Working Paper

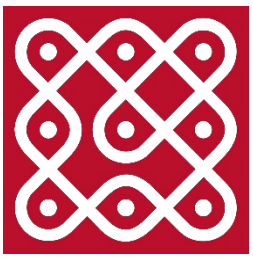
Fugitive Wellbeing: Thinking beyond/without global health for a future anthropology of health

José Enrique Hasemann Lara
CRIA-ISCTE
Marie-Curie Postdoctoral Researcher

28
2025

CRIA
Centro em Rede de Investigação em Antropologia
ISCTE NOVA FCSH UC UMinho

fct Fundação para a Ciência e a Tecnologia



CRIA
Centro em Rede
de Investigação
em Antropologia

Fugitive Wellbeing: Thinking beyond/without global health for a future anthropology of health

José Enrique Hasemann Lara
Marie-Curie Postdoctoral Researcher
(CRIA-Iscte-IN2PAST)
Livity.hasemann@gmail.com
Jose.lara@iscte-iul.pt

Abstract

There is a growing call for the decolonization of global health in anthropology. However, there is no agreement on what the decolonization of global health means or on how to accomplish it. In what follows, I outline how global health can be thought of as *colonized*. I follow this description with my own understanding of what constitutes global health. I then use this adapted definition of global health to assert (in consonance with Adia Benton) why the *decolonization* of global health is, at best, naive. Instead of striving for the decolonization of global health, I suggest decentering/displacing global health to make room for alternative world-building projects. I refer to one of these potential alternative world-building projects as *fugitive wellbeing*. Finally, I provide a brief example of what I mean by fugitive wellbeing (and suggest a starting place for future in-depth research) by drawing from exploratory research in Honduras. Ultimately, I argue 1) that global health is a politically informed project that falls under a larger category of social responses to the dilemma of distribution: *networked infrastructures for the distribution of public goods*; 2) that our understanding of what constitutes public goods currently shapes the limits of global health; and 3) that our understanding of public goods is in turn shaped by our ideas of the *human* and the *future.*

Keywords: Anthropology of global health; decolonization; coloniality of health; health as public good; Honduras

Palavras-chave: Antropologia da saúde global; descolonização; colonialidade da saúde; saúde como bem público; Honduras

Is global health colonized?

Over the last 30 years, scholarship on global health has analysed the nexus between global population health management and transnational concerns represented by governments, non-governmental organizations, and private interests (Birn 2009; Breilh 1994; Cueto and Palmer 2014; Packard 2016). Recent critiques of global health have added to this analysis by focusing on the philosophical grounding of global health as both historical phenomenon and as contemporary institutional practices situated in privileged realms of operation (in the so-called global North) that aid in the production and reproduction of historically structured systems of inequality (Benton 2017; Das 2015; Affun-Adegbulu and Adegbulu 2020; Adams et al. 2019). Discussions on what we could call the coloniality (Quijano 2014; Grosfoguel 2008) of health in anthropology (i.e., how ideas of what constitutes health, who is healthy/diseased, and how acceptable interventions are organized from within hierarchies of historically determined privilege to preserve that privilege) are not new (see Onoge 1975). However, more recent discussions have led to a pronounced moment of uncertainty within global health as practitioners begin to question if (and how) global health is fulfilling its own self-imposed mandate towards improving the exercise of human rights, achieving sustainability in local health-disease infrastructures, or guaranteeing justice, to name a few (see Adams et al. 2019).

Within these conversations, there is a divide between thinkers that disagree with the overall form of global health (i.e., vertical, foreign-led, technical interventions), yet hold out promise for a renewed and rethought form to preserve an already existing function (i.e., improving health) (Briggs and Mantini-Briggs 2003; Pearson 2018; Richardson 2020; Yates-Doerr et al. 2023); and thinkers that question if the form and function of global health can actually be addressed as separate elements (Benton, Adia 2014; White 2023), as this would essentially constitute separating global health from the historical conditions of its own emergence. In the former, gradual, general improvements in population health are regarded as achievable goals through distributed local and transnational consortiums of public and private interests structured around notions of equity or justice. The latter critiques how notions of health itself (as conceptualized, measured and later implemented within global health work) (re)produces racial categories and social difference (see Edu 2024). These camps of theoretical production stake claims between, respectively, calling for the decolonization of global health to preserve global health and, on the other side, arguing that the decolonization of global health entails dismantling global health. As anthropologist Adia Benton recently noted (see Yates-Doerr et al. 2023), can you, in fact, decolonize global health and still have global health?

Adia Benton (2014, 2017) addressed the ethical dimensions of global health by dealing with the uncomfortable and messy world-building aspirations that structure global health discourse/work. Benton (2014, 2017) demonstrated how the discourse that accompanies global health projects, as well as their overall geographic distribution and organization, recapitulates a separation between valued/infectable and dangerous/infected geographic locales and populations, along with hierarchies in the distribution of knowledge practices. These positions are predicated on lingering historical divides traceable to colonial occupation and ongoing neo-colonial exploitation (Amrith 2006; Borde and Hernández 2019; Edu 2024; Onoge 1975; Packard 2016; Suarez, González Uribe, and Viatela 2004). Within this vision of the world, global health (as a matter of design) reaffirms historically produced and ongoing global distributions of power (and accompanying socio-racial hierarchies); is dependent on satisfying access to a particular good within a market-based scheme; and is generally carried out in situ to either protect more valued populations in other locales (Lakoff 2010; Povinelli 2006; White 2023) or to expand into previously protected markets (see Harvey 2005; Birn, Nervi and Siqueira 2016). Under this conceptualization, the acceptability of care in global health grades across national territories and racial/ethnic/class/gender classifications, where the desire to improve the *health* of a given population is sufficient beyond altering any historically conditioned circumstances of daily life, addressing the social dynamics that lead to an unequal distribution of resources, or securing the stability of social and infrastructural support networks that manage and distribute the varied resources that make healthful lives possible under oppressive conditions (see Breilh 1994, 2021; Singer and Baer 1995; Hedva 2022). The issue here is not whether global health projects respond to a perceived emergency or need but the assumptions that shape the limits and expectations that accompany global health's responses.

What are we actually referring to when we say global health?

The term global health generally refers to a dominant configuration of international population health policy administered through the interrelations between governments, non-governmental organizations, and private local and transnational interests (Brown, Cueto, and Fee 2006; Buss and Tobar 2016; Janes and Corbett 2009). As a domain of practice, global health was recently identified by anthropologists as an "empty signifier" (Salm et al. 2021) capable of mobilizing diverse agendas, resources, and organizations towards a presumably shared vision of the future. I have three reservations with the notion of global health as an "empty signifier". First, "empty signifiers" only appear empty because they mobilize norms and values assumed to be common-sense and as such not worth sustained or serious scrutiny (see Hall and O'Shea 2013; J. A.

