VALUING LIFE AT THE BANK:
CONTESTED EXPERTISE, RACIAL POLITICS AND DEVELOPMENT BANK INTERVENTIONS IN GLOBAL PUBLIC HEALTH

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Alexis Kalilah Walker

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Alexis Kalilah Walker, Ph. D.
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Development banks had almost no involvement in the field of international health just a few decades ago, but today they shape the lives of millions of people by setting global health priorities and implementing health programs. In the context of neoliberal governance, "innovative finance," and the shift from international to global health, key actors and approaches in the field have shifted, and what counts as relevant expertise in global health has also been called into question. This dissertation examines relationships of power and knowledge in the health work of development banks—examining what comes to count as relevant knowledge, who gets to use it, and with what social and political consequences. It does so by bringing together ethnographic research on two development bank-coordinated projects in Guyana with interview and archival research at the headquarters of the banks that finance and oversee these projects: the Inter-American Development Bank and the World Bank. How do these international financial institutions investigate and understand health problems and implement solutions? What kinds of knowledge and values become influential as bank staff and consultants negotiate with Guyanese healthcare workers and government officials as to what problems will receive priority, through which

methods, and who will be served? These are questions about the practice of contemporary governance in late neoliberal capitalism, as past international enthusiasm for private management of social welfare has begun to transform.

While international financial institutions emphasize the importance of using economic tools and techniques to determine the "best investments" in public health, my research has highlighted the very different ways that economic knowledge comes to be valued across bank networks—even within a single project. Research and operations divisions, for example, have distinct understandings of how tools such as cost-effectiveness analysis ought to be used. And while economic analysis has been surprisingly absent from operational practice, experts in cultural anthropology and indigenous law have played a central role in shaping health projects in Guyana. In the process, their knowledges have become entangled with development bank histories and logics, and even as these institutions attempt to reform themselves, development bank health projects have continued to inscribe state racial codes in the bodies of Guyanese citizens.

BIOGRAPHICAL SKETCH

Alexis Kalilah Walker is a scholar of Science and Technology Studies (STS) specializing in the politics of global health. Her methods and interests lie at the intersections of postcolonial STS, medical anthropology, development studies, and Caribbean studies. She has conducted research and authored publications broadly on politics and power in biomedicine and public health—regarding vaccination in France, patenting biotechnology in the US and European Union, and histories of health governance in the Caribbean. Her most recent publications have appeared in *Social Science and Medicine*, as well as in a collaborative volume on intellectual property edited by Margo Bagley and Ruth Okediji. In addition to her PhD from Cornell University's Department of Science and Technology Studies, she holds a master's degree in Science, Technology and Society from the University of Strasbourg (France) and a bachelor's degree in Biology from Brown University.

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TABLE OF CONTENTS

INTRODUCTION

ENTANGLEMENTS: EXPERT NEGOTIATION AND POPULAR POLITICS IN GLOBAL PUBLIC HEALTH

In May 2015, Guyana inaugurated its first black president in twenty-three years. The ceremony was held at the National Stadium just outside of the country's capital city, where military and law enforcement personnel paraded extensively and three indigenous dancers encircled the new President to mark his official inauguration. The day after the ceremony, photos of President David Granger with his wife Susan Granger and the new Prime Minister Moses Nagamootoo emblazoned many Caribbean newspapers: the image of these two men of African and East Indian descent joined by a woman of Chinese and indigenous heritage was offered as a symbol of multicultural unity overcoming Guyana's previous decades of racial discrimination and race-based voting. The primarily Indo-Guyanese People's Progressive Party (PPP) had held control of Guyana's executive branch for over two decades, but it had finally been displaced by a large coalition including historically Afro-Guyanese and Amerindian parties as well as former members of the PPP.

In the weeks after the election, the new government announced that one of its first steps towards ending government corruption would be conducting an official review of development aid projects. In a meeting with the Regional Vice President for the Inter-American Development Bank (IDB) held in Georgetown the following month, Guyana's new Minister of Finance expressed concern about the bank's flagship health loan. Like the new Minister of Finance, the IDB Representative was a

Caribbean economist trained in the US and the UK in the late 1970s and early 1980s. But as the two economists discussed the health loan, they debated about the quality of the nutrition program it supported. The Guyanese Minister argued, based on his lifelong personal experience in Guyana, that it simply wouldn't work to ask Guyanese to sprinkle micronutrient supplements on their food, as the sprinkling of food additives after preparation was not part of "Guyanese culture." The IDB Regional Representative, however, argued that the project was certainly effective in Guyana, as it had already received many awards and had been "written up by Harvard" as an example of global health best practices. The Guyanese Minister was not convinced. He stressed that initial awards did not guarantee successful ongoing implementation, and he noted that the new government planned a detailed financial audit of the project.

Soon after the meeting between Guyana's Minister of Finance and IDB's Regional VP, the Government of Guyana officially ended the IDB project in question, and initiated a new IDB loan to support a different program for maternal and child health. Rather than focus on maternal health by offering preventative nutritional supplements and supplies, as had the previous project, the new project focused on institutional reform. The project framed high rates of maternal death as a problem of organizational management: of hospital referrals and the allocation of tasks for various levels of healthcare workers. This problem framing has privileged a very different set of voices; Guyanese nutritionists had a primary role in the former project, whereas the new project prioritizes international management consultants. The new program places emphasis on "health system strengthening" in three regions of Guyana deemed to

provide the best basis for future "scalability," rather than targeting women and children in the poorest districts nationwide, as had the previous project.

While these two projects present diverging constructions of Guyana's health problems and their appropriate solutions, neither project turns to the *traditional* tools of neoliberal health reform, such as public austerity, private insurance, user fees, or even discourses of incentives or market competition. Nor have these projects been planned based on economic evaluation using tools such as demand modeling or cost-effectiveness analysis, I found through participant observation on these health loans both at development bank headquarters and in bank country offices in Guyana. But how was this possible, I kept asking myself during my initial months of fieldwork: surely these financial institutions, known for their neoliberal rationalities and teams of economists, must be making use of the economic tools and market logics they otherwise tout, and for which they are so widely criticized by activists and scholars of public health (Pfeiffer and Chapman, 2010; Adams, 2013)? Or had neoliberal management here become so purely focused on bureaucratic rationalization, shunning its roots in market fundamentalism?

The reputation of development banks as quintessential neoliberal institutions is widespread among academic researchers, development practitioners, and even popular media; for over twenty years, activist challenges have garnered mainstream media attention in much of the world, drawing public attention to the banks' practices of privatization, liberalization, and environmental degradation (Keck and Sikkink, 1998). Much of this attention has surrounded the banks' structural adjustment loans, which required borrowing countries to implement major macroeconomic reforms aimed at

privatization and liberalization of their economies (Kapur et al, 1997; see Chapter 3 for further discussion). These loans have been a central means of spreading neoliberal thought and policy internationally, as they have required and given intellectual cachet to policies promoting private management and individual entrepreneurialism as the most efficient and effective means of governing (Harvey, 2005; Craig and Porter, 2006).[1] Economists and sociologists alike have strongly criticized these structural adjustment programs for undermining social services and leading to increased poverty—especially through monetary reforms and major cuts in public employment (Sparr et al, 1994; Abouharb and Cingranelli, 2007; Stiglitz, 2002; Keck and Sikkink, 1998). But beyond economic *policy*, neoliberal capitalism has promoted the extension of economic, business, and market *rationalities* into ever broader realms, including management of the self—where supposedly calculating individuals are made responsible for managing their own health and well-being rather than being able to benefit from systems of social promotion and solidarity (Brown, 2003; Lemke, 2001; Foucault, 2008[1978-9]).

In light of development banks' histories in advancing neoliberal reform, I began my research with the goal of examining how ideologies of individual responsibility, as well as the valorization of market mechanisms and private

[1] Amidst its evolutions and varied forms, neoliberal theory has been rooted in the assumption that individual entrepreneurialism and private control are the most efficient and effective forms of management, and should be favored over government intervention. These ideals have been applied at a variety of levels, from the management of national economies to forms of self-management (Foucault, 1991; Rose, 1996; Brown, 2015). But anthropologists, sociologists and political theorists have consistently shown that neoliberal policies work to enrich and empower the world's wealthiest at the expense of the poor and middle classes, and of social solidarity (Brown, 2003, 2015; Lave et al, 2010; Robison and Hewison, 2005; Elyachar, 2005; Sharma, 2008; Pfeiffer and Chapman, 2010; Karim, 2011).

management, operate in the banks' health projects. In their extensive health programs, do development banks treat health as a commodity to be bought and sold, incentivized, and improved through competition, as opposed to an essential government obligation of care for citizens? Along with this, I sought to examine the role of economic expertise as a key form of neoliberal knowledge, investigating how economic tools get mobilized in constructing the banks' understandings of public health. Still, after several further months of fieldwork in Guyana I was yet to observe such tools at work. I had designed my dissertation research to study how economic tools and rationalities were being mobilized in health projects run by the World Bank and Inter-American Development Bank, but I had seen no such thing, even after almost half a year of initial ethnographic work in Guyana with multiple bank projects.

While economic analysis seemed surprisingly absent from the practice of the bank projects I studied, what I did find was expertise on Guyanese racial and electoral codes, as well as knowledge of cultural anthropology and indigenous law, all being mobilized to shape health programs. But why did these observations differ so drastically from development banks' own self-representations and the visions scholars and activists offered of development banks as economically calculating institutions, even regarding public health? These tensions from my empirical work led me to broader questions both about development banks and Guyanese governance that guided my subsequent twelve months of ethnographic research in Guyana and at bank headquarters in Washington, D.C. This dissertation addresses these observations through questions in multiple registers. Taking public health as a site of power that shapes peoples' self-understandings and the opportunities open to them, as well as

relationships of national sovereignty,[2] the dissertation most broadly asks: how do development banks construct health problems and solutions? What relationships and visions of power, responsibility, resources, and justice do these projects enact? What kinds of knowledge come to be valued in this process, who gets to use them, and with what social and political consequences? And how do the entanglements of knowledge and values shape these processes?

Development Banks and Global Health

Although development banks had almost no involvement in the field of international health just a few decades ago, they have come to wield immense power over the lives of millions of people as some of the world's most central global health agencies: they mobilize large amounts of financing for the health programs they design and implement with borrowing countries, and they exert great influence in international debates over public health priorities and methods (Noy, 2013; Ruger, 2005; Brown et al, 2006). In Guyana, for example, fifteen to twenty percent of the country's health budget has been funded by the World Bank and Inter-American Development Bank over the past decade (Ministry of Health of Guyana, 2008). But what ideologies and knowledges guide these institutions' approaches? Do bank projects approach public health as a fungible commodity, as an essential responsibility of the state, or as the basis of social justice and solidarity, for example? Do these

[2] Scholars across the social sciences and humanities have emphasized how public health interventions influence peoples' conceptions of proper and possible lives, and also operate as spaces where governments, NGOs, international organizations, and private enterprises struggle over lines of influence and responsibility (Fanon, 2002 [1959]; Arnold, 1993; Crane, 2003; Boddy 2007; Biehl, 2007; Nguyen, 2009, 2010; Fullwiley, 2011).

institutions assume a world of economically calculating individuals who can always act on health knowledge provided to them, or do they focus on the structural constraints and valid logics behind people's many ways of being? Social scientists and anthropologists investigating development banks and power in public health have largely focused on development banks' structural adjustment projects, examining the health effects of monetary reforms and the large cuts to public spending that the banks often required in the public health sector (Lundy, 1996; Breman and Shelton, 2007; Pfieffer and Chapman, 2010). Devi Sridhar is one of few scholars who have studied in depth how development bank health promotion efforts beyond financial reforms, such as their nutrition programs, incorporate ideologies and relationships of power (Sridhar, 2008; Noy, forthcoming).[3] I build on this work in examining the knowledges and values shaping development banks' health programs today, and the dynamics of power that result.

