

'I'm Not that Kind of Doctor'

On Being In-Between in a Global Health Intervention

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ABSTRACT: Within multi-disciplinary global health interventions, anthropologists find themselves navigating complex relationships of power. In this article, I offer a critical reflection on this negotiated terrain, drawing on my experience as an embedded ethnographer in a four-year adolescent sexual and reproductive health research intervention in Latin America. I critique the notion that the transformative potential of ethnographic work in global health remains unfulfilled. I then go on to argue that an anthropological practice grounded in iterative, inter-subjective and self-reflexive work has the potential to create 'disturbances' in the status quo of day-to-day global health practice, which can in turn destabilise some of the problematic hubristic assumptions of health reforms.

KEYWORDS: adolescence, community participation, critical ethnography, gender, global health Latin America, reproductive health

This is the story of my experience being an 'embedded' anthropologist within the context of a biomedically focused health intervention in Latin America and how this experience shaped my understanding of relationships of power and the politics of knowledge in the discipline of global health. It is a reflection on what it meant to navigate the expectations of membership in a multi-country research consortium when my task was to position myself in-between the actions and impositions of intervention activities and the people at whom these interventions were targeted. If global health can be considered a discipline in its own right, rather than as layered and interconnected networks of competing truth claims, then this story is about my (possibly failed) attempt to resist certain ways of knowing and seeing as encouraged within the social world of a health research consortium. I seek here to contribute to the literature of feminist ethnographic practice and gendered interpretations of the 'ethnographic self' through an exploration of my shifting position as expectant mother and new mother within the context of participatory

research activities and participant observation (Bell et al. 1993; Biruk 2012; Biruk and Prince 2008; Coffey 1999; England 1994; Moore 1994; Pigg 2013).

In the early spring of 2010, I signed on as a post-doctoral fellow in medical anthropology at the University of Amsterdam's (UvA) Institute of Social Science Research (ISSR) as part of a four-year, European-Commission-FP7-funded health intervention known as Project CERCA (Community-Embedded Reproductive Health Care for Adolescents in Latin America) (Decat et al. 2013). The health research intervention sites – Managua, Nicaragua; Cochabamba, Bolivia; and Cuenca, Ecuador – were selected as representative of identified public health problems in the region, namely inadequate sexual and reproductive health services; insufficient knowledge of modern contraceptives and sexual health risks; early sexual debut; and socio-sexual norms complicating the discussion of sex and sexuality (Ali and Cleland 2005; Bearinger et al. 2007; Kostrzewa 2008; Lipovsek et al. 2002; Rani et al. 2003; UNFPA 2007). CERCA proposed a 'community-embedded' approach to in-



volve the populations targeted by the project (namely, adolescents, parents and 'community leaders') in project decision-making through ongoing research and consultations. The goal of embedding the project in local communities reflected a desire to increase active participation in health care and access to contraceptives for young people while avoiding the perceived paternalism of top-down public health interventions.

The core research method chosen to establish project impact was quantitative. The team initially hoped to achieve the gold standard in global public health evidence-making: the randomised controlled trial. In practice, the project applied a randomised approach to site selection in Managua, Nicaragua (after pre-selecting municipal units on the basis of income levels), whereas in Cochabamba and Cuenca site selection was purposive. In all three urban settings, the quantitative research teams carried out pre- and post-intervention surveys on knowledge, attitudes and practices in control and intervention sites.

Within this context, a qualitative research component was envisioned as the primary means of better understanding how 'community members' (a problematically assumed category from the outset) perceived the health intervention. While I had the support and critical feedback of an experienced anthropologist at UvA, in day-to-day operations of the project (emails, annual meetings, fieldwork trips) I represented the qualitative work package within the multi-country consortium. This stood in contrast to the substantially more peopled health intervention teams comprising obstetrician-gynaecologists, family practice doctors, nurses, public health professionals, psychologists, health economists, epidemiologists and behaviour-change communication experts.