Gordon 2014). Second, holding global health as an "empty signifier" fails to acknowledge that *the future* is a contested political space structured around aspirations (Bryant and Knight 2019; Campt 2014) as much as (violent) practices of inclusion/exclusion (Bear 2020; L. Gordon 2021; Puar 2015; Povinelli 2011). Third, conceptualizing global health as an "empty signifier" indicates that global health has shifted from a potential case study to explain a particular socio-political response to the dilemma of socially manufactured inequality (an object of study)—as seen through systematic worldwide differences in *health experiences*—to a paradigm emblematic of the totality of possible responses to the dilemma of differentially distributed wellbeing (a set of naturalized practices).

Melissa Salm et al.'s (2021) work provides a necessary survey of the disciplinary and ideological expanse contained by the term *global health*, while it also helps to explain why global health is increasingly understood as an ideal type rather than as a token within a larger category of potential responses (see Krause 2023). However, this cross-disciplinary protective measure also leads to theoretical production in the socio-health sciences that safeguards the status of global health as universal and value neutral by, for example, reading local acts of rejection to global health projects as acts of course correcting contestation (Yates-Doerr et al. 2023) (i.e., growing pains). Dominant theorizing in global health centers the *practice* of global health (i.e., the *efficient* distribution of access to specific health-related services under conditions of global *scarcity* and local *institutional absence/lack*) as justification for the *idea* behind global health (i.e., an *ethical determination* on how the distribution of specific *public goods* can be most *justly* managed across an unequal and socio-historically structured global landscape).

The universalization of global health conceals that global health operates as a system for the negotiation and distribution of a public good (i.e., *health*) (see Buss and Tobar 2016)[1]. To accomplish a seemingly just or acceptable distribution of this public good, global health has to mobilize (dominant) ideas of how the world operates and what we would want the world to become (see Walker, Rivkin-Fish, and Buchbinder 2016; Ruger 2016). In effect, *global health*, as a near-petrified infrastructure (see Berlant 2016), conceals *from itself* how these distributions are actually justified across a global landscape (see Wynter 2016).

So, what is global health?

[1] Paraphrasing Stephanie Schütze's (2018) definition of political economy as practices of negotiation over the distribution of and access to desired resources, global health (as a near-petrified infrastructure) administers the political economy of health.

Even though global health lacks an overarching set of clear unifying goals and a stable and coherent definition (Salm et al. 2021), global health has several influential characterizations. Global health has been characterized as a "heterogenous and contested historical phenomenon" that facilitates practices of inclusion/exclusion (Fassin 2012: 91); a means of introducing gradual change and spaces of contestation across unequal social landscapes (Biehl and Petryna 2013; Farmer 2001; Yates-Doerr et al. 2023); a political phenomenon devised to mobilize support for transnational projects (Brown, Cueto, and Fee 2006; Janes and Corbett 2009); a regime for the creation of capitalist value (Adams 2010; Beaudevin et al. 2020); a mechanism for the intromission of neoliberal governance in the global south (Birn, Nervi, and Siqueira 2016; Breilh 2013); and as a tool of imperial-colonial expansion through the regulation of trade, traffic, and peoples (Benton 2014; Packard 2016; White 2023). Seeing as how there are different ways of understanding global health, I opt for a chimeric characterization of global health. My characterization of global health foregrounds how an "empty signifier" (Salm et al. 2021) facilitates differentiation between populations considered worthy of institutional investment (Yarris and Castaneda 2015) and populations that can be sacrificed (L. Gordon 2004; Edu 2024) to satisfy neoliberal demands for the rational management and distribution of a public good (Bear and Mathur 2015): *health*.

To that effect, global health is a 1) socially, politically, and economically structured historical phenomenon that generates normative assessments for exclusion and inclusion (Edu 2024; Fassin 2012); 2) that relies on scientific rationality to justify the implementation of hyper-specialized vertical health interventions in the global south designed, devised and delivered as joint projects between multilateral organizations and transnational private enterprise (Adams 2010); 3) and that for their implementation at the local level recapitulates systems of governance that privilege the nexus between local and transnational elites (Breilh 2013), who nurture conditions of ongoing crisis (realized or potential) that demand time-bound and limited actions towards the realization of a given future (see Caduff 2015; Roitman 2014). Taken together, these conditions allow global health to function as a space for speculation (see Bear 2020) by justifying the immediacy and inevitability of foreign-led interventions and fostering the assumption that foreign management is needed to both address a perceived crisis and manage a crisis-prone populace.

Re: can we decolonize global health?

Whether or not we believe global health can be decolonized depends on how we choose to understand 1) the category of the *human*; 2) notions of *citizenship*; and 3) what constitutes *wellbeing*. Although having competing understandings on these matters may initially seem to

be a matter of praxis (Singer 2012), or how we envision that our output impacts/intersects with political projects and how we labour towards that realization, these matters of difference call for a fundamental meta-critique of the evaluative practices that currently guide theory-making in global health (see L. Gordon 2010).

First, these differing positions on the decolonization of global health (whether it is possible or not) reflect a different understanding of the operative category of the *human*: between cosmopolitan views that assume the lived-experience of Western European populations is universal and normative (see Coronil 2001; D. Harvey 2000); and views stemming from Black Radical philosophical traditions that caution how the "overrepresentation" of a Western transnational elite is the product of a strategic confusion meant to privilege transnational elites as emblematic of humanity itself (Wynter 2003, 2015). Centering a historically privileged human group in discourse lays the foundation for the (re)production and institutionalization of hierarchies of human difference (Federici 2014; L. Gordon 2021; Trouillot 2002; Quijano 2014). This "overrepresented" group becomes a standard against which all other groups are defined, principally by their utter failure to occupy a category placed on a pedestal as an ideal (see Affun-Adegbulu and Adegbulu 2020).

Second, they reflect a different understanding of what constitutes citizenship: between liberal philosophical traditions that assume entitlements will be justly distributed and needs adequately satisfied so long as institutional mechanisms are made predictable and transparent (Arias-Valencia 2017; Marmot 2004; Rawls 1999; Sen 2000); and a critical tradition that understands citizenship as a limited good or commodity that is operationalized as a mechanism for openly distributing privilege (Boatça and Roth 2016; Tambakaki 2015). That is, entitlements are predictably distributed following hierarchies of humanity reflected in differing degrees of valued belonging to the body politic. The aspiration that goods will be equitably distributed once proper norms are instituted replaces the actual institution of the material conditions that would make an equitable distribution possible (see Gordon 2021).

Third, they reflect a different understanding of the notion of wellbeing: between liberal traditions based on luck-egalitarianism that limit redress for existing structural inequalities to individual-level responses that can be supplied without altering existing structures (Anderson 1999; Reid-Henry 2016; Stoian 2014); and radical feminist and phenomenological traditions that question if it even makes sense to, first, separate individuals from the complex systems of relation that produce something that we can call the individual (Berlant 2016; Fanon 2008; L. Gordon 1995; Tsing 2012); or, second, to reduce wellbeing to the manifestation of a state-of-being taken as representative of the totality of human experience, like *health* (Hedva 2022).

Jointly, these distinctions make apparent that what we try to separate into the domain of health (or even health-disease) should really be thought of as part of a larger condition of existence that is non-reducible, local, and ultimately emerges from the stability of intricate, historically influenced relational networks of social and infrastructural support (Hedva 2022; Kittay 2016; Miranda 2020). Health becomes a stand-in for the progressive realization of individualized access to better conditions of life without actually altering overall conditions of life.