Development banks' growing influence in global health in the 1990s was part of a broader shift from "international" to "global health" (Brown, 2006)—a field of research and public health practice that increasingly turned to actors beyond national governments (such as private corporations and NGOs) and to methods rooted in business management (such as "innovative finance" and "public-private partnerships"). In the process, the forms of knowledge deemed relevant in global health have also been called into question. While development banks often frame their

[3] Other scholars have examined these dynamics without making development banks the specific focus of their analysis. Manjari Mahajan (2008), for example, has examined the World Bank as part of a conjunct of organizations implementing HIV/AIDS programs in India. However, I am interested in understanding the specific role of development banks as financial institutions operating in global health, between their headquarters and operations.

work as the result of apolitical, scientific analysis, any expert analysis is based on assumptions and values that deeply affect the analyses produced (Martin, 1991; Latour, 1983; Haraway, 1988). Such assumptions operate both in the creation of expert knowledge, and through the types of knowledge that come to be deemed relevant for expert decision-making (Porter, 1995; Jasanoff, 1990; Mahajan, 2008; Parthasarathy, 2017). Anthropologists and economists, for example, look at problems quite differently: whose expertise is to be valued in planning a health program? What forms of knowledge become legitimate in a meeting room at the Parliament of Guyana, where IDB representatives discuss project design with civil servants from the Ministry of Finance and Ministry of Health? Whose knowledge counts, and with what effects? If economic tools are not central to project operations, what role does economic expertise play in development bank health work (Chapter 4)? And how does this relate to other forms of knowledge, such as expertise in nutrition, clinical medicine, cultural anthropology or law (Chapter 5)?

In spite of my concern for these knowledge dynamics, my ethnographic work emphasized the importance of Guyanese racial and electoral politics in the relationships of power and marginalization that most concerned me. During my research, I continued to be struck by the ways that Afro-Guyanese were mobilizing black American discourses to counter marginalization by the majority Indo-Guyanese government, and interested in the racialized extraction of public resources for private benefit. It is clear that the dynamics of knowledge are deeply entangled with popular politics in the work of development banks. The World Bank and IDB's self-presentation as "knowledge institutions" advancing objective, evidence-based policies

to produce the best possible "development outcomes" (Goldman, 2005) runs up against their emphasis on national sovereignty and the democratic priorities of borrowing countries. International development agencies are not meant to interfere with the national politics and sovereignty of "borrowing countries;" as such, development banks have often ignored the popular politics entangled with their own projects, framing political problems as technical issues that can be addressed through technocratic solutions (Ferguson, 1994). But how do the shifting dynamics of knowledge in global health interact with these popular politics? Through my research in Guyana, as a corollary to my overarching questions, my research came to ask: how do expert debates interact with racial and electoral politics in constructing health problems and solutions? How do the entanglements of knowledge and values in expert decision-making relate to the knowledge and values at play in electoral and popular politics?

These questions arose through iterative research between field sites in Guyana and Washington, D.C. In its methods and focus, this dissertation moves among the Washington, D.C. headquarters of two development banks, their country offices in Guyana, and the varied sites of contestation, planning and implementation of two of the banks' health projects in Guyana. It combines ethnographic examination of these two health projects—one of which aims to eliminate neglected tropical diseases and the other to improve nutrition—with interview and archival work at the headquarters of the banks that finance and oversee the projects: the Inter-American Development Bank and the World Bank. In my research, Guyana does not serve simply a "case-study" of how development banks operate "on the ground," but as an essential

initiation of inquiry and insight regarding banks and public health, racialized governance, and Caribbean politics. In the interplay between my research sites, I came to see how, even as development banks have vastly expanded their expertise and notions of social justice in recent years, their health projects have helped re-inscribe state racial codes in the bodies of Guyanese citizens. Projects aiming to improve nutrition in Guyana have singled out indigeneity as malignant, and project designers have mobilized neglected tropical disease programs to confront racial and electoral tensions amongst Afro- and Indo-Guyanese.

To begin examining these processes, in this introduction I first highlight the intellectual and institutional histories that underlie my research questions, before discussing how multi-sited ethnography allows me to examine dimensions of power across development banks' networks. I then further elaborate the dissertation's central argument: that development bank health projects have operated as part of the institutions' efforts to reform their images and practices, but their mobilization of expertise on anthropology, indigenous law, and Guyanese racial codes have nonetheless furthered histories of marginalization both within development banks and Guyana.

Problematization, Knowledge, and Values

The overarching questions of this dissertation are fundamentally about problematization. In the early 1990s, James Ferguson described the great power that development banks wield by defining development problems in ways that position the banks as purveyors of essential solutions (Ferguson, 1994). Since Ferguson's early

work, social analysts have continued to build on the theory of Michel Foucault to highlight the importance of knowledge practices in defining certain processes and patterns as *problems* in need of intervention (Foucault, 1990[1978]; Bacchi, 2012: 1; Hodžić, 2016: 8).[4] Such problem framings fundamentally shape the ways that people are included and excluded from social programs and networks of power. Are single black mothers in the US understood as legitimate caretakers in need of social support, for example, or vilified as the source of racial inequality (Crenshaw, 2013; Harris, 1999)? And are indigenous Guyanese framed as a heterogeneous group with low levels of malnutrition, or as dependents whose cultural practices present a biological risk to their communities (see Chapter 4)? The forms of expertise and evidence brought to bear on such questions have major implications for the policies and programs that result, and the lives of people made the objects of such knowledge.

Development banks have become key actors in defining development problems and solutions (Goldman, 2005), including through the health projects that they finance and oversee. What counts as a nutritional problem, for example, and do such issues result from parents making poor choices, or from poor labor conditions that fundamentally shape the resources families can use towards child nutrition (Sridhar, 2008)? These dynamics motivate my interest in the construction of health problems by development banks through expert knowledge. STS scholars have consistently underlined the assumptions and values that shape not only the creation of scientific knowledge, but the very kinds of knowledge deemed relevant in various spaces of

[4] The far-reaching consequences of the way people delineate and represent social issues have also been the subject of sociological literatures on "framing" and "the construction of social problems" (Borah, 2011; Blumer, 1971).

decision-making—from courtrooms to government agencies (Jasanoff 1990, 1990b; Callon and Rabeharisoa, 2008). For example, environmental regulators in the US and Europe have taken different approaches to weighing mathematical models of toxic exposure against qualitative analyses of risk, leading to divergent approaches to environmental health. And in many parts of the world, patients have fought to have their experiences recognized as relevant expertise for defining drug protocols and approval timelines. Analyzing such dynamics, STS scholars have highlighted the power that comes from being able to define oneself as a relevant expert and define the knowledge on which democratically-significant decisions are made. Steve Epstein and others have called these negotiations over what counts as relevant expertise and who is able to mobilize it "the politics of knowledge" or "the politics of expertise" (Epstein, 1996; Hoffman, 1989; Parthasarathy, 2011; Baert and Rubio, 2012; Sending, 2015).

Within development bank projects, such politics of expertise are deeply entangled with popular politics; development institutions' dual goals of "objective" project planning by experts and "democratic" control by postcolonial countries often come into conflict. Following Ferguson and other critical development scholars, Richard Rottenburg (2009) has argued that actors shift between "scripts" in different circumstances in order to address the inherent tensions between expert decision-making and national sovereignty in international development. My research builds on this work in emphasizing how different *people* in different *positions* across development banks' networks mobilize very different understandings and visions of the institutions' work. The Director of IDB's Guyana Country Office, for example, has often quarreled with the institution's upper management as to the rightful place of

electoral politics in the design of health projects, revealing tensions among operations, research, and institutional policymaking (see Chapter 4).

This concern for the relationship between expertise and electoral politics emerges also at the intersection of literatures in science and technology studies (STS), cultural anthropology, and political theory. A central strand of science and technology studies developed in opposition to interpretations of power focused on political parties, military intervention, and class interests. In his influential 1983 essay "Give Me a Laboratory and I Will Raise the World," Bruno Latour criticized earlier scholars for focusing on politics almost exclusively as "elections and law," when science is so inherently political, in the sense that it defines the very nature of the world and the forces through which one can mold it (Latour, 1983). But prominent STS scholars such as Sheila Jasanoff have critiqued Latourian STS for its lack of attention to the moral relationships of social justice and conventional governance (Jasanoff, 2004; Restivo, 2005; Amsterdamska, 1990). Many STS scholars have joined Jasanoff in examining the politics of knowledge as they relate to questions of government, including tensions between expert decision-making and the concerns of citizens regarding such issues as genetically-modified organisms or nuclear energy (Campbell, 1985; Wynne, 1992; Porter, 1995; Hilgartner, 2000; Gupta, 2008; Gusterson, 2008; Jasanoff and Kim, 2009). However, this has not included much attention to electoral politics as such.[5] The black-boxing of electoral politics amongst international development agencies is mirrored by a similar process in the field of science and technology studies. By attending to the entanglements of electoral and expertise

[5] Notable exceptions include Gottweis, 1995; Lynch et al., 2005; Miller, 2015; Hajer, 2006; Oreskes, 2011.

politics, my work builds a fuller picture of the dynamics of power shaping contemporary governance.

Cultural anthropologists have paid far more attention to popular politics, rooted in the field's foundational focus on political systems (Evans-Pritchard, 1940; Southall, 1956). More recently, anthropologists have highlighted how development projects operate within the landscape of electoral politics, often interpreting such relationships by theorizing corruption – and perceived corruption – surrounding development efforts (Ferguson, 1994; Li, 1999; Lewis and Mosse, 2006; James, 2012). While corruption operates as a trope in the global North that denigrates postcolonial countries as "backwards," many anthropologists have recognized the power of local discourses on corruption and the importance of considering relationships of patronage and public theft, leading these scholars to analyze such relationships of power while avoiding stereotypes of poor countries as "more corrupt" than wealthy ones (Smith, 2008; James, 2012; Gupta, 1995). While I build on these analyses in examining the relationships of clientelism at play in development bank health projects, I do not see such patronage politics as "interfering" with objective technical knowledge – as have many analysts (Lewis, 2006; Dietrich, 2007; Gostin, 2014; Price, 2014; Anderson and Beresford, 2015). Instead, I draw on STS literatures emphasizing that scientific and technical knowledge is always deeply political; such knowledge always integrates assumptions and values that shape its production and use (Haraway, 1988; Martin, 1991; Bloor, 1991; Collins, 1985). My work shows that there is more to the interplay between development and politics than corruption; I demonstrate the shifting

discourses and spaces where popular politics come to be valued in the face of aspirations towards "objective" governance.

Working at the convergence of STS and political anthropology, my research draws attention to variances across development banks' networks in the forms of expertise that come to be valued, and also in the ways that justice comes to be understood and valued. I emphasize that the creation of knowledge (e.g. in economics) and the creation of values (e.g. democracy) rely on intertwined processes: assumptions shape economic calculations, just as ways of knowing shape visions of democracy. In addition to highlighting these entanglements, I emphasize the ways that both knowledges and conceptions of justice can be mobilized as currency to create value in the design and implementation of health projects. When disputes arise, actors can turn to various forms of knowledge, but also various conceptions of justice, in order to advocate for their perspectives.

