Over the past two decades, a sociology of global health has emerged. While this new subfield takes up some themes and issues that are familiar to the discipline as a whole—among them organizations, social movements, and the social construction of illness—it has also posed new questions and opened new research pathways by formulating and testing theory in environments radically different from the United States. This work has forced sociologists to confront the ethnocentrism of research paradigms that are grounded in the American experience and to consider classical assumptions and constructs in fruitful new ways. Notable recent literature reviews have taken up the issue of HIV/AIDS in sub-Saharan Africa, comparative healthcare systems, and the sociology of development. However, this review is the first to outline the contours of a coherent sociology of global health. It addresses several questions: What issues are being taken up in this emergent subfield? What added value comes from turning scholarly attention beyond our borders? And what new research agendas lie on the horizon? 

**KEYWORDS**

global health, development, global and transnational, literature review, sociology of global health

Over the past 20 years, a sociology of global health has emerged. Although it draws on numerous subfields, including organizational sociology, science and technology studies, and global and transnational sociology, the sociology of global health owes its existence primarily to the inability of sociology’s two most relevant subfields, medical sociology and the sociology of development, to provide frameworks and theories for understanding global health challenges and the national and transnational responses that accompany them.

Medical sociology textbooks have typically paid their respects to “international issues” by reserving a final chapter or two for comparing healthcare systems (mostly in the United States and Europe). Yet, no commensurate research program within medical sociology has developed that is aimed at explaining the complex contemporary global health landscape that has emerged, or the processes governing the web of transnational institutions that now serve critical functions in defining disease and protecting human life.

For its part, the sociology of development has historically understood development primarily as a problem of economic growth (McMichael 2008; Roberts and Hite 2007). Yet, the economic costs and consequences of global health challenges are enormous: over the past 30 years, emerging health challenges have prompted donor countries to spend vast sums of money and form new institutions dedicated to halting the rise of HIV/AIDS and other emerging infectious diseases. Apart from research inspired by Amartya Sen’s (1999) efforts...
to connect development to the enhancement of human capabilities, health has strangely not been a major reference point for sociological theories of development.

While some of the few important sociological analyses of the field of global health explore much longer timeframes (Inoue and Drori 2006), many argue that it is only in the last 20 to 30 years that we have seen a marked transition in the approach nations and public health institutions have taken to global health (Brown 2011; Collier and Lakoff 2013). Central to these changes have been the increased pace of trade and travel, the reemergence of infectious diseases, and the broader effects of globalization. International engagement with public health concerns, from responses to epidemics that threaten to cross borders (Chien 2013), chronic health risks (Brown and Bell 2007), and pharmaceutical access (Chorev 2012a) to universal health coverage (Harris 2017a), are increasingly coordinated through a network of national governments, health systems, NGOs, and multilateral organizations.

These actors are at least rhetorically bound to a shared project that aims to promote the physical and mental health of all people everywhere. Yet, great variation exists in organizational strategies and motives (Chorev 2012a; Lakoff 2010:59), and global health has been recognized as both an ideology of health promotion and a field of practice, even if a consensus definition remains elusive (Farmer et al. 2013; Koplane et al. 2009). Sociology, with its attention to structural forces and its abiding concern with inequality and global and transnational forces, has been particularly well suited to produce useful insights into these changes.

With few exceptions, books like Health and Health Care in Developing Countries (Conrad and Gallagher 1993) and Society, Health, and Disease: Transcultural Perspectives (Subedi and Gallagher 1996; see also Mechanic and Rochefort 1996; Light 2013) represented some of the first sustained efforts by prominent medical sociologists to take up health issues beyond the Western context. However, early contributions to the emerging sociology of global health, including work on HIV/AIDS, took place at the discipline’s margins in interdisciplinary, or health-, development-, or illness-focused journals (Watkins-Hayes 2014:434).

More recently these issues have been explored in sociology’s most prestigious journals and books from top academic presses. The AIDS epidemic, in particular, has opened the door for scholarship on a range of issues that the epidemic has impacted, from social structure and inequalities to culture and organizations to macro-social forces and actors. Interest in global health has also grown alongside vibrant new American Sociological Association sections on Development and Global and Transnational Sociology.