To that effect, global health is enmeshed in a web of global political and economic interests (Buss and Tobar 2016) informed by pre-existing relations of power and racial imaginaries that justify different types of interventions for geographic locales and populations that fail to conform to a given expectation (e.g., political stability) or norm (e.g., hygiene) (Edu 2024; White 2023), with the understanding that (structurally) limited and depoliticized interventions amongst vulnerable/racialized/feminized populations may be preferable to having no interventions at all (see Redfield 2013). Some have termed this an "emergency imaginary" (Locke 2016) or an "epidemic logic" (Bashford 2004; Lupton 1995) that turns narrow and technical health interventions into immediate necessities. These interventions become valuable/desirable because of their immediacy. This emergency imaginary becomes a temporally displaced conceptual space that justifies structurally and institutionally limited interventions by making guarantees about the future that cannot be verified because the future is always out of reach (Caduff 2015). This lack of verifiability bolsters the legitimacy of claims against/about necessary and desirable entitlements in a present defined by scarcity (see Bear and Mathur 2015), slowly reorganizing what we conceive of as the entitlements of citizenship and even citizenship itself (Abadía-Barrero 2015). Following Adia Benton (see Yates-Doerr et al. 2024), decolonizing global health is not possible because global health is structured by ideas of the human, citizenship, and wellbeing that reproduce (historic) unequal relations of power (see "coloniality," Grosfoguel 2008).

Decentering global health over decolonizing global health

Our intent should not be to decolonize global health but to find alternatives. We can find these alternatives by displacing or decentering global health following three interrelated approaches. First, we should pay attention to the norms embedded in global health and how these norms normalize (contemporary and historical) solutions to the dilemmas of socially manufactured inequality (i.e., health as a public good). Second, we should situate global health within a larger category of possible social responses to the dilemma of inequality: *networked infrastructures*

for the distribution of public goods. Third, we should pay attention to how ideas of the future are used to model concepts common to global health work (e.g., health and health-disease).

Health as a public good and the limits to health as a public good

Global health as practice (see Salm et al. 2021) does generally attempt to fulfil an ethical imperative (Walker, Rivkin-Fish, and Buchbinder 2016). Global health seeks to improve given populations' compromised states of life: being *healthy* or having balanced *health-disease interactions*. Health and balanced health-disease interactions become *public goods* or any resource that is generally regarded as providing a positive benefit to society as a whole (Bear and Mathur 2015). How global health organizes the mechanisms through which this public good is distributed is simply a testament to the increased participation of neoliberal speculators in public governance. Bureaucratic arrangements increasingly privilege languages and practices based on efficacy, efficiency, profits, and cost reduction that seek to re-orient bureaucracies towards implementing environments friendly towards private capital investments (Adams 2016; Erikson 2016). Although there is a pretense that these arrangements are value neutral and rational, these new arrangements aspire to a definite idea of the imagined future. Following Laura Bear and Nayanika Mathur (2015) we should remember that viewing bureaucracies as impersonal structures for rational management is indicative of a neoliberal ethos more so than bureaucracies themselves, which can also be thought of as populated by conscientious and ethically driven intermediaries that seek to regulate a balanced exchange between something we conceive of as the state and a general population (L. Gordon 1995, 2021).

Second, global health privileges health (and even health-disease) as a *total public good*: a public good considered either sufficient to satisfy the diversity of a given populations' needs or whose presence is taken as an indication that all other relevant social needs have been met. To think about total public goods, I take from Bear and Mathur's (2015) theorizing on the fate of public goods under neoliberal rationality and from Berlant's (2016) theorizing on the rigidity and self-preserving nature of institutions in late capitalism. Improvements in health or health-disease interactions, as measured in bodies, become the singular goal and serve as measures that a desirable distribution of public goods has been achieved. The point here being that global health privileges *health* as a *total public good* because a limited view of health satisfies a particular neoliberal rationality on public goods as finite and measurable and therefore efficient and scalable (Tsing 2012).

Global health as part of a category (not the whole category)

A problem arises when trying to study global health from within global health, having to do primarily with the fact that we are trying to evaluate a given thing from within the thing itself (Krause 2023). From this vantage point, the thing under study takes on qualities of universality (Trouillot 2001). We lose sight of the edifying concepts (e.g., health, health-disease), dominant moral values (e.g., human rights, justice), and institutions (e.g., World Health Organization, Bill and Melinda Gates Foundation, World Bank) that structure the object of study, and tacitly justify the validity of the thing itself and its accompanying infrastructure (Wynter 2015). In other words, we become blind to our own objects of inquiry because they are so central to our understanding of the world. To move around this obstacle, I draw from Monika Krause's (2023) proposition to theorize from "neglected cases" by selecting an object of study that lies outside of what we understand as global health, but that also draws on transnational networks, local movements, and local capital to arrive at locally effective ways of creating something we could call *networked infrastructures for the distribution of public goods*.

I draw on Lauren Berlant's (2016) understanding of infrastructure as somewhat loose arrangements of principles, persons, things, etc., that help us to organize our relationship to each other and to a world constantly in motion. The point of thinking with infrastructures is to bring attention to the potentially short life span of meaningful social projects, and to the fact that formally institutionalized social projects, like global health, represent the petrification of infrastructures. That is, infrastructures that have ceased to function as infrastructures because they have abandoned a certain transformative relationality to individuals and to the world and have begun to function for themselves. This petrification lends itself to the scalability (Tsing 2012) on which global health as practice and project depends (Adams 2016; Breilh 2021; Erikson 2016; Packard 2016; White 2023) at the expense of the populations that it is meant to help (Adams 2010; Hindmarch and Hillier 2023). In other words, what we now know as global health represents only one potential solution to a larger problem: the historic and systematic production of inequality. New social projects emerge continuously parallel to or beyond formally institutionalized practices and these may offer different ways of conceiving a problem holistically (and responding to it in an organized manner), instead of parceling out different aspects of the problem into respective domains of action (e.g., health, nutrition, climate change).

The teleology of networked infrastructures for the distribution of public goods

Laura Bear (Bear 2020) theorized capitalist speculation as a strategy for accumulating capital in the future that conditions accumulation to the creation of social difference and, concomitantly, the creation of desired social futures based on preserving that social difference.

It is well established that global health foments speculation in capitalist markets (Adams 2016, 2010; Dumit 2012; Erikson 2016; Farmer 2001; Petryna 2009). What is less discussed is how speculation in global health also produces violence in the future (Affun-Adegbulu and Adegbulu 2020; Hindmarch and Hillier 2023). To argue that global health fosters speculation is to argue that global health nurtures a desired future by limiting who can access that very same future (see Fassin 2012). Ideas of how the world is structured and operates are sustained through convincing social fictions that assure us that the world cannot be any other way and that the world progresses through linear developments (Trouillot 2002; Wynter 2015). These fictions are sustained through "geographies of imagination" and "management" (Trouillot 2002). The first provides a scheme for aspirations about the future (temporal) and the second fashions institutions in the present to achieve that future (physical). Crucially, "geographies of the imagination" may conceal that the future-as-promised is fashioned to benefit normative populations and as such is a limited good. As a set of practices (Trouillot 2001), global health can be understood to operate as a somewhat coherent institution (or a near-petrified infrastructure) capable of creating convincing images of the desired future. Through these dominant narrative accounts of the future (see Leins 2020) global health then organizes how we think about the distribution of public goods and then establishes mechanisms for the creation of that desired future.

