduction: This paper offers a series of interconnected vignettes to examine, first, imaginaries of a "healthy (Sámi) society"; second, the collisions of these imaginaries with the consolidation of the post-World War Two Nordic welfare state qua caring state; and, third, specters of societal pathology amidst flux in relations of care. Objectives: I interrogate the fraught and uncertain position of the invocations of "healthy (Sámi) society"; elucidate how Nordic welfare-state-making practices have collided with indigenous conceptions of care and aspirations for well-being; and foreground emergent forms of resurgent care in Deanuleahki — care among people and in relation to ecology that surges as a mode of struggle and striving. Methods: Over 25 months of continuous research in Deanuleahki, Sápmi in 2016-2018, with a core group of 60 interlocutors, I conducted interconnected biographical interviews on care among kin and within foundational livelihoods; collaboratively constructed genograms to map intergenerational histories of care and harm; examined and reconstructed intimate archives that detail such histories; and conducted participant-observation from driftnet fishing with elderly River Sámi to being present at moments of death and for processes of bereavement. Results: I develop the notion of

resurgent care and a methodological orientation to reparative labor in the intimate archives of care and harm. Conclusions: In Deanuleahki, the “healthy (Sámi) society” emerges as a term of assertive idealization; a language of critique towards state and dominant society; a facet of intra-community reckoning with violences past and present; and as an exhortation to fathom, reimagine, and recreate care as resurgence.

4. Alessandro Norsa (University of Verona, Italy). **AN INTERCULTURAL COMPARATIVE STUDY OF TRADITIONAL CARE SYSTEMS: PRELIMINARY DATA.** Introduction: in this work the preliminary data of a research begun in 2017 within the University of Verona (Italy) and with the collaboration of the Frazer Association for Anthropological Research are presented. Objectives: the focus of the study is the comparative analysis of traditional healing practices. Methods: the research project, which is the collaboration of 14 universities from different parts of the world, is composed of thematic areas that concern the aspects of physical, mental and spiritual health and their methods of care investigated through a questionnaire. As an example, we will analyze trance as a possibility of treatment in traditional cultures. Starting from the therapeutic results that can be found in some ceremonies of the Cuban *santería*, other cases of different cultures will be analyzed in which similar effects can be had through this state of modification of the conscience. Results: the study shows that, beyond rhythmic music (especially that of the drum), other methodologies can be used to modify the state of consciousness, in particular: the use of psychotropic substances, fasting, ascetic contemplation (transcendent meditation), the song, the rhythm of the movements (especially the rotatory or undulatory ones stimulating the semicircular canals), the hypnotic suggestion, the rapid hyper-breathing, the inhalation of fumes and vapors, the unconscious stimuli moved by symbolism and mythical references evoked by the ritual climate. Conclusion: in the cases examined, it is common, during the induction to the trance, the evocation by a priest-healer of a divinity that acts for the cure and healing of the patient.

Medical anthropological research in Latin America

3:15 – 4:30 pm, Room 14

1. Tirsia Colmenares-Roa & Ingris Peláez-Ballestas (Hospital General de México “Dr. Eduardo Liceaga”, México). **DIFERENCIA Y MERECEIMIENTO EN LA ATENCION DE PACIENTES VULNERABLES EN UN HOSPITAL MEXICANO.** Introducción: México posee políticas focalizadas para subsanar la inequidad sanitaria en población vulnerable. En hospitales públicos, trabajadores sociales deben identificar pacientes que sean vulnerables y atenderlos de manera preferente; sin embargo, no hay criterios estandarizados para hacerlo. Objetivos: Analizar las concepciones sobre vulnerabilidad y las prácticas de identificación y atención de pacientes vulnerables, de trabajadores sociales en un hospital público; contrastar con elementos teóricos y prácticos dados por académicos mexicanos a partir de la figura del palimpsesto. Métodos: Etnografía hospitalaria para explorar las concepciones y prácticas de trabajadores sociales que ejecutan la normatividad; grupo focal con académicos mexicanos para debatir su instrumentación. Resultados: El concepto de vulnerabilidad usado por los trabajadores sociales está vinculado a las necesidades sociales; la normatividad y su práctica es guiada por el modelo de los grupos vulnerables propuesto por el Estado, evidenciando controversias vinculadas con dilemas sobre la diferencia y el merecimiento. Los académicos señalan que la vulnerabilidad en el hospital debería referirse al no acceso a los servicios que la institución presta, debido a múltiples condiciones individuales y socioculturales, no a la pertenencia a un grupo preestablecido. La vulnerabilidad y su aplicación en este contexto son procesos que yuxtaponen acciones, significados e interpretaciones. Conclusiones: La vulnerabilidad es entendida como palimpsesto: una construcción surgida de interpretaciones contextuales reflejada en la conceptualización y ejecución de la política focalizada en el contexto hospitalario. El palimpsesto como dispositivo de producción y reproducción de sentido, es una figura de pensamiento que puede explicar dinámicas sociales y construir nuevas significaciones.
2. Claribel Gómez Vasallo (Universidad de La Habana, Cuba). **EPISTEMOLOGÍA DE LAS CIENCIAS SOCIALES PARA EL ESTUDIO DE LA SALUD MENTAL.** La reflexión que para este espacio se propone tiene como finalidad principal, el intentar hacer un llamado de atención sobre la imperiosa necesidad de impulsar, dentro de la agenda de las Ciencias Sociales cubanas el estudio del par salud-enfermedad mental. Ha sido este en el contexto cubano un tema históricamente poco abordado desde la investigación—por razones diversas—dentro de las Ciencias Médicas



y mucho menos estudiado con sistematicidad dentro de las Ciencias Sociales. Por esta razón de inicio las ideas que se exponen constituyen sobre todo una incitación para el diálogo. Las mismas están sustentadas en acercamientos empíricos de la autora a esta problemática cuyo interés ha estado movido fundamentalmente por los inquietantes datos estadísticos que muestran en el contexto cubano, latinoamericano y mundial un aumento creciente de personas que sufren algún tipo de problema mental. Los vínculos entre la Salud Mental y fenómenos sociales como los procesos de empobrecimiento, la marginalidad, el (des)empleo, la violencia y la exclusión social, por solo citar algunos, hace que se visualice sin dudas la necesaria convergencia de esfuerzos investigativos que haciendo uso de herramientas epistemológicas distintas converjan en interrogar a un mismo objeto. El diálogo entre Medicina y Ciencias Sociales se impone para la comprensión multidimensional de esta problemática.

3. Sixta Yesenia Martínez García (Universidad Nacional Autónoma de Honduras, Honduras). **LA FIEBRE AMARILLA EN EL CARIBE HONDUREÑO.** En esta ponencia se pretende explicar las estrategias y los discursos que encaminaron a un Estado sanitario en Honduras a inicios de la primera década del siglo XX en el Caribe hondureño y las discusiones sobre el origen y propagación de la epidemia. Ello en el marco del control y prevención de las enfermedades infectocontagiosas, epidémicas y los intereses de inversión estadounidense, ante la llegada de las compañías bananeras, justo en el marco de la política de los Estados liberales y la construcción del imaginario nacional. También es parte de un proceso de integración en el concierto de las relaciones económicas y políticas en un escenario latinoamericano, formando parte de las “zonas de intersecciones transnacionales, según lo han manifestado los estudios sobre las relaciones Estados Unidos y América Latina. Situación que permitió la estigmatización de poblaciones subalternas “obreros del banano y del ferrocarril” propios de un sistema colonialista. Como resultado de la investigación se tiene identificado el discurso sobre la política sanitaria y las discusiones sobre el origen y ruta de la fiebre amarilla en el Caribe hondureño; ante la ausencia de mostrar la muerte en cifras, se registran las manifestaciones del duelo o las formas del entierro. Para ello se han considerado los aportes e interpretación de una historiografía específica para el estudio de las epidemias, la muerte y los cementerios. El estudio se fundamenta en una variedad de fuentes primarias en archivos locales, nacionales, y estadounidenses, con cierto acompañamiento de fuentes orales.

4. Yanet Jordán Pita (Universidad de Ciencias Médicas de Santiago de Cuba, Cuba) & Zoe Díaz Bernal (Escuela Nacional de Salud Pública, Cuba). **LA ANTROPOLOGÍA MÉDICA: UNA NECESIDAD EN LA ENSEÑANZA MÉDICA ACTUAL.** En la Universidad Médica cubana representa se forman estudiantes cubanos y de otras nacionalidades, creándose un espacio donde confluyen culturas e idiosincrasias. Sin embargo, la ausencia de la Antropología médica como disciplina dentro de la formación curricular del educando, lo limita de apropiarse de herramientas necesarias que le permiten una mejor interpretación de la conducta humana como resultado de la cultura y su relación con el proceso salud –enfermedad-atención. Incorporar esta disciplina lo ayudaría a contrarrestar los efectos de determinados factores que contribuyen a la deshumanización de la medicina, y por ende del profesional que hoy estamos formando, como por ejemplo el creciente uso inadecuado de la tecnología médica. Por otra parte, el personal médico cubano presta servicios médicos en diversas latitudes del mundo y en esta posición, analiza el proceso salud enfermedad-atención de acuerdo con los parámetros de su propia cultura obviando la identidad cultural de la población, propiciándose una práctica intercultural forzada. Objetivos: reflexionar sobre la pertinencia de la Antropología Médica dentro de la formación médica cubana y proponer su inclusión dentro de la malla curricular actual. Métodos: revisión de la literatura nacional e internacional y análisis del contenido curricular de la carrera de medicina en Cuba. Resultados: se proponen objetivos docentes vinculados al conocimiento de la Antropología Médica, para dar salida a través de un sistema de contenidos que pueden ser introducidos en alguna de las asignaturas incluidas en la malla curricular actual dentro de la formación Ciencias Médicas en Cuba.

Global health 2

3:15 – 4:30 pm, Room 12 (gallery with posters) – please see annex.



Closing session

4:30 – 4:45 pm, Room 3 (plenary with translation)
Charles Briggs, Zoe Díaz Bernal, and Arachu Castro

String orchestra

Orquesta de cuerdas pulsadas de la Escuela de Música Paulita Concepción
4:45 – 5:00 pm, Room 3

Farewell dinner

5:15 – 6:30, pm, (Havana Convention Center dining room)

Friday, March 13th - MORNING

Visit to Anthropological Museum Montané, University of Havana, Vedado (*optional*)

9 am – 12 pm

Facultad de Matemática y Computación, Calle San Lázaro y L, Colina Universitaria, Building Felipe Poey, 2nd floor



ANNEX - GALLERY PRESENTATIONS

Presenters are expected to place their posters in Room 12 next to posters on the same theme on Wednesday morning and leave them until Thursday evening. The posters are structured around themes with a designated time during which the presenters will have 5 to 10 minutes to present their work, followed by discussion with other presenters and participants. Room 12 does not have audiovisual equipment.

