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Anthropologies in and of Evidence Making in Global Health Research and Policy

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Anthropologists are not generally known for being optimistic about the state and status of their discipline's contribution to health research, policy and practice. Contemporary debates around the forms and effects of knowledge production in health often focus—despairingly, and with good reason—on the continuing dominance of quantitative, narrowly-defined biomedical ways of knowing, the rise of the clinical trial and its broader project of evidence-based medicine (EBM), and the conflicted nexus between science and 'Big Pharma's' pursuit of new pharmaceutical knowledges, technologies and profits (Goldacre 2013; Lambert, et al. 2006; Mykhalovskiy and Weir 2004; Petryna 2009). Despite the long-standing efforts of advocates from anthropology, sociology, history and other disciplines to promote the importance of 'neglected' forms of social and behavioral research in health—research often glossed as 'qualitative research'—the picture that most often emerges of the health arena is of a terrain that consists almost entirely of lab experiments, computer modeling, and randomized controlled trials (RCTs). In the last few years, however, I have had the opportunity to be involved in two small, but potentially revealing developments in qualitative health research that might complicate this conventional narrative in useful ways. I describe these developments below and examine what they may signify for broader questions in medical anthropology about the current processes and politics of knowledge production in global health research and policy-making.

The first development was the formal inclusion of a variety of forms of qualitative evidence in the production of the WHO's recent 'Optimize' guidelines on optimizing health worker roles for maternal and newborn health (MNH) (WHO 2012). These guidelines provide recommendations to countries that are considering shifting certain healthcare tasks (e.g. immunization or breastfeeding counseling) from one cadre of health worker to another, but are concerned about the safety, efficacy, cost, feasibility, and acceptability of such a shift. The standard 'evidence-based' approach to developing this kind of guidance is to 1) search for all of the available high-quality quantitative evidence relating to the safety, efficacy and cost-effectiveness of the questions under consideration, and then to 2) summarize and synthesize this evidence base in the form of a 'systematic review' that uses a transparent and systematic methodology. In these reviews, the RCT is typically the most revered form of evidence and holds the most weight in developing review findings and recommendations for practice and policy.

For Optimize, however, in addition to drawing on the usual quantitative systematic reviews for guidance, the WHO's Department of Reproductive Health and Research also commissioned several forms of qualitative evidence synthesis. These included a thematic

analysis of an maternal and newborn health email discussion list, in-depth country ‘case studies’ of large-scale task-shifting programs, and four separate systematic reviews of qualitative evidence—two on lay health workers (LHWs), one on nurse-doctor substitution, and one on midwifery (see Annex 7 of the Optimize guidelines for more details).

Systematic reviews of qualitative evidence are relatively new (Lorenc, et al. 2012). They follow in many ways the basic logic of a quantitative review—thorough search of available evidence, assessment of study quality, clear guidelines for inclusion and analysis, and the use of multiple reviewers—but tailor their methods to the important methodological and epistemological differences between quantitative and qualitative research (Hannes and Macaitis 2012). In Optimize, these reviews were designed to provide guidance on the ‘acceptability’ and ‘feasibility’ of task shifting interventions. The Optimize guidelines were the first time the WHO had formally integrated qualitative evidence into the process of creating a guideline, a development that has been framed by those involved as a potentially significant change in both how and what kinds of research get translated into health policy and practice (Gulmezoglu, et al. 2013; Noyes, et al. 2014).

The second notable development was the inclusion of one of these systematic reviews of qualitative evidence in the Cochrane Library as an official ‘Cochrane Review’ (Glenton, et al. 2013). Within the EBM world, the Cochrane Collaboration is a vital, even hegemonic institution. Its central depository of Collaboration-approved systematic reviews, and the underlying Cochrane review methodology that strictly defines how these reviews can be produced, is seen by many, for better or for worse, as the touchstone of evidence-based medicine. For a long time, qualitative research was not even remotely on the radar of the Cochrane Collaboration and other EBM adherents. As the scope of the EBM enterprise has expanded, however, and as the questions its proponents aim to address have broadened, qualitative research has been included, slowly and carefully, in the discussion. In the late 90s, a ‘Cochrane Qualitative Research Methods Group’ was created, though the Collaboration only formally recognized it in 2006 (Hannes, et al. 2013). And in 2008, Cochrane’s Bible, the ‘Cochrane Handbook’ (Higgins, et al. 2008), added a new chapter on how to use information from external qualitative systematic reviews to “inform, enhance, extend or supplement” existing quantitative systematic reviews in the Cochrane Library (Hannes, et al. 2013).