Although the unfolding present may be best understood as the manifestation of institutions that give shape to a temporarily dominant (but not total) system (Berlant 2016), we can think and act outside of these congealed manifestations, like global health, as long as we are able to recognize that they are geographically and temporally restricted. This has been discussed theoretically as *fugitivity* (Campt 2014; Harney and Moten 2013; Hooker 2017) or the process of creating spaces of existence and sociality outside of what are assumed to be universal institutional arrangements (e.g., existing state architectures) and organizing principles (e.g., cosmopolitan human rights, capitalism, communism). Fugitivity is a means of securing something that has been denied by stepping outside of the dominant social institutions that sequester the thing denied (Hooker 2017). It is a means of exposing the contours and the limits of a system presented as an all-encompassing, natural trajectory of human socio-historical development (Harney and Moten 2013). It is also a process of creating the immediate necessary conditions to satisfy and ensure life in the present towards the fulfilment of the future (Campt 2014). Fugitivity exposes how existing institutions are historically produced and congealed

social relations of privilege[2]. In contradistinction to global health as an *empty signifier*, locating a *charged signifier* may allow a stable point of comparison against global health. A charged signifier would articulate its own positionality in relation to an explicit political project; it would articulate how the immediate effects of an envisioned world-building project unfold in consonance with the distribution of a variety of public goods in the future[3]; and it would articulate a rejection/contestation of existing institutional projects towards new infrastructures. I refer to these projects as *fugitive wellbeing*.

Furnishing a potential case-study for future research on fugitive wellbeing

Through a nationally organized network, OFRANEH (Organización Fraternal Negra Hondureña—Black Honduran Fraternal Organization)—a Honduran social movement associated with the Garifuna ethnic group—provided *care* during and after the COVID-19 pandemic 2020-present) to Garifuna throughout Honduras. OFRANEH initiated these care activities after it became evident that the Garifuna were systematically being denied treatment by both private and public health providers in Honduras (M. Martínez 2023; OFRANEH 2020). Eventually, these networks also began caring for non-Garifuna populations that steadily lost faith in conventional health providers as the pandemic progressed. These networks were organized, primarily, around a Garifuna political project towards self-sufficiency and self-sovereignty (M. Martínez 2023). To fulfill this mandate, OFRANEH shunned both governmental and non-governmental support to create and maintain a collective social project that responded to local health-disease processes, but which did not center either health or health-disease processes. Within these networks, healthy lives and balanced health-disease processes were understood to result from achieving larger social and political goals. *Care* within OFRANEH's scheme resulted from being attentive to relational stratagems that affected (and were affected by) the structuring conditions of life itself within a historically constructed (but not limiting/determining) social landscape that could be supplanted through persistent acts: care as a world-building project. Some have labelled approaches such as this one as "radical hospitality" (Miranda 2024), "radical kinship" (Hedva 2022), "relational care" (Kittay 2016), "solidarity" (Breilh 2010; Goodyear-Smith et al. 2021), or even "love" (Spray 2022).

[2] I increasingly understand the legal codes through which governmental institutions define and operationalize their functions as the petrification of elite privilege or as the materialization of elite *agency* (see Harney and Moten 2013; Wolin 2019; Wynter 2015).

[3] Here I take from Tina Campt's (2014) articulation of "futurity" or how the present and the future unfold simultaneously.

The eu-genesis of OFRANEH's networked infrastructure

The Garifuna are an Afro-Indigenous (Loperena 2022) ethnic group that first settled on the Honduran Bay Islands and then on the Honduran Atlantic Coast between 1797 – 1803 (Davidson 1984). The ethnogenesis of the Garifuna has been traced to the island of Saint Vincent, during the 1600s, where former West African groups (trafficked as slaves to the Americas) and Carib and Arawak Indigenous groups formed a single community isolated from British, Spanish, and French colonial control (Prescod 2022). During the late 1700s, British forces forcibly relocated around 2.000 Garifuna from Saint Vincent to the island of Roatán on the Honduran Bay Islands (Davidson 1984). Once on the Bay Islands, some Garifuna quickly mobilized to the Atlantic Coast of mainland Honduras, some were relocated by Spanish colonial forces, and others remained on Roatán. Over the course of 20 years, these original groups spread across Belize, Guatemala, Honduras, and Nicaragua in at least 4 different waves of migration. The largest Garifuna populations in Central America are in Honduras (~100.000) and Belize (~14.000), followed by smaller populations in Guatemala (~4.000) and Nicaragua (~1.000) (Mohr de Collado 2007).

Throughout Latin America, the negative impact of the COVID-19 pandemic was particularly pronounced amongst Indigenous and Afro-indigenous groups (CEPAL 2020; Flores-Ramírez et al. 2021). The disproportionate impact of the COVID-19 pandemic on Indigenous and Afro-indigenous populations can be related to a prolonged history of discrimination and systemic inequality (Hooker 2008), as well as on a more generalized reality of weakened public health systems prior to the pandemic (Alizadeh et al. 2023; Carmenate-Milián et al. 2017; Garcia Lemus 2022; Verdugo 2004). In Honduras, OFRANEH created their own health response systems during the early stages of the pandemic in late 2020 (OFRANEH 2020; M. Martínez 2023). These local systems were created to provide social assistance services (which included access to medical and ethnomedical treatments) to both Garifuna and non-Garifuna. These local response systems that began in the Eastern part of Honduras quickly spread to the rest of the country.

By late 2021, there were ~22 different response centers distributed throughout the country. As of January 2024, the majority of these centers continued in operation. The continued existence of these centers indicates that they continued to provide critical or necessary services that were not related to the pandemic itself. Exploratory conversations with Melissa Martínez (OFRANEH member) during 2022 and 2023, indicated that these organized response networks initially surfaced spontaneously and haphazardly. However, Martínez stressed these networks quickly turned into organized collective efforts capable of replacing the national health system

at the local level. In fact, the local public health system in the remote Eastern departmental jurisdictions of Honduras even requested assistance from these OFRANEH-led networks to deal with high patient numbers during the height of the pandemic.

OFRANEH's networks arose in response to institutional neglect during the COVID-19 pandemic. These networks were also informed by and grew through transnational collaborations with other Indigenous and Afro-Indigenous networks dispersed throughout Latin America (M. Martínez 2023; OFRANEH 2020). This elevated political capital made it possible to both shun governmental and non-governmental involvement in their particular local project and to establish temporary alliances with other Indigenous groups in Honduras through the establishment of Indigenous-run networks. OFRANEH's efforts to structure a movement for sovereignty and autonomy capable of rivalling the central government led to the development of transnational networks capable of mobilizing varied forms of capital to secure a local response to the COVID-19 pandemic. These networks also made it possible to act beyond the central government by laying claim to forms of recognition and legitimacy that were beyond the Honduran state itself (see Blackwell 2023; Schütze 2018).