Day 2 - Wednesday, March 11th – AFTERNOON

Clinical cultures

2 pm – 3:15 pm, Room 12 (gallery with posters)

1. Martina Fay, Jessica Guadarrama, Tirsa Colmenares-Roa, Ana G. Cruz-Martin, Ingris Peláez-Ballestas (Universidad Nacional de Rosario, Argentina / Hospital Infantil de México / Hospital General de México “Dr. Eduardo Liceaga” / Universidad Nacional Autónoma de México, México). **DERECHO AL BIENESTAR AL FINAL DE LA VIDA EN POBLACIÓN PEDIÁTRICA.** Introducción: El derecho a la salud universal incluye la atención al final de la vida, sin embargo, los sistemas de salud latinoamericano no contemplan los cuidados paliativos como una estrategia de bienestar al final de la vida, en especial en población pediátrica. En México, los cuidados paliativos tienen poca presencia en los hospitales públicos con población multicultural. Objetivos: Describir las dinámicas de atención del servicio de cuidados paliativos de un hospital infantil público recientemente instaurado y analizar las concepciones sobre su función por parte de profesionales de la salud y familias que son atendidas. Métodos: Etnografía hospitalaria. Entrevistas a profesionales de la salud y observaciones no participantes con pacientes y familiares. Resultados: El servicio de cuidados paliativos es atendido por un equipo multidisciplinario, con carga de atención alta y un ambiente de desinformación de parte de los pacientes, familiares, otros profesionales de la salud y autoridades. Los familiares narran el miedo a ser enviados al servicio por creer que allí van a “morir” los niños. Sin embargo, después de las experiencias en cuidados paliativos describen la importancia y la pertinencia del acompañamiento para el bienestar de los niños y su familia en esa etapa final de la vida respetando su contexto cultural. Conclusiones: La atención en los cuidados paliativos debe considerar el contexto cultural del niño y su familia. Los profesionales de la salud e instituciones considerar que la atención no sólo es la salud sino también al bienestar integral al final de la vida.
2. Marcela Valdata, Rosana Quintana, Sofía Fernández, Ingris Peláez-Ballestas, Ana Bensi, Martina Fay, Graciela Gómez, Cecilia Camacho, Jazmin Petrelli, Andrés Honeri, Viviana Arenas Solórzano, Gustavo Di Prinzio (Universidad Nacional de Rosario, Argentina / Grupo Latinoamericano de Estudios de Enfermedades Reumáticas en Pueblos Originarios / Hospital General de México “Dr. Eduardo Liceaga”, México). **ESTRATEGIAS EDUCATIVAS SOBRE LA ARTRITIS REUMATOIDEA PARA MÉDICOS Y COMUNIDAD QOM DE PRESIDENCIA ROQUE SAENZ PEÑA, CHACO, ARGENTINA. PRIMERA ETAPA.** Introducción: GLADERPO (Grupo Latinoamericano de Enfermedades Reumáticas en Pueblos Originarios) realizó un estudio epidemiológico y comunitario en la comunidad qom de la ciudad de Rosario. Se detectó una alta prevalencia (3.0%) de Artritis Reumatoidea (AR). Uno de los aspectos más significativos fue la alta movilidad entre Rosario y la provincia del Chaco, particularmente a Presidencia Roque Saenz Peña (PRSP), influyendo en la adherencia y seguimiento de los pacientes. Esto motivó al diseño de estrategias educativas sobre las enfermedades reumáticas en general y la AR en particular destinado a la comunidad qom y diversos actores de la salud. Objetivos: Describir las dinámicas de atención entre el primer nivel de atención y la consulta especializada en el hospital local; así como el rol de cada actor involucrado en dicho circuito. Métodos: Etnografía. Entrevistas a profesionales de la salud, a agentes sanitarios y representantes comunitarios. Observaciones participantes. Resultados: Los agentes sanitarios acompañan en casos particulares a los pacientes a la consulta especializada, para favorecer el entendimiento del paciente en el acceso al hospital. Tanto los agentes sanitarios como los representantes comunitarios juegan un rol esencial en este circuito. La implementación de diversas estrategias educativas son primordiales, mejorando el conocimiento del impacto que generan la AR en la comunidad. Conclusiones: La dinámica entre los diferentes niveles de atención puede mejorar con la implementación de estrategias educativas sobre las



enfermedades reumáticas tanto a nivel comunitarios como para los profesionales y actores relacionados con la salud de la ciudad de PRSP.

3. Maylene López Bueno, Yamila Fernández Nieves, María Regla Aballí Candelario, Olga Revilla Vidal (UCCFD “Manuel Fajardo”, Centro de Estudios de para la Actividad Física, el Deporte y la Promoción de Salud, PROSALUD, MINSAP, Cuba). **SALUD REPRODUCTIVA. INACTIVIDAD FÍSICA EN EL RIESGO PRECONCEPCIONAL.** La prevención de la morbimortalidad materno infantil y de problemas de salud de la madre décadas después, requiere la identificación de factores de riesgo preconceptionales que favorezcan el desencadenamiento de procesos morbosos capaces de hacer peligrar la salud del binomio, tal es el caso del sedentarismo y los consecuentes bajos niveles de condición física saludable de la mujer en edad fértil. Caracterizar el comportamiento del enfoque de riesgo reproductivo preconceptional en las usuarias y prestadores de servicios de salud y actividad física, en relación con la inactividad física de la mujer en edad fértil ayudara revertir esa situación. La investigación realizada fue de cualitativa, teórico descriptiva, de corte transversal, llevada a cabo entre octubre de 2017 y mayo de 2018, en tres municipios de la capital, donde se aplicaron encuestas a mujeres en edad fértil, practicantes sistemáticas de actividad física; así como encuestas y entrevistas a informantes clave de los servicios de salud (consultas de planificación familiar y de rehabilitación del suelo pélvico – CIMEQ-) y de actividad física comunitaria (metodólogos e instructores). Evidenciándose la insuficiente percepción del enfoque de riesgo reproductivo preconceptional, en relación con el sedentarismo y los bajos niveles de condición física saludable cardiovascular y musculoesquelética de la mujer en edad fértil, tanto en usuarias, como en prestadores de servicios de salud y de actividad física.
4. Mário Eugênio Saretta (Universidade Federal do Rio Grande do Sul, Brazil). **EFFECTS OF PLACEBO EFFECT: QUALITATIVE INTERVIEWS IN A CHRONIC PAIN CLINICAL TRIAL.** The placebo effect is an obligatory passage point required to understand rationality and development in randomized clinical trials. Attempts to delimit it as a concept require a definition of biosocial borders, which involves claiming an ontological privilege to establish it as the analytical vector of therapeutic rationality. This study goals to analyze enactments of chronic pain in clinical trials through an ethnographic research conducted at a teaching hospital. This paper explores the effects of the placebo effect by examining notions of body, mind, and reality through qualitative interviews conducted with clinical trial participants with chronic pain in Brazil. As results, it shows that medical measuring devices has mediation in the results of clinical trials. So, it concludes that what participants think about measure device is part of placebo as well of active effect of therapeutics tested.
5. Sarah Leister (American University, USA). **DOES SAVING LIVES SAVE MONEY? AVIATION AND MILITARY TRAINING MEET PROFIT-BASED HEALTH CARE IN THE U.S.** Crew resource management (CRM), a training model initially developed to improve aviation safety, has become widely popular in the U.S. health care industry. CRM aims to prevent safety errors by encouraging pilots/bosses to have a more benevolent and humble leadership style and the crew/staff to be more assertive in speaking up about potential errors. Using a critical medical anthropological approach, this paper will explore a case study of LifeWings Partners LLC (LifeWings), a health care consultancy firm founded by ex-military pilots. The paper incorporates ethnographic interviews with the CEO of LifeWings, a LifeWings trainer at a hospital in the U.S. Southwest, and a hospital employee who took a LifeWings-based training. By marketing patient safety as profitable and employing militarized strategies (e.g. FBI hostage negotiation techniques) and discourses (e.g. “bomb-throwers”) to deal with staff resistance, LifeWings may exclude other models of patient safety that fall outside of profit-making initiatives. This paper argues that LifeWings, using military strategies, responds to and deepens neoliberal privatized models of healthcare by linking safety with profitability, individualizing responsibility for patient safety, and foreclosing resistance.
6. Matthew R. Dudgeon (Emory University, USA). **“PRACTICING” MEDICINE AT NIGHT: SIMULATION TRAINING FOR INTERNAL MEDICINE RESIDENTS.** Introduction: Medical simulation, an increasingly important component of resident training, typically occurs in the context of “boot camps” separated from clinical responsibilities and with large groups of residents. Residents typically receive little directed medical education at night. Overnight rotations provide an opportunity for simulation training with small groups of residents. Objectives: We describe a novel approach to medical simulation training during overnight rotations in a large teaching hospital. Methods: During training sessions, (n=64), which occur with one post-graduate year 1 and one post-graduate



year 2 resident per session, residents received training in three common bedside procedures (ultrasound-guided peripheral intravenous access, intraosseous access, and ultrasound-guided diagnostic paracentesis). We outline the steps involved in the design of the course, including model creation and curriculum building. Ethnographic observation was employed during training sessions to probe resident experiences with simulation and procedures. Post-procedural evaluation surveys were then conducted (n=29, ongoing) with participants. Results: Providing overnight procedural training provided unique opportunities for reinforcement of skills with procedures involving patients in near-time proximity to simulation training. Residents demonstrated a wide range of familiarity with procedural equipment, knowledge of ultrasound use and technique, and procedural proficiency at the outset of training. In post-training evaluations, many residents endorsed improved perceived proficiency and procedural confidence after training, as well as anxiety around these procedures. Conclusion: This project demonstrates the utility of procedural training with small groups of residents in the course of overnight rotations and explores some of the unique circumstances of medical education and medical “practice” at night.

7. Myranda L. Pierce (Boston University, USA). **SUPPORTING SEX: DISABILITY IMAGINARIES AMONG CARE PROVIDERS FOR ADULTS WITH INTELLECTUAL DISABILITIES.** Introduction: New state mandates require disability services providers to document sexuality and interpersonal relationship supports for people with intellectual disabilities. Direct support providers are often perceived as unable to achieve successful programs due to lack of organizational ‘enculturation’, and attempts to remedy this include trainings to ‘fix’ these ‘broken’ perceptions. However, perceptions of sex and disability are complex. Methods & Objectives: This ethnographic study uses personal accounts from providers along with participant observation in residential and social settings to contextualize the complex nature of disability supports, demonstrating the importance of assessing not only specific services provided, but systems through which supports are established and maintained. Findings: Disability imaginaries are constructed along a continuum of progress narratives, which encourages future-oriented goals of ‘inclusion’ and ‘community’ to exist as temporary states which can be achieved in the present rather than a destination which is all-encompassing and permanent. Documentation of ‘small wins’ in sexuality supports is necessary to maintain certifications, funding, and other forms of organizational capital. However, current documentation requirements emphasize in-the-moment “audit culture” rather than establishing foundations for more inclusive futures. Conclusion: This suggests the need for systemic evaluation regarding what steps may be implemented toward shifting organizational culture on a broad scale in ways that allow providers to explore a more expansive conceptualization of sexuality supports. Current practices of one-off supports are difficult to sustain, but long-term planning which incorporates provider perspectives (and not merely top-down mandates) may address many of these present issues.

8. Chuan Hao Chen (University of Pennsylvania, USA). **PATIENTS AT A DISTANCE: INFRASTRUCTURES OF CARE IN CLINICAL LABORATORY LIFE.** “I don’t like cleaning bed pans, but running tests still allows me to care for patients at a distance, without the physical interaction,” said Mary, a laboratorian I interviewed at the hospital pathology lab. I was curious about the “invisible technicians” of medicine who operate the machines that turn thousands of patient tissues samples into objectified diagnoses every day. How do they care for patients without face-to-face contact, far away from the wards? Where critical medical anthropological approaches have unpacked social determinants of health, tracing how political economic structures produce illnesses, care has been understood as either a response to or a mask for such structural violence. Care emerges out of one’s encounters with structurally-produced pain and suffering. Yet the experiences of laboratory technicians also challenge us to account for care beyond such interpersonal ethical frames. How can care be constituted in the hidden “staff, stuff, space, and systems” – the personal and physical infrastructures – that undergird biomedical care? In this paper, I utilize theoretical reflections on infrastructure and bureaucracy to demonstrate how care emerges from affective and materials flows through laboratory practices and architecture. Drawing upon participant observation at clinical labs as well specialized lab planning firms that create them, I trace how laboratorians’ “caring at a distance” is a mediated process built into the material structures of biomedicine, serving as a condition of possibility for care as encounter or witnessing. Infrastructural perspectives, I further suggest, allow us to turn critical understandings of health determinants towards critical designs of care.



