Global Health: The Debts of Gratitude

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Global Health: The Debts of Gratitude

Nora J. Kenworthy

*It permits us always to say: “Careful, you think there is gift, dissymmetry, generosity, expenditure, or loss, but the circle of debt, of exchange, or of symbolic equilibrium reconstitutes itself according to the laws of the unconscious; the ‘generous’ or ‘grateful’ consciousness is only the phenomenon of a calculation and the ruse of an economy. Calculation and ruse, economy in truth would be the truth of these phenomena.”*

_Jacques Derrida, Given Time: I. Counterfeit Money_

In early April 2013, Madonna’s ongoing troubles with Malawi boiled over in a spat with President Joyce Banda that aired across the Internet (Gumede 2013; Ross 2013). Without delving into the disputed details of Madonna’s pitfalls trying to “do good” (Fisher 1997) in the country, it is worth repeating a small part of the lengthy statement released by President Banda’s office as Madonna departed Malawi in a flurry of complaints, her public relations team still sparring with critics (Ross 2013). The statement, which President Banda later said she had neither seen nor approved, nevertheless resonated so powerfully with many in the country that few expected a retraction (Harding 2013; “Joyce Banda Disowns” 2013). An early section reads: “Granted, Madonna has adopted two children from Malawi. According to the record, this gesture was humanitarian and of her accord. It, therefore, comes across as strange and depressing that for a humanitarian act, prompted only by her, Madonna wants Malawi to be forever chained to the obligation of gratitude. Kindness, as far as its ordinary meaning is concerned, is free and anonymous. If it can’t be free and silent, it is not kindness; it is something else. Blackmail is the closest it becomes” (Ross 2013).
To focus solely on Madonna’s sense of entitlement or her misbehavior here is to miss the larger source of Malawians’ anger and take all-too-easy aim at the pitfalls of celebrity philanthropy. African leaders and their citizens are no strangers to the “obligation of gratitude” incurred while at the receiving end of philanthrocapitalism, development schemes, or humanitarian aid. Even the most elementary student of theories of exchange will remind us that no gift is merely a symbol of generosity but is embedded in complex relations of hierarchy and expectations of reciprocity (see Derrida 1992; Graeber 2001; Mauss 1990). The language of “obligation” and “blackmail” reflects the ways in which “gifts” become debts, and charity creates subtle forms of peonage. What is notable in this incident—and indeed, vaguely titillating for critical Western observers—is that Banda steps so boldly outside her role in the contrived theater of aid recipiency.

Even on the eve of African independence, however, Frantz Fanon (1963) unmasked the dangers of colonial charity:

And when we hear the head of a European nation declare with hand on heart that he must come to the aid of the unfortunate peoples of the underdeveloped world, we do not tremble with gratitude. On the contrary, we say among ourselves, “it’s a just reparation we are getting.” So we will not accept aid for the underdeveloped countries as “charity.” Such aid must be considered the final stage of a dual consciousness—the consciousness of the colonized that it is their due and the consciousness of the capitalist powers that effectively they must pay up (59; emphasis in the original).

Fanon reframes the seeming generosity of the developed nations as material and psychological reparations. Here, the final step toward liberation requires a psychological shift, in which the mystifications of charity fall away, and what is given becomes what is owed.

The perceptual shift Fanon once anticipated seems long forgotten, buried under layer upon layer of initiatives for the betterment of the Global South. More recently, the vast expansion of global health programs has provided a new platform for the mystifications of donation, aid, and generosity. Although many recent critiques of global health endeavors have emphasized their unintended costs, and the exacerbations of inequalities and hierarchies they can elicit (see, for example, Benatar 2005; Crane 2011, 2013; Lewis 2007; Swidler 2009), a more explicit focus on debt may help us to fully grapple with the obligations and disenfranchisements
that continue to arise despite the good intentions, “best practices,” and humanitarian ideals of global health enterprises (Bornstein and Redfield 2011; Elyachar 2006).1

In this brief critique, I attempt to elaborate some of the ways in which pernicious forms of debt accompany global health efforts, drawing on my own work in Lesotho. Obligations and unfair exchanges enter the calculus of global health programs in myriad and unexpected ways, particularly at the level of aid agreements and donor expectations (Adams, Novotny, and Leslie 2008; Baylies and Power 2001; Esser and Keating Bench 2011; MacKellar 2005; Nguyen 2010). Here, however, I focus on three dynamics that are centrally important for recipient-citizens but often overlooked in global health research: first, the voids created by what is not given, or recognized as deserved, in priorities and projects; second, the unforeseen costs of partnership; and third, the democratic deficits of global health governance. First, however, I briefly describe how global health projects emerge from earlier debts and inequalities between countries of the Global North and South.