Studying the knowledges and values at play in development bank work in Guyana and in Washington, D.C. within a common frame helps me find a mode of analysis that takes seriously both electoral politics and the politics of expertise; it allows for finding a space between the conventional ambits of political science and of post-structural analyses, theorizing relationships among these major forms of power that have so often been treated separately. My focus on Guyana is an essential element of investigating power of both Politics and the political. Guyana has not been allowed in either popular or academic understandings (both in Guyana and abroad) to have a political life beyond racial and electoral machinations. This is not because other kinds of politics are not at play, but because popular frameworks of power have so strongly

focused on ethnic politics between African and East Indian descendants and the political parties associated with each (Bissessar and La Guerre, 2013; Quinn, 2017; Wilson, 2012; Hinds, 2011; Williams, 1991; Vaughn, 2012). These histories help reveal how racial and electoral politics integrate their own assumptions and expertise, including experience with the racial codes of the Guyanese state.

This dissertation examines how knowledge and values are enmeshed in decisions both within the work of development banks and in the government agencies they contract with in Guyana, and especially in the liminal spaces where healthcare professionals, government finance representatives, bank staff, and consultants negotiate about what problems will receive priority, through which methods, and who will be served. And while my dissertation emphasizes the importance of the specific legitimacy politics in Guyana, it is just as concerned with *provincializing* development banks: highlighting the personal connections and aspirations that shape the banks' approaches far beyond (and inherent to) expert calculations of development (Chakrabarty, 2007[2000]). But studying these multiple spaces across expansive networks is a complicated task. In the following section I introduce the methodological basis of my research, which I discuss further throughout the text.

Methods for Studying Lifeworlds and Systems

In his 1995 *Annual Review of Anthropology* paper, George Marcus took up the question of whether the "emergent methodological trend" of multi-sited ethnography allowed for the in-depth knowledge that standard ethnography has been prized for, writing:

> The issue then arises of whether multi-sited ethnography is possible without attenuating the kinds of knowledges and competencies that are expected from fieldwork…One response is that the field broadly conceived and encompassed in the fieldwork experience of most standard ethnographic projects indeed already crosses many potentially related sites of work, but as research evolves, principles of selection operate to bound the effective field in line with long-standing disciplinary perceptions about what the object of study should be. Thus, fieldwork as traditionally perceived and practiced is already itself potentially multi-sited (Marcus, 1995: 100).

While highlighting the novelty of multi-sited research, Marcus emphasized that even in the supposedly "single-sited" work that has occupied imaginations of anthropological methods, research also involves choices of where to focus, and often brings together many "sites" within a single geographic space.

My own research is based on seventeen months of ethnographic fieldwork in Washington, D.C. and Georgetown, Guyana between 2013 and 2016. This included participant observation on both of the World Bank and Inter-American Development Bank (IDB) health projects in Guyana that were ongoing during the period (one of which aims to eliminate neglected tropical diseases and the other to improve nutrition), as well as ethnographic research within the health divisions at IDB and World Bank headquarters. In addition to participant observation, I conducted formal and informal ethnographic interviews and oral histories with over ninety healthcare professionals, bank staff, consultants, members of the Guyanese government, program participants, and volunteers,[6] and I conducted extensive archival research within the archives of the World Bank and IDB's headquarters, the National Archives of Guyana, the holdings of the Pan-American Health Organization at the University of Guyana,

[6] Throughout this dissertation I have used pseudonyms in referring to my informants, except in the case of published professionals who authorized me to use their full names. This research has received ethical approval through Cornell University's Institutional Review Board.

and in the personal files of a variety of current and former high-level administrators in Guyana's national health system. Through these documents and oral histories, I investigated health projects implemented through development banks starting from the first such project in 1979, and I examined government public health discourses in the 1970s, prior to development banks' earliest health projects in Guyana, allowing me to enrich my ethnographic investigation of two ongoing projects through a broader look at the breadth of development bank health projects.

This is a multi-sited ethnography in the sense that I lived in two cities on two different continents during the "field" research (and in several others in New York state during preliminary and follow-up research). But even in the "single" location of Georgetown, my participant observation on project teams included many sites: day-to-day meetings in IDB's country office, within Guyana's Ministry of Health, at clinics in the city center and in villages a morning's bus ride away. In Washington, D.C. my research involved observations of institution-wide meetings within the World Bank, meetings of health economists within IDB's Social Protection division, of World Bank legal staff with trust fund directors and finance officers, etc. – it included work both in operational divisions focused on health and in research segments investigating finance and the "social sectors."[7]

In both Guyana and Washington, D.C. I conducted extensive oral histories regarding the history of the World Bank and IDB's health programs, and the experience of healthcare workers and administrators with shifting regimes of public

[7] IDB's official languages are English, Spanish, French and Portuguese. My proficiency in the first three allowed me to follow movements between languages that are common at IDB headquarters and among IDB teams visiting Guyana. However, daily operations in Guyana's IDB Country Office are conducted in English.

health governance. As I discuss further in Chapter 3, I take oral history interviews not as a direct representation of the past (Cole, 2001; Chamberlain, 2007), but as significant references regarding the experiences of these nurses, economists, bureaucrats, etc. with the health programs of the World Bank and IDB. And while I recognize the important ways in which subsequent experiences shape recollections, there are nonetheless significant overlaps in the methodological concerns of analyzing oral histories and interviews regarding more recent experience (Charlton et al, 2007); neither is a direct representation of reality: both involve choices in how interviewees represent their experiences. When a Guyanese physician emphasizes the similarity in public health policies advanced by the current government and those implemented by Guyana's controversial former president-cum-dictator, this is a representational choice. When a World Bank consultant emphasizes corruption in the payment systems of the Guyanese government, this too is a choice in representation. The challenge of analysis lies in untangling the elements that shape these representations, by considering life histories, publicly-circulating discourses, professional values, etc.

Multi-sited research also helps unravel these dynamics, allowing me to see my research sites from multiple vantage points—to take seriously the self-representations of the people and institutions I study, while also taking note of the contradictions that emerge across sites within the expansive networks that make up these institutions. Amidst these tangled stories, this dissertation is a tale of displacement, one that becomes visible in motion across bank networks: between research and operations, headquarters and country offices, "lender" and "borrower." Projects are planned and implemented in concert across these networks. IDB and the World Bank have

produced research and designed their health programs with an eye towards countering negative images of the institutions, but in mobilizing health projects to counter criticism, the banks simply have concentrated development discourses onto seemingly remote populations. In the following section I demonstrate how these development banks have attempted to remake their neoliberal image, in part through enrolling cultural anthropologists and legal experts; I argue that even as these specialists have moved the banks towards providing broader public programs and social services, they have played a key role in maintaining histories of marginalization within Guyana and within development banks. This argument speaks to the work of ethnographers such as Michael Goldman and Aradhana Sharma, who have emphasized development banks' ability to enroll critics and their knowledges in entrenching their own power (Goldman, 2005; Sharma, 2006). But my analysis is also an inversion of this work and Tania Li's (2007) famous research on "the will to improve" enacted by development institutions upon the subjects of development: here I describe development's most central institutions striving to improve their *own* practices. In the process these banks have entrenched their histories of marginalization, in which they have created development projects that disenfranchise indigenous peoples, and generate racial divides. To examine these arguments, in the following section I return briefly to my conundrum of the "missing" neoliberal knowledge and health practices in development bank health programs.

Remaking a Neoliberal Image

In spite of development banks' histories of neoliberal health reform and my own interest in examining such logics in public health, the power of neoliberal governing rationalities did not emerge as the most significant dynamic in my empirical work. I did not find that the bank projects and practices I studied were promoting privatization, economic or financial knowledge, individual responsibility, the power of pharmaceuticals or corporations, market logics, incentivization, or management. While the nutrition projects I studied aimed to encourage pregnant women to seek prenatal care by offering food vouchers at their visits, program organizers designed the vouchers explicitly as a form of wealth redistribution (Chapter 5). And while the neglected tropical disease project I studied in Guyana is based on drug donations from multi-national pharmaceutical companies, the project moves far beyond global health's growing emphasis on pharmaceuticals (Biehl, 2007), combining understandings of environmental causes of disease with an emphasis on preventative care (Chapter 4). With regard to economic expertise as neoliberal knowledge, I found that the banks' promotion of economic tools for public health decision-making has not much guided operational practice (Chapter 4). And, as I discuss in Chapter 3, the oral histories I conducted with Guyanese healthcare workers, and my subsequent archival research both highlighted how central neoliberal values – such as individual responsibility, efficiency, and even incentivization – were key discursive elements promoted by socialist politicians and administrators in 1970s Guyana. These perspectives emphasize the need for precision in examining what exactly is novel about the banks' current discourses of capitalism and power.

One can argue that a food voucher program is an extremely limited form of wealth distribution that enables ongoing international exploitation by giving the impression that development banks are sincerely engaged in the project of addressing global inequality. Indeed, global health as a whole functions in much this way, as I discuss below. Neoliberal rationalities have certainly not been altogether absent from the development bank health projects I examined. In the early 2000s, IDB and the World Bank both financed health loans in Guyana that were rooted in neoliberal understandings of federal government as regulator, rather than provider of social services. IDB's USD $23 million Health Sector Program loan aimed to contract health provision from the federal government to Regional Health Administrations, which would provide a narrow set of "essential health services," in line with the selective primary healthcare approach advocated by the World Bank since the late 1970s. Likewise, the World Bank's 2004 USD $10 million HIV/AIDS Prevention and Control Project loan was designed to enact neoliberal values of civil society and the private sector as primary implementers. However, the private sector was not ultimately a focus of that project, which focused more on "multi-sectoral collaboration" across government ministries, as well as an anti-retroviral therapy provision program for the 11,000 HIV positive people in Guyana at the time (World Bank, 2010b).

But since the early 2000s, the World Bank and IDB have both promoted expanding government expenditure on health in Guyana, although they have argued this should be supplemented by "creating the conditions for increasing the contribution of the private sector" (World Bank, 2002: viii). This is a part of an explicit shift within these two banks away from market-based health projects and policy. These

development banks now promote a form of neoliberalism that is explicitly self-aware and which has incorporated widespread criticism of their earlier practices of privatization. The term neoliberal has become a part of the banks' lexicon, although members of these financial institutions use the term in a much more narrow fashion than the critical social science and humanities literatures do – restricting it to the macroeconomic tenets of the Washington Consensus.[8] But even as the institutions' leadership publicly reject "neoliberal" governance (Stein, 2014), development banks continue to promote neoliberalism's basic tenets in a form of what political economist Jamie Peck has called "zombie neoliberalism" (Peck, 2010). This means that privatizing forces are slightly more hidden than they've been in the past: the World Bank's flagship health effort since 2010 has been Universal Health Coverage (UHC), and while this sounds like a rather leftist goal, one has to dig deeper to find that the World Bank's version of UHC often amounts to the promotion of private health insurance (as opposed to broad, publically-provided healthcare). However, these institutions have long thought of health as an "emotional" sector with major implications for their public image, which has been a major driver of the institutions' approaches to health (see Chapter 1). Michael Goldman has described how the World Bank's ability to reformulate itself and enroll critics has been one of its strongest assets (Goldman, 2005), and public health is a key site through which development banks promote the idea of a bank that truly does good for the poor.

[8] The Washington Consensus is a set of policy prescriptions that DC-based financial institutions promoted in the 1990s, including privatization, liberalization and deregulation of the economy (Naím, 2002).

Today, neoliberal values play a central role across the field of global health, which differentiated itself from its precedents in international health through its focus on involving non-state actors and mobilizing public-private partnerships, business management tools, "innovative finance," and economic modeling (Thomas, 2004; Brown et al, 2006). Development banks have played a key role in the promoting these approaches, for example through the banks' widely-circulated reports and substantial data sets, and their prestigious training courses. As Vincanne Adams has suggested, "commitments to market-driven solutions have impacted the very business of how we think of doing global health work" (Adams, 2016). The work of development banks has opened space for much more wildly capitalist visions of global health in other spaces, such as profit-making global health investment projects that claim to make global health "pay for itself," as in the Global Health Investment Fund structured by JP Morgan Chase and the Bill and Melinda Gates Foundation (JP Morgan Chase & Co., 2017). Other branches of the World Bank Group also operate more clearly in extreme capitalist modes than do the health functions within the World Bank itself (see Chapter 1): for example, the venture capital funds of the IFC that invest in healthcare startups.