War zones, conflict, and trauma

2 pm – 3:15 pm, Room 12 (gallery with posters)

1. Dina M. Asfaha (University of Pennsylvania, USA). **UNDERGROUND HOSPITAL: CONCEPTIONS OF SOVEREIGNTY AND CONFLICT MEDICINE.** After UN sanctions on Eritrea were lifted (2018), Assistant Secretary Tibor Nagy issued a statement about U.S. interests in Ethiopia, citing “significant concerns” in its bilateral relations with Eritrea. US foreign policy has historically defended Ethiopian infringement of Eritrean territorial boundaries, insisting it is a stabilizing force in a region plagued by terrorist activity and “failed states.” Ethiopia is heralded as the only African nation to have never been colonized; few people realize it was a colonial power, occupying Eritrea in 1952. Eritrea defeated imperial Ethiopia during its liberation struggle (1961-1991) despite having a military one-tenth the size because doctors trained scores of ordinary Eritreans—farmers, mothers, and adolescents—as *agar Hakaim* (“barefoot doctors” in Tigrinya) to quickly evaluate and treat injuries. Guerrilla strategy sustained Eritrean revolutionaries in the face of insufficient provisions, medical instruments, and a hazardous geography. Eritreans created an underground hospital, Orotta, in the rural town Nakfa and developed medical practices in order to manage mass casualties and ballistic injuries caused by U.S.- and Soviet-donated weapons. Using interviews with veteran medical personnel and political officials, this paper examines how recollections of the underground hospital and conflict medicine inform contemporary articulations of territorial jurisdiction. Eritreans understand political power and territorial jurisdiction as intimately bound with the ways they mediated medical training, diagnosis and treatment, and injury in the clandestine healthcare network across various armed conflict zones. This paper shows how medical practice and infrastructure concretize a framework for sovereignty—a historical process, and quotidian practice exercised by citizens.

2. Garssandra I. Présemy-Leblanc (Boston University, USA). **REWRITING THE PRESENT: INCLUDING HISTORICAL CONTEXT OF TRAUMA IN THE SOCIAL DETERMINANTS OF HEALTH DISCOURSE.** Introduction: Social determinants of health (SDOH) are often used to explain health inequities and systemic barriers experienced by minority populations. In the United States, the intersection of SDOH leave these populations vulnerable to negative health outcomes. Missing from the SDOH discourse is the underlying historical causes for these disparities. Medical-Legal Partnerships (MLPs) have undertaken the role of educating the health and human services (HHS) workforce on interdisciplinary collaboration, cultural competence, and the skills to recognize experiences of negative SDOH. However, current research does not explore the foundational impact of historical trauma on experiences of negative SDOH. Methods & Objectives: This ethnographic case study uses the personal accounts of black female HHS workforce members and participant observation from within a MLP to examine how historical trauma may affect the complex interactions of SDOH. Results: The SDOH discourse does not challenge the medical and legal institutions which contribute to how minority populations experience negative SDOH. MLPs reproduce a pedagogical narrative that erases the lived experiences of SDOH. Black female HHS workforce members agree that historical context is missing (e.g. Post-Traumatic Slave Syndrome) from the SDOH discourse and contemporary experiences of racism and discrimination. Historical context would change how HHS workforce members advocate for their patients as well as engaging in system-challenging praxis within the medical and legal institutions. Conclusion: This case study suggests the need to examine how our educational system excludes particular histories and reinforces a white supremacist and patriarchal narrative.

3. Kathleen Watson (Drexel University, USA). **“IT KEEPS ME UP AT NIGHT”: VICARIOUS TRAUMA EXPERIENCED BY SEXUAL ASSAULT RESPONDERS IN THE EDUCATION SYSTEM.** Introduction: 1 out of 5 women and girls will be sexually assaulted through the course of their education. Even where there are dedicated professionals to respond to these cases, the professionals are often underprepared and unsupported in their work. This qualitative study examined the experiences of these professionals in the United States. Objectives: Better understand the training, preparation, and experiences of people who respond to sexual assault cases in educational settings. Methods: Semi-structured qualitative interviews. Results: Professionals who respond to incidents of sexual violence are suffering from their own symptoms of trauma after being exposed to the traumatic experiences of students. These professionals display symptoms of trauma that fall into the 3 categories named by trauma expert, Judith Herman: Intrusion, Hyperarousal, and Restriction. Conclusions:



Practitioners and advocates who respond to sexual violence in society must be supported and educated to minimize the impact of vicarious trauma on the workforce.

4. Ashwak Hauter (University of California Berkeley and San Francisco, USA). **FAG'A (FRIGHT) AND KHAWF (FEAR): SPATIAL AND SPIRITUAL BORDERS.** This paper explores encounters of fears, aspirations, and danger generated by border-crossings and psychic boundaries, but also the impossibilities to cross and return. The reception of the estranged in Jordan, Saudi Arabia, and Yemen, whether they travel for knowledge (mubta'thin), migration (ghurba), or visitation (ziwar), condenses the themes of crisis, conflict, and dispossession. Centering on the case of the persistent Jaundice of a Yemeni refugee, and border crosser, the illness is understood as an enactment of an imbalanced soul due to fright (faja'). The illness is opposed to the breaking of the nafs (soul/self) that may result from the refusal to provide care by biomedical physicians because of the what it implicates. The anticipated refusal is a form of a collective trial (ibtila) resulting from the placement of doubt onto the physicians' obligation to treat. The doubt of the physicians' souls stems from the loss of the fear of the divine (khawf), which orients a disposition toward the divine and the law and grounds relations to one's self/soul, others, and the community. This scene is one of many expressions of the tribulation (fitna) and corruption (fasad) that plague the region amidst socio-economic and political upheaval, from the greed of a vicious doctor to the absence of an anthropology that addresses the polysemy of the soul, to the straightening of borders and the absence of neighborly hospitality. The resulting ills, illnesses, and illusions due to the constriction of the soul (diq al-nafs) are viewed as apocalyptic visions, suffocating the dismembered Muslim community (ummah) and calling for bearing witness to personal and collective renewal/purification (tahara).
5. Nia C. Parson (Southern Methodist University, USA). **TRAUMA, RESILIENCE AND THE STATE IN CHILE AND THE US.** This paper builds on medical anthropological scholarship on violence, trauma and resilience to focus on meaning-making in resilience processes with attention to social ecologies of resilience in Chile and the US. It examines how resilience from trauma is shaped by intersecting social, political, and economic forces at different scales. This analysis is based on my research on women's experiences of intimate partner violence, structural violence and symbolic violence and their attempts at recovery in Santiago, Chile and among Spanish-speaking immigrants in the US. Research methods included participant observation at non-governmental agencies where women sought care; life history and semi-structured interviews with a total of over 120 women; demographic surveys and psychiatric scales. Women's gendered relationships to the state in both Chile and the US shaped their forms of help-seeking in the wake of intimate partner violence and therefore their forms coping and resilience. In particular, in the US research, many women were undocumented or precariously documented which in effect made them stateless and vulnerable in terms of legal protections and health care. Women in Chile were also made vulnerable by difficulties accessing the judicial system, housing, and educational and labor opportunities. In spite of the states' often discriminatory policies and practices in both Chile and the US, women who suffered intimate partner violence found many ways to engage in and create their own forms of resilience. Resilience is an on-going, social, political and economic process and while deeply subjective and personal is also intimately shaped by gendered relationships to the state.
6. Paula Skye Tallman (The Field Museum of Natural History & Salve Regina University, USA). **ECOSYNDemics: THE POTENTIAL SYNERGISTIC HEALTH IMPACTS OF HIGHWAYS AND DAMS IN THE AMAZON.** Introduction: Ecosyndemics refer to disease interactions that result from environmental changes that are commonly caused by humans. It is an extension of the original syndemics term, which refers to a set of enmeshed health problems that synergistically interact within the context of noxious biosocial conditions to amplify the overall disease burden on a particular population. Objectives: This paper investigates whether mega-development projects in the Amazon rainforest create a unique biosocial "fingerprint" that facilitates ecosyndemic interactions among multiple diseases and stressors. Methods: We examine two case studies—the Belo Monte hydroelectric dam in Brazil and the Southern Interoceanic highway in Peru—to assess the likelihood of socio-environmental factors combining and leading to ill health in a ecosyndemic fashion. Results: Data from each study indicate that the construction of dams and highways in tropical forests create the conditions for increases in vector-borne illnesses, such as dengue and malaria, surges in prostitution and sexually-transmitted infections and increased psychological stress resulting from violence, delinquency, and the erosion of social cohesion. However, we find differences in the potential impacts of the Interoceanic highway and the Belo Monte dam on food, water, and



cultural systems and observed that community and corporate-level actions may bolster health in the face of rapid socio-ecological change. Conclusions: Looking at the case studies together, a complex picture of vulnerability and resilience, risk and opportunity, complicates straight-forward predictions of ecosyndemic interactions resulting from these development projects but highlights the role that the ecosyndemic concept can play in informing health impact assessments and future research.

Addiction

3:15 – 4:30 pm, Room 12 (gallery with posters)