Contributions to the emerging sociology of global health have therefore examined familiar themes in sociology—among them, social movements and the social construction of illness—while simultaneously reimagining them in interesting new ways. Exploring the realm of the global is not only distinct from nation-state perspectives (Brenner 1999; Go 2014) but also sensitive to cultural differences and accounts for nonstate actors and spaces that make up global relations (Buranwoy et al. 2000). Though this work recognizes the position of states as arbiters of rights and laws, and the management of populations remains an integral component of sociological macro-analyses, domestic agents are now understood within a broader constellation of actors (Morgan and Orloff 2017).

Research in historically neglected international contexts provides fertile opportunities for testing theory that is grounded in the “exceptional” American experience, and for generating
new theoretical concepts that are applicable to large swaths of the world. Taking a more global perspective also enables us to understand existing concepts in novel ways. This review points to the dominant themes in this emergent scholarship to show how it both builds on existing theory while distinguishing itself as an active subfield characterized by its own unique concerns and debates.

PURPOSE AND LIMITATIONS

This review explores the nascent field of global health within American sociology, work which we believe responds to calls to make the “international” a more robust theoretical category [that will] . . . extend the discipline’s global reach [and its] . . . theoretical range, not only its empirical scope” (Kennedy and Centeno 2008:671). We point to sociological research on health that has sought to transcend national borders and train our gaze beyond the United States. While many publications cited draw from the discipline’s leading journals—including the American Journal of Sociology, American Sociological Review, Social Forces, Social Problems, Theory and Society, Sociological Theory, Politics and Society, and Gender and Society—this review also takes account of important sociological work published in other journals and books.

Our focus on American sociological contributions allows us to pinpoint how interest in global health among American sociologists has changed over time and to specify the contributions of one of the largest, most active national associations to the study of global health while bracketing wholesale examinations of important journals such as Social Science and Medicine, which though influential are interdisciplinary in nature. The focus on American sociology echoes the findings of others: that American medical sociology has remained relatively insular relative to medical sociologies produced in other nations (Collyer 2011; Lichenstein 2001).

While we acknowledge that epidemiologists and demographers have made many important contributions to the study of global health, this review does not focus on that work and avoids many traditional concerns of demographers entirely, including birth, migration, aging, and fertility. A number of recent reviews capture more recent contributions by demographers in the developing world (Bollen, Glanville, and Stecklov 2001; Dodoo and Frost 2008; Juárez and Gayet 2014; Zuberi et al. 2003).

Global health is inextricably linked to development. However, to bound the review, we reference work that takes health as a focus more specifically. Some of the work reviewed is necessarily on the border between the subfields of global health and development. As with all reviews, there are some issues readers may find receive too much emphasis and others that do not receive enough. However, this article showcases the growing interest in the nascent sociology of global health.

MAPPING THE TERRAIN

While the gaze of American sociologists has frequently remained trained on objects, institutions, and people in the United States, the transcendence of borders that characterizes the emerging sociology of global health opens up new possibilities for scholarship.

Global health institutions have been reimagined as neglected drivers of the global social construction of disease. The greater frequency with which instability, war, and
authoritarianism plague low- and middle-income countries has led to study of the differential effects of these variables on health. Different cultural contexts become rich spaces for understanding how new technologies, medical ethics, and medical practices that cross borders have unintended consequences that result in new tensions and social realities. The new sociology of global health likewise embraces the study of race, class, gender, and ethnicity in radically different contexts. However, it also takes up “macro-level” issues that have been traditionally neglected, including health systems, international organizations, regime types, and war. In inductively mapping the terrain, we identified three broad themes animating the sociology of global health: macro-level variables and processes, including the relationship between knowledge and power and global health inequities; social structure and health within and across nations, including race, ethnicity, nationality, gender, environment, and culture; and social movements and organizations involved in global health efforts.

Macro-Social Forces

Sociologists of global health have sought to explore the relationship between health and national and international issues and institutions. While political scientists have approached these issues with a lens that emphasizes the importance of national borders and security, the comparative advantage of sociology is to understand transnational actors in relational terms, recognizing the networks in which they are embedded. This approach leads to new possibilities for conceptualizing important issues, including health governance and epidemiological response. Cable, Shriver, and Mix (2008), for example, highlight how institutions that expose people to health risks use organizational resources to create an ambiguous environment for public discussion of exposure to dangerous substances. Lakoff (2017) shows that although epidemiological response is viewed as a problem of preparedness, authorities remain perpetually surprised by new outbreaks, and genuine health security remains elusive. Though global health may not operate as a closed field of actors guided by a dominant strategy, parties that act in response to particular forms of health threats often do so with a unified vision and coordinated action.