The ongoing development bank health projects that are the focus of this dissertation are strongly rooted in the institutions' efforts to remake their neoliberal image: a dynamic that becomes especially evident based on my methods, and especially my work in Guyana. As sociologist Shiri Noy has pointed out, qualitative studies of how the World Bank's agendas have shaped public health in postcolonial countries "have focused on the most extreme examples" (Noy, 2013: 82). Selecting a

quintessential neoliberal project as an object of study shapes the analyses that result. Studying the banks' interventions through time in Guyana, with a focus on the breadth of the banks' current projects as I have, instead draws attention to the role of global health in development banks' branding efforts, and the shifting place of the banks in the terrain of global health. While in the late 1990s, development banks administered almost thirty percent of global health funds around the world, by 2013 that percentage had dropped below ten, with new funding channeled largely through partnerships such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Global Alliance for Vaccines and Immunization (IHME, 2016: 21). Development banks have attempted to position themselves as central players in these new partnerships, although there has been tension surrounding the role of development banks: should the World Bank simply hold the funds for these partnerships, or should they have a central voice in how funds are administered (SM Interview, 2012)? Responding to critiques of their work has been significant for development banks trying to retain power in these new global health partnerships. In the following section I further explain how, in using health programs to respond to such critiques, the banks have entangled cultural anthropologists and legal specialists as they have re-inscribed state racial codes in the bodies of Guyanese citizens.

Displacing Critique

In recent years, development bank reports and publications have often made reference to "neoliberalism" in critiquing the institutions' own past emphasis on market-based policies, especially in public health. Since the early 1990s, members of

the banks' health divisions have attempted to distance themselves from structural adjustment efforts; today they often argue that the health divisions had little power in these privatizing programs, which were designed by the banks' macroeconomists. While this is a strategic representation that absolves health divisions of blame for the decreased health budgets and increased poverty that resulted from adjustment measures in many countries, my research has pointed to the very different approaches to health at play in different parts of the banks' networks. While senior staff within the World Bank and IDB have recognized the negative effects structural adjustment loans have had in many parts of the world, many economists working in development banks still argue that such negative effects resulted from the incomplete application of adjustment measures, rather than the basic tenets of privatization and liberalization (Rogers, 2010; World Bank, 2005). This perspective on implementation failure differs drastically from the visions of structural adjustment that operate in the banks' health sectors, where today staff and consultants quickly denounce the idea that cutting public health budgets and massively diminishing public employment might improve life for the world's poorest.

Throughout the dissertation, I emphasize the very different priorities and perspectives of different divisions, enclaves, etc. within these banks. I argue that while development banks have responded to critiques of their coercive approaches by promoting "country ownership" and public participation,[9] these principles have held a very different place in research and operations divisions. As I describe in Chapter 4, operations divisions' emphasis on democratic priorities has differed drastically from

[9] Development banks have both contributed to and played upon broader development and governance discourses in this regard.

the methods advanced by economists in the banks' research divisions, such as cost-effectiveness analysis for determining health priorities. These contradictions explain why bank practices so often misalign with development banks' self-representations and those offered by critics. Here my research draws attention to the very different forms of knowledge deemed relevant in various spaces of global health, even within a single project.

But across these contradictions, development banks' mobilization of health programs has helped re-inscribe state racial codes and institutional histories in the bodies of Guyanese citizens. The banks' emphasis on democratic priorities has helped IDB's neglected tropical disease project to operate as a form of patronage aiming to bridge Afro- and Indo-Guyanese populations, and critiques of the banks' treatment of indigenous peoples have led to the singling out of indigenous Guyanese as "racialized citizens," presumed to be bound by a culture that harms their health and biological well-being. In responding to critiques, these banks have often simply concentrated development discourses onto seemingly more remote populations, such as indigenous Guyanese. But while my argument builds on substantial literatures regarding the "elite capture" of development projects (Swindler, 2009; Smith, 2003; Ferguson, 1994; van de Walle, 2001), I do not see this as a simple case of government actors making use of development projects towards their own ends of maintaining electoral majorities. Instead, I describe the racialization produced in negotiation among both government representatives and bank managers seeking legitimacy, enrolling anthropologists and legal specialists who contribute to reproducing histories of dispossession.

But the particular forms of dispossession produced through these projects exist within a much larger framework of development banks' work internationally. In the final section of this Introduction, I address how this micro-level study fits into the larger context of the banks' work.

Aid and Extraction

During the course of my research, many people I worked with took me for a program evaluator: someone who would gather data as to how many pills were being distributed, how efficiently resources were being used, or how well a project was doing in achieving its goals. I consistently explained to project staff, but also American academics and my own family members, that my goal was not to evaluate how many people the institutions' projects were "saving," or whether the money was being used "appropriately." My goal was to understand how health projects both contain and create assumptions, values, and relationships of power, not only within the terms of development discourse, but within more expansive understandings of justice – informed by post-structuralist, feminist, and critical race theories.

But what would it mean in the current study for the World Bank and the Inter-American Development Bank to be doing "a good job with public health"? While this is not the lens I have used in framing my research, a version of the question is embedded in my work: in seeking to understand the knowledges and values that shape health projects, my research investigates whether these projects are rooted in expansive notions of social justice, if they are supportive of broader systems of exploitation, and how these dynamics of justice and inequality function. However,

taking a more explicitly normative approach to development banks' health interventions draws attention to the values of leftist scholarship underlying my research.[10] It requires me to highlight that first and foremost, I understand global public health as a part of aid efforts that are dwarfed by the ongoing exploitation of Guyana and other postcolonial countries by governments and corporations of the world's wealthiest countries (Griffiths, 2014). According to analysis by the University of Washington's Institute for Health Metrics and Evaluation, such governments and corporations devoted 36.4 billion US dollars to public health interventions in low- and middle-income countries in 2015 (Institute for Health Metrics and Evaluation, 2016).[11] However, regulatory schemes established by Northern countries continue to promote forms of extraction that far outweigh global health funding and financing. Since 2002, net official development funds have consistently moved from poor to wealthy countries, because loan repayments are greater than new aid (Browne, 2006). Compound interest payments on past development loans by themselves (i.e., not including repayment on the principal loan) amount to more money annually than all development aid for health (Hickel, 2014). This is on top of global financial regulations that create licit tax breaks and facilitate illicit tax evasion (especially through global financial deregulation) amounting to over a trillion dollars extracted from poor countries annually (Kar and Spanjers, 2014; Dyreng et al, 2008), as well as trade and intellectual property schemes that further exploit resources and labor from

[10] My own research is not exempt from the inherent entanglement of knowledge and politics that I describe in development bank projects; my leftist stance is informed by the extensive literatures and evidence I cite throughout the text.

[11] This includes concessionary loans from development banks, which have to be repaid (IHME, 2016: 16), so its categorization as "aid" is somewhat misleading. Aid in the sense of support that does not have to be paid back would thus be even lower.

postcolonial countries to the benefit of wealthy ones (Amoah, 2015; Cimoli et al, 2014).

In spite of the very sincere efforts on the part of global health professionals, the field does little in comparison to the ongoing damage inflicted in poor countries by the same governments, corporations, and organizations that fund global health efforts. The overlap between global health financers and the key players in predatory trade and regulatory schemes suggests that global health may in fact play an obfuscatory role. Jason Hickel has argued: "Poor countries are net creditors to rich countries. Aid serves as an illusion to mask this fact; it makes the takers seem like givers" (Hickel, 2014: np). While Hickel addresses development aid broadly, his claims are valid for global health specifically: financing programs to improve the health of the world's poorest does a great deal to maintain the international relationships that allow wealthy countries to preserve systems of extraction. Without efforts to alleviate the effects of such exploitation, the governments of wealthy countries would likely be subject to massive protest in both wealthy and poor countries. To really improve the health and wellbeing of people around the world, Northern countries need to support a robust global financial regulatory system that does not allow for licit and illicit corporate tax avoidance, and that compensates poor countries and their citizens for their labor and resources.

Nonetheless, leftist critics have been successful in pushing development banks to increasingly support government social spending, the use of local vendors and consultants for bank projects, and avoiding the enrichment Northern companies through bank loans. In the process, development banks have enrolled environmentalist

and feminist critiques to continue to position themselves as essential organizers of international development in the face of strong academic and popular criticisms of their work; they have made environmentalism central to their work, and have taken over feminist languages of "empowerment" (Goldman, 2005; Sharma, 2008). In public health, the Inter-American Development Bank has been particularly explicit about moving away from market-based projects. The most recent internal evaluation of IDB's health efforts argued that the very basis of the institution's lending in the health sector – "a set of key reform measures, largely based on market instruments and incentives, defining the approach followed by the Bank during the 1995-2005 period" – could not lead to IDB's goals of efficiency, quality, and equity in health systems (IDB, 2006: ii). Specifically, the evaluators argued:

> The conclusions and findings derived from each of the main reform measures supported by the Bank indicate that they contain sufficient limitations and drawbacks to suggest that, as a whole, this set of measures was unlikely to have been able to improve efficiency, quality or equity of the health systems of the Region (IDB, 2006: ii).

IDB's evaluators critiqued the very ideological basis of the institution's market-based lending for public health.

Low-interest loans for health projects do allow low-income countries the possibility of immediate financial resources for domestic public health programs, but internal evaluations of both the World Bank and IDB's health sector work have suggested that the banks' health efforts have not gone far towards improving lives internationally. World Bank evaluators have argued that even after the institution moved away from explicit privatizing efforts in the health sector in the early 2000s, the World Bank has pursued "irrelevant objectives" in health, often with

"unsatisfactory results" (World Bank, 2009: xvii). A 2009 evaluation conducted by the World Bank's Independent Evaluation Group stressed that the percentage of projects deemed at least "moderately satisfactory" in the health sector – sixty-eight percent in 2006 – had consistently lagged behind other areas of World Bank lending, with a growing divergence since the mid-1990s (World Bank, 2009: 19). This included "weak accountability in delivering health results for the poor," in spite of the fact that "studies of the incidence of public expenditure have shown that in most countries, public health spending favors the non-poor; mere expansion of services cannot be assumed to improve access of the poor relative to the non-poor" (World Bank, 2009: xvi). The bank's Internal Evaluation Group emphasized that without specific efforts to address access issues among the poor, increased public health spending usually benefits mainly the wealthy.

Development banks' own evaluations have suggested that these institutions are not doing all that well in public health, based primarily on the institutions' own espoused concerns for equity and serving the most marginalized. But these were also the priorities that development banks expressed in the 1990s when the institutions were pushing for (and often requiring) anemic government health budgets and the privatization of healthcare: the banks argued that their privatizing methods were to benefit the poor (Chapter 3). While the World Bank's management has accepted that privatizing efforts often have detrimental effects, many within the institution continue to argue that the negative effects of structural adjustment projects resulted from incomplete applications of the prescribed reforms (Rogers, 2010; World Bank, 2005). Likewise, the critique of neoliberalism advanced by IDB evaluators is launched from

within the framework of development banks' own priorities and assumptions, although these differ substantially across the institutions' networks. These evaluations maintain the concerns for quantitative and economic data that underlie the banks' external publications and research, and the critique of privatization remains in a very limited form.