1. Alicia W. Peters (University of New England, USA). **“JAIL IS THE ONLY THING THAT IS GOING TO KEEP THEM ALIVE”: HUMAN TRAFFICKING, VULNERABILITY, AND THE OPIOID EPIDEMIC.** Introduction: A complex web of factors, including economic and material inequality, lack of labor protections, and restricted access to legal migration, intersect with inequities based on class, race, gender, sexual identity, age, and other relationships of power, increasing an individual's vulnerability to human trafficking. Over the past decade there have been mounting numbers of trafficking cases in which opioid dependence either serves as a precipitating factor to trafficking or is used as a means of control within the trafficking situation. Objectives: The paper explores how notions of vulnerability, particularly for individuals with opioid use disorder working in commercial sex, intersect with conceptions of trafficking among those involved in the human trafficking response in a region of the United States where human trafficking has only recently been recognized as a problem. Methods: The paper draws on two years of ethnographic fieldwork in the northern New England region of the U.S., including participant observation and interviews with law enforcement professionals, social service providers, and survivors of trafficking. Results: Law enforcement professionals who are "tuned in" to trafficking at once acknowledge and overlook the importance of social determinants by conflating identification and "rescue" of victims with prevention of trafficking. Officers enacting carceral protectionism task themselves with keeping opioid-dependent sex workers, who they identify as "trafficked" (but who may or may not meet the legal definition), alive by means of arrest. Conclusions: The paper concludes that prevention of trafficking be re-envisioned through the lens of structural vulnerability by addressing inequalities that transcend trafficking itself.
2. Allison V. Schlosser (Case Western Reserve University, USA). **“THAT’S THE DIFFERENCE BETWEEN ME AND OTHER PEOPLE”: MORAL CITIZENSHIP AND HARM REDUCTION IN THE U.S. OPIOID PANIC.** Introduction: In the U.S., the rise in opioid overdose death among broader sociodemographic swaths has led to increasing distribution of naloxone opioid overdose antidote, a lifesaving biotechnology that challenges cultural beliefs about abstinence from drug use. The emergent debates about its use reflect the tenuous moral citizenship of opioid consumers; a status that shapes how individuals experience naloxone. Objectives: Drawing on critical medical and psychological anthropology, this paper examines how opioid consumers experience moral discourses related to naloxone, how they position themselves in relation to other drug consumers, and how this positioning influences their naloxone use. Methods: In spring 2019, a rapid qualitative assessment of naloxone beliefs and practices among opioid consumers was conducted in Cleveland, Ohio, including semi-structured, open-ended interviews with 30 opioid consumers recruited from a syringe exchange program. Participants were largely self-identified as White (76%) and male (76%). Analyses presented here focus on emergent themes related to moral belonging. Results: Participants described themselves in contrast to other opioid consumers seen as “junkies” seeking a “high,” versus individuals maintaining an opioid habit. This moral distancing promoted riskier opioid use, including use in isolation and reluctance to carry naloxone to avoid being stigmatized as a reckless “addict.” Conclusions: These analyses underscore how stigmatizing discourses about naloxone place opioid consumers in moral double-binds. As they internalize moral judgements and distance themselves from others, they place themselves at greater risk of overdose death through social isolation. These attempts to salvage moral citizenship should inform broader stigma-reduction interventions beyond naloxone distribution.
3. Carlos Martinez (University of California, San Francisco and Berkeley, USA). **PREDATORY CARE AND THE CARCERAL MEDICALIZATION OF DEPORTED DENIZENS IN THE US/MEXICO BORDERLANDS.** Introduction: Tijuana is the largest recipient of Mexicans deported from the US, a number of whom enter a state of



homelessness after deportation. Since 2015, a policing program named Tijuana Mejora has been deployed in the Tijuana River canal where at any one time up to 1,000 people resided—many of whom were deportees and injection drug users. The program has involuntarily placed hundreds of deportees into religious drug treatment centers. Objectives: This project examines how the global deportation regime and Tijuana’s drug decriminalization regime are acting in concert to dispossess, medicalize, and confine migrants. I take up the concept of predatory care to consider how biopolitical cultivation and sovereign violence, often theorized as distinct logics, may be coinciding in these carceral-therapeutic assemblages. Methods: This project is based on ongoing ethnographic fieldwork currently being conducted over a period of twelve months in Tijuana. Results: Preliminary results indicate that Tijuana Mejora represents an emergent model of punitive drug decriminalization that disproportionately targets Mexico’s structurally vulnerable populations. Coercive rehabilitation is acting as a mode of limited social, if not political, incorporation for estranged deportees. Conclusions: I conclude that we are witnessing a novel form of medical hybridization in contemporary Mexico, in which the state’s adoption of biomedical discourses of addiction has converged with a religious conception of addiction. Homelessness and addiction are becoming central targets in a recharged sanitary revolution in Latin America under a renovated version of 18th century medical policing.

4. Christopher Caulfield (Rensselaer Polytechnic Institute, USA). **HOW STIGMA AND SYSTEMIC BARRIERS AFFECT OPIOID USE DISORDER TREATMENT IN THE NORTHEAST US: A TREATMENT SYSTEM CAUSING HARM.** Introduction: Given the central place of stigma and social shame in the experiences of those living with addiction, addiction research should take cognizance of how stigma impacts treatment. This ethnographic study describes how clinicians experience stigma entering into clinical encounters. Objectives: These interviews investigate the following two questions: (1) How do stigmatized attitudes expressed within clinical practice, policy and law, insurance regulations, and general moral panic regarding substance use disorders (SUDs) affect people seeking treatment for substance use disorders? (2) How do SUD treatment systems and legal systems cause harm? Methods: The data analyzed in this paper was collected during five months of ethnographic fieldwork conducted with key informants working in drug treatment in four US metropolitan areas. It consists of 13 semi-structured interviews (approximately 14 h). Results: Responses were coded to identify key themes related to stigma and barriers to treatment. This paper emphasizes two categories of barriers to treatment: (a) stigmatized attitudes of clinicians; (b) systemic barriers to treatment including ‘fail first’ insurance policies, prior authorization requirements for pharmacotherapy, institutionalized resistance to harm reduction approaches, insufficient public transportation, and a culture of treatment which fails to treat underlying causes of SUDs. Conclusion: Findings suggest that improving access to treatment will require the following: public education campaigns about the benefits of pharmacotherapy, increased medical school training for treatment of SUDs, reform of insurance laws and regulations, and engagement with clinicians, law enforcement, and other stakeholders to change stigmatized attitudes and laws relating to SUDs.

5. Emery Rose Eaves, Bonnie McCormick, Bailey S. Kohlbeck (Northern Arizona University, USA). **METHADONE GOVERNANCE AND COMPLIANCE WITH PRENATAL CARE: CARE-SEEKING AND DESERVINGNESS IN THE CONTEXT OF DRUG USE DURING PREGNANCY.** Introduction. Women who use drugs during pregnancy face extreme forms of medical governance, stigma, and shame when seeking care for themselves and their infants. Detoxing during pregnancy is discouraged if not disallowed completely, and women are told that withdrawal during pregnancy can cause miscarriage. Providers say they are aware that miscarriage is not increased, yet they maintain that methadone is the best treatment for these women because it increases compliance with prenatal care. Objectives. In this presentation, I consider prenatal care compliance from a critical medical anthropology perspective and suggest that prior to gaining admission to methadone maintenance therapy (MMT), women have already fluctuated between high levels of drug use and periods of extreme detox and withdrawal. Methods. Results are based on ongoing ethnographic research with: pregnant women and new mothers in intensive MMT programs for opioid and polydrug use during pregnancy; and providers and clinical directors of those treatment programs. Results. Mothers described the process of getting in to MMT or other medication assisted treatment programs as long, challenging, and hurtful. Repeated failed attempts to gain access to any form of medical care make relapse the only option to obtain relief from withdrawal. Conclusions. Although methadone leads to longer hospital stays and greater need for morphine to treat neonatal withdrawal symptoms than heroin, it remains the gold standard treatment for this population. In the meantime, pregnant



women sleep at bus stops and behind dumpsters, turned away repeatedly from the very care they are accused of failing to comply with.

6. Bonnie McCormick, Emery R. Eaves, Bailey S. Kohlbeck (Northern Arizona University, USA). **CREATION OF A DRUG REHABILITATION CENTERED GROUP PRENATAL PROGRAM.** Introduction. Recent research has shown that mothers who experience opioid dependency throughout their pregnancy lack appropriate prenatal care, which can result in a number of adverse health effects, including neonatal abstinence syndrome (NAS). The concept of governance can be readily applied here when considering the experience of mothers receiving addiction treatment and why mothers may not choose to attend prenatal care. While there are many beneficial prenatal programs for mothers, a search of pertinent literature for group prenatal programs designed for mothers who use drugs is scant. Objectives. The objectives of my project are to answer what mothers wanted and experienced during their prenatal care. Methods. This presentation is focused on interviews, analysis of the previous prenatal program evaluations and participant observation with mothers who used drugs and mothers in post-partum groups not focused around drug use. The goal of this applied project was to use a medical anthropology perspective to determine how to better serve mothers in prenatal and postnatal care, and how to best tailor a support group for pregnant women who were recovering from drug use during pregnancy. Results. To promote equity among women who use drugs during pregnancy, there is a need for care focused on health and wellness, advocacy and reassurance. Conclusions. Group prenatal care for pregnant women trying to recover from drug use can provide a safe environment without fear of stigma by focusing on the specific needs of these women and treating them as capable and deserving mothers.
7. Jordy King (Northern Arizona University, USA). **PROBLEMATIC PERCEPTION AROUND INTRAVENOUS DRUG USE IN EAST AFRICA.** Introduction: In recent years much of the attention around intravenous drug use has resolved around Europe and the United States. There is however more concerning use of intravenous drug use that exist due to the global drug trade and its impact on East Africa. Perceptions around intravenous drug use have led to a problematic situation in which sharing of needles and the act of fast-blooding or the infusion of one's blood into another are becoming common practice around East Africa's impoverished community. Objective: Analysis of the perceptions surrounding drug use are encouraging the negative stereotypes of use and promoting those using not to seek treatment. Methods: The critique of current perceptions both by the wider Tanzanian public and the Tanzanian government support the claim that perceptions are promoting use and threatening the potential for more widespread harmful behaviors. Results: Without a focused campaign at adjusting the dialogue around drug use in Tanzania the growing Heroin epidemic will continue to impact a growing number of communities and create a new HIV crisis. Conclusion: This analysis of perceptions around drug use in Tanzania offers an example of how perception impact the decisions of users to seek treatment and addresses stereotypes of use. Further research in the field of perceptions of use are needed in order to counter growing attitudes toward prevention.
8. Michelle Anne Parsons (Northern Arizona University, USA). **THE ENTANGLEMENT OF ADDICTION AND HARSH WORKING CONDITIONS IN RECOVERY NARRATIVES IN NORTHERN ARIZONA.** Introduction: Addiction and overdose deaths in midlife are a public health priority in the US. Objectives: The research presented here is part of an ethnographic case study of midlife mortality, driven largely by suicide and drug and alcohol related deaths, in a county of Northern Arizona. This paper explores trajectories of addiction. Methods: This paper draws on in-depth interviews conducted in 2018 with 16 individuals undergoing addiction treatment at a residential facility in Northern Arizona. Results: Interview data suggest that drug use and addiction are sometimes related to harsh working conditions. Conclusion: Addiction is often framed as a problem of the individual will or, in more social accounts, a problem of unemployment. The data here suggests that addiction is entwined with harsh working conditions.
9. Parsa Bastani (Brown University, USA). **SPACES OF BELONGING: INSTITUTIONAL HOME-MAKING AMONG ADDICTED WOMEN IN TEHRAN, IRAN.** Introduction: In Iran, families often sever relations with kin who suffer from addiction to illicit drugs. Despite growing awareness of the medical underpinnings of addiction, many families continue to regard addiction as a source of shame. This is especially the case for women, who can face abandonment, and sometimes violence, after kin discover their addiction. In 2017, an Iranian NGO created the



first free addiction rehabilitation center for women without financial means. As one of the only safety-net institutions in the country, this clinic attracted addicted women who had nowhere else to turn following family abandonment. Objectives: This paper examines how staff and abandoned women experienced the clinic as a space of chronic residence. Methods: Three months of qualitative fieldwork (interviews and observation) in Tehran, Iran at the women's clinic. Results: Literature in medical anthropology often approaches the clinic as a space in which patients learn how to perceive and transform their bodies through continuous surveillance. I observed that the clinic was a space of not just disciplinary power but also of belonging. Conclusions: This paper examines what I call "institutional home-making" or collective efforts to craft institutional spaces into long-term homes for the chronically addicted. As I will discuss, this process simultaneously engenders belonging for some while preventing it for others.