While scholarship on health systems within medical sociology has focused primarily on Europe and North America, new work in the sociology of global health demonstrates the importance of relations between providers, the state, and global connections that are often left unexplored in medical sociology. Kwon (2011) shows that in Korean health insurance reform particular institutional attributes, such as the level of state commitment to welfare and state capacity, determine the resilience of social policy to crisis. Chaufan (2016) demonstrates that more effective communication about single-payer healthcare and the political enfranchisement of those most in need are critical in the United States and Switzerland. Merli, Qian, and Smith (2004) show that in the transition to market economies, local governments in China find policy autonomy within centralized bureaucracies, though poorer areas remain underserved.

Scholarship on the relationships between biomedicine and more traditional forms of health care around the world has demonstrated that people often incorporate elements of traditional medicine and cultural practice with biomedical interventions to achieve effective...
health outcomes, especially in settings where access is limited (Decoteau 2013; Manglos and Trinitapoli 2011; McDonnell 2016). This research explores the pressures national health systems face from international organizations and other countries, showing that the actions taken toward states and the responses to them are rarely uniform (Flynn 2014; Noy 2015, 2017). However, it has yet to take up complex responses to the health needs of populations like medical tourism.

Parkhurst and Lush (2004) find that political leadership, bureaucracy, health infrastructure, and relations with external actors play complex roles in STD management and sexual behavior change. Lieberman (2009) illustrates that ethnic fragmentation conditions whether epidemiological response is weak or aggressive. Chambre (2013) demonstrates that while activism took different forms in Brazil, South Africa, and the United States, diverse actors were involved in expanding AIDS treatment. Other research shows how rival coalitions frame and assess health risks differently (McMullan and Eyles 1999). Small and Baddeo (2011) demonstrate that the need for health-sector reform, limited feminist-based intervention, and cultural norms hindered HIV prevention in Ghana. Gómez and Harris (2015) find that while collaborative state–civil society relations are important for producing an effective AIDS response, regime type hasn’t correlated with aggressiveness of response. Building on other work (Sutherland and Hsu 2012), Long (2018) shows that transnational AIDS institutions challenge authoritarian arrangements in China but also reinforce them. Collectively, sociological work in this area has shed light on the social forces and relationships that influence disease response. However, comparative research on noncommunicable diseases and emerging threats like Zika would help draw out how responses fundamentally differ across disease area and geography.

Important research in this area has also explored the relationship between democracy, social policy, and inclusionary developmental strategies, frequently upending commonly held assumptions. While Gibson (2012) finds women’s democratic participation in India to produce positive effects on local development, Burroway (2016) does not find democracy to have a positive effect on child health. Although conventional wisdom holds that democratization empowers the masses, Harris (2017a, 2017b) finds that professional movements composed of elites from esteemed professions play a critical role in expanding access to healthcare and medicine. Friedman and Mottiar (2005) argue that South Africa’s Treatment Action Campaign offers a model for social activism at a time when democratization has not always led to greater equality. This work has enhanced our understanding of the mechanisms that have led to the broadening of social rights and democracy, and their effects. Yet, more sociological research is needed on new forms of welfare provision that have gained currency in contemporary global development efforts, like conditional cash transfers.

Although many of these studies represent important qualitative contributions, much of the research aimed at macro-social issues has been quantitative, aimed at identifying statistically significant relationships between health outcomes on the one hand and trade, debt, democracy, war, and foreign investment on the other. Shen and Williamson (1997) find that foreign direct investment and debt dependency have negative indirect effects on child mortality, while state strength has positive effects. Shandra et al. (2004) find that social and economic modernization reduces infant mortality, while corporate penetration and transnational economic linkages
increase it, particularly at lower levels of democracy. Austin and McKinney (2012) find modernization to be a very robust predictor of life expectancy in a sample of developing countries, with HIV strongly determining life expectancy in sub-Saharan Africa.