Forms of Debt

Contemporary global health crusades have not emerged in a vacuum: they remain bound up in postcolonial histories of debt and deficit policy in poor countries. In response to the “third world debt crisis,” neoliberal policies were embedded in structural adjustment programs (SAPs) as conditionalities on loans for already indebted countries. As many scholars have noted, SAPs dismantled social services, with devastating effects on health systems and population health (Fort, Mercer, and Gish 2004; Pfeiffer and Chapman 2010). Not only were such impacts foreseen, they were upheld as necessary: free market ideologies insisted that if only cash-strapped governments would adopt austerity policies, development would follow. Market reform and development, therefore, were seen as precursors to wealth-driven population health improvements (Sparke 2013).

Even as austerity policies proved disastrous in most countries, and as the World Bank carefully recalibrated its messaging in recent decades, free market ideologies were hardly left by the wayside. Instead, as Matthew Sparke (2013) argues, a “New Washington Consensus” is emerging that promotes global health programs as integral to future development. Make people more healthy, so the new ideology goes, and they will be more pro-
ductive. What is insidious about this new global health ideology is that it inverts the discursive linkage between wealth and health (and between poverty and illness). Rather than conclude that poverty is a structural cause of illness, it promotes the idea that a better biological functioning of citizens will be sufficient to stimulate economic growth. In the slogans of global health institutions such as the Gates Foundation (“We believe every person deserves the chance to live a healthy, productive life”), Sparke asserts, we can discern a causal chain built on techno-biological interventions that become free market “fixes”: pills, productivity, prosperity (364–80).

Interestingly, it is the histories of third world debt that allowed the flourishing of many public emergencies and rampant health disorders to which global health now so urgently responds (see Fort, Mercer, and Gish 2004; Pfeiffer and Chapman 2010). Nor are the effects of austerity limited to poor countries: a recent example of the effects of fiscal policy on public health comes from Greece, where extreme austerity measures were implemented in the wake of the global financial crisis; infant mortality rose by 40 percent after 2008, and rates of new HIV infections more than doubled during a six-month period in 2011 (Stuckler and Basu 2013, 77–90). Debt creates the founding conditions for global health efforts (and the exceptional measures they often employ) but also contributes to its ideologies and means of response. Johanna Crane (2013) demonstrates how the persistent global inequalities between donors and recipients, patients and providers, and researchers and those researched retain an inherent value for knowledge production and the enterprises of global health science, which so often relies on diseased but underserved populations for research. At least certain aspects of the global health industry, then, profit from global inequalities exacerbated by debt even as they purport to ease disease burdens. This helps explain, in part, why wealth redistribution is so rarely included in programmatic interventions, even as more and more attention is paid to inequities (Commission on Social Determinants of Health 2008).

It is against this backdrop of more widely recognized linkages between debt and global health that I hope to highlight some more subtle patterns of obligation and debt. My own research on the political ramifications of HIV scale-up and broader global health programs in Lesotho (Kenworthy 2013) has repeatedly brought me face-to-face with the strange kinds of debts incurred when good works do less good, and cost much more,
than recipients initially hope. Much of my fieldwork, conducted between 2008 and 2011, focused on communities, patients, clinicians, and support groups as they interacted and came into contact with HIV policy, donors, nongovernmental organizations (NGOs), and campaigns. At the time, the so-called scale-up of HIV programs was vast, a dizzying deployment of HIV money, resources, programs, and ideologies. But I found myself most often in social landscapes of hopes deferred, labors unrecognized, and promises unfulfilled—as organizations and initiatives circulated rapidly through clinical and communal sites, conferring programs and technologies and pharmaceuticals, but rarely the means of robust or secure survival. These are patterns of symbolic and political—as well as economic—deficit. They created the kinds of resentment and distrust that accumulate when gestures of charity are not wanted, not at all what was hoped for. It is to these debts of “gratitude” that I now turn.