Despite this increasing recognition of qualitative research and reviews in the last 15 years in EBM, qualitative research has typically been understood, in classically gendered fashion, as an ‘add-on’, as complementary to and ‘supportive’ of quantitative systematic reviews. The acceptance of the Optimize qualitative systematic review on LHWs as a stand-alone review in the Cochrane Library, however, represented an important shift in approach, both practically and rhetorically. The vaunted title of ‘Cochrane Review’ had never really been considered an option for qualitative systematic reviews, and even today, a year after its publication, most colleagues I meet who haven’t heard of this review initially dismiss out of hand the possibility that it could have been registered as a ‘real’ Cochrane review.

A Seat at the Table?: ‘Doing’ Medical Anthropology in a Systematic Review

So what does this all mean for a medical anthropology of knowledge production in global health? What do these two events signify and, more broadly, what is at stake for us in the growing interest in mainstream EBM in systematic reviews of qualitative evidence? As I argued above, the conventional critique in anthropology and even in some quarters of biomedicine is that EBM has established itself as the hegemonic foundation for making authoritative knowledge claims in biomedicine (Lambert 2009); Mykhalovskiy and Weir 2004) EBM is described as the clear winner in a Cold War between quantitative and qualitative research, a victor that (often mindlessly) celebrates the RCT as the paragon of knowledge and naively believes trials and reviews of trials can identify the best solutions for all sorts of real-world health and social problems (Adams 2013).

This narrative, with all of its metaphors of the (neo)colonial subjugation of marginalized qualitative knowledges, rings both true and false in important ways. To be sure, the language and logic of evidence-based healthcare and policy are well established and ubiquitous in medicine and public health, and many of the underlying and problematic assumptions of EBM are left unchallenged in daily discourse and practice. But this critique often oversimplifies the power of EBM and, even worse, personifies it as an independent actor. This became evident to me in the course of working on the Optimize reviews and realizing that rather than a radical and contentious rupture in EBM orthodoxy, the inclusion of qualitative evidence in WHO policymaking appeared to be proceeding with little fanfare or debate.

The initial idea to integrate qualitative evidence in the guidelines had its start in the working relationship between a WHO program director and researchers at a knowledge translation institute called the Norwegian Knowledge Centre for Health Services. They decided to propose the formal integration of qualitative evidence in the Optimize guidelines to the WHO’s Guideline Review Committee (which approves all WHO guidelines) and received approval for the experiment. Though I had no prior experience with qualitative evidence synthesis, I was invited to participate in the review process for a number of reasons, including my training in both anthropology and epidemiology, my experience researching the issue of task shifting, and my role as an academic in a Southern university (enabling my participation to be framed as a ‘North-South capacity-building collaboration’ in contemporary global health parlance).

As an anthropologist schooled in a fairly critical strain of American cultural anthropology, I approached my new project with a mix of cynicism and enthusiasm—cynicism with respect to the idea that one could do a systematic review of qualitative evidence in the first place, and enthusiasm at the prospect of witnessing global health knowledge production and policymaking from the inside. What I discovered, however, was not an environment where qualitative research had been relegated to subsidiary status, or straight-jacketed into a borrowed and inappropriate methodology lifted from quantitative research. Rather, I encountered a thoughtful, supportive and nonetheless critical and creative setting. There was broad interest and confidence among the guideline committee’s stakeholders in the potential import of the contributions of the qualitative evidence to the guidelines. There was a pragmatic openness among the review team to inventing new and more appropriate review

methodologies that fit the circumstances of the review process and question. And there was robust epistemological reflection and critique among team members both within the qualitative evidence synthesis process itself, as well as when we started to integrate the qualitative and quantitative findings and translate these into concrete recommendations.

In my new seat at this table, itself quite new, I found myself ‘doing’ anthropology in a number of ways. I contributed my content knowledge about lay health workers and community-health system engagement and helped to shape where we looked for literature and how we used existing theories to interpret the findings of the studies we found. My training in deconstructing common-sense notions of ‘evidence’ and assessing the politics of positionality with respect to knowledge claims proved useful when discussing how to appropriately translate existing systematic review methodologies and concepts to suit our purposes. My disciplinary authority ‘as an anthropologist’ even seemed to play an important role in the social life of the review process. Anthropologists were spoken of by many of those involved as a sort of slightly mysterious ‘high priest’ at the top of the qualitative researcher hierarchy (and there were in fact some interesting structural parallels in the ways people spoke with reverence about both RCTs and ‘deep ethnography’).

There were certainly times where the process felt alien to my anthropological self. The pragmatism and inventiveness of those on the review team came alongside a strident concern with transparency, audit and standardization that felt awkward and sometimes incongruent with the end goals of the process. At the same time, however, my anthropological self was also challenged and I was forced to confront and rethink some of the conventional dismissals I had at the ready for the aims and procedures of evidence-based medicine.