Within each country team, the decision on how best to sub-divide the 'target' communities was made independently. Although the original proposal for the health research intervention made clear a desire to generate comparative data, pragmatically speaking the selection of control versus intervention populations reflected the particular urbanisation patterns of each city, as well as the political relationships of each country programme partner that would enable or constrain access to clinics, schools and neighbourhoods. For example, in Cochabamba, Bolivia, the team carried out health education in as many high schools as was possible within the boundaries of defined municipal districts, as well as capacity-building efforts in the public health clinics located within these districts. In Managua, Nicaragua, two partner organisations, one of which had extensive experience doing community-based outreach, worked

across a randomly selected group of geographically contained neighbourhoods (smaller in size by unit than those in Cochabamba), bringing their sex educational efforts directly to people's doorsteps as well as to the public health clinics in those same districts. In Cuenca, the team chose individual public high schools (one each) and primary health-care posts located in two semi-rural parishes, Chiquintad and El Valle, as well as one urban high school and one district health centre in Cuenca's city centre.

The ethnographic research was split into two parallel strands. In the first strand, I would do the kind of engaged sitting advocated by some anthropologists as a corrective to the act of 'doing something' about defined global health problems (Pigg 2013). My senior colleague at UvA encouraged the kind of 'deep hanging out' that would lend itself to generating thick ethnographic description in the vein of Clifford Geertz (1973, 1988). With this in mind, I situated myself as a participant-observer of the Cuenca-based health intervention activities, which comprised education and outreach in high schools, capacity-building and training of health workers, health fairs, project meetings, and political engagement activities at the municipal level. This work was split into three-month, six-month and one-month periods to capture distinct moments in the life cycle of the project. One of the target communities, the peri-urban parish of Chiquintad, emerged as the focus of my 'deep hanging out' by virtue of the strength of the relationships that I developed with a range of local gatekeepers (the parish priest, the community librarian, the Elders Club and the high school principal).

In the second, comparative strand of research, I was responsible for a group of project staff members assigned to contribute a percentage of their working time (5%–15%) to the qualitative work package by helping in the recruitment, facilitation and preliminary analysis of peer-group discussions with adolescents and the parents/carers of adolescents that occurred quarterly during the 18-month intervention period. Colleagues in Nicaragua and in Bolivia took responsibility for a select number of peer-discussion groups using a shared facilitation guide. The peer-discussion-group method was chosen to build trust with a select group of young people and their adult carers living in target areas, with the aim being to gain an iterative perspective on the project as it was carried out (Bohmer and Kirumbira 2000; Harrison 2008).

Over the course of the intervention period (leaving out the focus-group interviews and key-informant interviews that formed my first period of fieldwork

in Cuenca), my personal tally came to 68 in-depth interviews, 35 peer-conducted interviews, the facilitation of 22 peer-group discussions, and the production of two documentary films. Beyond these formal data-collection moments, I compiled 22 notebooks of field observations. In effect, I watched and listened and learnt about ‘community perceptions’ of the health intervention, but I was also observed, tested and challenged in the act of practising anthropology by those responsible for the ‘intervening’ itself – that is, the members of the CERCA consortium. It is this position of in-betweenness, with its necessary brokerage and negotiation, that I turn to next.

Imperfect Understandings

How I came to understand the contested truth claims of the project has been necessarily influenced by my grounding in particular kinds of literature and debates. In the four years since Project CERCA ended, I have had the opportunity to contribute to research on conceptualisations of gender in global health (for related work, see Hawkes et al. 2017) and on accountability relationships as they impact health equity (Nelson et al. 2018). This work has given me ample pause to rethink the hierarchies of knowledge that structured the format and functioning of the CERCA health intervention and the ways in which it remained ‘gender-blind’ with regard to internal power dynamics in spite of being a sexuality-and-reproductive-health-focused intervention. In teaching students what it means to ‘do anthropology’ in global health or to work in collaboration with anthropologists, I have revisited debates over the place and power of metrics in this field (Adams 2016; Merry 2011), on the potential of ethnographic work to disrupt and critique ‘business as usual’ in the practice of global health (Biruk 2012; Nichter 2008; Scheper-Hughes 1990), and on the ways in which gender, race, class and any other number of identity markers shape not only the health status of those who we study, but also our own participation in and contributions of voice to the field (England 1994; Moore 1994; Morgan et al. 2016; Waldman et al. 2018).