The Void Between Need and Desert

Global health initiatives have earned criticism for emphasizing program priorities that do not always align with recipients’ most urgent or important needs (Esser and Keating Bench 2011; MacKellar 2005; Shiffman 2006). At a systemic level, this priority mismatch is fueled by the politicization of health initiatives, competition among donors and organizations, and thriving ideologies about what is best for recipient nations. As global health funding continues to expand, these priorities seem to go through wavelike shifts, as donors move en masse from one issue area to another. This, combined with “vertical,” or “silo,” programming to address specific issues (rather than broad-based determinants of health and health system weaknesses) (Ooms et al. 2008; Pfeiffer and Nichter 2008), ensures that the lived experience of “global health” for recipients is one of shifting terrains, fragmented responsibility, and persistent inequalities.

There is much we could highlight here, but allow me to focus on two dimensions of global health priorities. First, much of the effort in global health is directed toward shuttling technologies, drugs, educational programs, or behavioral interventions into the minds and bodies of the sick or potentially sick in developing countries (Parker 2000). What it does not typically provide (though of course there is great variability in programs) is redistribution of goods, resources, or revenue to the poor. As a result, much of what filters down to patients or communities is of little recogniz-
able value, no matter how much patients appreciate once-scarce antiretroviral therapies, or NGOs use social marketing to distribute public health goods (Pfeiffer 2004).

By contrast, the proliferation of jobs, vehicles, and resources for NGO and government programs reeks, from the perspective of citizens, of a sinister misdirection of funds. As one of my informants put it, “Funding comes for TB, for HIV, but it only goes for their fancy hairstyles in Maseru,” referring to the intricate, frequently changing hairstyles of civil servants and NGO employees in the capital (Maseru) who seem to profit so visibly from the funding of HIV and AIDS. And community care workers, referring to the HIV test kits they transported back to clinics during Lesotho’s national testing campaign, angrily reminded me, “We are the ones who are bringing [the government] the blood!” These workers speak literally of the spots of blood on the HIV tests they collect during community testing drives and bring into the government clinics, and of the sick patients they send to clinics for testing. But “bringing [the government] the blood” draws on more sinister perceptions of how the government attains power and HIV money, the uses to which the bodies of the sick are put, and care workers’ own complicity in these processes. Such dialogues reference pervasive beliefs in southern Africa that the rich gain power and wealth through occult practices of consuming and using the bodies or blood of the poor (Ashforth 2005, 41; Ranger 2006; Bayart 2009).

The government here is portrayed as a consuming power, using the diseased blood of patients in order to obtain funds for HIV. Common rumors in Lesotho echo such sentiments: many claim that the government ensures HIV test results are positive so it can count more and more people as HIV positive—and thus continue securing HIV funding. These perceptions hold a telling mix of fact and fiction: in many ways it is the testing, counting, and regulation of bodies by which the government is able to retain its grasp on HIV funding flows. In the “HIV Corner” at a local clinic supported in part by donor funds, an elderly gentleman with HIV and TB invoked the oft-used language of eating as he explained that funds never seem to reach those in need:

We are living under oppression [khatello], because you know that when [NGOs] come and tell us, “We’ll do this and that,” . . . They come to us—and we realize that this is the way that they eat from us. Because the money that they receive will be coming from other countries and they will be saying that they are doing something for us, but these are
just empty promises. . . . These other countries think they are giving aid [phallela] to these people [living with HIV], but the aid never reaches them. They eat from us.

This ghastly sentiment, coming from a man whose own body bore the distinctive curves and hollows of advanced HIV and TB, is expressed in a dual language. Here, the “consumption of the poor” (Farmer 2000) denotes metaphorical, as well as pathogenic, ways that the bodies of the sick are being “eaten” (see similar discourses in Ferguson 2006, 73; Kalofonos 2010). From the debt of things owed but not given emerges a new illness variant, where the wasted figures of the sick embody suspicions about who eats, who does not, and what (or whom) is being consumed.2