Research has also taken more direct aim at the relationship between health and human capital investments. Noy (2011) finds that emerging welfare states respond to different pressures than OECD nations, with international financial institution presence leading to higher health spending and lower welfare and social-security spending. Noy and McManus (2015) suggest, somewhat surprisingly, that globalization fosters greater investment in public health than neoliberal cutbacks do, while Noy and Sprague-Jones (2017) find periods of convergence and divergence in health expenditures in the OECD and Latin America. This research illustrates how spending bears on health and how macro-social forces affect that spending.

Modrek and Cullen (2013) find that workers’ hypertension and diabetes risk increase at layoff-stricken manufacturing plants. Stuckler and Basu (2013) illustrate the pernicious health effects of austerity in response to the Great Recession, while Burgard and Kaloussova (2015) show that economic recession can have positive and negative health effects and trace the negative health consequences of macroeconomic changes. Other work examining mental health in Europe shows that the most negative effects of recession were limited to the countries worst affected economically, while mental health in less economically devastated countries actually improved (Reibling et al. 2017). Carlton-Ford and Boop (2010) demonstrate that civil war not only has negative impacts on child mortality, but also accounts for the effects of a great deal of other life chances on the same variable. This research has generated a more refined understanding of how war and recession influence health. Amid tensions over North Korea, Syria, and other global flashpoints, further research remains to be done on the health effects of continued preparations for war, cyber-crime, and surveillance.

Knowledge and Power

Although other disciplines, like international relations, investigate power relations between countries, critical research on power relations has a storied history in sociology, from Marx to dependency theory to world-systems theory. Research in this area has explored three main issues: the sociocultural and political underpinnings of Western science and biomedicine, the relationship between health and capitalism, and the relationship between health and neoliberal institutions.

New research that links global processes and geopolitical concerns to the production of scientific and medical knowledge yields insight into not only how knowledge is constructed but also how social constructions of illness and disease travel across the world. While scholarship on biomedicine has shown how medical systems in the global South have been influenced by Western biomedicine, Baronov (2010) and Pollock (2014) illustrate how African medical systems have transformed Western biomedicine. Shim, Bodeker, and Burford (2011) demonstrate how institutional heterogeneity results from interactions between Western and traditional medicine at the global level. Holdaway et al. (2015) find that overseas training has often exacerbated knowledge and treatment gaps between rural communities and health centers in India and China. Scholarship on HIV/AIDS demonstrates that the
proliferation of biomedical approaches has transformed the illness experience and patient response to the sick role (Decoteau 2013; Genberg et al. 2009; Heimer 2007). Benjamin (2013) and Shostak (2013) reveal how the conduct of cutting edge science impacts the vulnerable, raising concerns about the exclusivity of science. Collectively, this work has highlighted the important roles that underappreciated actors have played in knowledge creation and exchange.

Scholarship has also problematized the lack of comparative research on “medicalization” for inhibiting development of more robust theory on the topic (Olafsdottir 2011; Pescoso-lido, Mcleod, and Alegria 2000). Research has pointed to the challenges in universalizing diagnostic methods around the globe (Lakoff 2005). This research has shown how pharmaceutical firms, diagnostic criteria, and Western psychiatry speed processes of medicalization globally (Bell and Figert 2015; Busfield 2010; Clarke et al. 2010; Conrad and Bergey 2014; Schelly, González, and Solís 2015) and how resistance to medicalization in the global South contributes to medical experiences that are fundamentally defined by the use of pharmaceuticals (Béhague 2015). This engages a broader stream of work concerned with pharmaceuticalization (Abraham 2010; Mamo and Epstein 2014) and the growing influence of pharmaceutical corporations in daily life (Padamsee 2011). Building on work that has suggested that theories of medicalization are “ultimately theories of power” (Olafsdottir 2011:241), it points to the need to more systematically elaborate the political economy of medicalization.

Emerging work has also probed the social construction of disease at the global level. Abeysinghe (2013) examines contestation over the classification of epidemics at the World Health Organization and demonstrates that no common understanding exists over how to assess the risk of epidemic. White (2018) has pointed to the colonial underpinnings of contemporary global health architecture, while other work has argued that incorporation of civil society in HIV/AIDS initiatives is emblematic of political projects that entail legitimation and justification (Doyle and Patel 2008; Nambiar 2012). King (2002) compares the ideology of contemporary responses to disease with those of the colonial era, showing that similar concerns and priorities motivated both. Cairns and Johnston (2015) contend that diets that support responsible and active engagement in making health choices promote a form of disciplinarity that exposes women’s bodies to particular forms of surveillance. This research has illuminated power relations that underlie contemporary response to disease.