Public health scholars have consistently highlighted the importance of wealth redistribution for improving the health and well-being of people who have been marginalized and oppressed (Fort et al, 2004; Marmot et al, 2008). These literatures have also suggested that broad social systems are crucial to supporting people who continue to face the effects of social exclusion beyond economics (e.g. based on personal networks, availability of time, etc.) (Birn and Starfield, 2007). Some development bank programs have specifically pursued these dual goals of income redistribution along with broad, supportive social services; the Basic Nutrition Program that I discuss in Chapter 5 (in its early years) is one example. In addition to these elements of wealth redistribution and expansive social services, an essential element of public health interventions lies in the ways such programs construct people and social relations. And while the World Bank and IDB ostensibly focus on respecting "local knowledge" and the perspectives of "project beneficiaries," their approaches and priorities are still often rooted in patronizing or detrimental representations of the people they aim to help (see Chapter 5).

In recent years the banks have put a great deal of effort into "conditional cash transfer" (CCT) programs, which provide cash grants to individuals and "households" dependent on recipients completing medical visits or other "desired health behaviors"

(Baird et al, 2016). IDB's Basic Nutrition Program mobilized a similar logic by providing food vouchers only at post-natal visits, although the project avoided the market-based language of "incentivization" that CCTs usually mobilize. CCTs are built on the assumption that people should only benefit from social services when they behave in the ways that governing bodies deem acceptable. Since the 1980s, development banks have received intense criticism for their loan conditions, which have required poor countries to implement wealthy donors' policy prescriptions at the expense of national sovereignty, and often with hugely detrimental consequences for poverty and national economies (Pender, 2010; Best, 2007; Abouharb and Cingranelli, 2007; Stiglitz, 2002). But conditions at the individual level through conditional cash transfer projects are strongly reminiscent of conditions for national policy.

A growing movement is pushing development agencies to provide people cash transfers without strings attached (Goldstein, 2013; Blattman et al, 2013; Kenny, 2013).[12] True to form, the World Bank and IDB have been quick to get involved in research on unconditional cash transfers (Hernani-Limarino and Mena, 2015; Blattman et al, 2013; Baird et al, 2016; Ozler, 2015). But the banks have also begun to frame a broad span of their previous work in terms of this new terminology, emphasizing social security programs as forms of unconditional cash transfer, and even framing universal healthcare as an unconditional transfer (World Bank, 2014).

[12] Unconditional cash transfers are a site where leftist promotions of wealth redistribution overlap with economistic visions of rational choice that frame such projects as "an attempt to test one of the simplest ideas in economics — that people know what they need, and if they have money, they can buy it" (Goldstein, 2013: np). This is similar to the overlaps that Dean Jamison described in Chapter 3: both leftist politics and strong free market economics lead to an emphasis on individuals knowing better what they need than do development institutions. Some development practitioners and researchers have also promoted unconditional cash transfers as simply a more efficient means of administration, not subject to "leakages" and corruption (e.g. Muralidharan et al, 2013).

Nonetheless, these development banks are starting to promote the idea of wealth redistribution as an essential intervention for health and development. And while a broad vision of income redistribution may appear far too "activist" to expect of development banks, I would suggest that expanding the frameworks of possibility is essential to challenging the status quo. Global health efforts need to continue to highlight the massive funds that could be made available for wealth redistribution with improved trade policy and global financial regulation.

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But what is to be gained from studying a small part of such a large system of extraction – from studying the daily minutia within several health projects and within health division operations at two development banks? Some such "micro-level" analyses have revealed the broader logics of exploitation that infuse oppressive systems, with daily operations serving as a microcosm of systemic issues (Foster, 2005; Petryna, 2005; Foley, 2009; Peterson, 2012; Erikson, 2012). My own study, however, highlights the mobile and shifting nature of late neoliberalism; it emphasizes the ways in which financial institutions are using health projects to address criticisms launched at the organizations, by transforming their previous market-based and privatizing health policies. Many of the banks' most recent projects do not present the trappings of traditional economic neoliberalism, nor neoliberalism's characteristic focus on systematized management and management of the self. While such values do infuse some bank projects still, this is far from universal. Late neoliberalism is here instead characterized by the combination of such logics with projects that are explicitly designed to move the financing institutions beyond their neoliberal image.

Understanding the topography of these practices can help scholars and activists alike imagine where and how efforts towards change might best be focused.

I build my analysis in this dissertation through six subsequent chapters. In the first chapter I further introduce the histories of Guyana and of development banks that health projects encode in their subjects, and in the second chapter I show how development bank health work looks on a daily basis in Guyana and in Washington, D.C. In Chapter 3 I demonstrate how Guyanese healthcare workers have mobilized a framework of continuity to describe health system governance before and after structural adjustment in Guyana, and I argue that these frameworks are rooted in the similarity of discourses of socialist politicians in the 1970s and World Bank reformers in the late 1980s and early 1990s. In this chapter I emphasize the very different functioning of neoliberalism in the global North and South, as a means of understanding the continuities that healthcare workers describe. In Chapter 4 I demonstrate the very different valuations of economic expertise that operate across development banks' networks, focusing on approaches to cost-effectiveness analysis. I argue that cost-effectiveness analysis has been mobilized as an aspirational discourse within the banks' research divisions, and I show how these visions are countered by a focus on democratic politics within operational divisions. Here the banks' responses to widespread academic and popular critique underlie a racialized form of patronage politics. In the fifth chapter I show how Guyanese electoral politics combine with the politics of expertise within development bank headquarters to racialize indigenous Guyanese and construct culture as a biological phenomenon. While economic expertise has held little power in bank operations, cultural anthropologists and

specialists in indigenous law have shaped the ongoing marginalization of indigenous Guyanese. In the dissertation's conclusion, I emphasize how development banks' efforts to reformulate their neoliberal images have re-inscribed state racial codes in the bodies of Guyanese citizens, and I further consider what it would mean for development banks to be doing "a good job" in global health, arguing that the global financial and trade regulations supported by the banks and their funders are the largest ongoing impediment to health and equity globally.

CHAPTER 1

INSTITUTIONAL HISTORIES AND RACIAL LOGICS: GOVERNING ACROSS DEVELOPMENT BANK NETWORKS

In the fall of 1978, over 900 members of the People's Temple died in a mass murder-suicide in Guyana, most of them black Americans that had moved from the San Francisco Bay area to the Temple's commune in Guyana's Northwest—billed by the cult's leader Jim Jones as a socialist utopia within a black-led socialist nation, a place to get away from the racism of the US and start anew. But in their discussions of this Guyanese utopia, the Temple's leadership paid little attention to the accusations of racism between Indo- and Afro-Guyanese that have been so central to Guyanese electoral politics throughout the country's post-independence period. That same year, in 1978, the Government of Guyana signed its first health loan with the Inter-American Development Bank (IDB): a USD nine-million-dollar loan to support the training of healthcare workers and infrastructural improvements at the country's largest hospital. Although international financial institutions had expressed concern about Guyana's increasing connections with the Soviet Union, they continued to lend to the Caribbean country throughout the 1970s. So how did this loan fit into the historical context of governance within Guyana and the IDB in the late 1970s? At the time, other international financial institutions were very little involved in public health. Why then did IDB, which has consistently followed the World Bank in its lending priorities and policies, begin providing health loans years before its larger

competitor-cum-colleague? In this chapter I demonstrate how the early histories of public health lending within the World Bank and IDB reveal the institutions' concern for public health as a unique public relations issue, and I begin to demonstrate how these concerns have interfaced with Guyanese popular politics in shaping health programs. I emphasize that the dominant popular and academic framework of racial tension between Indo- and Afro-Guyanese has been essential to development interventions in the country, and I highlight the ways that these framings constrain possibilities for indigenous Guyanese. I begin by examining the shifting ideologies of governance shaping the World Bank's growing attention to public health in the 1980s and 1990s, against concerns long expressed by its Executive Board.

Development Banks and Global Health

In the late 1990s and early 2000s, international health circles were abuzz with commentary on the newly influential role of the World Bank in the field (Ruger, 2005). A 1998 editorial in the *American Journal of Public Health*, for example, argued that "the WHO's leadership role has passed to the far wealthier and more influential World Bank" (Silver, 1998: 728). Over the previous decade, the World Bank had begun to provide large amounts of financing for health projects, and had taken on a prominent role in establishing agendas for health aid internationally—through the institution's research and reports, and through engagement in various global health fora, such as conferences and international meetings, which the World Bank often convenes.

Observers often suggested that the World Bank's new position in global health was rooted in its financial power. But while development banks' ability to mobilize large amounts of finance certainly impacted their influence in the emerging field of global health, the idea of the "wealthy" World Bank obscures the fact that the institution provides health financing almost entirely through *loans*, as opposed to other organizations' *grants*; development bank financing ultimately has to be paid back.[13] This lending relationship contributes to development banks' emphasis that they *finance and oversee* loans, rather than *implement* them. While the banks design the projects that they finance as a concerted process through their headquarters and country offices, these projects are officially implemented by the borrowing government, most often by a consulting firm hired under the banks' conditions—through which banks can shape project implementation (Rottenburg, 2009).

And while the WHO had a full fifty years of experience in international health by the late 1990s, the World Bank had extremely limited involvement in the field of international health as little as twenty years before. The World Bank's original focus was lending money to the governments of Western Europe for the reconstruction of roads and other physical infrastructure after the Second World War. However, with the United States' Marshall Plan providing European governments with funding that did not have to be repaid, the World Bank moved quite quickly to start making loans for projects outside of Europe (Goldman, 2005).

The World Bank was initially named the International Bank for Reconstruction and Development (IBRD), and it was established based upon the agreement of forty-

[13] Both the World Bank and IDB do provide some grants, mainly in the form of "Technical Cooperations" that pay for consultancies to prepare further loans.

four countries at the Bretton Woods Conference convened by the US government in 1944, where the International Monetary Fund was also set up. While agreements at the conference were primarily influenced by the world's imperial powers, which still controlled much of their colonial empires, the conference did include delegations from Latin American nations and some of the first countries that had attained independence from Britain – including South Africa and Egypt (Goldman, 2005; Kapur, Webb and Lewis, 1997). In the following years, these post-colonial countries joined other newly independent governments in calling for an institution that would provide loans at lower interest rates for countries deemed the world's poorest; in 1960 the International Development Association (IDA) was established as a part of the World Bank that would provide such concessional loans. Several other organizations have been established under the umbrella of the World Bank Group since the IBRD was first established, including the International Finance Corporation, which was established in 1956 with the goal of investing specifically in private sector activities. However, the IBRD and IDA alone form the institution known as the World Bank (versus the World Bank Group), and they focus on providing loans to governments.

Michael Goldman has described how even after the establishment of IDA, the World Bank continued to follow a conservative lending strategy focused on the construction of roads, ports, and power plants, which the institution's Wall Street investors imagined were most certain to produce capital to repay the World Bank's loans.[14] Goldman credits Robert McNamara, who became president of the World Bank in 1968 after his much-maligned stint at Secretary of Defense during the Vietnam

[14] In the World Bank's early years, almost two-thirds of its capital came from World Bank bonds, sold to such private investors (Kapur, Webb and Lewis: 137, 961).

War, for introducing a focus on "the absolute poor" and the need to make loans specifically focused on "poverty alleviation." McNamara argued that the World Bank could expand its impact, influence, and lending by directly targeting the world's poorest. Instead of lending only for large infrastructure projects aimed at improving economies writ large, the bank could make more loans by also lending for agriculture projects to address rural poverty, and for projects in education and in family planning, which McNamara emphasized as an aspect of population control.

Although the World Bank's Executive Board[15] expressed concern about this new direction of lending for poverty alleviation, McNamara was able to make use of rhetoric from scholars in development studies such as Dudley Seers as well as postcolonial leaders like Indira Gandhi, along with a new emphasis on the quantification of poverty that he established within the World Bank (Goldman, 2005: 72-73). McNamara was able to get initial support for work in population and rural development, and even some environmental programs, but the World Bank's board was concerned that public health loans would be a public relations problem because denying such a loan could vilify the institution (World Bank, 1975). The Board expressed these concerns in their 1975 decision to forbid the World Bank from making stand-alone health loans, and the author of that 1975 report further explained to me the context of the decision when I met with him in the winter of 2013.