Second, dialogues of sustainability, medical rationality, and accountability often translate, at local levels, into unmet desires and obligatory sacrifices. This is reflected in antiretroviral therapy (ART) trainings that encourage patients to eat protein and nutrient-rich diets that they cannot afford but that physical hunger and clinical expertise obligate them to attain (Kalofonos 2010; Marsland 2012). Or there is the policy put forth recently by a UNICEF representative in response to Lesotho’s acute food crisis, in which UNICEF would fail to provide enough nutritional support to households in crisis. “It doesn’t even cover 40% of household needs,” the representative reported confidently, “and it’s on purpose, by the way. Because we don’t want to create a welfare state” (Magubane 2012). Fears of dependency among aid agencies continue to rewrite the historical conditions of Lesotho’s entrenched food insecurity (Ferguson 1994). There is no room here for the kinds of debts carried over from colonialism—in this case, Lesotho’s loss of fertile lands and ensuing reliance on food imports—and sustainability-minded policies create new, terrifying debts for those families facing the gaping void of their remaining 60 percent of household needs. Taken together, these policy legacies represent, in the words of Ferguson (1994), the continuing “anti-politics” of development enterprises; but they also evoke forms of what we might call, drawing on Freire (1970), an “anti-conscientization” as citizens internalize and repeat the ideological justifications for the debts by which they are bound. This is reflected as poor neighbors in Lesotho accuse each other of being “lazy” and dependent, citing what is popularly called a “culture of handouts.” It is when recipients fail to see such ideologies as problematic—fail to see those missing nutrients or unfair distributions as resources they are owed, services they deserve—that the real debts of gratitude begin to take root.
The Costs of Partnership

Other authors in this special issue point to the ways in which debt has become a grounds for establishing legitimacy and, moreover, membership in social and political worlds. Debt is only one of the conditions under which the institutions of late liberalism partition aspects of citizenship, replacing them with shifting, temporary bonds of partnership (Povinelli 2011; Schild 2000). Certainly, partnership acts as currency among those who rely on aid projects for survival (Swidler 2009). But strivings for partnership seem like residual echoes of what James Ferguson (2006) calls “haunting claim[s] for equal rights of membership in a spectacularly unequal global society” (174–75). Increasingly, many global health partnerships have not produced the kinds of membership that would entail rights, entitlements, or even varieties of citizenship but rather the kinds of membership rooted in inequality, supplication, and debt. Ann Swidler (2009), for example, argues that funding reconfigures and reinforces patronage politics among AIDS organizations in sub-Saharan Africa. Vinh-Kim Nguyen’s (2010) research from West Africa demonstrates how antiretroviral therapies provided in a context of scarcity enact a damaging politics of triage, eliciting new subjectivities through “therapeutic sovereignty.” As a Westerner, I found myself unwittingly drawn into recipients’ perceptions of what partnership meant: “Maybe you are just like these people,” one interviewee said upon meeting me, “who are just using us—saying you are doing things for the sake of people with HIV, talking to us, and maybe you are going to get some funds [because of it] and they will be no use to us!”

Many global health initiatives draw on post–Cold War celebrations of civil society (Comaroff and Comaroff 1999; Igoe and Kelsall 2005) and thus pay great attention to the power of community and the productive value of participation. Particularly in Africa, many interventions rely on the efforts of relatively unskilled, community-based workers as a means of providing low-cost labor for projects, disseminating particular kinds of knowledge, ensuring patient compliance, and encouraging mutual support (Beeker, Guenther-Grey, and Raj 1998; Low-Beer 2010). Much of this work is carried out by women, and while these are unmistakable new labors, many efforts go underrecognized and unpaid (Callaghan, Ford, and Schneider 2010; Govender 2013; Tlali 2009). Although forms of care work and community health outreach vary widely, in places like Lesotho,
labors are inadequately reimbursed, with “stipends” often promised but rarely and inconsistently granted.

By institutionalizing care work as global health efforts undertaken in the spirit of volunteerism and goodwill, community-based global health strategies simultaneously transform labors into charitable efforts, economically undermine the value of such work, reinforce gender stereotypes, and obscure the conditions of poverty, gender inequality, and desperation that produce such labors. In the absence of more formal, institutionalized social safety nets, community-based workers whom I accompanied were often forced to fill gaps in social provision from their own slim resources, doling out money for medicines, transport, and orphan care. ‘M’e ‘Makabelo, an unpaid treatment supporter in a peri-urban village in which I worked, was one of many who faced the problem of how to support patients on HIV and TB treatment without supplemental resources. Some of her patients would arrive at her door, medicines in hand, and refuse to take their pills until she shared her own household’s food with them. “I know that this patient shouldn’t take the treatment without eating, or on an empty stomach,” she explains, “[so] I enter inside my house, and share the bread I have made for my children, which is not even enough [for them]. . . . And I am left there with the drama of replacing that portion [of the bread] for my child.” ‘M’e ‘Makabelo’s neighbor engages in a bizarre practice of claims-making, eking out nutritional survival by impinging on the generosity of his neighbors, making claims about what he deserves, not to the state but to his resource-strapped caregivers, arguing that without food, the toxicity of the medicines he takes will kill him. An irony of much aid at these microcosmic levels is that, even as it purports to help those in need, it can cast local workers into further nets of obligation and create hungers for patients that cannot be filled. In the absence of broad political entitlements, the needs of neighbors and patients become obligations to be fulfilled by care workers themselves.