Some of the earliest contributions to critical scholarship on capitalism implicated dependent relations as causes for the underdevelopment of health in the global periphery (Navarro 1974). Waitzkin (2000, 2011) drew attention to the imperial foundations and contradictions of capitalist healthcare arrangements, which has been extended in the quantitative scholarship described above. Subsequent research has examined the consequences of international institutions for the health of people in industrializing nations. Ugalde and Jackson (1995) provided one of the first critical reviews of the World Bank’s role in health policy. More recent work in this area related to neoliberalism and international organizations will be taken up later in the review.

This work expands the scope of this field dramatically while also indicating opportunities for further research. Empirical explorations of divergent concepts of health and illness in
different settings may provide novel insight while also exploring the mechanisms of medical knowledge production.

Global Health Inequities Sociologists concerned with macro-level analysis have explored not just macro-level variables and processes and power relations, but also global health inequities. Beckfield, Olafsdottir, and Bakhtiari (2013) find that higher socioeconomic status is positively correlated with health, varying by institutional context and other dimensions of stratification. Other scholarship has shown that while advances in medical technology and care have been significant, achievement of health equity, especially across gender lines, is still greatly dependent on geopolitical rather than medical factors (Blumberg and Cohn 2015). Altman (1999) finds that not only are HIV/AIDS responses the product of cultural and social factors, but also vulnerability is tied to globally constituted socioeconomic status. Dagadu and Patterson (2015) argue that the burdens of infectious and noncommunicable disease faced by developing nations warrant equal attention within the countries most affected.

Other work in this area examines the relationship between socioeconomic status and health in industrializing societies, finding that a number of health gaps associated with socioeconomic status remain constant or increase with population age, rather than narrowing (Park 2005). Zimmer et al. (2010) find that a health advantage accrues to urban Chinese residents due to socioeconomic status and access to healthcare. Similarly, De Maio (2007) shows that self-reported health in poorer settings in Argentina underestimates morbidity and mortality.

Social Structure and Health Within and Across Nations

Race, Ethnicity, and Nationality Sociologists of global health have also explored issues of race, ethnicity, and nationality. Wood and Lovell (1992) find that a mother’s race affects child mortality in Brazil. Monk (2016) finds that skin tone is a stronger predictor of health inequality than census categories in Brazil. Related research has explored the relationship between citizenship status and access to healthcare. Gorman, Read, and Krueger (2010) find that health declines associated with Mexican American acculturation are shaped by gender and access to medical care. Katz (2014) highlights the role Latino children play as brokers in their families’ healthcare interactions. Marrow and Joseph (2015) illustrate how states and cities reduced exclusion of undocumented immigrants from healthcare amid federal laws prohibiting inclusion. Noy and Voorend (2015) find that variation in migrant healthcare access is a function of international norms, existing national policies, and countries’ healthcare systems. Harris (2013) shows that even in supposedly universal healthcare systems, access is stratified by work status, employer type, and citizenship. Other work draws attention to how social assistance is conditioned by ethnic identity (Yörük 2012). Wu (2006) and Zhou (2007) have shown how social constructions of illness and stigma are formed out of geopolitical animosities, illustrating the global interconnection of social constructions. This work extends the literature on race, ethnicity, and nationality to important new contexts. However, at a time when xenophobia and populism are ascendant, more research that interrogates the robustness of hard-earned social rights is needed.
Gender has also proven to be a particularly active area of interest (Agadjanian et al. 2011; Mojola 2014b; Trinitapoli and Yeatman 2011). Important work has explored the social and structural dimensions of HIV risk. Behrman (2015) finds an inverse relationship between girls’ schooling and HIV risk in Malawi and Uganda. Moore and Oppong (2007) show that concerns like having a baby lead people living with HIV/AIDS in Togo to ignore the risk of infection to partners. Asiedu, Asiedu, and Owusu (2012) find HIV rates of infection in four countries to be higher among women, urban residents, and the middle-aged. Esacove (2010) illustrates that Malawian HIV prevention strategies draw on oversimplified heteronormative images of villagers, reinforcing the linkage between HIV risk and modernity. Mojola (2014a) demonstrates how gendered dynamics associated with modernity compel educated Kenyan women to put themselves at risk for HIV infection, posing a formidable challenge to Link and Phelan’s (1995) widely accepted “fundamental cause” theory. While HIV has been a chief reference point for much of this work, comparative research on the gendered dynamics and consequences of other diseases remains to be done.