10. Beth Uzwiak & Anastasia Hudgins (Ethnologica, USA). **DYING ALONE, DYING AT HOME: QUALITATIVE RESEARCH WITH NEXT OF KIN OF OPIOID OVERDOSE VICTIMS IN PHILADELPHIA.** This poster presents a collaborative qualitative research project between Ethnologica and the Philadelphia Department of Public Health (PDPH) to better understand the experiences of persons who are dying of opioid overdose in their homes. Philadelphia, Pennsylvania is in the midst an opioid crisis that claimed 1,217 lives in 2017. As local governments develop interventions and response efforts to prevent and reduce overdose, it is critical that they are appropriately informed by local context and trends. The Philadelphia Department of Public Health (PDPH) sought to do this by conducting a cross-system data match to identify city systems (i.e. jail, behavioral health, police, etc.) with which overdose victims interacted prior to death. Results revealed that overdose victims who died in private residences were less likely to interact with city systems before death. This was particularly concerning given the majority (75%) of victims died in a private residence out of public sight in 2017. To better understand this trend, the researchers collaborated with PDPH to design a qualitative research study to learn more about people who use drugs who are overdosing at home. We conducted 35 open ended exploratory interviews with 52 next of kin of people who died of an overdose in 2017 and 2018. The interviews addressed topics that included the person's trajectory of drug use, how and whether they interfaced with any social services, medical organizations, or law enforcement agencies, barriers to care and attitudes toward illicit drug use, communities to which the decedent belonged, family efforts (if any) to address the decedent's drug use, and how the decedent approached wellness. This poster presentation will discuss key findings from the interviews and how these findings are being used to inform overdose prevention and response efforts by PDPH.

Nutrition, body weight, and culture

3:15 – 4:30 pm, Room 12 (gallery with posters)

1. Alan Frank Schultz (Baylor University, USA). **MARKETS, MOVEMENTS AND THE SYNDEMOGENESIS OF ABDOMINAL OBESITY AND HYPERTENSION IN ONE OF THE WORLD'S MOST HEART-HEALTHY SOCIETIES, THE TSIMANE'.** Syndemics are synergistic population-level clusters of context-specific social and health problems that increase the severity of disease burden. The syndemics framework has proved particularly useful in the analysis of noncommunicable epidemics linked to globalization and nutrition transition. However, few studies have assessed syndemogenesis among small-scale societies at the early stages of market integration. I assessed the interrelationship between central adiposity (waist-height ratio Z-score; WHtR-Z), systolic blood pressure (SBP) and self-rated health (SRH; bad, average and good) among 193 Tsimane' forager-horticulturalists aged ≥ 15 years from eight communities in 2012-2013. I modeled each outcome against the others and in relation to two sociocultural predictors, subjective community social standing and cultural consonance in social life—a combined measure of individual approximation to local prototypes of lifestyle and social support. Accounting for several key covariates, OLS regressions suggest that SBP and WHtR-Z have a synergistic relationship that is mediated by SRH. Participants whose good SRH was incongruous with objective measures (+1 SD WHtR-Z or +1 SD SBP) had ~ 8 mmHg higher SBP (SE=0.00, $P < 0.01$) and ~ 0.5 higher WHtR Z-score (SE=0.01, $P < 0.04$). An interaction between wealth and community standing mediated SBP ($B -0.16$, SE=0.0, $P < 0.01$) while dummy variables of increasing market proximity trended towards lower WHtR-Z and worse SRH. Cultural consonance moderated SBP ~ 5 mmHg (SE=0.0, $P < 0.02$) and WHtR ~ 0.6 Z-score (SE=0.1, $P < 0.00$). The findings suggest an ongoing process of



syndemogenesis linked to the chronic stress of market integration and early-stage nutrition transition but moderated by a countersyndemic of cultural consonance in social life.

2. Emily Spangler, Allison Kellam, Rebecca Shannon, Chad Morris (Roanoke College, USA). **CULTURE, DIET, AND NONCOMMUNICABLE DISEASES IN THE REPUBLIC OF PALAU.** Introduction: Palauan culture is fully integrated with local foodways and some traditions are associated with consumption of large portions of unhealthy foods. Current nutritional norms in Palau have led to high rates of nutrition-based noncommunicable diseases (NCDs). Objectives: We aim to characterize the relationship between Palauan culture and the associated barriers to improved nutrition and to identify potential interventions which would alleviate the burden of noncommunicable diseases in Palau. Methods: Focus groups were conducted with parents and teachers in eight Palauan public schools to characterize the intersections between modern Palauan culture and healthy eating. Participants were asked about nutritional norms, assets and barriers to nutrition at home and at school, and their recommendations for effective and culturally sensitive health interventions. Results: Palauan culture affects individual decisions to consume certain foods. Sharing food, large portion sizes, and the close ties to one's family and clan were all associated with intersections between cultural values and diet. In many contemporary Palauan customs, large portion sizes and unhealthy foods are commonplace. Respondents attributed the frequency of customs and the reluctance of adults to regulate their children's eating in these situations as another important driver for the high rates of NCDs. Conclusions: Some Palauan cultural norms and customs are associated with poor eating decisions. Many respondents attributed these traditions as a main contributing factor to the Palauan NCD epidemic. Due to the value placed on Palauan traditions, interventions to alleviate the burden of nutrition-based NCDs should use Palauan culture to leverage healthy eating behaviors.

3. Aisha A. Chughtai (University of Pennsylvania, USA). **WAR ON OBESITY: THE AFTERMATH OF THE 2017 PHILADELPHIA SODA TAX.** As of 2018, the United States is currently the most chronically "obese" nation in North America, with over 36% of the population having a body mass index (BMI) of over 30. The epidemic of chronic obesity has been at the center of heated socio-political, public health, and policy debates for over a decade now, with questions intended to address and target the roots of this condition. What are the major risk factors contributing to such high rates of chronic obesity throughout the nation? How effective are legislative policy changes in policing diets, food access, and lifestyle modifications to combat the continued rise of epidemic rates of childhood and adult obesity? In 2017, in response to an exponential rise in rates of obesity and a growing concern around health and wellbeing climate, the city of Philadelphia—following suit after numerous policy changes in other cities and states across the nation—implemented the controversial "Soda Tax." This led to an increase of 1.5 cents per ounce on all sweetened drinks, including artificially sweetened beverages. This paper will discuss the implications of the Soda Tax in Philadelphia by evaluating quantitative changes in rates of obesity throughout the city. Further, this paper will adapt an anthropological framework to understand the qualitative ramifications of the Soda Tax as a policy intended to modify and reshape the everyday lifestyles and wellbeing of Philadelphia residents, focusing specifically on impacts on quality of life and access, autonomy, and the redistribution of socio-cultural and economic burdens.

4. Lisa Grabinsky (Oregon State University, USA). **USE OF DIETARY GUIDELINES IN NUTRITION CONSULTATIONS AND THEIR IMPACT ON DIETARY PATTERNS IN MEXICO CITY.** For the last 30 years, the population of Mexico has grappled with overweight, obesity, and associated chronic diseases, such as type-2 diabetes and hypertension. To standardize care among healthcare providers and dietitians, an official nutritional guideline was published in the early 2000s, which included a non-modifiable food based dietary guideline in the shape of a plate called El Plato del Bien Comer ("The Plate of Good Eating"). In this paper I examine El Plato's current use among young Mexican dietitians in their private consultation with office workers to consider the impact that it is having on dietary patterns in Mexico City. I draw on participant observation in regular private nutrition consultations, in depth interviews with five patients, and a focus group of four Mexican dietitians using photo-elicitation, as well as in depth interviews with two nutrition experts who helped to develop guidelines. I illustrate the diversity in consultation styles and health education tools among the dietitians who have been mandated to use El Plato. I also describe the divergence in patient's "healthy" eating practices, which varied greatly between the weekdays and weekends. The paper highlights the debate El Plato stirred among participant



dietitians of my study and concludes with a suggestion with how Mexican officials might redesign El Plato's dietary guidelines today.

5. Cindi Sturtz Sreetharan, Alexandra Brewis, Sarah Trainer (Arizona State University and Seattle University, USA). **"IF I POKED YOU WITH A PIN, YOU'D EXPLODE!": STIGMATIZING DISCOURSES AND BODY PROJECTS IN OSAKAN DAILY LIFE.** Introduction: Stigmatizing discourses that blame and shame an individual for their weight are globalizing. The types of damage they create in people's lives are embedded in local socioeconomic inequalities, moral frameworks, and norms around how personal improvement projects should be conducted. Objectives: In Japan, it is common to hear a variation on "the nail that stands out gets hammered down" refrain, indicating the importance of conformity to social norms. We seek to shed light on how this applies to local understandings of overweight in urban Japan. Methods: We use detailed narratives of Osakan women's and men's daily lives to understand how they react to and internalize body-shaming from family, friends, and physicians. Results: Key themes we identified include the connection of weight to smell and other "disgusting" body markers, as well as the self-management practices in which people with non-conforming bodies engage to reduce their perceived offensiveness. These practices can include complicated rituals around dressing, erasing sweat, and bathing that are meant to negotiate the moral meanings and behaviors in which a non-conforming body is "read" socially. Conclusions: Such responses end up being emotionally and practically cumbersome but are perceived as vital for managing stigma. They also underscore the high value placed on social conformity, especially around a body perceived as failing to conform.

6. Adriana Agramonte Machado, Andrew J. Gordon, Silvia María Marín Juliá, César Ochoa (Instituto Nacional de Endocrinología de Cuba, University of Houston & Western University, USA). **INTERGENERATIONAL TRANSMISSION OF DIABETES TYPE 2.** Epidemiological study has observed the emergence of juvenile diabetes type 2 (ages 15 and below) in Houston and Havana, two distinct locales where a focus on family patterns may be examined, independently of political-economic causes. In this presentation, we first recognize endogenous features of juveniles as a neuro-endocrinological drive to consume foods rich in sugars and fats. We understand this drive to consume as an effort to replenish the diminished sources of energy as a result of insulin resistance and less glycolysis; and, as well, we understand this drive as a means to dispel the negative emotional consequences coming from an inactivation of dopaminergic neurons; this too as a result of insulin resistance and less glycolysis. Before endogenous features become established there are exogenous features (sociocultural and psychological) that come from the interaction with parental figures or guardians. Understanding the transmission of exogenous features is the heart of our presentation. We include evidence of food preference and availability, the uses of high glycemic foods to ameliorate adverse emotional conditions and the round of festive eating occasions as well as household-based rituals of consumption. With repeated patterned activity in the household the exogenous becomes endogenous and, too often, part of a child's life, often for rest of life. To explain how "the exogenous" becomes "the endogenous" in juveniles, this paper draws on data from ethnographic work in Houston and psychotherapy in Havana.



