We are all familiar with an approach to values that emphasizes philosophy, political theory and other high-level, discipline-based, theoretical discussions of values. These top-down approaches are important in our estimation because they outline core issues through rigorous analysis of ethical principles and reasoning. The social sciences and humanities, however, also have a central role in adding a contextually rich empirical approach. In contrast to theory from above, such approaches begin by describing on-the-ground, lived values, conflicts, and practical quests for resolution. Ethnographies, social histories, survey studies, and narrative analyses then move outward to make larger claims about how actual moral experience and ethical formulations are articulated.

We simply have to look to current events to see the potential importance of social science and humanities methods in global health initiatives. In April 2007, BBC news reported on a new child vaccination initiative in Iraq (2007). With the ongoing violence in the country, a cohort of young Iraqis missed routine immunizations, leaving them vulnerable to several deadly childhood diseases. In particular, the international health community has been worried about a measles outbreak. In April, teams of vaccinators,
overseen by UNICEF and the World Health Organization began working towards their goal of inoculating 3.9 million children against measles, mumps, and rubella. The BBC story followed an Iraqi woman vaccinator, Um Rafid, who had more than 15 years of experience. The vaccinators walked from door to door in a neighborhood asking if there were any children under 5, and if so vaccinated them and then marked the door. Um Rafid’s fears of knocking and finding men with guns haunted her work. And yet her most visible frustration was with young mothers who were afraid to have their children vaccinated or lacked even the basic health knowledge to recognize disease symptoms in their own children. The structural factors impeding the success of this program are overwhelming: ongoing sectarian violence, the erosion of social trust, massive internal migration, and a foreign occupying power that throws the motives of all “aid” workers into question. The ethics of the situation seem relatively clear: children should and must be vaccinated. But the necessary question of implementation is murky indeed. Um Rafid’s actions and those of her co-workers animate a lived reality of value commitments, emotions, and conflicts that are inseparable from their local world and from the large political and military forces that have transformed that world so that it is radically different for vaccinators in Iraq today than it was prior to 2003 or in the US and the UK.

In this paper we will explore similar tensions in global health and offer an approach to global health values drawing on the concept of moral experience. Through several examples from global health, we will demonstrate both the appropriateness of this approach and its utility for practical questions of values in the field.
I. Critiques and Responses

The field of bioethics has been the object of several scholarly critiques in the last decade. In 1999, a diverse group of scholars published a special issue of *Daedalus* calling for a re-examination of bioethics to complicate its seemingly narrow geographical and epistemological focus (Kleinman, Fox, and Brandt 1999). Taking a global and historical approach, the volume called for a new framework that would recognize dominant bioethics as one particular local discourse rather than a universally shared set of norms. The authors suggested that the social sciences and humanities could provide a renewed understanding of bioethics by focusing on context and practice as a strategy to move beyond universal normative judgments. They sought to enable ethical discussions that seriously engaged with non-Western cultures, radically different political and economic relations, and empirical studies from ethnography and social history to legal, literary, and neuroscience analyses.

Since the publication of the special issue of *Daedalus* on bioethics, the field has undergone further transformations over the last 8 years. The most notable is an increasing attention to ethics in an international context, leading to the creation of several new journals devoted to global bioethics, most notably *Global Bioethics*. Social scientists have also begun to address systematically questions of ethics, traditionally reserved to philosophers. New ethnographies of social suffering, illness experiences, medical technologies, and political violence (see Cohen 1998, Lock 2002, Petryna 2002) have gained a prominent space within our own field of anthropology, thus making ethics a mainstream concern of our discipline as well as other fields in the medical humanities. As new frameworks develop, however, very valid critiques have soon followed.
The new discourse of ‘global bioethics’ has raised concern among those of us weary of neo-humanistic discourses that may hide the imperialistic norms behind a veil of “ethics for all.” Despite the movements in both the social sciences and in bioethics towards a global framework, our analyses still lack cohesion. Too rarely do philosophers and social scientists engage with each other and infectious disease and other global health experts as we are doing today to share and synthesize our knowledge. To answer the pressing ethical dilemmas we face today we have to find a new common direction, such as the medical humanities that structurally bring together scholars from a variety of disciplines around this one issue.