In their ethnogenesis, the Garifuna celebrate their emergence as an ethnic group constituted from a mixture of rebellious African and Indigenous groups (Prescod 2022). This leads to a representation of origin that stresses how the Garifuna are the product of groups that have either always been free or have always fought to remain free (Arrivillaga Cortés 2007; N. Martínez 2009). That is, as a group that has always sought to exist outside of imposed modes of governance. In the particular case discussed here, that mode of governance is represented by the Honduran government. Within M. Martinez' (2022, 2023) geography of "imagination" (Trouillot 2002) the Garifuna can be, and will eventually become, a self-sovereign population. Likewise, within Martinez' geography of "management" (Trouillot 2002), the Garifuna are locked in a constant struggle to achieve the conditions that will make it possible to obtain that self-sovereignty. The distributed networks that OFRANEH created to respond to the COVID-19 pandemic sought to reorganize the distribution of public goods in such a way that impacted health outcomes, however the actions carried out by OFRANEH were really orientated towards seizing an opportunity for exercising local self-determination and political control.

Concluding remarks: Mobilizing crisis to move beyond global health

Crisis is generally regarded as a moment of heightened attention to an unfolding episode that spurs action to conceal a socially damaging event and to limit the scope of envisioned solutions (Roitman 2014). Under this conceptualization, crisis demands that structural problems be

addressed through narrow implementations of solutions and solutions are usually framed in terms of necessary sacrifices in return for a known/predictable outcome. Ultimately, a crisis becomes a foil to justify an unpopular decision through, basically, prophecy (see Caduff 2015; Guyer 2007). However, we could go to the root of *crisis* (see "*kreinen*," L. Gordon 1995) and take crisis as an existential impasse where a decision must be made between continuing to participate in a system rooted in bad-faith or pursuing alternatives. We could also complement *crisis as a decision* with a *crisis as method* (Brennan 2024) that conceives of social action in deprecated/vulnerable locales as (sometimes) spontaneous action that may or may not contest a given social structure or that may or may not transform into geographically and temporally extended collective social movements. In both cases (crisis as decision and method), crisis leads to acting outside of/parallel to hostile social structures. Crisis brings to the surface obstacles, challenges and/or insults against which we can organize collective or individual responses while remaining open to the emergent properties of (at least initially) undirected, yet potentially significant, social action (see also "technologies of the imagination", Sneath, Holbraad, Pedersen 2009). Neither crisis as decision nor crisis as method provide a guaranteed or predictable resolution, but they do afford an avenue towards something that is *not this* or *not totally this*.

OFRANEH's political project allowed alternate logics for the distribution of public goods to surface. OFRANEH's project of care represented both a decision and a slow and uncertain (but certainly determined) movement towards a new way of existing without the Honduran government. Within ORANEH's networked infrastructure, the limit to the distribution of public goods depended on achieving self-sovereignty. The total public good under consideration was nothing short of liberation. These two conceptions on goods simply had a positive impact on local health experiences, proving we can impact health by focusing on issues larger than *health*. As noted above, the horizons that accompany world-building projects serve to alter what we should expect from particular social institutions (see Ruger 2016) and aid in formulating spaces of exclusion and inclusion (Fassin 2012). However, the spaces of exclusion and inclusion formulated under OFRANEH appeared to be exclusionary of particular ideas and modes of governance, not groups of people. In Martínez' (2022, 2023) account, the success of OFRANEH's project lay in the momentary separation of local communities from the central government and in local communities' ability to distribute available resources as needed. The inability of the central government to provide an adequate response created the conditions for OFRANEH to demonstrate an ability to self-govern during a generalized moment of crisis that then impacted positively on the health experience of Garifuna and non-Garifuna in the areas

serviced by OFRANEH's distributed networks. Following Martinez' (2023) accounts, OFRANEH's distributed networks offer a compelling alternative case study to global health's world-building projects.

Acknowledgments

Research and writing were made possible by the European Commission (HORIZON-MSCA-2021-PF) through GA 10106593 ("Racializing Health").

References

ABADÍA-BARRERO, César Ernesto, 2015, "Neoliberal Justice and the Transformation of the Moral: The Privatization of the Right to Health Care in Colombia", *Medical Anthropology Quarterly*, 30(1): 62–79.

ADAMS, Vincanne, 2010, "Against Global Health? Arbitrating Science, Non-Science, and Nonsense through Health", *in* Jonathan Metzl and Anna Kirkland (eds.), *Against Health: How Health Became the New Morality*. New York: NYU Press, 40-58.

———, 2016, "Metrics of the Global Sovereign: Numbers and Stories in Global Health", *in* Vincanne Adams (ed.), *Metrics: What Counts in Global Health*. Durham: Duke University Press, 19-48.

ADAMS, Vincanne, DOMINIQUE Behague, CARLO Caduff, ILANA Lowy and FRANCISCO Ortega, 2019, "Re-Imagining Global Health through Social Medicine", *Global Public Health*, 14: 1383–1400.

AFFUN-ADEGBULU, Clara and Opemiposi ADEGBULU, 2020, "Decolonising Global (Public) Health: From Western Universalism to Global Pluriversalities", *BMJ Global Health*, 5(8): https://doi.org/10.1136/bmjgh-2020-002947.

ALIZADEH, Hadi, Ayyoob SHARIFI, Safiyeh DAMANBAGH, Hadi NAZARNIA and Mohammad NAZARNIA, 2023, "Impacts of the COVID-19 Pandemic on the Social Sphere and Lessons for Crisis Management: A Literature Review", *Natural Hazards*, 117:2139–64.

AMRITH, Sunil, 2006, *Decolonizing International Health: India and Southeast Asia, 1930-65*. Cambridge: Palgrave Macmillan.

ANDERSON, Elizabeth, 1999, "What Is the Point of Equality?", *Ethics*, 109:287–337.

ARIAS-VALENCIA, Samuel, 2017, "Epidemiología, Equidad En Salud y Justicia Social", *Revista de La Facultad Nacional de Salud Pública*, 35(2): 186–96.

ARRIVILLAGA CORTÉS, Alfonso, 2007, "Asentamientos Caribes (Garífuna) En Centroamérica: De Héroes Fundadores a Espíritus Protectores", *Boletín de Antropología Universidad de Antioquía*, 21(38): 227–52.

BASHFORD, Alison, 2004, *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health*. United Kingdom: Palgrave Macmillan.

BEAR, Laura, 2016, "Time as Technique", *Annual Review of Anthropology*, 45:487–502.

———, 2020, "Speculation: A Political Economy of Technologies of Imagination", *Economy and Society*, 49(1): 1–16.

BEAR, Laura and Nayanika MATHUR, 2015, “Introduction: Remaking the Public Good”, *Cambridge Journal of Anthropology*, 33(1): 18–34.