Sociological research has also deepened our knowledge of the relationships between gender, violence, sexual behavior, and stigma. Maman et al. (2009) argue that fear of suffering, death, and the burden of caring for the infected drives HIV stigma and discrimination, while Biradavolu et al. (2009) document the political engagements sex workers in India undertake to challenge their precarity. Yount and Carrera (2006), Friedemann-Sánchez and Lovatón (2012), and Asiedu (2014) examine the causes and social, economic, and health effects of intimate-partner violence in Cambodia, Columbia, and Ghana, respectively.

Other work has explored how epidemics have reshaped gender roles. Upton (2003) illustrates how gender hierarchies in Botswana have been reinforced in the HIV/AIDS era. Dworkin et al. (2012) and Wyrod (2016) explore how masculinities have been transformed by HIV/AIDS across Africa. Carpenter and Casper (2009) show that gender-based approaches to HPV prevention triggered concerns about female promiscuity. These works, which focus on the micro-dynamics of healthcare and sexual-health decision-making, expand sociological understanding of the factors that produce gender inequalities and how these inequalities affect health.

Quantitative work has illustrated the larger trends in this field. Burroway (2010) finds secondary school enrollment to have a pronounced effect on AIDS death rates. Female empowerment and access to health resources affects the distribution of HIV and malaria (Austin and Noble 2014; Austin et al. 2014). Shandra, Shandra, and London (2010) find that women- and health-focused NGOs reduce infant mortality in democratic nations. Stroope (2015) finds an inverse relationship between dowry frequency and health. Yount (2004) shows that in Egypt maternal education has more of an effect among Christian families than among Muslim families. This work engages with a larger literature that has explored the relationship between women’s empowerment and development (Gibson 2012; Hughes et al. 2017; Paxton and Hughes 2016; Swiss, Fallon, and Burgos 2012; Viterna, Fallon, and Beckfield 2008). These contributions provide novel theoretical frames that sociologists may apply to questions of gender in the developing world that are not derivative of wealthy nations.
Environment  Within the broader category of environment and health, sociologists of
global health have shown a particular interest in the relationship between housing and
health. In this area, an important vein of scholarship has begun to examine how people nav-
igate threats and preserve stability in the large urban slums of the industrializing world
(Weinstein 2014). Reed et al. (2011), for example, find housing instability to be associated
with violence, unprotected sex, and sexually transmitted infections among Indian female sex
workers. Jorgenson and colleagues likewise demonstrate the importance of the built envi-
ronment to health outcomes (Jorgenson and Rice 2016) and highlight how urban poverty
has risen (Jorgenson, Rice, and Clark 2012). Yet, work is needed that addresses how the large
urban slums of industrializing mega-cities fundamentally challenge sociological conceptions
of neighborhoods rooted in the experiences of the global North.

Further work has explored food networks and environments (Sanderson 2012). Brindle-
Fitzpatrick (2015) finds that Mexican “food swamps,” which expose residents to unhealthy
foods, produce worse outcomes than food deserts. Som Castellano (2016) shows that
women engaged in work on alternative food systems expend more labor than those who do
not. Otero, Pechlaner, and Gürcan (2013) find that developing countries are more depen-
dent on basic foods, while industrialized nations rely more on luxury foods. This work high-
lights the effects of different forms of food production.

Important research also examines the issue of planetary health. Work in this area shows
that deforestation associated with export drives up malaria rates (Austin 2013), and that
agricultural export exacerbates hunger (Austin, McKinney, and Thompson 2012). Frank,
Hironaka, and Schofer (2000) demonstrate that world society drives national environmen-
tal protections, while Givens (2014) shows world society to have weak effects on Kyoto
Protocol ratification. Other research (Jorgenson 2008; Jorgenson and Kuykendall 2008) has
found a positive relationship between foreign investment and use of pesticides and fertilizer.
This work has helped us understand the health effects of environmental change. Yet, the
growing frequency of climate-related disasters begs for more sociological research on trans-
national responses to environmental disaster.