II. A Theory of Moral Experience

Building on this broad platform of the medical humanities, we would like to begin with the idea of moral experience, which the first author developed more extensively in his Tanner lectures (Kleinman 1999) and What Really Matters (Kleinman 2006) before we return to the subject of global bioethics. Moral experience is made up of the flow of interactions between people living in what anthropologists have called “local worlds”. By local world we refer not only to the traditional anthropological imaginary of the ethnographer’s village, but to the range of communities that characterize contemporary times. These may be, as they are so often in our globalized world, institutions, transitory communities or even transcontinental networks. Within any given local world, life is, by definition, a social, inter-subjective experience lived with others. It is in these interactions with others within a particular local world that experience may be described as the flow of our engagements.
Experience is therefore not limited to the individual but understood as intersubjective or interpersonal. And this means that experience is also necessarily moral because there are things deeply at stake for the person, the network, and the local world. In this framework, morality is explicitly distinct from ethics. While ethics, in a narrow sense, stands for the universalistic discourse of norms and values produced by powerful players on the global stage and in the broadest sense stands for the trans-local aspirations of individuals, morality is contextual, localized, and highly specific. Morality is what is at stake for each of us and our communities, and may at times be profoundly unethical. Because there are things most at stake for each of us, whether they are particular or whether they are widely shared concerns, all of our lives are serious, moral undertakings that turn on how we live, express, and negotiate deep values. These widely shared concerns are easily recognizable in the world and they include how material resources, religious commitments, close relationships, the self, and life itself matter to us. Although many of these fundamental concerns are shared across societies, undoubtedly culturally distinct and personally particular issues are also at stake in any particular local world. And, of course, the value commitments of individuals and groups can be and often are conflicting.

There are also threats to what is most at stake that constitute the source of social danger in our lives. In all societies danger is a central part of what it means to be human. Key words, like “endurance”, “survival”, “making do”, “doing what is necessary to get on”, indicate how important danger is in people’s lives, in the transmission of knowledge, and in all the activities that make up our social world. There is however, besides the threats that we feel to things that are at stake - like family relations, like our own lives –a
second order danger, which is the danger that can come from our responses to the threats that we perceive. This second order danger happens when we attack or seek to eliminate others who we feel in some way are challenging that which is most at stake for us. In the face of danger, of our local world being endangered by perceived threats, we make decisions that are essentially moral even though they may be far from ethical. In the following sections we will draw from extended case studies of suicide in China, Stigma in the United States and China, and political violence in Argentina to demonstrate precisely the utility of this model and its attention to experience and morality.

III. Illustrations from Global Health

Suicide in China

According to the World Health Organization there are approximately one million suicides in China each year\(^1\). Suicide accounts for three to six percent of all deaths, making it the fifth most important cause of death in China, across all age groups (Murray and Lopez 1996). Among young adults and adolescents, 15-34 years of age, suicide is the leading cause of death, accounting for almost 20% of all deaths (Desjarlais et al. 1995). The rate of women’s suicide is 25% higher than that of men, which is truly remarkable in cross-cultural perspective given that India is the only other country with more suicides in women than in men. In fact, forty percent of all suicides of women in the world occur in China, which is almost twice the percentage of women worldwide who are Chinese (Murray and Lopez 1996).

\(^1\) see http://www.who.int/mental_health/resources/suicide/en/index.html
The enormity of the problem in China can be attributed to the large number of suicides in young rural women (Phillips, Liu, and Zhang 1999). Rural rates are three times higher than urban rates and 90% of all suicides occur in rural China. When one looks at the causes for suicide in Chinese society the data suggest that less than 60% of all suicides in China and maybe as few as 40% are due to a mental illness (Lee and Kleinman 2000). These findings (see also Ji, Kleinman, and Becker 2001) temper Western biomedical beliefs that suicide is primarily the outcome of depression or related mental illnesses.

From an outstanding recent ethnography on the issue by Wu Fei as well as research by Lee and Kleinman (2000), we have evidence that a leading reason for suicide is perceived social injustice in the family setting (Wu 2005). For example, take the case of a woman whose husband has gone to the city, leaving her alone with the responsibility of taking care of elderly in-laws, farming, and raising the children. This coupled with the very real possibility that over time, the husband working in the urban settings will gradually reduce the amount of money he returns to the family and may even start a new family in the city, creates tremendous intra-familial tensions, which can eventually lead to suicide as a response to the perceived enormity of social injustice. This social basis for suicide is of course familiar to historians of classical times. In ancient Rome suicide was considered an appropriate response to public humiliation, and indeed as one of the few paths to recoup honor and status. The view of suicide as necessarily caused by clinical depression –central to contemporary Western biomedical practices- may obscure some of the less ego-centric forces at work. As we see illustrated in this case, suicide may be related to economic migration and other developments that intensify conflicts between
family and self. In other words, suicide is an individual act within a local moral world where that act carries multiple, powerful meanings. Through an attention to moral experience as a contextual manifestation of what is at stake for people and groups, we can understand suicide outside the limits of an individual-based model. More importantly, these findings allow us to develop more effective interventions that take into account the social nature of suffering and are therefore better equipped to address the rise of suicides in contexts such as China.