BEAUDEVIN, Claire, Jean-Paul GAUDILLIERE, Christoph GRADMANN, Anne LOVELL and Laurent PORDIE, 2020, “Global Health and the New World Order: Introduction”, *in* Claire Beaudevin, Jean-Paul Gaudillière, Christoph Gradmann, Anne M. Lovell and Laurent Pordié (eds.), *Global Health and the New World Order: Historical and Anthropological Approaches to a Changing Regime of Governance*. HAL open science, 2-27.

BENTON, Adia, 2014, “What’s the Matter Boss, We Sick?”, *The New Inquiry*, December 11, https://thenewinquiry.com/whats-the-matter-boss-we-sick/.

———, 2017, “Ebola at a Distance: A Pathographic Account of Anthropology’s Relevance”, *Anthropological Quarterly*, 90(2): 495–524.

BERLANT, Lauren, 2016, “The Commons: Infrastructures for Troubling Times”, *Environment and Planning D: Society and Space*, 34(3): 393–419.

BIEHL, Joao and Adriana PETRYNA, 2013, “Critical Global Health. Evidence-Based Global Public Health”, *in* Joao Biehl and Adriana Petryna (eds.), *When People Come First: Critical Studies in Global Public Health*. New Jersey: Princeton University Press, 1-20.

BIRN, Anne-Emanuelle, 2009, “The Stages of International (Global) Health: Histories of Success or Successes of History?”, *Global Public Health*, 4(1): 50–68.

BIRN, Anne-Emanuelle, Laura NERVI and Eduardo SIQUEIRA, 2016, “Neoliberalism Redux: The Global Health Policy Agenda and the Politics of Cooptation in Latin America and Beyond”, *Development and Change*, 47(4): 734–59.

BLACKWELL, Maylei, 2023, *Scales of Resistance: Indigenous Women’s Transborder Activism*. Durham: Duke University Press.

BOATÇA, Manuela and Julia ROTH, 2016, “Unequal and Gendered: Notes on the Coloniality of Citizenship,” *Current Sociology Monograph* 64 (2): 191–212.

BORDE, Elis and Mario HERNANDÉZ, 2019, “Revisiting the Social Determinants of Health Agenda from the Global South”, *Global Public Health*, 14(6–7): 847–62.

BREILH, Jaime, 1994, “Las Ciencias de La Salud Pública En La Construcción de Una Prevención Profunda: Determinantes y Proyecciones,” *in Lo Biológico y Lo Social: Su Articulación En La Formación Del Personal de Salud*, Washintgon, D.C.: Organización Panamericana de la Salud, 63-100.

———, 2010, “Las Tres ‘S’ de La Determinación de La Vida: 10 Tesis Hacia Una Visión Crítica de La Determinación Social de La Vida y La Salud,” *in* R. Passos Nogueira (ed.), *Determinaçao Social Da Saúde e Reforma Sanitária*. Rio de Janeiro: Cebes, 87-125.

———, 2013, “La Determinación Social de La Salud Como Herramienta de Ruptura Hacia La Nueva Salud Pública (Salud Colectiva)”, Presented at the VIII Seminario Internacional de Salud Pública: Saberes en Epidemiología en el Contexto del Siglo XXI. Colombia: Universidad Nacional de Colombia.

———, 2021, *Critical Epidemiology and the People’s Health*. Oxford: Oxford University Press.

BRENNAN, Eugene, 2024, “Crisis as Method: Politics, Temporality, and Agency”, *The South Atlantic Quarterly*, 123(2): 231–54.

BRIGGS, Charles and Clara MANTINI-BRIGGS, 2003, *Stories in the Time of Cholera: Racial Profiling during a Medical Nightmare*. Berkley: California University Press.

BROWN, Theodore M., Marcos CUETO and Elizabeth FEE, 2006, “The World Health Organization and the Transition from ‘International’ to ‘Global’ Public Health”, *American Journal of Public Health*, 96(1): 62–72.

BRYANT, Rebecca and Daniel KNIGHT, 2019, *The Anthropology of the Future*. Cambridge: Cambridge University Press.

BUSS, Paulo and Sebastián TOBAR, 2016, “Health Diplomacy in the Political Process of Integration in Latin America and the Caribbean”, *in Oxford Research Encyclopedia of Global Public Health*. Oxford: Oxford University Press, 1-27.

CADUFF, Carlo, 2015, *The Pandemic Perhaps: Dramatic Events in a Public Culture of Danger*. California: University of California Press.

CAMPT, Tina, 2014, *Black Feminist Futures and the Practice of Fugitivity*. Helen Pond McIntyre ’48 Lecture. Barnard Center for Research on Women. https://www.youtube.com/watch?v=2ozhqw840PU.

CARMENATE-MILIÁN, Lino, Alejandro HERRERA-RAMOS, Dany RAMOS-CÁCERES, Kathy LAGOS-ORDOÑEZ, Tania LAGOS-ORDOÑEZ and Cesar SOMOZA-VALLADARES, 2017, “Situation of the Health System in Honduras and the New Proposed Health Model”, *Archives of Medicine*, 9(4:1): 1–8.

COMISIÓN ECONÓMICA PARA AMÉRICA LATINA Y EL CARIBE (CEPAL), 2020, “El Impacto Del COVID-19 En Los Pueblos Indígenas de América Latina-Abya Yala: Entre La Invisibilización y La Resistencia Colectiva”, Documentos de Proyectos LC/T5 2020/171. Chile: CEPAL.

https://www.cepal.org/sites/default/files/publication/files/46543/S2000817_es.pdf.

CORONIL, Fernando, 2001, "Towards a Critique of Globalcentrism: Speculation on Capitalism's Nature", *in* Jean Comaroff and John Comaroff (eds.), *Millenial Capitalism and the Culture of Neoliberalism*. Durham: Duke University Press, 351-374.

CUETO, Marcos and Steven PALMER, 2014, *Medicine and Public Health in Latin America: A History*. Cambridge: Cambridge University Press.

DAS, Veena, 2015, *Affliction: Health, Disease, Poverty*. New York: Fordham University Press.

DAVIDSON, William, 1984, "The Garifuna in Central America", *in* M.H. Crawford (ed.), *Current Developments in Anthropological Genetics*. New York: Plenum Press, 13-35.

DUMIT, Joseph, 2012, "Prescription Maximization and the Accumulation of Surplues Health in the Pharmaceutical Industry: The_BioMarx_Experiment", *in* Kaushik Sunder Rajan (ed.), *Lively Capital: Biotechnologies, Ethics, and Governance in Global Markets*. Durham: Duke University Press, 45-92.

EDU, Ugo Felicia, 2024, "Anthropological Knowledge under Redaction: Meditations on Race, Health, and Aesthetics", *Medical Anthropology Quarterly*, 38(4): 462–76.

ERIKSON, Susan, 2016, "Metrics and Market Logics of Global Health", *in* Susan Erikson (ed.), *Metrics: What Counts in Global Health*. Durham: Duke University Press, 147-162.