Again, none of this is to suggest the broader critiques of EBM hold no merit or that the inclusion of qualitative evidence in the Optimize guidelines represents a seismic shift in the politics of health knowledge production. There were important ways in which the terms of our participation around this particular table were established and managed by a biomedically-informed status quo. And there were many ways in which the micro-practices and micro-politics of the qualitative review team were disciplined by the persisting power differences between quantitative and qualitative research traditions more broadly.

What I take away, however, in ways that I am still puzzling through and trying to name, are some of the ways of ‘doing’ anthropology even in spaces like a WHO guideline committee. Those ways of doing anthropology are not limited to being the essentializing ‘culture expert’ or the constant critic of ‘neoliberal science’. Doing interesting anthropology in spaces like these, however, does require a willingness to work across disciplines on a goal that is not conventionally anthropological in nature. It requires a capacity to balance critique and invention, deconstruction and reconstruction. And it requires an ability to lay claim to and maintain one’s seat at the table. I have already mentioned the role that my identity as an anthropologist played in that process, but my training in and affiliation with epidemiology (however minor) also proved quite critical, ironically, in establishing the credibility of some of my more anthropology-informed arguments.

Evidence of Anthropology and Anthropologists of Evidence

I want to conclude by arguing that there are rich insights and benefits to be gained by doing both anthropologies of, and anthropologies in, these emerging spaces for qualitative evidence synthesis in health policymaking. What do we as anthropologists have to offer in these spaces? First, we have a training in and an insight into the complexities of social and political worlds that will always force us to push researchers and policymakers past the typical understanding of qualitative research as relating only to questions of ‘acceptability’ and ‘feasibility’. We can then as a simple first step broaden the conversation about what counts as relevant in health research. We also bring rich models of ‘process’, ‘context’, ‘structure’ and ‘theory’ to the table, understandings that move far beyond the common mechanistic and one-dimensional versions of these concepts in health research (Armstrong 2007; Denzin 2009; Green 2014). These models can help us to outline and defend the principles and values of ‘slow research’ that Adams, Burke and Whitmarsh (2014) have recently argued for in these pages, even in spaces of ‘fast research’ like systematic reviews. And we bring a well-developed practice and a set of tools for both epistemological and ethical reflection and critique (Green 2014). What we don’t often have, and what I believe I usefully took away from the experience with Optimize, is practice in applying these insights and techniques outside our home turf and towards an end that is not ethnographic but in some ways the opposite of ethnography’s depth and nuance: global health policy recommendations. This process not only helped me to better understand the worldviews, agendas, and distinct contributions of doctors and policymakers; it also helped me to understand anthropology better and to be more clear about what anthropology does and does not claim to be able to know or do.

If doing anthropology *in* these spaces can be a mutually ‘enlightening’ experience, what might an anthropology *of* qualitative research in EBM and policymaking have to teach us? How might these new developments help us to understand something about the world more broadly and what are the theoretical issues at stake? As I argued above, there are likely lessons to be learned in the ways new forms of knowledge get identified, legitimated and then disciplined within the context of the biomedical status quo. The ‘inclusiveness’ and ‘pragmatism’ that I and the others involved in Optimize often celebrated seemed both a genuine reflection of the people and the process in concrete terms, as well as a language that had the subtle effect of policing and containing the potentially more critical claims of the qualitative evidence we were reviewing. We know that this kind of framing and disciplining has happened in related domains, such as the careful maintenance of the discourse of the ‘social determinants of health’ in global health circles (Brassolotto 2014); Ottersen, et al. 2014).

But this line of critique, again, risks becoming over-determined and uni-dimensional. The opportunities for integrating qualitative research in the Optimize guidelines, and for the publication of the qualitative Cochrane Review were not conspiracies of an anthropomorphized EBM orthodoxy that set out to recognize but then reduce and restrict qualitative research in a safe but subordinate position. This may be one of the threats that the project and its promoters faces going forward. But the opportunities for these developments

emerged out of concrete and specific relationships between individuals, ideas and institutions.

As much as these developments may reflect important lessons about the political structure of medical knowledge production in the contemporary world, they are also ripe for something like an actor-network theory-informed ethnographic interpretation (Latour 2005), one that can more usefully explain how they came about, what their emergence and effects signify, and what import they may have in the future. As with anthropology more generally, our 'fields' tend to outpace our understanding of them, and theory always ends up playing catch up. The growth, however shifting and uncertain, of new forms of qualitative knowledge in the world of global health research and policy-making presents us with just this kind of new opportunity to revisit the field and revise some of our theories about the production, circulation and consumption of knowledge in health policy and practice.

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