Culture  Global health provides something of a natural laboratory for important research
on the sociology of culture. Work in this area has explored how national institutions have
responded to particular cultural issues. Good et al. (2011), for example, show how American
medicine has responded to the growing challenges posed by diversity, what culture means to
providers and patients, and how it shapes medical practice. Other work has pointed to the
role of cultural resources and social networks in explaining why some societies are more suc-
cessful than others at promoting health (Lamont and Hall 2009).

Further scholarship has explored culture in relation to disease. McDonnell (2014) outlines
methods for making internalized moments of automatic and deliberative cognition visible,
using materials from AIDS media campaigns. Watkins (2004) uncovers novel disease-
prevention strategies and community perspectives used by Malawians to navigate the
AIDS epidemic, while Tavory (2014) finds that humor is key to measuring cultural
shifts in Malawi. Decoteau (2008) shows that effective treatment renders the AIDS epidemic
invisible, erasing the experiences of HIV+ persons. McDonnell (2016) finds that AIDS
media campaigns often fail because outside of controlled environments people don’t interpret messages the way designers intended. Vrecko (2010) demonstrates how pharmaceuticals, marketing, and research diffuse certain social constructions of obesity around the world. This work shows that culture is shaped by illness but also shapes individual and collective response to disease in substantial ways. Events such as the West African Ebola outbreak provide novel sites for understanding the effects of health emergency on cultural practice.

Research in this area has explored the cultural reception of medical technologies. Tavory and Swidler (2009) show that semiotic constraints help explain resistance to condom use in sub-Saharan Africa. While McReynolds-Pérez (2017) draws attention to the role lay activists play in increasing access to safe abortions in Argentina, Suh (2014, 2015) reveals the process by which physicians obscure abortions, using medical records to prevent policy inquiry, and probes the politics of technology use in post-abortion care. Coast and Murray (2016) find that trusted advice, risk perceptions, delays in care-seeking, and cost influence women’s decisions to have abortions in Zambia. Boyle, Songora, and Foss (2001) demonstrate that regulation of female genital cutting is conditioned by international pressure. This work considers how cultural contexts shape the use of technologies and practices that bear on health. More work is needed to understand the cultural reception of contemporary practices in global health like telemedicine, as well as the effects of international pressure on other gendered cultural practices like acid throwing and stoning.

Related work on medicine and ethics has also been an important concern of sociologists of global health (Epstein 1996; Heimer 2013; Timmermans and McKay 2009). Grol-Pokopczyk (2013), for example, compares the moral reasoning of Thai and American physicians who write on medical ethics, finding that important differences may hinder cross-cultural collaboration. Angotti (2010) highlights the critical function that HIV test counselors serve in mediating between international norms and local communities, while concurrently finding that patients frequently experience voluntary testing as something that is compulsory (Angotti et al. 2009). Examining the ways in which culture structures individual health decisions and how these decisions are implicated in larger global circuits is a key contribution of sociology to global health.

Social Movements and Organizations

The growth of new health-related movements and organizations has also provided fertile ground for contributions to the sociology of organizations. Very generally, contributions in this area have focused on the deeply political nature of international organizations, including the WTO, World Bank, IMF, and WHO (Babb and Kentikelenis 2017; Chorev 2005, 2012a, 2012b; Kentikelenis, Stubbs, and King 2016; Noy forthcoming), drawing attention to the harms and tensions produced by neoliberalism (Babb 2005; Pandolfelli and Shandra 2013; Shadlen 2011). This work frequently emphasizes the role of cost-effectiveness and quantification (Adams 2016; Biradavolu et al. 2009; Kenny 2015), although some important research has shown how economics and public health sometimes produce synergies that can improve population health (Chorev 2012b; Shadlen and Massard da Fonseca 2015).
Work in this area has shown that the secretariat of WHO exercises surprising autonomy over the directives of governing member states (Chorev 2012b). Robinson (2017) illustrates how experiences in family planning prefigure national HIV prevention strategies in sub-Saharan Africa, while Esacove (2016) argues that the failure of HIV prevention efforts in sub-Saharan Africa is linked to Western sexual norms embedded in U.S. policy. Asad and Kay (2015) detail how concepts of culture at Partners In Health, OXFAM, and Sesame Workshop relate to projects’ success and failure. Grayman (2014) finds that technologies like email reinforce tensions in medical humanitarian work at the International Organization for Migration. Ward (2004) illustrates the challenges of navigating racism, sexism, and homophobia within an organization’s workplace and amid external forces. Fox (2014) offers an ethnographic profile of Doctors Without Borders. Collectively, this work provides critical insights into the inner workings of well-known global health organizations. However, sociological research on other influential global health organizations, including the Gates Foundation, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and Gavi, is sorely needed.