FANON, Frantz, 2008, *Black Skin, White Masks*. New York: Grove Press.

FARMER, Paul, 2001, *Infections and Inequalities: The Modern Plagues*. Berkley: University of California Press.

FASSIN, Didier, 2012, "That Obscure Object of Global Health", *in* M. Inhorn and E. Wentzell (eds.), *Medical Anthropology at the Intersections: Histories, Activisms, and Futures.* Durham: Duke University Press, 95-115.

FEDERICI, Silvia, 2014, *Caliban and the Witch: Women, the Body and Primitive Accumulation*. Second edition. New York: Autonomedia.

FLORES-RAMÍREZ, Rogelio, Alejandra BERUMEN-RODRÍGUEZ, Marco MARTÍNEZ-CASTILLO, Luz ALCÁNTARA-QUINTANA, Fernando DÍAZ-BARRIGA and Lorena DÍAZ DE LEÓN-MARTÍNEZ, 2021, "A Review of Environmental Risks and Vulnerability Factors of Indigenous Populations from Latin America and the Caribbean in the Face of the COVID-19", *Global Public Health*, 16(7): 975–99.

GARCIA LEMUS, Victor Manuel, 2022, "Disaster Risk Governance in the Midst of the COVID-19 Pandemic in Central America: The Case of Guatemala", *in* T. Izumi, I. Pal and R. Shaw (eds.), *Safety and Resilience of Higher Educational Institutions*. Singapore: Springer, 83-94.

GOODYEAR-SMITH, Felicity, Karen KINDER, Aimee EDEN, Stefan STRYDOM, Andrew BAZEMORE, Robert PHILLIPS, Melina TAYLOR, Joe GEORGE and Cristina MANNIE, 2021, "Primary Care Perspectives on Pandemic Politics", *Global Public Health*, 16(8–9): 1304–19.

GORDON, Jane Anna, 2014, *Creolizing Political Theory: Reading Rousseau through Fanon*. New York: Fordham University Press.

GORDON, Lewis, 1995, *Fanon and the Crisis of European Man: An Essay on Philosophy and the Human Sciences*. Great Britain: Routledge.

———, 2004, "Philosophical Anthropology, Race, and the Political Economy of Disenfranchisement", *Columbia Human Rights Law Review*, 36(1): 145–72.

———, 2010, "Theory in Black: Teleological Suspensions in Philosophy of Culture", *Qui Parle*, 18(2): 193–214.

———, 2021, *Freedom, Justice, and Decolonization*. New York: Routledge.

GROSFOGUEL, Ramón, 2008, "Towards a Decolonial Transmodern Pluriversalism", *Tabula Rasa*, 9: 199–215.

GUYER, Jane, 2007, "Prophecy and the near Future: Thoughts on Macroeconomic, Evangelical, and Punctuated Time", *American Ethnologist*, 34(3): 409–21.

HALL, Stuart and Alan O'SHEA, 2013, "Common-Sense Neoliberalism", Soundings, 55: 8–24.

HARNEY, Stefano and Fred MOTEN, 2013, *The Undercommons: Fugitive Planning and Black Study*. Brooklyn: Minor Compositions.

HARVEY, David, 2000, "Cosmopolitanism and the Banality of Geographical Evils", *Public Culture*, 12(2): 529–64.

———, 2005, *The New Imperialism*. Oxford: Oxford University Press.

HEDVA, Johanna, 2022, "Sick Woman Theory", Topical Cream. https://topicalcream.org/features/sick-woman-theory/.

HINDMARCH, Suzanne and Sean HILLIER, 2023, "Reimagining Global Healht: From Decolonisation to Indigenization", *Global Public Health*, 18(1): 1–12.

HOOKER, Juliet, 2008, "Afro-Descendant Struggles for Collective Rights in Latin America", *Souls*, 10(3): 279–91.

———, 2017, *Theorizing Race in the Americas: Douglas, Sarmiento, Du Bois, and Vasconcelos*. New York: Oxford University Press.

JANES, Craig and Kitty CORBETT, 2009, "Anthropology of Global Health", *Annual Review of Sociology*, 38: 167–83.

KITTAY, Eva Feder, 2016, "The Liberal Autonomous Subject and the Question of Health Inequalities", *in* Mara Buchbinder, Michele Rivkin-Fish and Rebecca L. Walker (eds.), *Understanding Health Inequalities and Justice: New Conversations across the Disciplines*. North Carolina: University of North Carolina Press, 112-134.

KRAUSE, Monika, 2023, "Theorizing from Neglected Cases", *Distinktion*, 25(2): 250–66.

LAKOFF, Andrew, 2010, "Two Regimes of Global Health", *Humanity*, 1(1): 59–79.

LEINS, Stefan, 2020, "Narrative Authority: Rethinking Speculation and the Construction of Economic Expertise", *Ethnos*, 87(2): 347–65.

LOCKE, Peter, 2016, "Anthropology and Medical Humanitarianism in the Age of Global Health Education", *in* S. Abramowitz and C. Panter-Brick (eds.), *Medical Humanitarianism: Ethnographies of Practice*. Philadelphia: University of Pennsylvania Press, 193-208.

LOPERENA, Christopher, 2022, *The Ends of Paradise: Race, Extraction, and the Struggle for Black Life in Honduras*. Stanford: Stanford University Press.

LUPTON, Deborah, 1995, *The Imperative of Health: Public Health and the Regulated Body.* London: SAGE.

MARMOT, Michael, 2004, *The Status Syndrome: How Social Standing Affects Our Health and Longevity*. New York: Henry Holt and Company.

MARTÍNEZ, Melisa, 2022, Exploratory Interview with Melissa Martínez, OFRANEH member.

———, 2023, Follow-up Interview with Melissa Martínez, OFRANEH member.

MARTÍNEZ, Nancy, 2009, "La Historia Como Discurso de Identidad. La Dominación y 'el Arte de La Resistencia' Entre Los Garífunas de Guatemala", *Revista Pueblos y Fronteras Digital*, 5(8): 60–84.

MIRANDA, Dana, 2020, "The Future of Alienation and the Possibilities of Fanonian Sociodiagnostics", *Entreletras (Araguaína)*, 11(2): 53–71.

———, 2024, *The Coloniality of Happiness: A Conversation with Dana Francisco Miranda*. Iscte-CRIA, Portugal. https://www.youtube.com/watch?v=R5xs2WdxbCs.

MOHR DE COLLADO, Maren, 2007, "Los Garinagu En Centroamérica y Otros Lugares: Identidad de Una Población Afro-Caribe Entre La Tradición y La Modernidad", *Indiana*, 24: 67–86.

ONOGE, Omafume F, 1975, "Capitalism and Public Health: A Neglected Theme in the Medical Anthropology of Africa", *in* S.R. Ingam and A.E. Thomas (eds.), *Topias and Utopias in Health*, The Hague: De Gruyter Mouton, 219-231.

ORGANIZACIÓN FRATERNAL NEGRA HONDUREÑA (OFRANEH), 2020, *Medicina Ancestral Garífuna: Alternativas Para Combatir El Coronavirus*. Honduras: Red Nacional de Defensoras de Derechos Humanos de Honduras.