Fred Golladay was the primary author of both of the first two internal World Bank reports regarding public health lending, the first in 1975 and the second in 1980. An economist of education by training and an assistant professor at the University of

[15] The World Bank's Executive Board is controlled primarily by the countries that contribute the most funds to the institution, including the United States and the United Kingdom.

Washington, he was recruited to the World Bank in 1975 to examine the possibility of the institution making loans for public health projects.[16] Sitting in the living room of his spacious Washington, D.C. home, Dr. Golladay's wife – a retired statistician – offered the two of us tea as Dr. Golladay reminisced about his first years at the World Bank. He argued that the institution's board had been concerned that public health loans were "a bottomless pit":

> FG: McNamara's decision to make the bank a poverty-oriented development institution flew in the face of what everybody thought, and so there was a lot of resistance in '71, '72 to his initiatives in environment and population and rural development. *And health was the last to come on board and it was the most controversial*. The senior VP at the time was a man by the name of J. Burke Knapp. He and McNamara didn't get along very well. Knapp was the old bank, McNamara was the new bank. And Knapp really thought that health was a bottomless pit; that if you opened yourself to requests *it would have an emotional appeal*, you're doing good things, humanitarian things, but *you wouldn't really have a way of saying no that wasn't embarrassing to the Bank*. And it was so far from the original charter of the bank that he resisted. I may overstate his role in this, but there was that tension.
>
> AW: And do you think it was a question of return on investment?
>
> FG: No, *it was about how do you discipline lending in this area*. And there was the World Health Organization and the Pan American Health Organization sitting around in principle doing the same thing.

Golladay argued that the concern about public health loans was not their return on investment, but the highly "emotional" character of public health (as he called it): how could the institution ever say no to a loan in such an emotionally-charged area as health?

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[16] Golladay had some experience working on health issues, but he stressed that health and education are very similar: "From an economists' point of view they're basically the same sets of problems: public provision, lots of subsidies lurking in the background, a lot of highly emotional content, big constituencies on both the providers side and the public side; kind of unmanageable institutions in both instances."

However, the World Bank had already begun substantial efforts in family planning, nutrition, and even disease control. One of the institution's earliest public health interventions was the Onchocerciasis (river blindness) Control Program that the World Bank initiated in 1973 with the World Health Organization (World Bank, 1975). For this project, the World Bank provided an initial $750,000 grant, and also worked to raise funding from the governments of Canada, France, the United States, the Netherlands, the United Kingdom, Belgium, and Iraq. The program originated as a vector-control project that would provide insecticide spraying in West Africa with the goal of opening new areas to settlement and agricultural production, but expanded in 1987 to include "mass drug administration" under one of the world's first large scale corporate pharmaceutical donation programs (Liese et al, 2010).

But in light of the concerns of the World Bank's Executive Board as to the public relations issues surrounding public health lending, the organization's leadership came to the agreement in 1975 that the World Bank would not make specific loans for public health projects, although it would "clean up after itself" (FG Interview, 2013). The final version of Golladay's 1975 report phrased it thus:

> The Bank has decided that, in the coming years, it will continue to strengthen its awareness of the health consequences of the projects it supports, and of opportunities for improving health that are available under present patterns of lending. In other words, while the health benefits of projects are expected to increase, the patterns of lending will remain basically unchanged. Although this implies that the Bank will be less deeply involved in health than if it had decided to lend for basic health services, the scope and potential of the policy is not to be underestimated (World Bank, 1975: 5).

The report set out the policy that the World Bank would not make "stand alone" loans for public health, but it would make efforts to minimize negative health effects of its

projects; it would continue to include "health components" of projects in other sectors. Furthermore, the report emphasized that the institutions' projects in water supply, sewage, and housing all had major public health effects (World Bank, 1975: 5).

At the time, the World Bank, along with many people in the areas of its first rural development projects, had observed that irrigation projects could lead to major changes in the patterns of water and vector-borne diseases such as schistosomiasis and river blindness (Lee, 1985). As the World Bank's first full-time "health specialist," Fred Golladay was made responsible for reviewing all World Bank loans to identify any possible health risks, especially relating to such water and vector-borne diseases. The following year, in 1976, the World Bank hired its first medical doctor (Bernhard Liese), who joined Golladay and another economist (Caio Koch-Weser) on the institution's first health team, which operated out of the new Office of Environmental Affairs.

Tasked with helping project teams design and implement project elements, the team remembers offering services that were much appreciated by project planners across the World Bank (FG, CKW, BL Interviews, 2013).[17] Five years later, in 1980, the World Bank's board requested further review of the issue of health lending. And while Golladay's 1975 and 1980 reports make very similar arguments regarding the economically productive nature of such interventions, the 1980 report he co-authored with Bernhard Liese led to the approval health lending by the World Bank, where the 1975 report had not been successful. Golladay attributes the success of the second

[17] Golladay, Liese and Koch-Weser all emphasized the services their team offered in ways quite similar to what David Mosse (2011) has described with respect to anthropologists at the World Bank. Mosse has argued that development bank staff commoditize forms of expertise in order to establish themselves and their specialties within the organizations.

report to the retirement of the most vocal board member that had been opposed to health lending, as well as the growing acceptance in and outside of the institution of McNamara's emphasis on poverty alleviation (FG Interview, 2013).

When the World Bank began making loans for public health specifically, Golladay's health group was moved into the institution's population division, where a strong divide emerged between the small group of economists and physicians on the health team and the much larger group of demographers who had previously made up the population division. Golladay quipped: "I know something about mergers and acquisitions. What's the old joke? If you make horse stew and add a rabbit, it still tastes like horse" (FG Interview, 2013). He emphasized that health lending played a very minor role within the population division. And although having a physician as the new division's director in the early 1980s helped bolster the health aspect of the new Population, Health and Nutrition unit, Dr. John Evans[18] left the World Bank in 1983 and was replaced in his position by a long-time bank bureaucrat who again paid little attention to health matters per se (Simmons and Rushikesh, 1988).

In the subsequent years, the institution multiplied its structural adjustment lending. International financial institutions had designed this new type of loan in the late 1970s as a means of responding to international economic crisis (Kapur et al, 1997).[19] The loans' requirements for economic liberalization and privatization formed the basis of the emerging "Washington Consensus": a set of policy prescriptions that had been broadly promoted by DC-based financial institutions and which have often

[18] Dr. John Evans' son Dr. Tim Evans is now the Senior Director of Health, Nutrition and Population at the World Bank.
[19] See Chapter 3 for further discussion of structural adjustment projects.

been cited as the heart of neoliberal economics (Naím, 2002). While structural adjustment projects were not the purview of the World Bank's health divisions, they had major impacts on public health: through decreased public health budgets as part of "public sector downsizing," and also through increased poverty associated with the loss of public sector jobs, increases in commodity prices due to monetary reform, and the loss of many local businesses that were unable to compete with large foreign companies whose products no longer carried tariffs (Pfeiffer and Chapman, 2010).

In the 1980s, while development banks were making extensive structural adjustment loans around the world, the World Bank's health division focused its efforts on providing loans for physical infrastructure of health facilities and for primary healthcare services such as the provision of essential medicines, but the division was not able to entice many governments to take such loans (Fair, 2008). When the World Bank underwent a major reorganization in 1987, health specialists were distributed throughout the regional and country offices, giving them more direct contact with client governments (Birdsall, 1992). But the 1980s also saw the leadership of the World Bank's research divisions taking an increasingly market-based approach to the institution's social programs. The same year as the World Bank's reorganization, the research division published a report on *Financing Health Services in Developing Countries*, which was based on the assumption that public health spending in poor countries could not be increased; the report offered the solution of asking citizens to pay (either through fees or insurance) for care that benefits them directly as individuals, rather than society as a whole. The report stressed that "individuals are generally willing to pay for direct, largely curative care with obvious

benefits to themselves and their families" (World Bank, 1987: 2). This resort to private payment was a major shift from the promotion of broad social services and understandings of health as an essential aspect of domestic and international solidarity, which had wide international support less than ten years before—promoted in such international forums as the 1978 Alma Ata Conference.

Following on *the Financing Health Services* report, in 1993 the World Bank's research division produced a World Development Report on "investing in health;" although it represents a less wildly capitalist view of healthcare than the 1987 report, the 1993 WDR had much broader circulation and in public health circles it came to represent the World Bank's conservative approach to health (see Chapter 4). And while many public health practitioners criticized the framing of health as a commodity, the World Bank's central role in international governance and growing leadership in international health helped produce a sevenfold increase in the institution's health lending from the late 1980s to the late 1990s (Nelson, 1999: 50). These loans were oriented primarily towards health system reform, promoting decentralization and often the institution of user fees, following World Bank researchers' arguments that governments could not afford to provide free national healthcare and needed to supplement their resources by charging for services.

At the end of the 1990s, the division was re-named Health, Nutrition and Population, reflecting the new centrality of health over population lending (Fair 2008, 5). At that time, the division began lending substantially for HIV/AIDS interventions, and from 1997 to 2006 the division's total lending multiplied from 6.7 billion USD to 16 billion (IEG, 2009). However, a 2009 report by the World Bank's Independent

Evaluation group argued that the World Bank had had limited impact through its health lending, due to "irrelevant objectives, inappropriate project designs, unrealistic targets, and an inability to measure the effectiveness of interventions" (IEG, 2009: xvii).

The World Bank has in recent years recognized that the Washington Consensus is a "damaged brand," and that the language of "market-based solutions'' as the primary answer to development problems of all types is not well-met internationally (Naím, 2005; Birdsall et al, 2010). The institution has acknowledged that structural adjustment policies often had detrimental effects on the lives of poor citizens and even on national economies (see Chapter 3), and that user fees excluded large numbers of people from health services, even when the poor were meant to be exempt from the fees (Rogers, 2010; World Bank, 2005). The institution has increasingly framed health as a right which demands government investment, rather than purely a commodity to be economized—although economic efficiency and private healthcare continue to be central in the World Bank's health research. The election of Jim Kim – a physician and cultural anthropologist by training – as the organization's president has signaled the desire of the institution's board to reform the World Bank's widespread reputation for being more concerned with finance than development (Engler, 2012), as well as the central role of public health in this rebranding.

Throughout this dissertation I examine how these shifting ideologies have shaped the practice of health programs both at the World Bank and the Inter-American Development Bank. And although similar dynamics have shaped the health programs of the two institutions, there are some fundamental differences between the

organizations. When IDB was founded in 1959, the World Bank had already undergone major shifts in how it interpreted its mandate during its nearly fifteen years in operation, moving from a focus on post-war reconstruction in Western Europe to a focus on infrastructural investments in the rapidly decolonizing areas of the world. However, European powers continue to be overrepresented in the governing procedures of the World Bank even today, where France, Germany and the UK, along with the US and Japan, together hold forty percent of the Executive Board's votes, the remaining sixty percent divided among both borrowing and lending countries. The importance of having a development bank led by borrowing countries was a key argument leading to the establishment of IDB in 1959 as the world's first regional development bank (Tussie, 1995: 17).[20]

Although the World Bank occupies a great deal of international attention, the Inter-American Development Bank provides a larger proportion of development financing in Latin America and the Caribbean. The two development banks have pursued very similar objectives and methods, and overlap strongly in their areas of focus in the Western Hemisphere. IDB has even been criticized by some of its shareholders for its lack of independent strategy, as the organization often follows the policy directions of the World Bank (Nelson, 1999). The movement of staff and consultants between the two institutions certainly contributes to the organizations' alignment. But beyond the banks' commonalities, scholars and policymakers have framed IDB as unduly "reactive," arguing that instead of setting strategic policy

[20] Although IDB's institutional structures give borrowing countries more executive power than they have at the World Bank, the US alone holds thirty percent of the votes on IDB's Executive Board, in addition to the country's substantial diplomatic influence.

directions, it reacts to ad hoc circumstances. IDB staff usually frame the organization instead as "attentive," emphasizing the importance of member countries in shaping its programs: IDB does not tell its member countries what to do, staff often claim, but instead follows what borrowing countries ask. To support this argument, IDB employees often reference the decision-making procedures of the IDB Executive Board, where borrowing countries hold a majority of votes.