Thus, one of the most remarkable social phenomena of community health interventions in Lesotho is the tension between mutual care and mutual vulnerability. Support groups—first imagined by Western agencies as psychosocial associations for eliciting better biomedical outcomes—often come to resemble mutual aid societies, whose members organize hoping to gain access to new global health resources but frequently find themselves burdened by the financial weight of members’ illnesses and deaths (Marsland 2012). Since many organizations and granting agen-
cies view support groups as productive associational venues for the dissemination of knowledge or the rollout of specific projects, their goals are unlikely to closely align with those of support groups, whose most proximate concerns are survival, food security, and assistance for dying members (Marsland 2012; see also Kalofonos 2010).

In one support group whose meetings I attended for nearly a year, members constantly fought about how to divide scant resources to support multiple sick and dying members. Organized as a group by the clinic, most members initially had only their HIV status in common. They quickly found that new forms of social organization also created more people for whom they were potentially responsible. In one heated meeting, a frustrated group member suggested that they bring the corpse of one of their deceased members—for whom they could not afford funeral expenses—to the steps of the Department of Social Welfare to protest the department’s lack of support for those affected by HIV. While NGO-community partnerships in global health expand the responsibilities of citizens to each other as well as to transnational entities, they rarely extend the obligations of global health agencies to meet needs that are crucially important to citizens, as what citizens typically want are social services and basic goods that fall outside organizational mandates and conflict with ideologies of sustainability. Evidence above and elsewhere points to the pervasive absence of social safety nets, such that even as global health programs treat the body, they fail to safeguard the person.

The forces causing such a dismantling of responsibility for social goods and basic needs are complex. What is worth noting here are the ways in which such partnership arrangements institutionalize collective vulnerability and decentralize obligations to care, even when they also show positive program outcomes and promote social solidarity. Partnership itself can take on the appearance of well-orchestrated theater, as organizations or donors sporadically appear, carry out dialogues or give out goods, and then, in the words of my informants in Lesotho, “disappear.” Citizens tend to be aware of the roles they are expected to play in such dramas—to be the supplicant, thankful community, endorsing any plan that brings in resources. These rituals discourage more open dialogues about complex needs and desires, limiting opportunities for equitable dialogue and priority-setting, even as they purport to endorse participatory approaches. As Sarah White (1996) argues, participatory efforts “may be the means through which existing power relations are entrenched and reproduced”
other development critics have called participation a “new tyranny” (Cooke and Kothari 2001).

**Democratic Deficits**

Not surprisingly, the final horizon of these debts is a political one. As partnerships frequently exacerbate and reinforce power inequalities between citizens and donors, weakening their voices in priority-setting, global health apparatuses participate in an unwitting dismantling of the state. This is not simply an emptying out of the state, nor can it be attributed only to surging support for NGOs and civil society organizations. Rather, in Lesotho, the funding cycles, short-term time horizons, and vertical implementations of a project culture disrupt and partition off the social contract, relieving the national government of direct obligations to citizens and sending citizens themselves scrambling to procure participation in one project or another for survival. Many do not succeed at all in meeting shifting program criteria. What results is a vast disruption of political landscapes already marred by earlier incursions of colonialism, development, and structural adjustment. Recipiency replaces entitlement; biopolitics and the administration of promises replace the social contract. I want to suggest that the debts of gratitude are more often enacted here through the relations between donors, organizations, and recipients, a dynamic that enforces the crucial misrecognitions of gift exchange (Derrida 1992).