Day 3 - Thursday, March 12th - AFTERNOON

Bio-eco-cultural perspectives

11:30 am – 1:00 pm, Room 12 (gallery with posters)

1. Cemre Gunes Sengul (École Normale Supérieure de Lyon, France). **A CROSS-CULTURAL CRITICAL DISCOURSE ANALYSIS OF ADHD DIAGNOSIS IN FRANCE & TURKEY.** In recent years, numerous amounts of neurobiological studies have been dedicated to ADHD, in spite of this intensive effort and quite high budgets, polemics have been continuing. Because in addition to neurobiological structures, psychiatric knowledge depends on the political economy issues and the cultural dimension of problems. Defining ADHD only as a biomedical approach disconnects it from its socio-cultural context. The aim of this study is to scrutinize how ADHD differs across cultures. The discourse of psychiatrists about ADHD were analyzed in France and Turkey, to observe the effects of social and cultural context on the decision of diagnosis and treatment of ADHD. I conducted 20 in-dept interviews with child and adolescent psychiatrists from two aforementioned countries. Moreover, the books written by those psychiatrists for general public, and videos that are recorded for social media and TV were included in the analysis. Critical Discourse Analysis approach has been used to analyze all the written and audio-visual materials. As a result, the threshold of defining the lack of attention, hyperactivity and impulsivity symptoms differentiate in France and Turkey depending on socio-cultural context; and the exigencies arising from this context have an effect on the decision of diagnostic and treatment. Consequently, even ADHD has a neurobiological base, it is determined within the social interactions. The subjectivity of psychiatrists is also shaped according to the values of society in which they grow up and were educated.
2. Maryann R. Cairns, Erin Symonds, Gordon Ulmer, Megan Brown, Adriana Gonzalez, Javier Gallard, Paolo Cesar Rivera Navarro Rivera, Darnier Mora Alvarado, Valerie J. Harwood, and Mya Breitbart (Southern Methodist University, USA). **TOURISM, ENVIRONMENT, AND WASTE IN RECREATIONAL WATERS: EXPLORING RISK AND RESILIENCE.** The MERA investigation addresses the impact of wastewater in coastal tourism environments on both human health and environmental sustainability. This work asks how pathogens, water, sand, and people interact at the beach—and how those entanglements impact both human and environmental health long-term. As popular destinations across the globe face overtourism, they often experience complex socio-environmental outcomes related to waste streams influenced by tourists and the tourism industry. In this study, a political ecology of health framework elucidates how models and plans for tourism, development, and community infrastructures combine with the lived realities of waste disposal and water access on the coast of Costa Rica. Through this interdisciplinary large-scale research project, which includes data from an epidemiological study with more than 5,000 respondents, extensive water quality sampling, participant observation, interviews, and behavioral observations, MERA explores how considerations about human waste and its impact are connected for all stakeholders—including locals, national and international tourists, and investors. MERA elucidates the disparities and differences in experiences, access to resources, and health that those in coastal tourism communities may face. By placing anthropology and ethnography at the forefront of this study's design, findings from the work are poised to advance innovative, critical approaches that address major theoretical and practical concerns in medical anthropology, biology, and engineering.
3. Naomi Schoenfeld (University of California San Francisco, USA). **BIOCOMPANIONS: TOWARD THE SOCIAL LIVES OF TUMORS.** Introduction: Researchers in the Cuban state-run biotechnology sector are advocating reframing advanced and metastatic cancer with a new term: chronicity (*cronicidad*). Chronicity, here, is linked to a novel mode of biopharmaceutical treatments called therapeutic vaccines. This article explores how chronicity, in the Cuban context, reimagines the relationship between humans, tumors and time. Objectives: Building on the Cuban oncology sector's notion of chronicity, I introduce the concept, biocompanion, as a new frame to account for the relation between humans, tumors, and time. Methods: This paper draws on interviews and observations conducted over four years with researchers, clinicians, marketers, regulators, and laypeople, primarily in Havana, Cuba, but also in smaller towns. I interviewed 25 individuals, four of whom were interviewed two to three times. Iterative, open coding enabled questions to be refined and altered as new themes emerged. These findings were placed in conversation with published texts by leading Cuban oncology researchers. Results: This



paper focuses on results from a sub-set of the interviews conducted in the larger study, in conversation with the published materials. Thematic content analysis revealed the importance of social integration to the idea of chronicity. Conclusion: Inspired by recent turns in anthropology to decenter the human through multi-species approaches, I introduce a new concept, biocompanion, to account for the relation engendered between humans and tumors over time through *cronicidad*.

4. Sarita Panchang (University of South Florida, USA). **URBAN SANITATION INSECURITY: SHEDDING MORE LIGHT ON EMBODIED BURDENS.** Introduction: Sanitation research focuses commonly on gastrointestinal illness, while dimensions of gender inequity are still relatively new. Recent scholarship suggests that women who experience sanitation insecurity may alter their daily routines to avoid defecation, including diet restriction, but this issue is not well-understood. Objectives: This study was part of a larger effort to examine sanitation insecurity among residents of informal settlements in urban India. The study explores how women’s challenges in accessing daily sanitation may shape the decision to construct a household toilet. Methods: Research included 2 focus groups, including social mapping activities, and 46 interviews with women residents in 2 settlements across Pune, India. Interviews were recorded, transcribed verbatim, and analyzed for themes, using critical medical anthropology and urban political ecology theory. Results: Women without a household toilet experience overlapping challenges, centering on community toilet blocks or open defecation. These challenges pertain to the lack of maintenance of community toilets, safety concerns attributed to male alcoholism and violence, and housing insecurity. Thus, daily sanitation routines may involve being creative to avoid community toilets at certain times, and potentially reducing food intake strategically to avoid having to go. Conclusions: Because sanitation insecurity concerns issues not openly acknowledged, this gendered challenge becomes clearer by understanding how women manage routines and navigate their space to respond to sanitation constraints. Strategies to avoid the bathroom – including restriction of meals– illustrate the embodied burden women experience regarding sanitation. I suggest how this insight can be harnessed to develop more effective sanitation programming.

5. Jessica Lee Dailey (University of Notre Dame, USA). **HIPPIE MOMS IN NORTHERN CALIFORNIA: SOCIAL POWER AND THE REJECTION OF BIOMEDICINE.** Introduction: I will discuss a small population who seeks out alternative forms of medical care, including midwife-attended homebirth, and vaccine refusal and delay. Objectives: This research explores what it means for an economically and socially powerful group to actively choose non-dominant forms of medical care. Methods: Ethnographic fieldwork in Sonoma County, California. Results: Because of the relative expense of alternative care modalities, the ability to access them becomes a function of social and economic advantage. Participants—who, concordant with population trends in the region, are majority white, highly educated, and affluent—leverage their powerful social positions in order to reinforce strongly-held values and beliefs by rejecting the dominant model of medical care. Conclusions: For this population, resistance against medical authority can be partially understood as a means to demonstrate belonging to a group that valorizes alternative philosophies, countercultural lifestyle choices, and distrust of institutions. Interrogating the connections between social privilege, group identity, and resistance against medical authority provides a valuable research avenue for refining understandings of how medical care is socially stratified. Considering the social drivers of avoiding biomedical care is particularly salient at this moment in history, given the growing incidence of anti vax beliefs, and the related resurgence of diseases once thought to be on the decline—such as the recent measles outbreak in New York, USA.

6. Samantha Primiano (University of Maryland, USA). **CARING FOR THE SELF: FITNESS, MORALITY, AND RESPONSIBILITY IN THE NEOLIBERAL AGE.** In recent years, the concept of self-care has emerged as a coping mechanism, a capitalist mantra, and a means of self-fashioning – most significantly a means of caring for oneself at the level of the individual. In conjunction with self-care, there occurred the development of step counters, viral fitness regimens, nutrition and exercise applications, and specialized diets that emphasize a sentiment of personal responsibility. This presentation considers individualized solutions to personal and health problems, specifically looking at the development of the concept of self-care and its implications for the moral dimensions of caring for others and for one’s self. By investigating the burgeoning fitness industry, specifically CrossFit and its associated organizations, I explore the potential for “care” to assume the weight of personal responsibility, thereby deflecting the responsibility of care from governments, insurance providers, and employers. Thus, considering care as a neoliberal strategy. This project draws on one year of fieldwork in a CrossFit gym in the



United Kingdom. Fieldwork included interviews, participant observation in the gym, as well as a linguistic analysis of CrossFit materials and the CrossFit journal. This case study reveals that caring for the self is imbued with a moral value, such that “good health” is deemed morally virtuous, while variations imply personal failing or a lack of discipline. The continued popularity and prescience of self-care has the potential to have long-term implications for care provision and for provider’s expectations of individuals who seek care and treatment.

Global health 1

2 pm – 3:15 pm, Room 12 (gallery with posters)

1. Puneet Misra & Shashi Kant (Center for Community Medicine, USA & AIIMS, India). **STUDY OF SOCIO CULTURAL PRACTICES FOR MENSTRUAL HYGIENE IN A RURAL COMMUNITY OF NORTH INDIA.** Introduction: Menstrual hygiene is worldwide recognized as an important component of reproductive health. There are certain taboos related with menstruation like avoidance of bathing, certain foods etc. Many women utilize old cloth as menstrual absorbent rather than napkins. Objective: To study the Socio cultural practices for menstrual hygiene in a rural community of north India. Methods: This study was carried out at CRHSP-AIIMS. respondents in each village was decided on the basis of probability proportionate to size (PPS) methodology. Women in the age group of 15-45 years who were residing in the house visited by the interviewer were eligible to participate in the study. The interview schedule was used. IRB approval was obtained from the AIIMS institutional ethics review board prior to initiation of study. Results: Total number of households visited was 1217. From these households, there were a total of 995 women who were found to be eligible and consented for the final interview. Only 30 percent of females were using sanitary napkins, while majority of females were using old cloths for same. There were various reason cited for using or not using it. We also found reasons for using old cloths and reasons for it, detailed results would be presented during this meeting. Conclusions: Majority of females don’t know cause of menstruation, less than half of females have received information about menstruation. Majority of these got it in the family; role of health sector was quite low and their normal activities were not suffered during menses.
2. Betty Wolder Levin (City University of New York, USA), Martha Livingston (State University of New York Old Westbury, USA). **CRITICAL ANTHROPOLOGICAL PERSPECTIVES ON THE HEALTH CARE PAYMENT SYSTEMS IN THE UNITED STATES AND CANADA.** Introduction: Historically and culturally, Canada and the United States (US) are very similar in many respects. Their medical education and health service delivery systems are very much alike. Yet their payment systems for health services are very different. In the US there are a multitude of private and public payment mechanisms; many people can’t access needed care. In Canada, health services are paid for through a tax-funded “single payer system” which covers most needed care for all citizens and residents. Objectives: To look at how Canada and the US developed profoundly different health care payment systems and situate historic and contemporary political debates within their unique historical, political, cultural and social contexts. Methods: Participant observation and interviews; examination of government, scholarly and popular sources. Results: Specific historical differences arising principally from the Great Depression and World War II resulted in Canada adopting a provincial-based payment structure with national criteria, covering all residents, whereas in the US the private, for-profit insurance industry has been largely unchecked. Structural racism in the US has been a contributing factor. The US has the most expensive health care system in the world while Canadians now pay less than three-fifths per capita of US costs. Conclusions: Most Canadians take pride in their universal health care system guaranteeing health care for all. In the US support for the “right to health care” is growing yet it is still a controversial issue in the 2020 election debates.
3. Daina Stanley (McMaster University, Canada). **SHACKLED AT SEVENTY: EXAMINING AGING BEHIND BARS AND CARE OF THE ‘OLDER’ PRISONER.** Introduction: The ‘older’ prison population is growing exponentially around the globe. The ‘correctional aging crisis’ is especially pronounced in the U.S., a consequence of harsh sentencing policies and changing population demographics. Additionally, the ‘local biologies’ of prisoners may accelerate the aging process, with the health status of a prisoner similar to someone 10 years older in the community. Objectives: I explore the experiences of older men imprisoned in U.S. state prisons and examine the diverse and shifting ways prison services care for aging and older persons. Methods: The study involves extensive



ethnographic fieldwork in correctional medical and health care units and follows the journeys of older incarcerated men in several state prisons. The paper also draws on interviews with older prisoners, correctional medical staff, and prisoners who volunteer as providers-of-care. Results: Through the lens of applied medical anthropology, I discuss: 1) the unique health and social needs of older prisoners; 2) the intersections and tensions between custody and care, highlighting challenges care(ing); and 3) suggest policy frameworks and innovative care models that meet the unique and complex needs of older prisoners in humane ways. Conclusion: Penal systems are challenged to care for aging populations and the health and well being of older prisoners has emerged as a critical health issue. Understanding the experiences of older prisoners will inform the development of humane health care policies and concrete modalities of geriatric and palliative care, and thus, has key implications for the health and well being of older persons behind bars.