Other work has focused on emerging phenomena such as global health volunteering (Lasker 2016), community responses to Ebola (Abramowitz et al. 2015), and social movements in health (Brown and Zavestoski 2005). Banaszak-Holl, Levitsky, and Zald (2010) show that collective health challenges take place amid a multiplicity of sites and actors. Hess (2004) shows how the incorporation of the challenges posed by health social movements has given way to a new public shaping of science, while other work shows how they have taken on distinct relationships with professions, industry, and the state in the industrializing world (Flynn 2014; Gibson 2016; Harris 2015, 2017a, 2017b). Desai (2004) has shown how social movements produce changes in gendered relations, norms, and practices globally.

Another strand of research has explored how groups at local and national levels manage international pressures related to global capitalism (Merli, Qian, and Smith 2004; Yu 2008) and the HIV/AIDS epidemic (Klug 2008; Swidler 2006; Watkins and Swidler 2013). While some research in this area has shown how certain health policies have been promulgated “for export only,” for others to adopt (Barrett, Kurzman, and Shanahan 2010), other work has shown how industrializing nations and even pharmaceutical companies have played important roles in deviating from and subsequently altering global models (Chorev 2012a; Light and Maturo 2015). Amid growing interest in the BRICS countries, more research is needed aimed at understanding how industrializing nations shape global health agendas in light of resource constraints and without the power of conditionality.

Findings in this area have had both theoretical and practical implications. Watkins and Swidler (2013) show that AIDS agencies, in their attempts to please donors, are left with a small repertoire of practices, explaining why AIDS projects adhere to similar organizational forms. Barrett and Tsui (1999), as well as Robinson (2015, 2016), explore the lengths to which resource-constrained countries must go to receive funding from donor and international organizations and show that resource-constrained countries with more ties to the central development actors are more likely to receive support. Krause (2014) points to the incentives that lead humanitarian relief organizations to focus on those who are easiest to help, while Swidler and Watkins (2017) reveal global contradictions in an aid process that
ultimately relies on middlemen. This work illustrates how organizational concerns for autonomy and authority take place within a global sphere of nations and other health actors that shape health policy decisions.

CONCLUSION
This article outlines the contours of an emerging sociology of global health, drawing attention to the way this work is both embedded in existing subfields and expanding these subfields in novel ways. These works, for example, shed light on central questions related to the production of scientific knowledge in science and technology studies as well as the role of transnational actors and activities in global sociology. Research on global health raises questions important to these subfields and challenges the embeddedness of scholarly perspectives locked in a purely localized reading of social phenomena. While the emergent sociology of global health shares a concern with the broader discipline with respect to using comparison to advance sociological knowledge and generate new concepts, this field is also concerned about producing knowledge with important implications for practice.

Important gaps remain which provide exciting opportunities for new research. Our understanding of how scientific knowledge is constructed and affected by transnational flows and research sites remains a critical area for further study. How do social constructions of disease and illness transform and transmit different meanings when interpreted across new spaces? Some work has already been done in this area (Decoteau 2013; Zhou 2007), yet interesting questions remain regarding how global policy and actions are determined based on these constructions. The emergence of novel actors in the field of global health, such as the Bill and Melinda Gates Foundation and the Global Fund, offer the potential for new work on the role of private foundations and international financing mechanisms in global governance, and how social networks operating within and across these organizations shape global health action and agendas.

And while we might say that HIV/AIDS has generated research interest across a range of topical areas, greater investigation is needed into noncommunicable diseases and mental health. The problem of antimicrobial resistance remains wholly unexplored sociologically. The incorporation of new viewpoints and non-Western perspectives will yield much needed scholarship in these areas and provide fertile ground for novel theory and knowledge production. These are just a few of the promising opportunities in this emergent field.

REFERENCES


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NOTE

The articles in this special issue on global health and development are Noy (2019); Harris and White (2019); Sommer, Shandra, Restivo, and Reed (2019); Jafflin (2019); Angotti, McKay, and Robinson (2019); and VanHeuvelen and VanHeuvelen (2019).