I share Ida Susser’s concerns about the anthropologist functioning merely as a ‘social critic’ when carrying out research in countries and in communities of which the anthropologist himself or herself is not a member, particularly when it concerns highly politicised health issues such as HIV/AIDS (Susser 2010) or, in the case of CERCA, adolescent sexuality and sexual health. Like Susser, I worked to include

in both interviews and group discussions those individuals whose political views and socio-sexual norms ran counter to the those of the project team and affiliated community leaders. In Cuenca, this meant Colombian migrants, feminist activists, political youth groups, sociologists affiliated with the public university (but not involved in the project), and the head of the local International Planned Parenthood affiliate.

All of these factors shape my current analysis. The direct outcomes of the ethnographic and participatory ethnographic research were analysed and written up previously (Nelson et al. 2014; Nelson and Howitt 2013), but my perspective on the meanings of Project CERCA have undeniably shifted over time. There have been attempts made by former project colleagues to rehash the successes and limitations of the community-embedded approach that CERCA sought to test (Cordova-Pozo et al. 2018; Ivanova et al. 2016), but my take is a different one.

Stacey Leigh Pigg suggests that the policy and decision-making apparatus of global health looks to ethnography as ‘a source of information’, whereas ethnographers themselves, in listening and ‘being *in situ*’, create space for ‘the questioning of received certainties through a responsiveness to multiple viewpoints and contested perspectives’ (2013: 127). In this situatedness, Pigg argues, in this being in the middle of ‘it’, where ‘it’ includes the practices, the knowledge production, and the negotiation of relationships of power inherent to global health, we can only ever understand ‘it’ imperfectly (128). Yet, in openly acknowledging the imperfection of the ‘evidence’ that is gained through watching and listening, or in pointing out the problematic evidentiary claims of certain ‘metrics’, the ethnographer is put into an impossible bind. To explore the nuances of these research dynamics in a reflexive way, I borrow from Pigg’s use of the storytelling format because, as she compellingly argues, ‘narrative better captures the complexity of a research praxis that unfolds in and through complicated intersubjective relationships’ (128).

(In)auspicious Beginnings and Messy Middles

It is 4 May 2010. You are sitting in an icily air-conditioned conference room at the all-inclusive *Barceló Montelimar* beach resort in Nicaragua together with 20-odd consortium partners of the newly minted Proyecto CERCA. This meeting is the inaugural event, bringing together representatives from seven partner organisations from six countries.¹ You will sit at

this conference table for the next three days, making introductions, presenting on work packages and initiating the planning process for phase one.

In this first meeting, a senior member of the CERCA consortium begins by explaining the project's origins. Beamed onto the wall is a photograph of a young woman standing in the doorway of a corrugated tin shack. A thin, white, tank top barely covers her uncomfortably stretched pregnant belly. The senior team member reads out the recorded testimony:

This is Elena, aged 15. When she was 12, she was already looking after her siblings on her own, as her mother left to go the States. She ended up pregnant. She wanted to have kids, but she also wanted to study. She says that it is hard to study with a son. Now she lives at her 26-year-old boyfriend's house. She has problems with her mother-in-law. She says she wants to study and be a lawyer. Lots of her friends are also pregnant, at 13, 14, 15 years of age, just like her. (Field notes, 4 May 2010)

Around the table, your Latin American colleagues are nodding in recognition. They know girls like Elena. They see them in their clinics in Managua, in Cuenca, in Cochabamba. The senior team member concludes: 'I think this testimony is the reason that Proyecto CERCA exists. . . . We can help them to have a better life, a healthier life, the opportunity for an alternative' (Field notes, 4 May 2010).

