



# Tobacco Control and Public Health in Eastern Europe

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## Social and political embeddedness of approaches to health and illness: author's response

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Dr. Tatiana Andreeva's reflection (Andreeva, 2013) on the diversity of approaches to public health problems strikes very close to the heart of my own research. Her assertion that "contrasting paradigms [of public health] that dominated in the former Soviet Union and in Western countries may include ... certain pathologies, which are not recognized as such in other societies" rings particularly true. I have been researching public health responses to HIV and IV drug use in Ukraine since 2007, and I have been involved in harm reduction efforts in my home country, the United States, since 2003.

Throughout the last decade, I have sought to better understand how society's perception of drug use (or, perhaps, I should say how different perceptions of drug use that emerge in different societies) shape social and medical responses to drug use and how those responses affect the lives of addicted persons.

Though she makes many points that are worth considering, I want to acknowledge, in particular, Dr. Andreeva's observation that the medicalization of addiction serves to "exonerate" the individual drug

user from certain moral and social responsibilities. This observation has been a key point of interest throughout the anthropological study of addiction in the American academy. From this observation, there are two important points to be made.

First, if we accept the idea that the disease concept of addiction frees addicts from some degree of moral responsibility for their actions (and I contend, in agreement with Dr. Andreeva, that this is fundamentally true), then we must acknowledge that medical approaches to human behavior, no matter how scientific and technological they may appear, accomplish concrete moral and ethical work. Thus, it is shortsighted to think about medical responses to human health and illness as something that can exist outside of social and moral contexts. In fact, scientific knowledge and medical technology are, themselves, part of the social fabric.

Second, if we, then, accept that medical science exists in the social realm and is not an *a priori* reality whose empirical soundness transcends human culture, then we

must also acknowledge that moral and symbolic work must go into the formation of medical and scientific responses to health and illness as well. In other words, cultural forms and social structures can shape what we think empirical science and medical knowledge are in the first place. Not only are disease epidemics "fundamentally social processes" (Maher, 2002, p. 312), but the most fundamental medical and scientific facts about health and illness are also "the outcomes of social relationships ... not transparent representations of something biological" (Koch, 2013, p. 142).

Very early in my graduate career, I was inspired by the following observation made by medical anthropologist Philippe Bourgois: "Even the best of intentions to help or to serve the socially vulnerable can also simultaneously perpetuate – or even exacerbate – oppression, humiliation and dependency of one kind or another" (Bourgois, 2000, pp. 168-169). I interpreted Bourgois' words as instructions for my own research. I have since then tried to bring to light the ways in which differences in social context creates different kinds of health,

different kinds of illness, and different kinds of medical approaches to these issues. Dr. Andreeva, in her commentary, rightly observes “how differently the same things can be understood in different parts of the world.” For this reason alone, I believe that it is of great importance that we recognize the social and political embeddedness of the most dominant biomedical approaches to health and illness—particularly when these approaches are engaged in parts of the world that are far from their geographic and cultural origins.

This brings me the second of Dr. Andreeva’s thoughtful observations, which I would like to highlight here: namely, that “unsuccessful efforts of health system reforms may result from the introjection of foreign concepts without real digesting, i.e. understanding their elements and following back to their roots.” I could not agree more. While Bourgois’ observation is somewhat of a cautionary tale for health researchers (i.e., be careful of what you create, because it could have unexpected consequences), Dr. Andreeva’s words provide marching orders for the current generation of public health professionals. We work in a world dominated by powerful global actors (the WHO, the Global Fund, USAID, UNAIDS, etc.) who have the financial capacity to implement health reforms on a national, or even a global, scale; however, they do not always have the administrative or procedural capacity to critically evaluate their interventions within a social context or consider those interventions *as* social constructs.

This, I believe, is where local, critically trained public health experts are vital. Standardized health programs, no matter how standardized, can never be truly ‘technological fixes’ that are applicable anywhere

regardless of context. We know very well that the same intervention cannot be implemented in the same way in all places, and yet talk of ‘internationally recognized standards’ has come to dominate so much dialog. Perhaps this global push towards the standardization of medical care and public health policy has hindered the critical reflection, innovation, and adaptation that are needed to ensure the success of larger health system reforms. This seems to be some obvious truth in this, and yet there remains a momentum in the world of global health towards doing things in the same way (treating addiction with methadone, controlling TB with DOTS, etc.) all of the time.

The question that Dr. Andreeva’s reflection anticipates, I believe, is this: how should we, as scholars, as researchers, as activists, as experts in our field, choose to engage with that momentum. Are the paradigms, etiologies, and logics of treatment promoted by international public health efforts a right fit for every local context? Do they seek the same ends and hold the same values? Rather than feeling obliged to promote the standardized agenda of a powerful international group, public health professionals deserve to practice their trade with greater intellectual and epistemological freedom, in a way that is not limited to a singular worldview. By considering the social construction of medicine and of public health practice, we can escape dominant paradigms, enter into new kinds of thinking with new kinds of concepts, involve new kinds of morality, engage with a flexibility of method and analysis that, instead of weakening our analytical approach, allow us to see, discover, understand, and innovate so much more than we could otherwise.

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