PACKARD, Randall, 2016, *A History of Global Health: Interventions into the Lives of Other Peoples*. Baltimore: Johns Hopkins University Press.

PEARSON, Jessica Lynne, 2018, *The Colonial Politics of Global Health: France and the United Nations in Postwar Africa*. Cambridge: Harvard University Press.

PETRYNA, Adriana, 2009, *When Experiments Travel: Clinical Trials and the Global Search for Human Subjects*. Princeton: Princeton University Press.

POVINELLI, Elizabeth, 2006, *The Empire of Love: Toward a Theory of Intimacy, Genealogy, and Carnality*. Durham: Duke University Press.

———, 2011, *Economies of Abandonment: Social Belonging and Endurance in Late Liberalism*. Durham: Duke University Press.

PRESCOD, Paula, 2022, "Introducing Entanglements and Interdependence in the Americas: Perspectives from the Carib-Kalinago-Garifuna People"*, FIAR,* 15(1): 6–11.

PUAR, Jasbir, 2015, "The 'Right' to Maim: Disablement and Inhumanist Biopolitics in Palestine", *Borderlands*, 14(1): 1–27.

QUIJANO, Anibal, 2014, "Colonialidad Del Poder, Eurocentrismo y América Latina", *in* Elizabeth Arámbulo (ed.), *Cuestiones y Horizontes: De La Dependencia Histórico-Estructural a La Colonialidad/Descolonialidad Del Poder*. Buenos Aires: CLACSO, 777-832.

RAWLS, John, 1999, *A Theory of Justice: Revised Edition*. Cambridge: Harvard University Press.

REDFIELD, Peter, 2013, *Life in Crisis: The Ethical Journey of Doctors without Borders*. California: University of California Press.

REID-HENRY, Simon, 2016, "Just Global Health?", *Development and Change*, 47(4): 712–33.

RICHARDSON, Eugene, 2020, *Epidemic Illusions: On the Coloniality of Global Public Health*. Massachusetts: MIT Press.

ROITMAN, Janet, 2014, *Anti-Crisis*. Durham: Duke University Press.

RUGER, Jennifer Prah, 2016, "Global Health Inequalities and Justice", *in* Mara Buchbinder, Michele Rivkin-Fish and Rebecca L. Walker (eds.), *Understanding Health Inequalities and Justice: New Conversations across the Disciplines*. North Carolina: University of North Carolina Press, 64-87.

SALM, Melissa, Mahima ALI, Mairead MINIHANE and Patricia CONRAD, 2021, “Defining Global Health: Findings from a Systematic Review and Thematic Analysis of the Literature”, *BMJ Global Health*, 6(6): e005292.

SCHÜTZE, Stephanie, 2018, “The Emergence of Transnational Political Spaces”, *Etnográfica*, 22(1): 131–148.

SEN, Amartya, 2000, *Development as Freedom*. New York: Alfred Knopff.

SINGER, Merrill, 2012, “Medical Anthropology and Public Policy: Using Research to Change the World from What It Is to What We Believe It Should Be”, *in* M. Inhorn and E. Wentzell (eds.), *Medical Anthropology at the Intersections: Histories, Activisms, and Futures*. Durham: Duke University Press, 183-205.

SINGER, Merrill and Hans Baer, 1995, *Critical Medical Anthropology*. UK: Routledge.

SNEATH, David, Martin HOLBRAAD and Morten PEDERSEN, 2009, "Technologies of the imagination: An introduction," *Ethnos*, 74(1): 5-30.

SPRAY, Julie, 2022, “Love and Agency in Ethnogrpahic Fieldwork with Children.” *Ethnography*, 0(0): https://doi.org/10.1177/14661381221120209.

STOIAN, Valentin, 2014, “Property Owning Democracy, Socialism and Justice: Rawlsian and Marxist Perspectives on the Content of Social Justice”, PhD Dissertation. Hungary: Central European University.

SUAREZ, Roberto, Catalina GONZÁLEZ URIBE and Juan Manuel VIATELA, 2004, “Dengue, Políticas Públicas y Realidad Sociocultural: Una Aproximación al Caso Colombiano”, *Revista Colombiana de Antropología*, 40: 185–212.

TAMBAKAKI, Paulina, 2015, “Citizenship and Inclusion: Rethinking the Analytical Category of Noncitizenship”, *Citizenship Studies*, 19(8): 922–35.

TROUILLOT, Michel-Rolph, 2001, “The Anthropology of the State in the Age of Globalization: Close Encounters of the Deceptive Kind”, *Current Anthropology*, 42(1): 125–38.

———, 2002, “North Atlantic Universals: Analytical Fictions, 1492-1945”, *South Atlantic Quarterly*, 101(4): 839–58.

TSING, Anna, 2012, “On Nonscalability: The Living World Is Not Amenable to Precision-Nested Scales”, *Common Knowledge*, 18(3): 505–24.

VERDUGO, Juan Carlos, 2004, “The Failures of Neoliberalism: Health Sector Reform in Guatemala”, *in* Meredith Fort, Mary Anne Mercer and Oscar Gish (eds.), *Sickness and Wealth: The Corporate Assault on Global Health*. Cambridge: South End Press, 57-68.

WALKER, Rebecca, Michele RIVKIN-FISH and Mara BUCHBINDER, 2016, “Introduction”, *in* Mara Buchbinder, Michele Rivkin-Fish and Rebecca L. Walker (eds.), *Understanding Health Inequalities and Justice: New Conversations across the Disciplines*. North Carolina: University of North Carolina Press, 1-30.

WHITE, Alexandre, 2023, *Epidemic Orientalism: Race, Capital, and the Governance of Infectious Disease*. Stanford: Stanford University Press.

WOLIN, Sheldon, 2019, "Fugitive Democracy", *in* Nicolas Xeno (ed.), *Fugitive Democracy and Other Essays*. Princeton: Princeton University Press, 100-116.

WYNTER, Sylvia, 2003, “Unsettling the Coloniality of Being/Truth/Freedom: Towards the Human, After Man, Its Overrepresentation--An Argument", *The New Centennial Review*, 3(3): 257–337.

———, 2015, “The Ceremony Found: Towards the Autopoetic Turn/Overturn, Its Autonomy of Human Agency and Extraterritoriality of (Self-)Cognition”, *in* J. Ambrose and Sabine Broeck (eds.), *Black Knowledges/Black Struggles: Essays in Cultural Epistemology*. Liverpool: Liverpool University Press, 181-245.

YARRIS, Kristin and Heide CASTAÑEDA, 2015, “Discourses of Displacement and Deservingness: Interrogating Distinctions between ‘Economic’ and ‘Forced’ Migration”, *International Migrations*, 53(3): 64–69.

YATES-DOERR, Emily, Lauren CARRUTH, Gideon LASCO and Rosario GARCIA-MEZA, 2023, “Global Health Interventions: The Military, the Magic Bullet, the Deterministic Model--and Intervention Otherwise”, *Annual Review of Anthropology*, 52: 187–204.