Later, one consortium member states that for a project that combines investigation with intervention, the 'most important output will be academic articles'. The central objective, in this later presentation, is to 'develop a strategic model for participatory interventions' (Field notes, 4 May 2010). You draw a big star and underline this statement three times in your field notes.

In team introductions, the Ecuadorean team lead begins by saying '*soy médico*'. He tells the group that he is a specialist in obstetrics and gynaecology. You note that everyone follows suit, stating their medical professional status and then their area of expertise. Up until this moment you had not realised quite how medical this project was going to be. When it is your turn, you say 'I'm Erica. I'm a doctor but not that kind of doctor. I'm an anthropologist, an ethnographer'.

Your daughter kicks you in the ribs. You are nearly six-months pregnant, billowing out from your normal compact self. You do not know this yet and no one will tell you until the project is in its final stages, but your colleagues are questioning your ability to carry out your project role as a soon-to-be new mother (and perhaps, questioning your commitment

to the tasks of new motherhood as well). You are in that stage of pregnancy when your body is the subject of public concern and comment. Three days after this workshop, you will be in a craft market in Managua on a sightseeing outing with the CERCA group. A healer notices you. She is squatting down on a small stool with her packages of herbs and tinctures at her feet. She points across the aisle of the market at your belly and shouts, loudly enough for all of your colleagues to hear, 'you are having a girl!' You nod. She is right, after all. Your colleagues turn to consider the size and shape of your belly and agree.

This will be a first ethnographic moment of realising that you have, unwittingly, collapsed some distance between yourself and the so-called 'objects' of the intervention. You will not have read this article yet, because it has not yet been written, but later when analysing the data you will realise just how true it is what Anita Hardon and Deborah Posel (2012) have written about embodiment and secrecy. You *have* a body, and you *are* your body, and your body is saying things at this moment in time that are not in keeping with how you would wish to present yourself to the nascent social world of this health intervention.

You are also on your back foot. It transpires that the terms of reference for research assistants you had drafted together with your UvA colleague has generated controversy among the Latin American partners. You realise, over the course of these three days, that no budgetary line item was established for your work package within individual country programme budgets. Colleagues express a wish to use the money for quantitative research costs and question the validity of an ethnographic approach. One colleague is particularly flummoxed by the possibility that this research will occur in 'control' spaces and thus skew what would otherwise be a 'clean investigation' (Field notes, 4–6 May 2010). There is evident confusion over the ethnographic methodology that you attempt to describe in a presentation, distinguishing it from methods which are qualitative but not anthropological. You lose the battle over resources. Instead of having the necessary funds and management oversight to carry out a multi-country anthropological project, the Latin American partners agree to give a small percentage of one staff member's time per country to the proposed participatory ethnographic work and recruitment of key informants. This is in spite of adamant protests on your part that having the self-same individuals responsible for 'intervening' *also* responsible for gathering community perceptions on the 'intervening' is counterproductive.

And here is another ethnographic moment, just one week later. You are providing a three-day training to colleagues from Ecuador, Bolivia and Nicaragua on a particular type of participatory ethnographic research method (Price and Hawkins 2002). The trainees include a nursing instructor and two physician instructors from the University of Cuenca School of Medicine (the country partner in Ecuador). You find yourself in the unenviable position of trying to run the training while battling back waves of nausea. Your *cuencano* colleagues decide that you must be taken to the public hospital's obstetric ward just down the street to be checked. In the space of one hour, you go from leading a workshop to being in stirrups, belly exposed and covered in ultrasound gel in an open room filled with women in the early throes of labour. A woman whose moans have gotten increasingly loud is wheeled out of the room and down a corridor. You observe the way your colleagues speak to the women in this room (who are darker-skinned than any of your colleagues) versus how they speak to you. They speak to you with a greater show of respect, but it is clear that you are nonetheless a medical object. You notice that people are noticing you, a *gringa*, strapped to a gurney with her shirt pulled up. You hear your daughter's heart beating on the ultrasound machine.