4. David Meek (University of Oregon, USA). **FARMER SUICIDES AND FOOD SOVEREIGNTY: SYNTHESIZING THE POLITICAL ECOLOGIES OF HEALTH AND EDUCATION.** Introduction: Rates of farmer suicides are skyrocketing among agrarian societies throughout the world. This crisis is rooted in volatile commodity markets, indebtedness, and high input technologies associated with the corporate food regime. While scholars have identified the processes driving the farmer suicide crisis, there has been little attention to grassroots movements' own forms of intervention. Objectives: This presentation seeks to shed new light on the role of sustainable agriculture in potentially mediating mental health stressors. Methods: I analyze the role of Zero-Budget Natural Farming within an Indian agrarian social movement known as the Karnataka Rajya Raitha Sangha (KRRS). KRRS leaders argue that educating farmers about Zero-Budget Natural Farming (ZBNF) has the potential to improve financial autonomy, mitigate the farmer suicide problem, and ultimately contribute to food sovereignty. I conducted oral histories, semi-structured interviews, and agricultural field visits with approximately 35 ZBNF farmers in the Chamrajnagar, Tumkur, and Mysore districts of Karnataka I gathered data on farmers' historical engagement with chemically-intensive agriculture, their rationales and processes of converting to natural farming, and self-reported changes in ecological conditions, livelihoods and mental health. Results: My analysis suggests that farmers' livelihoods are more resilient following their transition to ZBNF, and that their overall levels of anxiety and depression are reduced. Conclusions: The theoretical framework is well-suited to shed light on the experiences of disparate agrarian communities beyond India who are experiencing mental health crises, which they explain as a consequence of the consolidation of the agricultural system.
5. Megan Schmidt-Sane (Case Western Reserve University, USA). **STREET'S DISCIPLE: HUSTLING AND THE SOCIAL DETERMINANTS OF HIV AMONG MEN IN LOW-INCOME URBAN UGANDA.** Introduction: Men are increasingly becoming the center of HIV policy and programming priorities worldwide, evidenced by discussions at the recent International AIDS Conference 2019. In Uganda, this resonates as men have lower outcomes across the HIV care continuum and are increasingly the focus of national HIV priorities. However, approaches to resolving these disparities have included traditional, often single-focused, public health interventions. Objectives: This paper discusses the social determinants of men's HIV vulnerability, with implications for HIV programming and services in Uganda. This paper demonstrates that interacting factors such as low employment, unstable income, housing and food instability, social support systems, stress, and access to health services pattern men's HIV vulnerability. Methods: This research is based on a multiyear ethnography (2016-2019) in Kampala, Uganda that included a survey (n = 292) and in-depth interviews (n = 54). This paper reports on the qualitative results, and data were analyzed using thematic analysis. Results: Men described the challenges, but also benefits of living in a low-income urban area, locally termed a "ghetto." Spending their formative years in the ghetto, on the "streets," men report lower access to economic opportunities. Their job status connects to other facets – from food access to housing to hustling to survive. Meanwhile, their social support systems engender norms that are beneficial in the ghetto, but also influence higher alcohol intake and uptake of HIV services. Conclusions: This paper presents aspects of the social environment that should be accounted for in HIV programming, especially for low-income urban men in Uganda.
6. Rai Sanjay Kumar, Ahamed Farhad, Haldar Partha, Kiran Goswami, Ayush Lohia, Kumar Pradeep, Misra Puneet, Kant Shashi (India Institute of Medical Sciences, India). **NON-PARTICIPATION RATE OF INJECTING DRUG USERS IN HIV SENTINEL SURVEILLANCE 2017 AND ITS EFFECT ON OBSERVED HIV PREVALENCE IN INDIA.** Background: During HIV sentinel surveillance (HSS) 2017 round in India, the sampling strategy to recruit Injecting Drug Users



(IDUs) was changed from consecutive unlinked anonymous to linked random sampling with consent. We assessed the effect of this change in sampling strategy on the observed HIV positivity rate among IDUs. Methods: The data were collected from IDU sentinel sites located in five provinces of India called Central Zone for HIV Surveillance. The HIV positivity rate among IDUs who participated in HSS 2017 was compared with HIV positivity rate of those who did not participate. HIV status of the participants was obtained from HSS 2017 data. The master lists of participating sentinel sites were accessed to obtain the last known HIV status of the eligible non-participants. Results: Non-participation rate of IDUs from central zone during HSS-2017 was 9.6%. The HIV positivity rate among non-participant IDUs (9.6%) which was significantly higher ($p=0.015$) than participant IDUs (7.0%). Conclusions and recommendations: Selective participation of eligible IDUs had led to the under-estimation of HIV positivity rate among IDUs in central zone states in India during HSS-2017 round.

7. Gergely Mohácsi (Osaka University, Japan). **TRANSPLANTING GRASSROOTS: PLANETARY HEALTH ON THE GROUND.** Introduction: In this paper, I use the cultivation of pharmaceutical plants as a case to explore the technosocial entanglements of ecosystems and human bodies in what has been referred to as “planetary health” in recent years across disciplines including medical anthropology. I follow the grassroots activities of a group of young Vietnamese ethnobotanical experts that resulted in a unique constellation of bringing plants and people together in the face of environmental damage and political injustice. Rather than simply cataloging and conserving such knowledge, they are forming new alliances by transplanting various types of rare medicinal plants into home gardens. Objectives: Planetary health, as I will try to show, may be thought of as a series of practices including different levels of transformation and transplantation across human bodies and urban ecologies. Methods: Ethnographic fieldwork in two herbal gardens and a research facility in Northern Vietnam have been conducted since 2015. From a methodological perspective, I argue that comparative ethnographic methods are laterally implicated in the ongoing experiments at these sites. Results: Thinking through the question of how people and medicinal plants come to cultivate and be cultivated by one another highlight the stakes that are involved in practices of transformation and transplantation. Conclusions: I hold that the gardening of medicinal plants can be seen as the alignment of human well-being with the health of the planet. Herbal gardens are places where humans and plants tinker with new forms of cohabiting and co-constituting each other’s worlds.
8. Isabel Pires (University of Lisbon, Portugal). **“WHITE PERIL”? SKIN LIGHTENING AND THE SEARCH OF ACCEPTANCE IN THE ASIA DIASPORA IN LISBON.** The literature dedicated to “Whiteness” as an important element in contemporary postcolonial understandings of beauty, highlights that Asian countries have long pre-colonial histories of utilizing white skin as a criterion of personal beauty, success, social status and wealth. Focusing on skin whitening practices among the Asian diaspora populations in the Greater Lisbon area (Portugal), in this paper I will reflect on the ideological value of whiteness as an aspiration and a desire for perfection. By confining the research to the cosmetic and grocery stores, beauty salons, and supermarkets in the center of Lisbon and to the migrant population of Pakistan, Bangladesh or India origin, I analyse the pervasive presence of skin-lightening or skin-“brightening” products in the marketplace, many with toxic ingredients that have a toxic effect not only on the skin but on overall health. By analyzing “ideal” beauty images circulating in global markets and the discourses of cosmetic advertising, my main research questions are: How do they shape the collective imagination of Asian beauty? How do they influence immigrants’ logic of integration and social acceptance? How does it affect their self-identity as individuals and migrants? The purpose of the presentation will be to show how physical beauty is not only defined inter-rationally, by static opposition, but mostly intra-rationally, by dynamic hierarchy, reproducing thus power hierarchies, reifying hierarchical social structures, and crossing ethnic and political boundaries.
9. Jidong Sung (Sungkyunkwan University, South Korea). **UNFIT FOR WORK? SOCIAL STIGMA AND EXCLUSION OF YOUNG PEOPLE WITH HYPERTENSION IN NEOLIBERAL SOUTH KOREA.** Introduction: Hypertension is a very common condition, often associated with aging and lifestyle of the industrial world. While having a high blood pressure is usually not considered to be a stigma as such, it can be a significant weakness in a fiercely competitive neoliberal society in which individuals should do their overworking duty even with the cost of their health. Objectives: To investigate how the common assumption about hypertension makes the experiences of young people with hypertension invisible and thereby exacerbate their suffering in neoliberal Korean social context



Methods: This work was based on the in-depth semi-structured interviews 19 men and women with diagnoses of hypertension in a single cardiology clinic of a training university hospital. **Results:** Young people with hypertension frequently mention exclusion caused by stigmatization. They are rejected for private life insurance plan because those with hypertension are considered to be at 'high risk'. They experience discrimination in workplace by being considered 'unfit' for their job. Health problems associated with overwork are common in Korea and because hypertensive people are considered to be at risk, they are not preferred for duty involving overwork and thereby excluded from important positions. Having afterhour social drinking which often leads to binge may be an essential part of the work and those with high blood pressure are often excluded from it. **Conclusions:** Young people with hypertension have suffering of social dimension which impose significant unwanted change on their life. Illness experience would be better understood in relationship with working experience.

Global health 2

3:15 – 4:30 pm, Room 12 (gallery with posters).

1. Laurin Baumgardt (Rice University, USA), Rebecca Henderson (University of Florida, USA), Carol Mathew (University of Florida, USA). **UNHOMELY SPACES: THE DIAGNOSIS OF HOARDING DISORDER AND THE CONCEPT OF HOME.** Introduction: Since 2013, The DSM-5, a manual for diagnosis of psychiatric disorders used by mental health professionals in the US, has contained an entry for Hoarding Disorder (HD). Clinical discourse surrounding HD as a persistent difficulty associated with discarding possessions centrally draws upon discussions of homes and sick spaces. Objectives: Through a careful examination of the ways that clinicians, the public, and individuals with hoarding problems come to understand spaces as “sick” or “well,” “normal” or “abnormal” and “homey” or “uninhabitable,” we propose to critically unpack these binary concepts. Methods: Using 30 semi-structured interviews with clinical experts, we examine the process of diagnosing a patient with HD. We combine this analysis with talk of home-making within several long-running American reality television shows featuring individuals with HD. Finally, we draw from ongoing semi-structured interviews with patients with HD in which they describe their space and notions of home. Results: In order to diagnose HD, clinicians often take into account not only the patient, but also their living spaces. As such, HD represents a curious instance of a mental illness that is, in part, external to the patient’s mind. While patients with HD recognize their departure from the “normal,” their notions of what constitute a “hoarded” space differ from those of clinicians. For patients, homes are stigmatized and thus discussed in terms of damaged sociability. Conclusions: A careful tracing what makes a home “unhomely” or “uninhabitable” enough to constitute mental illness permits a reexamination of anthropological and philosophical notions of home and inhabitance.
2. Kirsten Langeveld (Leiden University Medical Center, The Netherlands). **EL ‘HALF MINOR GLOBAL HEALTH’ CUBA. UN PROGRAMA INTERNACIONAL: UNA COMBINACIÓN DE ANTROPOLOGÍA Y SALUD PÚBLICA.** Introducción: Con el desarrollo de la globalización y disminuyendo la distancia entre países y sus poblaciones, la urgencia de los contactos internacionales, se presentan. También en la facultad de Leiden ‘Universitary Medical Center’, la necesidad de internacionalización es una realidad. Y por eso hay varios programas internacionales de intercambio. Uno de los programas trata sobre salud global. La asignatura de este programa se denomina: ‘Half Minor’ Salud Global Cuba. Objetivos: Los dos objetivos del programa ‘Half Minor’ Salud Global Cuba son: Enseñar a los estudiantes sobre la salud pública en Cuba. También obtener más conocimientos acerca de: la relación de la salud y el largo contexto de la sociedad de Cuba. Métodos: Para aprender sobre la salud pública los estudiantes están en la práctica médica durante cuatro semanas viviendo en Cuba. En el mismo período, los estudiantes hacen investigaciones cualitativas, utilizando el diseño antropológico como forma de adquirir el conocimiento de la salud en el contexto de esta sociedad. Resultados: Los estudiantes poseen más conocimientos sobre el sistema de salud en Cuba en dos maneras: tienen más conocimientos acerca de la organización de la atención. También han profundizado sus conocimientos en especialidades como: Geriátría, Salud Maternal e Infantil. Las investigaciones cualitativas han proporcionado conocimiento a los estudiantes acerca de varias temáticas. Ejemplos de temas son: madres adolescentes y transexualidad. Conclusiones: Este programa Salud Global da forma a la internacionalización. Hace que los estudiantes sean conscientes de la importancia de conocer el contexto en relación con la salud.