**Stigma**

Research on stigma has traditionally been conceptualized in individualistic terms, focusing on the exclusion and marking of the individual who is stigmatized (see Goffman 1963, Jones 1984). Recent work in medical anthropology has attempted to retheorize stigma in terms of moral experience through two examples: mental illness in China and first-onset Schizophrenia in the United States (Yang et al. 2007). Treating stigma as an essentially moral issue allows for an attention to what is at stake for people both those who are stigmatized and those who stigmatize. In a move towards a more global theoretical approach, Yang et al. borrow the Chinese concept of face to conceptualize how stigma is at once *moral-somatic* –that is that values are linked to physical experiences-- and *moral-emotional* –that is that values are linked to emotional states. Although these emotional and physical states are necessarily individual, they cannot be extracted from the local moral world and interpersonal flow of lived experience that is the ground for their being. Thus a focus to moral experience, rather than a narrowly individual or structural approach, allows for a renewed attention to the complex nexus
that characterize something that is at the same time deeply personal, profoundly experiential, and necessarily intersubjective. More importantly, Yang et al. move outward from their theory to propose practical adjustments to research and stigma prevention programs, namely the use of transactional methodologies and a reliance of multiple perspectives to capture the complexity and diversity of stigma.

**DNA Identification in Argentina**

Between 1976 and 1983 a military dictatorship in Argentina disappeared approximately 30,000 young Argentines in what was termed a process of national reorganization and in reality amounted to a war against the political and social left. Those taken by the State to clandestine torture centers and eventually killed ranged from activists and social reformers to guerillas, priests, and even babies in their mothers’ arms. Children born in captivity or kidnapped with their parents were given to military families to be raised, quite literally, “right”. These political prisoners and kidnapped babies came to be known internationally as Argentina’s disappeared – *los desaparecidos*.

The state-sponsored terrorism of this period had important effects not only on families left searching for their missing children, but also on society more broadly, creating a climate of fear and silence. Now more than twenty-five years later, family members are still searching for the disappeared. In present day Argentina, this means searching for a son or daughter’s body that has been missing for 25 years or a grandchild who has lived his or her whole life never knowing his or her biological family. Given the reality of time and the powerful political forces keeping such knowledge safely hidden, families have turned to science, rather than political processes to accomplish this task.
Although technologically this process might seem relatively straightforward given the sophistication of DNA and anthropological methods of identification, in practice it has proven beyond difficult leading to the successful identification of only 300 bodies out of 30,000 and 86 missing children out of 500 in of twenty five years of scientific work.

By focusing on moral experience we gain a more nuanced understanding of the multiple stakes at play in a seemingly simple identification. Over fourteen months of fieldwork by the second author has shown that the morality surrounding forensic DNA identification is anything but simple; rather, it carries with it a host of meanings and implications about the biological basis of identity, the possibility for criminal prosecution, and the stability of personal and collective histories. For a grandmother who has spent her life searching for her grandchild a positive DNA match speaks of a return to truth. For the state, that same test announces a continued commitment to redress the wrongs of the past. And, for a young adult finding out her biological identity often means facing the reality that the only family she has ever known was complicit in the death of her biological parents. By looking at what is at stake for people in the face of not only historical dangers but also the dangers inherent in processes redress, we recognize the danger in reductionistic technological interventions. Although global health initiatives are quite justifiably oriented towards practical problem-solving tasks, the Argentine case points to the exaggerated promise and limited power of such approaches. Unequivocally, identification has been crucial to processes of political, social, and individual health. Nonetheless it has been unable to fulfill its promise as an arbiter of the truth about the past. Although questions of violence and trauma are often excluded from traditional global health agendas, we suggest that violence and its legacies are intimately linked to
health and must therefore form a core part of global health concerns. Facing the murky ethical questions of violence, responsibility, and political and social reconstitution are essential in building any effective global health initiative in a post-conflict setting.