Later that day, you write in your field book diary about how shockingly swift the power dynamic shifted on entering the hospital. One minute, you were teaching doctors and nurses about interview techniques and the construction of open-ended questions, and in the next you were on the receiving end of their medical attention: a patient to be seen, a body to be observed.

When you return for the pre-intervention fieldwork in January 2011, you are accompanied by your husband and your four-month-old daughter. You are raw with new motherhood. You experience a completely different type of fieldwork from anything before. You bring your daughter (and sometimes your husband) when the participant observation takes you to Chiquintad or the centre of town. Your daughter is present at peer discussion groups when breastfeeding demands it. She is strapped to your chest as you and your husband film interviews with young people. She is cuddled and cuddled by a wide range of key informants, peer-group participants and colleagues. You have a different set of emotions connected to your work with teen mothers and mothers-to-be, to young women and young men involved in peer research, now that you are a mother yourself.

You attempt, early on in the process, to carry out observations of contraceptive counselling at one of the intervention clinics but find yourself unnerved by how the doctor (a project colleague) bypasses your attempts to explain and seek informed consent. Consequently, you abandon this line of enquiry. This particular moment – in the clinic – is one with which you will continue to wrestle. You want to understand the dynamics of communication on sex and reproductive health in multiple project spaces, but you cannot reconcile how to achieve this in a way that gives the 'observed' person – and in particular the 'observed' woman – a genuine choice of consent, given the powerful positions held within the local medical establishment by members of the CERCA team. You know intimately what this medicalised embodiment feels like, and you do not want to do your ethnographic 'sitting' in a space where your presence could be interpreted as complicit in how women's bodies are medically judged, or how their bodily concerns might be dismissed.

You return twice more to Cuenca. You spend time with young men and young women, with their parents – or in the absence of their parents – with aunts, uncles, grandparents. You compile stories about the race/class hierarchies that intersect with the norms of adolescent romance. You have far-reaching conversations in the context of peer-group discussions with young people about all the topics that they say are forbidden to discuss with their parents – *What is romantic love? How do you know when you 'have' it? How do you know when you are ready to have sex? What do you say to someone the morning after you have sex? Is porn bad?* You do your best to steer clear of advice-giving in discussion groups or in one-to-one conversations. You try to keep it all open-ended, but in Cuenca – where the sexuality education you have observed has been biomedically focused, you find that these peer-group discussions have become another type of intervention. They open up a performative and creative space of enquiry about the nature of affective relationships and gender norms that, once opened, you now realise cannot be closed so easily.

Later, when not in the field, you read Catherine Ashcraft's (2006) work on the 'discourse of readiness' in adolescent sexuality education. She writes about how this discourse is closely related to adult fears that 'open talk' on sex constitutes evidence of having sex or can induce sexual initiation when it would not otherwise happen. You realise why your work has become so problematic in Ecuador, where colleagues preach an abstinence-before-marriage message in the intervention schools. The very act of your open

communication with young people, in the context of soliciting their perspectives on the intervention, is in itself creating risk. If you are willing to talk about things that other adults are not willing to talk about, then – according to this logic – you might create conditions of ‘sexual readiness’ before young people are deemed ready by their adult carers or by the medical professionals involved in CERCA. In Cuenca, becoming sexually active with someone who has a lesser degree of *palanca* constitutes a major social and economic risk, (*palanca* refers to the reciprocity ties that help ensure access to jobs and political power). All this open talking threatens established gender, race-based and spatial hierarchies of power.