While IDB followed the World Bank's orientations to structural adjustment lending and privatizing programs in the health sector throughout the late 1980s and the 1990s, IDB began health lending before the World Bank. As opposed to the World Bank, "social development" was a central aspect of IDB's mission from its initial establishment. In the 1970s IDB began to make loans for physical infrastructure of hospitals and clinics (Nelson, 1999: 75). The first development bank health project in Guyana was a USD 8.8 million dollar IDB loan agreed upon in 1978, which provided for infrastructural improvements at Georgetown Hospital, as well as for the training of healthcare workers. And while both IDB and the World Bank have emphasized their evolutions away from seeing physical infrastructure as the heart of public health improvement, recent bank loans in Guyana look strikingly like the institutions' earliest loans. Although program materials for IDB's 2004 Health Sector Program focus on "organizational development and institutional capacity improvement," only about one quarter of the loan's twenty-three-million-dollar budget are devoted to these activities; the other $17 million dollars are for infrastructure (IDB, 2004). So while development banks' approaches to public and private investment in health have shifted substantially

in recent decades, the practice of health as infrastructure has remained surprisingly resilient.

This continuity in approaches mirrors the long timescale that connects the Guyanese government to past bank loans through repayment: this original 1978 loan is still being repaid by the Government of Guyana, even with the major debt relief programs that both IDB and the World Bank have put into place over the last fifteen years (IDB, 2016; IDB, 2017). Development specialist Shalmali Guttal has emphasized that such debt relief programs primarily serve to keep poor countries within the banks' systems of loans and repayments, because the astronomical levels of compounding interest on earlier loans would otherwise lead borrowing countries to either revolt *en masse* or simply refuse to pay sums that multiply far more quickly than national economies (Guttal, 2000). In spite of these debt relief agreements, IDB remains Guyana's largest creditor: debts to IDB alone account for 42.8 percent of Guyana's external public debt (Cooperative Republic of Guyana, 2016: 9).

Financing health projects through loans shapes the dynamics of development banks' involvement in global health. These loans are a part of the broader international finance system; development financiers see these low-interest loans as a way of testing whether countries are "good performers" that follow the "discipline" of loan conditions and repayment schemes (International Development Association, 2002). A 2002 World Bank report emphasized that such lending:

> has therefore often been seen by other bilateral and multilateral agencies as providing a signal to initiate or expand assistance programs, and, as countries develop, this becomes a signal to private capital markets as well (International Development Association, 2002:4).

Here the World Bank frames health and development lending as an essential aspect of international financial growth, as a means of testing the "climate" for private investment.

But while health projects are shaped in large part by such institutional histories and ideologies, development bank logics and practices have varied substantially across the institutions' networks: from research to operations, headquarters to country offices, and across the agencies and firms involved in negotiating, planning, and implementing projects. How then do development banks' ideologies interface with governing logics across the institutions' networks as the institutions plan and implement health programs? In Guyana, both popular and academic analyses have framed racial tensions between Indo- and Afro-Guyanese as the most essential dynamics of governance. So how do governing logics in Guyana interface with the knowledges and values at play in development bank health projects? To examine these relationships, I start by analyzing how the country's racial politics have been conceived of by academic and popular analyses in Guyana and abroad, and how these popular politics have shaped approaches to public health in Guyana.

Guyanese Governing Logics and the Politics of Race

From speeches of elected officials to elementary school classrooms and the country's national anthem, one hears of Guyana as a "land of six peoples"—a colonial racial stratification among so-called East Indians, Africans, Amerindians, Chinese, Portuguese, and Europeans (Spencer, 2007). These racial classifications are rooted in

Guyana's labor history, which has been constructed by consecutive governments as a foundational framework for the independent Guyanese nation. Postcolonial theorist Shona Jackson has eloquently shown how post-colonial Guyanese elites have mobilized these racial stratifications in formulating notions of national belonging rooted in contribution though histories of "modern" labor: from the descendants of enslaved West Africans first brought to Guyana under Dutch rule in the mid-seventeenth century, to those of indentured servants from India and Portuguese Madeira and laborers from Hong Kong brought to Guyana in the late nineteenth century after the abolition of slavery in the British empire in 1834 – twenty years after the British took control of the territories of Guyana (Jackson, 2012; Kwayana, 2002; Moore, 1987). The *labor* of Portuguese indentured servants thus distinguished them in Guyana's racial classifications from "Europeans" who oversaw and disciplined the labor of others.

As Jackson points out, this stratification left little room for indigenous Guyanese to claim belonging through the defining pair of arrival and colonial labor. In the all but absence of British settlers, especially after independence, Jackson demonstrates how "those brought in as forced labor" enact what she calls "settler-Creole social belonging and material right" (Jackson, 2012: 11), which turns on the spatial division of coastland versus interior spaces. "Afro-Creole" and "Indo-Creole" populations, which make up over eighty percent of Guyana's population, live in vast majority in and around the capital along the Atlantic coast. These spaces were expropriated from indigenous Guyanese for plantations and coerced labor; Amerindians now live primarily in the western regions that border Venezuela down

through the savannahs and forests close to the Southern border with Brazil (Jackson, 2012; Bulkan, 2014). In using the terms Afro- and Indo-Creole, Jackson places emphasis on the narratives of Caribbean hybridization and labor history that are at the root of what she calls "Creole indigeneity": a means through which the descendants of laborers brought to Guyana from West Africa and the Indian subcontinent have positioned themselves as the true "natives" of Guyana. But while I draw on Jackson's insights, in this dissertation I use the terms Indo-, and Afro-, and indigenous Guyanese, which place greater emphasis on shared Guyanese histories across these groups.

In the face of these racial frameworks, the government of Guyana has enacted discourses of pluralism since the country won its independence from Britain in 1966, relying especially on the symbolism of holidays and festivals, as historian Ramesh Bhagirat (forthcoming) has emphasized—from national holidays rooted in Christian, Hindu and Muslim traditions to commemorations of Indian indentured servitude and African slavery (Indian Arrival Day and Emancipation Day) and an Amerindian heritage month.[21] However, these celebrations contrast with regular accusations of racism and "racialism" in Guyana's electoral system—terms that Guyanese use regularly in describing voting practices and the distribution of government benefits based on racial party affiliation. Discourses of multiculturalism serve to counteract such perceptions of racial hostility and polarization. But amidst this "land of six peoples," public discourses frame Guyanese politics as a division between just two: between Indo- and Afro-Guyanese and the political parties associated with each.

[21] In chapter 4 I discuss the contrast between limited space for indigenous citizenship claims and public symbolism of "indigenous culture."

Control of the executive branch in Guyana has only changed parties twice in the country's history: from 1966 until 1992 the government was controlled by the People's National Congress, which has been understood as the party representing Afro-Guyanese. From 1992 until 2015, the People's Progressive Party held control of the government, and has been understood to represent Indo-Guyanese. The excerpts below are characteristic of frequent editorials in Guyanese newspapers, which highlight the discourses underlying this framework of political and ethnic divides between Afro- and Indo-Guyanese.

> I am cognizant of the fact that racism has touched the lives of all Guyanese. However, Indo-Guyanese face the brunt of this problem. Indo-Guyanese must understand the propellers to this problem if we are going to safe guard ourselves… We rarely stand up for our rights. We rarely join the picket lines or engage in civil unrest, riots or similar aggressive behaviors even when we are abused. We almost never engage in street crimes and almost never menace another race / ethnicity. Our good nature portrays us as weak and so we are taken advantage.
>
> -Dr. Annie Baliram, *Kaiteur News*, August 2016

> Issues are not the overriding thing here, race is. For the Indian, whatever the complaint, it only affects black people. Therefore there are no outraged Indians. There is no reason for the Indian voter to be on the picket line, for even though he suffers the same humiliations, he identifies with the Government.
>
> -Milton Bruce, *Stabroek News*, October 2014

> Every Guyanese knows that race-relations in this country, especially between Africans and Indians, are being skillfully balanced on a knife's edge; it's a powder-keg waiting to explode at any time given the right conditions. In the circumstance, [Member of Parliament] Edghill's remarks are akin to throwing gasoline on a smoldering fire…He is deliberately fanning the flames of racial hatred, bigotry and discord in this country, in an undisguised attempt to ingratiate himself with the PPP's Indian-support base.
>
> -Osafo Lynch, *Kaiteur News*, June 2016

In addition to emphasizing the framework of division between Afro-and Indo-Guyanese, these excerpts highlight claims to exploitation advanced by both groups, as well as the shifting racial terminology at play: while some Guyanese would refer to Indo- and Afro-Guyanese, others (or in other circumstances) would refer to "black," "African" or "Indian."

Both in popular and academic accounts, Guyana's history has been read through these racial divides. Historian David Hinds has argued that

> while other factors such as class, party politics, ideology, gender and political personality have been prevalent in the political process, these have been manifested within the context of the ethnic competition and conflict between East Indians and African Guyanese. In the final analysis ethnicity has been the dominant factor in shaping the country's political evolution (Hinds, 2011: xi).

While he acknowledges other factors, Hinds argues that ethnicity clearly wins out as the "dominant factor" shaping Guyanese history and politics. Sociologist George Danns has similarly argued that racial divides have determined fundamental government decisions in Guyana's history such as country's move to pursue independence alone rather than united with other Caribbean colonies; Danns argues Guyana's Premier Cheddi Jagan rejected membership in the West Indies Federation in the early 1960s due to his concern over losing his East Indian majority if allied with largely Afro-Caribbean colonies (Danns, 2013).

But alongside the framework of racial division, there has been broad popular recognition of the role of British colonialism in creating these racial structures. In 2010, the government's Minister of Home Affairs published a news editorial excoriating the British High Commissioner for his comments on race relations in

Guyana, emphasizing that Guyana's racial divides were *created by* the British colonial government:

> The British High Commissioner, Mr. Wheeler, must be living in a fool's paradise. For him to state publicly that the "politicized racial divide is hindering development in Guyana" is to either falsify history or to strike out on his own whimsical agenda. The High Commissioner must be knowledgeable of his country's history of resorting to the divide and rule policy in the British colonies of which British Guiana was an integral part. The racial divide in this country did not emerge yesterday; it was imported, fostered and institutionalized by the British ever since they landed in the colonies which were eventually combined to form British Guiana…The British High Commissioner should put these historical facts in his pipe and smoke them.
>
> -Clement Rohee, Stabroek News, July 2010

Minister Rohee had strong words for the British High Commissioner, emphasizing racial divides as the result of explicit efforts on the part of the British. This public commentary on the role of the British colonial government in promoting racial division is rooted in scholarly analyses by David Hinds and Eusi Kwayana, who have described ethnically-based colonial land and labor policies that pitted indentured servants against emancipated African slaves (Hinds, 2011; Kwayana, 2002).