3. Melina Taylor (University of South Florida, USA). **GOVERNMENTALITY AND SEXUAL CITIZENSHIP: HOW SEXUAL EDUCATION INFLUENCES SEXUAL BEHAVIOR OF YOUNG PEOPLE IN THE U.S. SOUTHEAST.** Introduction: Sexual education is a contentious topic in the U.S., often split along political party lines between abstinence only republicans and comprehensive sexual education democrats. Federal, State, and local political party affiliations and religious ideologies tend to control sexual education curriculum, leaving many students unprepared for healthy and fulfilling sexual encounters. Objectives: This study examines how governmentality defines sexual education of young people in the U.S. Southeast, and how students absorb this knowledge into their decision-making strategies for sexual encounters once they reach university. Methods: Participants were 18–24-year-old undergraduate students at three large, public universities in the U.S. Southeast. Data collection used a mixed-methods approach of online surveys (750) and in-depth, semi-structured interviews (53) at each fieldsite. Surveys were used to collect demographic data; interviews were recorded, transcribed verbatim, and coded for themes. Results: Using a governmentality and sexual citizenship theoretical framework, several themes identifying the intersection of sexual education and sexual behavior were illuminated, including (1) self-determination of readiness for sex, (2) perceptions of “healthy” relationships, and (3) information seeking behaviors regarding contraceptives and STIs. Conclusions: The majority of students, regardless of sexual orientation or gender identity, are lacking in sexual education exposure through the public education system. LGBTQ+ students are additionally marginalized and isolated due to government views of cisgender and heteronormative ideals for legitimate sexual encounters. Students are often confused regarding contraceptive methods, sexually transmitted infections, and how to identify and engage in healthy sexual relationships.

4. Nakai R. Flotte (Harvard University, USA). **ETHNOGRAPHY AS CARE: LGBTQ+ CENTRAL AMERICAN VIOLENCE ACROSS THE MIGRANT JOURNEY.** Introduction: This paper proposes that Mexico’s policies after the implementation of the US-influenced “Southern Border Plan” created a crisis of immobility in the Mexico-Guatemala border, later producing the “caravanization” of migration to the US-Mexico border. Objectives: This paper proposes “ethnographic accompaniment” as a methodological approach that places migrant care as a priority; functioning as a method to both gather data but to also identify areas in need of responsible intervention to meet basic human rights. Methods: I use three spatiotemporally diverse ethnographic moments to explore the possibilities of “ethnography as care” from before, during, and after the massive Central American exodus of 2018. Results: The transformation of Mexico’s immigration policies, as well as Trump’s private prison boom and new asylum restrictions, has resulted in the silent development of novel forms of physical and psychological violence that can be visualized and addressed by an ethnography of care. Conclusions: As the Global North intends to criminalize displaced migrants and those who commit to “accompany” them, ethnography must emerge as a possibility to better understand the role of care, reciprocity, and advocacy for people assigned necrophiliac value, both for the state and civil society.

5. Niccolò Lucarini (Università degli Studi di Torino, Italia). **CRAFTING PROOFS OUT OF WORDS: CREDIBILITY ASSESSMENT IN THE ITALIAN ASYLUM SYSTEM.** In the last four years, the number of asylum seekers arriving in Italy has significantly increased. In the absence of material evidence (often represented by medical certificates) attesting the ‘true’ nature of the subject’s traumatic experience, the main ground to determine the possible “well-founded fear of being persecuted” if deported back in the country of origin (the legal sine qua non for being recognized as a refugee) is an interview, where applicants are asked to produce a detailed account of their life story. The claimants’ words are thus scrutinized in order to assess their credibility. This proposal looks at how asylum seekers come to present themselves as ‘credible’ subjects through the mastering of specific narrative strategies, crafting coherent and linear accounts of their experiences that can meet the judge’s expectations. As a wide variety of academic literature has shown, in fact, the relationship between memory and traumatic experiences is far from uniform: accounts of physical and psychological vexations are by definition fragmentary and syncopated, as well as subjected to cultural variability. Through a cross-disciplinary approach (ethnographic interviews, reading of the hearings’ minutes, critical analysis of legal texts), this paper endeavors to analyze the epistemological and political profiles of the relationship between the traumatic experience lived by refugees, and the narrative styles they have to adopt in order to be seen as ‘credible’ subjects. The asylum system is thus exposed in its inherent politicized nature: credibility can’t be assessed, but only negotiated.



6. Niyonkuru Aine-Ernest (Hope Africa University, Burundi), McLaughlin Eric (Hope Africa University, Burundi), Heath Gregory (University of Tennessee Chattanooga, USA), Inamuco Sonia (Hope Africa University, Burundi), Topazian Hillary M. (University of North Carolina Chapel Hill, USA), Davis Mike (University of Tennessee Chattanooga, USA). **HEALTH PROFESSIONAL ATTITUDES IN BURUNDI REGARDING ARTEMISININS AND QUININE.** Background. Malaria is a significant cause of morbidity and mortality throughout the world and particularly sub-Saharan Africa. The World Health Organization and the Burundi Ministry of Health recommend artemisinin-based therapy as first-line treatment for malaria. Implementing this recommendation requires understanding culture and health professionals' acceptance of this treatment as the optimal choice. Implementation studies have been performed in a variety of settings across sub-Saharan Africa. Comparative analysis of this phenomenon in the setting of Burundi is the aim of this study. Methods. A survey was conducted across 32 health facilities in 10 provinces among Burundian health professionals to assess attitudes regarding artemisinins versus quinine for treating malaria. Respondents included both physicians and nurses who provided responses about their antimalarial treatment preferences for a variety of clinical scenarios. Comparisons among health professionals, their level of training, work setting, and length of work experience were examined using a series of stratified analyses, including the Pearson Chi-square statistic and odds ratios. Results. 94% of respondents correctly identified artemisinin-based treatment as first-line therapy according to the national protocol. However, 24-40% of respondents preferred the use of quinine in various hypothetical clinical scenarios. Overall, nurses were at greater odds of preferring quinine versus artemisinins compared with physicians. Conclusions. Though artemisinin-based therapy was recognized as the recommended treatment, a high proportion of Burundian health professionals, especially nurses, prefer using quinine in a number of clinical scenarios. These findings identify a significant cultural barrier to the satisfactory implementation of national and international recommendations.

7. Vishala Parmasad (University of Wisconsin Madison, USA). **TUG-OF-WAR OR BALANCING ACT: ANTIMICROBIAL STEWARDSHIP AND THE PRESCRIBING PRACTICES OF PHYSICIANS.** Antibiotic resistance is a global threat to human health, and is escalating rapidly with the rise of multi-drug resistant pathogens. To counter this, international experts recommend that antimicrobials be used more judiciously, through practices of "antimicrobial stewardship". This paper provides an overview of the complex, multi-layered negotiation that stewardship entails in the intersubjective space of doctor-patient therapeutic interactions and prescribing practices. I draw upon a systematic review and meta-ethnography performed of the biomedical literature from the last 20 years on the determinants of physician antibiotic prescribing, to explore the tensions between evidence-based best-practice guidelines and institutional norms of practice, the variations in weighting individual versus collective "good" in different medical subspecialties, and the possibilities for more nuanced understandings of "practice" that are excluded by the criterion-based approach of biomedical research. I draw upon the Bourdieusian concepts of habitus, practice, and field explain the habitus of early, prolonged, and broad-spectrum antibiotic prescribing in the fields of some subspecialties. Drawing on this meta-ethnography, I also typify the field of antimicrobial stewardship as a struggle between the social capital of experts and infectious disease physicians who seek to decrease the rise of antimicrobial resistance and the economic capital of pharmacies, pharmaceutical companies, and industrial agriculture, who continue to seek to maximize profits even at the expense of humanity's long-term well-being.

8. Irem Nihan Balci (École Normale Supérieure de Lyon, France). **OCCUPATIONAL HEALTH RISKS AFFECTING ROMA WASTE PICKERS IN TURKEY.** Waste pickers work in the streets to collect recyclable materials in household waste. They are continuously exposed to occupational accidents, hazardous chemicals and biological agents which can potentially generate short-term and long-term effects such as cuts at hands, respiratory problems, musculoskeletal damages and infectious diseases including hepatitis. Even though these working conditions are unfavourable for all waste pickers, some of them are more vulnerable than the others due to cumulative disadvantage in the socioeconomic spheres. This study has an objective to discuss how social factors and doing a dirty work have an impact on health by explaining the triple vulnerability of Roma waste pickers in Istanbul. In Turkey, informal waste picking is mostly carried out by ethnic groups such as Roma, Afghans, Kurds and Syrians. I conducted my fieldwork by observation and by in-depth interviews in Istanbul with Roma and Kurdish waste pickers for two years. During my fieldwork, I observed that Roma waste pickers have a triple vulnerability. Firstly, they are reluctant from taking any preventive measure for work safety. For example, they refuse to wear gloves



and mask. Secondly, unlike other groups, they have a longer exposure time to hazards because they do this job beginning from early ages, as child labor represent an important income for everyday survival of Roma people. Thirdly, they represent one of the most disadvantaged community in Turkey with limited access to housing, healthcare services and nutrition which aggravates their health problems.

9. David Mensah (Northern Arizona University, USA). **BELIEFS AND ATTITUDES TOWARD MENTAL HEALTH AND THEIR INFLUENCE ON HELP-SEEKING BEHAVIOURS – A PROPOSED STUDY IN ANKAFUL PSYCHIATRIC HOSPITAL, GHANA.** Introduction: Research indicates that beliefs and attitudes towards mental illness in Ghana influence help-seeking behaviour, including the spiritual attribution of mental illness. Socio-demographic factors such as the educational status of people with mental illness and their family members can also impact help-seeking and treatment, as can stigma, caregiving practices, and social inclusion. Other factors include the fear of psychiatric hospitals and the scarcity of psychiatric services in Ghana. Objectives: This research seeks to explore the mental health help-seeking trajectories of Ghanaians who receive treatment at the Ankaful Psychiatric Hospital, Cape Coast, one of three psychiatric hospitals in Ghana. Methods: The research methods will include participant-observation and interviews about the experiences of patients, families, and caregivers at the institution. Results and Conclusion: Researching the cultural context of mental disorders in Ghana is one avenue to provide support for and social integration of those with mental disorders through clinical intervention and mental health promotion.