Your final trip, this time solo, is to attend an international conference hosted by the Cuenca team. One afternoon, you lead a small group of non-Ecuadorean colleagues to lunch at a favourite local place. As you walk along, a project colleague asks: ‘Why were you never part of our group? Why did you keep yourself separate from the CERCA team?’² The question surprises you, both because it is a blunt statement of the obvious and because, at the same time, it reveals a truth that you assumed would remain implicit. You offer up something about the nature of ethnographic enquiry and the need to distance yourself from the ‘intervention’ in some way in order to build relationships of trust with those at whom the intervention was targeted. You blather a bit about the value of multiple, potentially critical, perspectives on the project, but your colleague’s words niggle at you. You wonder whether maintaining that in-between space of ethnographic research within the context of a health intervention necessarily demands slippery allegiances, or whether you were just ‘doing your job’.

Narrative Ruptures and Unsatisfactory Endings

The truth of what I experienced as ‘not that kind of doctor’ on a biomedical health intervention was much more complex than I was able to formulate in that introductory moment of the project. How much of the conflict over what an anthropologist could or should contribute to an adolescent sexual and reproductive-health intervention was tied up in my personal experience of pregnancy and birth and motherhood? To what extent was my position within the project defined by the methods that I used, and to what extent was it defined by assumptions about the values that I represented? Was I functioning as what David Lewis and David Mosse (2006) would

term a ‘broker and translator’ between the objectives of a European-funded development initiative and a target population, or was I performing the role of anthropologist as social critic? Did I conduct my fieldwork in a way that was fully cognisant of what Benedetta Rossi calls ‘the complex issues of self-reflexivity, positionality and power?’ (Rossi 2004).

In truth, I struggled to negotiate my position in a health intervention that was sceptical towards anthropological methods at best, and obstructive at worst. This disciplinary and inter-subjective negotiation itself is not new. After all, as Henrietta Moore posited in 1994, ‘the position of the anthropologist has always been ambiguous and uneasy because it has depended on a stable division between “us” and “them”’ (1994: 5). However, the fact of my pregnancy and new motherhood added an additional dimension to the instability of this division. In past fieldwork experiences (Bolivia), I had dealt with unwanted (male) attention and harassment on a daily basis, but the nature of my sexual proclivities was subject to speculation rather than direct questioning. Now, I found my sexual life and reproductive choices were fair game for open questioning by colleagues and project participants. Whereas in the past the concern of the people I worked with was whether I was *capable* of getting a husband and getting myself pregnant, now the questions were more specific: *How had I avoided getting pregnant for so long? What contraception did I use? Did my husband want more children? Was I trying for more children? When did I first become sexually active?*

By the same token, my listening-focused practice and outsider status turned me into a *de facto* professor of project colleagues’ personal lives. I was told of unwanted pregnancies, forced marriages, physically and emotionally abusive relationships, the stigmatisation of being divorced, and confidential information that I should not have been given (and for which I did not ask) about clinic-based interactions with young people involved as peer researchers. The notes that I took on these encounters with colleagues, as valid as a potential source of anthropological analysis as the data collected from focus-group discussions, were silenced in the context of co-authored articles. I was caught in the bind of having insights into the internal gender dynamics and personal politics of the teams responsible for carrying out a sexuality- and gender-focused intervention while being contractually obligated to produce research results that spoke to the objectives of the intervention as if these teams were neutral parties.

The tension that underlay my engagement at the country level stemmed from two unresolved ques-

tions: first, *at whom was my critical gaze directed?* and, second, *with whom were my alliances formed?* Latin American colleagues were not wrong to understand this critical gaze as threatening (Colvin 2015; Scheper-Hughes 1990; Susser 2010). After all, I had been trained to pay attention to discursive strategies, competing epistemologies and negotiations over meaning within social groups – *how could I not* train my critical gaze on the CERCA consortium itself? To ignore the power struggles over how best to ‘render technical’ (Rossi 2004) young people’s sexual behaviours in a European-Commission-funded health intervention would be to turn my back on disciplinary teachings and long-standing debates on the role of anthropology in development and global health (Biruk and Prince 2008; Escobar 1991; Hopper 2013).