*Iraq: what can we learn?*

A framework that makes us account for the social dimensions of individual experience can be invaluable to global health issues more broadly. Returning to the case of immunization campaigns in Iraq, it is clear that a simplistic individual-based model of healthcare is failing the task. When Um Rafid decries a mother’s failure to seek or allow preventative treatment for her child as an issue of health education, she is inadvertently putting the blame on the individual and discounting the effects of larger structural inequalities. An approach based on moral experience allows for both an acknowledgement of the lack of education as well as larger social values and stakes that lead to this particular moral dilemma. When a health official knocks at a mother’s door to immunize her child, that encounter is laden with the dangers of social life. Will that official harm her child? Who does the official represent, in a country torn apart by foreign invasion and internal civil war? What will the X marked on the door upon the official’s departure signify to neighbors, spies, and representatives of the government? In such a treacherous local moral world, the standard bioethical debate about vaccinations – framed in terms of parental autonomy vs. public interest in the United States- takes on dangerous and sinister meanings.
In the final section of this talk, we will layout what we see as the core ongoing issues in Global Health and offer recommendations, growing out of the insights of an attention to moral experience.

IV. On-going issues in Global Health and Recommendations

Conflicts of Interest

Global health, like much of contemporary Western biomedicine, is necessarily deeply entwined with the market. Researchers and practitioners face questions of conflict of interest in much of their work. Although there is an increasing attention to these conflicts in US biomedicine, global health is curiously devoid of such debates. Given the great potential for abuse in exploitation framed as “help” to impoverished and needy others, it is imperative that global health formulate effective means for making conflicts of interest transparent. Standard reporting practices already in place in US research endeavors and publications are a necessary first step. However, we suggest that an attention to moral experience might also be useful in this context. When we discuss moral experience, we often think of it as something that the people we study possess and that our attention to it will allow us to be more attuned to values on the ground. The same can be said for researchers themselves. By explicit attention to what is at stake for researchers and global health practitioners, we can begin to recognize the range of motivations behind our work and begin to develop better practices for dealing with the various conflicts of interest that necessarily arise in global health research.
Social Suffering

We want to make a renewed appeal for an attention to social suffering (Kleinman, Das, and Lock 1997) in global health initiatives. The global health agenda has been framed rather narrowly primarily around infectious disease. But international researchers undoubtedly recognize that structural issues are often the largest impediments to effective interventions, as we see so clearly in the case of Iraq. On the ground illness experience is deeply shaped by political economy, and we suggest that therefore it can’t fall out of our programs and interventions. As the inspirational work of Partners in Health has shown us, addressing these fundamental injustices is a necessary part of effective interventions. Traditional ethics approaches because of their focus on the individual often miss the centrality social and structural oppression. If we focus on morality with its interpersonal view of experience, we necessarily attend to structural violence and its very real health implications.

Global Hegemony

In this new century we are seeing shifts in global dominance as new countries and world regions are on the rise. No doubt this shift in will have important effects on the salience of western bioethics approaches. What would a truly global bioethics look like? We suggest that bioethics should and must incorporate non-western perspectives and valuations if it is to continue to be a useful tool for addressing the ethical quandaries of our times (Hyakudai 2002). Although moral experience is a western social theoretical model, it may be a first step towards incorporating non-western viewpoints. By recognizing that bioethics is one particular local moral discourse, albeit one invested with
power, among many local moral discourses, we can begin to destabilize its truths making way for a multiplicity of perspectives more in tune with the globalizing world.

V. Conclusion: The Medical Humanities

In conclusion, we offer the medical humanities as an emerging discipline capable of bridging multiple academic fields and producing a more-comprehensive set of perspectives on key issues in global health. We speak of the medical humanities as that broad array of disciplines from the history of science and medicine to medical anthropology, medical sociology, and including literary, aesthetic, and religious studies of health and illness. We view medical ethics as one of the important contributors to this field. Like medical ethics, the other disciplines in the medical humanities are also concerned with deep values. Newer approaches to medical ethics share with these other disciplines concern for empirical research on moral experience that can enlarge and deepen the knowledge base that is crucial to ethical deliberation. We take this to be especially important in global health, where significant differences in cultural, political, and economic realities create greatly distinctive local worlds and where globalization is reworking indigenous value traditions. In such a diversity of settings, it is simply essential to be able to describe the nested contexts –community network, family, self—where what is most at stake is worked out in health, illness and health care.
Works Cited