In some cases, these dynamics add fuel to old patterns of hierarchy (Smith 2003; Swidler 2009). In other cases, citizens observe the seeming complicity of governments in these new arrangements and conclude that the close working partnerships between donors and ruling parties look a great deal like nepotism and corruption. When the U.S. Millennium Challenge Corporation (MCC) offered an enormous grant to Lesotho in 2008, opposition parties and citizens took to the streets in protest, arguing that their government did not deserve the money and was too corrupt to qualify for MCC selection criteria, and claiming that the grant would only further corrupt politics. Global health money provides support to ruling parties in myriad ways, even when donors are painstaking in their efforts to reduce corruption.

Because policies have largely come from donors, and donors require new efforts of accountability from recipient states, the normal patterns of accountability between states and citizens are disrupted. It is little wonder
that citizens, bound up in the politics of charity, find themselves saddled with a deficit of power. Nor is it surprising that these debts seem ephemeral, secondary compared to the urgent material debts of life lived at the margins. Much as moments of resistance from my informants are important to note, they are incomplete and ineffective in the new power arrangements encouraged by global health initiatives. Few citizens can afford, as President Banda can, to step outside the theater of recipiency and name it false. Perhaps the best and only recourse to the disenfranchisements of charity is the one offered by Aminata Sow Fall (1981) in her novella *The Beggar’s Strike*, in which the indigent poor of a West African city contest the government’s efforts to evict them by refusing to accept alms. It is only in their refusal that their necessity—as vessels for the charity required in order to be a good Muslim and also to be considered a fully fledged citizen—is demonstrated. Sometimes, the book seems to argue, the poor guard the gates to power as well as those to salvation.

**Conclusion**

My intent here is to initiate a reconsideration of global health politics through the lens of debt and, in doing so, to extrapolate how charity and the debts of gratitude affect recipients of global health aid. These are, of course, very broad strokes. Global health takes many forms, and the efforts of organizations and programs demonstrate great variability; there are many praiseworthy exceptions to these generalizations. While I speak here of my observations in a single country, they echo the findings of many scholars from across numerous disciplines. I offer this piece as a reflection, a rethinking of the dynamics of gift, obligation, entitlement, and membership among recipient citizens.

Fanon (1963) reminds us that debt more often lies in the Global North, rather than the South. As long as global health is understood and practiced as a gift and an intervention, it may be difficult to convince Fanon’s (1963) “unfortunate peoples” that they need not “tremble with gratitude.” Although the long-lasting effects of colonialism, global inequalities, and structural adjustment programs have confined large portions of the world’s poor to lives damaged and foreshortened by illness, we still rarely conceive of global health efforts as anything more than works of generosity and goodwill. But as Derrida (1992) argues, “The ‘generous’
or ‘grateful’ consciousness is only the phenomenon of a calculation and
the ruse of an economy”—parts well played by both parties, but nonethe-
less a cunning fiction. Renewed attention to justice and rights in global
health makes some headway in recognizing health as a debt owed; such
efforts should continue to be supported. Yet evidence from Lesotho and
elsewhere indicates that even well-intentioned global health efforts have
far-reaching and unexpected consequences, leaving in their wake new
debts, obligations, and forms of peonage for recipients. We urgently need
to attend to these broader injustices as well: it is not just reparations, but a
balancing of power and voice, that is owed to those at the receiving end of
global health endeavors.

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Notes

1. As one example of unintended costs, scholars at Yale University recently
published compelling evidence that UN intervention in Haiti after the earth-
quake was directly related to, and indeed, a cause of, the deadly outbreak
of cholera that began in 2010 (See: Transnational Development, Global
Health, and Association Haitiënne 2013). The more recent harms in post-
earthquake Haiti are expertly contextualized by Petchesky (2012).
2. Of course, the notion of “being eaten” is not a new illness idea in Lesotho,
where certain expressions of illness translate literally as, “I am eaten,” or,
“where are you eaten?” But the physical manifestations of AIDS and TB, and
the suspicions of corruption arising from the influx of HIV/AIDS and global
health funding, reinforce the linkages between “eating” as unfair consumption of resources, “being eaten” as illness, and the emaciated bodies of the sick appearing to have been “eaten away.”


4. I do not intend to downplay the equally important role of generosity and solidarity that motivates many volunteers but instead wish to emphasize that such selflessness coexists with acute wants.

**Works Cited**