The discursive practices of global health that serve to conceal disjuncture and discord are well established. These narratives of project success and lessons learnt do not need more adherents. The very nature of expanding the ethnographic work to include participatory approaches created and encouraged dynamics that generated fiction within the consensus-building aims of the project. There was no ‘one’ community, neither within the time-bound social world of the project itself, nor within the geographic spaces labelled and marked as sites of community-embedded intervention (Biruk and Prince 2008; Nelson et al. 2014). With a background in critical analyses of sexuality education for adolescents (Ashcraft 2006; Bay-Cheng 2010; Gúzman et al. 2003), it was impossible not to be tuned in to how project representatives framed the ‘problem’ of certain adolescent sexual behaviours in moral and gendered terms or idealised certain paths to motherhood. Ultimately, I could not be part of the consensus-building aims of the project because I was not part of the consensus itself.

Conclusion

The final official event of Project CERCA was an international conference organised by the Ecuador team, which targeted medical professionals and public health practitioners in the Andes region. CERCA consortium members were expected to present the results of their respective work packages, including quantitative measures of impact and qualitative research results. The prized attendee was a senior representative from the World Health Organization. In his keynote speech, he emphasised the importance of such health interventions delivering measurable outcomes, logical frameworks, determinants of health

that can be measured and programmatic models that can be brought to scale – all standard global health goals and framings. He exhorted the audience to help generate models of success that could be replicated. It was clear that he took a dim reading of the initial quantitative data collected by Project CERCA, which failed to demonstrate significant impact on the markers of change that were identified. In conversation later that day, I asked him where the place for anthropology was in this imagined future of scaled-up sexual health intervention models and a global reduction in adolescent pregnancies. Where would local and context-specific perspectives fit in? What role was there for disciplines like anthropology? He replied: ‘Multi-disciplinarity is important, but why all this poetry? Where is the evidence?’ (Field notes, 12 February 2014).

When I first drafted this article, I hoped that I might be able to offer some kind of useful insight into how to position anthropology, and the anthropologist, within the field of global health. The truth is that it is a constant dance and that there is no stable foothold to be found. There is no prescribed ‘best practice’ for an engaged anthropology that sits, purposively, in the in-between spaces that multi-disciplinary global health research or community-based health interventions create. However, there is much to be gained from the affective and relational disturbances that ethnographic practices can give rise to in the status quo of the discipline of global health. There are cracks and fissures in the positivist cataloguing of people and behaviours that begins to open up, or as one colleague told me: ‘I now understand that target groups are people too’. While the discipline of anthropology, broadly speaking, has spent ample time in a reflexive and self-critical modality, the discipline of global health could use more time in the trenches of inter-subjectivity and intersectionality. These are tricky epistemological borderlands that are made trickier by the multiple selves which the anthropologist brings to bear on the practice of fieldwork in global health and the navigation of its distinct social worlds. Perhaps all this talking is (productively) dangerous after all.

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Notes

1. Project CERCA's team members included the International Centre for Reproductive Health, Ghent, Belgium (ICRH); the University of Amsterdam's (UvA) Institute of Social Science Research (ISSR), Amsterdam, the Netherlands; Instituto Centroamericano de Salud, Managua, Nicaragua (ICAS); Centro de Investigaciones y Estudios de la Salud, Managua, Nicaragua (CIES); The South Group, Cochabamba, Bolivia; the University of Cuenca Medical School, Cuenca, Ecuador; and the Department of Family Medicine, Lithuanian University of Health Sciences (LSMU), Kaunas, Lithuania.
2. This is the quote as remembered later that same day when written into my field notes, whereas other quotes were taken from shorthand transcriptions of direct speech.

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