Popular discourses in Guyana also draw attention to the role of British and American governments in destabilizing Guyanese labor coalitions in the 1950s. Guyanese newspapers have carried numerous stories and editorials on the topic in recent years, covering releases of formerly-classified primary documents as well as new secondary sources describing how British and American governments intervened in British Guiana in the late 1950s and early 1960s to help re-orient political divides away from labor issues and towards ethnic divides (Fletcher, 2010; Mars and Young, 2004; Misir, 2009; Correia, 2016; Rabe, 2006). Such stories often reference the 1953

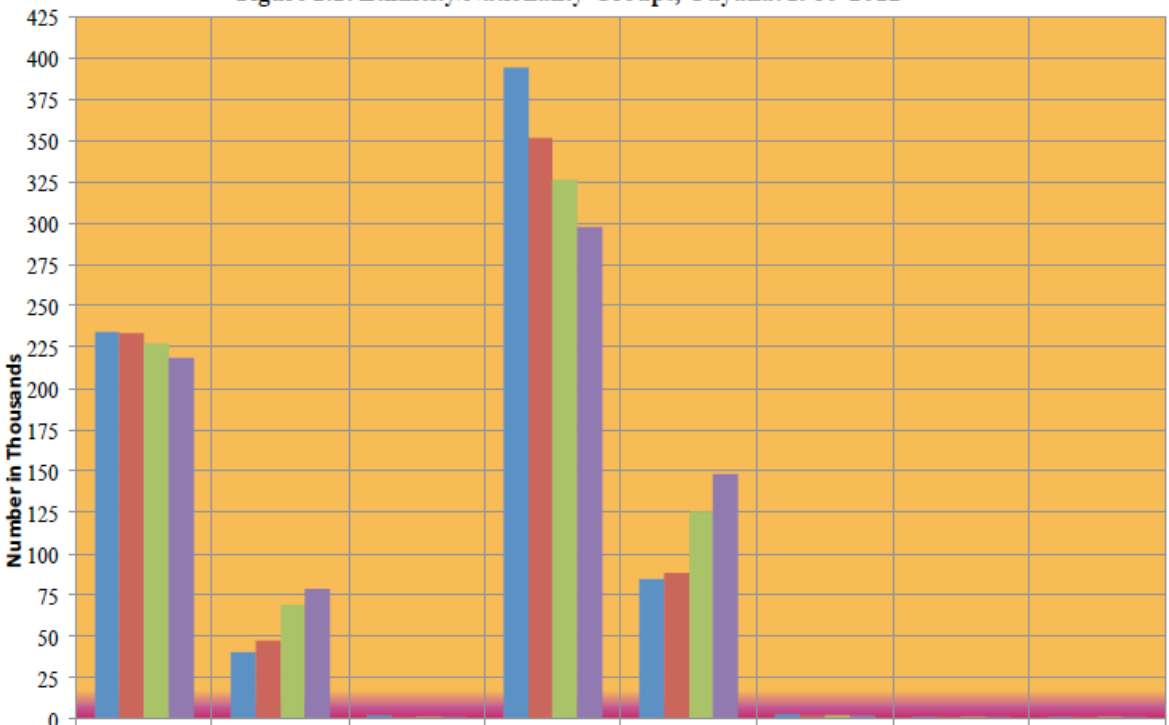
military intervention by British troops following Guyana's first elections under universal suffrage, which led to suspension of the new democratic constitution based on the supposed threat of a Marxist revolution under Cheddi Jagan's newly elected government (Premdas, 1979; Stabroek News, 2011). In this intervention, British intelligence officers worked to promote race-based coalitions working against leftist organizers.

However, in recent years demographic changes have been challenging long-held assumptions and racial calculus in Guyanese electoral politics (Bulkan, 2014). Amidst very little change in the total Guyanese population over the past four decades, the percent of Guyanese identifying as "East Indian" has dropped from forty-nine percent just prior to the PPP's election in 1992 to thirty-nine percent in 2012. While growing numbers of Guyanese identify as "mixed," there has also been substantial emigration among Indo-Guyanese (Guyana Bureau of Statistics, 2016). In contrast, populations identifying as "Amerindian" have grown steadily, from five percent of the Guyanese population just after independence to over ten percent in 2012 (see chart below from 2012 Census). The Guyanese-Canadian anthropologist Janette Bulkan has argued that growth of Amerindian populations has led to a conundrum of increasing government focus on Amerindians as targets of patronage politics, without recognition of indigenous groups as genuine political agents (Bulkan, 2014; see Chapter 5).[22] Throughout the 1990s and early 2000s the PPP could depend on winning elections with extremely limited votes beyond their Indo-Guyanese base, but that is no longer

[22] In Chapter 4 I address how these electoral politics converge with expertise politics within nutrition projects to position indigenous culture as a biological phenomenon, undermining indigenous agency and creating a biological basis for discrimination.

the case; these shifting demographics were an important factor in the PPP's loss of the executive branch in 2015 for the first time in twenty-three years.

Figure 2.1: Ethnicity/Nationality Groups, Guyana: 1980-2012



	African / Black	Amerindian	Chinese	East Indian	Mixed	Portuguese	White	Others
1980	234,094	40,343	1,864	394,417	84,764	3,011	779	294
1991	233,465	46,722	1,290	351,939	87,881	1,959	308	107
2002	227,062	68,675	1,396	326,277	125,727	1,497	477	112
2012	218,483	78,492	1,377	297,493	148,532	1,910	415	253

Source: Guyana Bureau of Statistics, 2016[23]

These intersections of race, colonial histories and electoral politics have certainly shaped public health in Guyana. Historian Ramesh Gampat has described how the colonial government moved to expand health services in the 1930s after the end of indentured servitude made labor scarce, and keeping laborers healthy became

[23] This chart is drawn from the most recent Guyanese census; rather than represent demographic shifts based on population percentages, it presents them based on tallies of total individuals: the report notes, for example, that in 2012 there were a total of 415 people in Guyana identifying as "white." This approach highlights the extremely personalized nature of national politics when dealing with such a small population.

more important to colonial administrators than it had been previously. However, Gampat stresses that in the late colonial period health services remained oriented around the sugar estates rather than comprising any substantial form of broad public health service (Gampat, 2015). In this period all sectors were governed through a central legislative council and the colonial governor; no Ministry of Health as such existed until after independence (Williams, 1991).

In 1970 Guyana's first Prime Minister – Forbes Burnham – declared the country a "Cooperative Socialist Republic," to be organized around agricultural and business organizations owned and run by their members. As I discuss in Chapter 3, Burnham promoted public health as a central aspect of socialist solidarity, and the 1970 Constitution provided the right to free medical care for all citizens. Throughout the late twentieth century, the percentage of total government expenditure devoted to public health in Guyana remained in the middle of rankings in South America and the Caribbean (PAHO, 1994). Nonetheless, healthcare workers have described extreme scarcity in the Guyanese healthcare system throughout the late twentieth century, including shortages in basic drugs, surgical dressings, and antiseptics, as well as constant understaffing (Misir, 2015).

Throughout most of Guyana's independent history there has been high emigration among healthcare workers, especially as the US and British governments have actively recruited nurses and health aides from the Anglophone Caribbean since the early 1970s (Bach, 2003). However, Guyana did not have a medical school prior to 1985; the PNC government had long deemed it a better use of resources to educate small numbers of physicians outside of the country (Ramnath, 1998). In the 1970s and

early 80s the Guyanese government supported small numbers of fellowships to train physicians in Cuba, Jamaica, and the Soviet Union, and also relied on employing a substantial cadre of Cuban physicians; in 1984, over half of Guyana's physicians were either Cuban citizens or had been trained there (Doma-Nguez, 1989). Large numbers of Guyanese physicians continue to be trained in Cuba today: while Guyana had a total of 161 actively employed physicians in 2010, there were 301 Guyanese students in Cuban medical schools that year (USAID, 2010: 61). And of the physicians working in Guyana in 2010, over half were citizens of Cuba, China, or India (USAID, 2010: 55).

In spite of development bank efforts to promote private health services, public health services in Guyana continue to far outweigh private care with respect to spending, infrastructure, and employment. A 2010 USAID Health System Assessment emphasized how low private expenditure on healthcare is in relationship to total health expenditure in Guyana – only 12.3 percent as compared to the Latin America and Caribbean average of 43.17 percent (USAID, 2011: 8). However, the report also noted that the entirety of private health spending in Guyana is out of pocket because private health insurance is essentially non-existent (USAID, 2011: 8). Public health services are primarily funded by the Government of Guyana; in 2010, only 36 percent of total health expenditure was financed by international development agencies and donors (Persaud, 2010).

This lack of health insurance coverage and minimal private payment for services runs against several of the central policy aims of both the World Bank and IDB over the last several decades. And while I have argued here that infrastructural

projects have been the most enduring form of health intervention that development banks have pursued in the face of the World Bank's early concerns about health lending, the construction of health facilities has been closely bound up with the racialized electoral politics I have described here. In the following chapter I turn to the daily practices of development bank health projects, which often run counter to the policy prescriptions and self-representations offered by development bank headquarters.

CHAPTER 2

‘NEGLECTED TROPICS’: PRACTICING HEALTH AND DEVELOPMENT FROM GUYANA TO WASHINGTON, D.C.

At the fifth annual meeting of the Clinton Global Initiative in the fall of 2009, everyone was trying to get an invite to the Inter-American Development Bank cocktail party at New York’s Warwick Hotel. The bank was launching its Neglected Tropical Disease (NTD) initiative, and it had enrolled high-profile partners including the Miss Universe Organization and the Brazilian National Soccer Team. Many observers would just have to settle for coverage the following day:

> Beauty queens, politicos, and major international players were among over 100 attendees that turned out to celebrate this unprecedented commitment. … The crowd was incredibly enthusiastic, though some of the guests had only recently learned about the devastating impact of NTDs. Political consultant and strategist James Carville was overheard stating “This [issue] could really take off.” Paula Shugart, President of the Miss Universe Organization, emphasized how excited the Miss Universe Titleholders are to “get their boots on the ground—even if the boots have six inch heels” (End the Neglect, 2009).

Such reports often read like fan blogs and gossip magazines, highlighting big names in US media and electoral politics and well-worn clichés of beauty queens in philanthropy. To all this fanfare, IDB was committing to “mobilize” $30 million towards NTD control in the Western Hemisphere, alongside the Global Network for Neglected Tropical Diseases—a coalition of NGOs working on NTD research and “applied solutions.” But while IDB and the Global Network linked their names to this large sum, these organizations were certainly not promising to offer the funds themselves; they would seek to raise the $30 million from “public and private sources”

(IDB, 2009). Large publicity events promising sums of money for global health interventions arose quite often in my research, but the monies came through much less often.

Speakers at the 2009 event stressed that neglected tropical diseases—including soil transmitted helminths, Chagas disease, dengue, schistosomiasis, leprosy, and lymphatic filariasis—"produce extreme poverty through their impact on children's physical and cognitive development, pregnancy outcomes and worker productivity" and "are some of the most common disabling and disfiguring diseases afflicting the poorest people living in the Americas" (IDB, 2009). Here speakers mobilized recurrent themes in IDB's health messaging, including the idea that health issues among the poor lead to problems in mental capacity, and in people's ability to work later in life—frameworks that I discuss in Chapters 4 and 5 of the dissertation.

The terminology of "neglected tropical disease" had become increasingly institutionalized over the years leading up to the IDB launch, after the WHO officially established a department under the title in 2005 (Savioli et al, 2011). In the years prior to that, several international meetings had drawn attention to "neglected diseases" *tout court*, especially in relation to the emergence of "the big three" (HIV/AIDS, tuberculosis and malaria) as a central focus of the millennium development goals (MSF, 2002; WHO, 2003; Caines, 2004). The addition of the term "tropical" makes these diseases seem more distant from sites of fundraising and planning like the IDB event at the Clinton Global Initiative, evoking an eighteenth-century notion of the "torrid tropics," whose climate itself caused disease (Harrison, 1999), and the nineteenth-century "pathologization of space" that undergirded the idea of tropical

medicine (Naraindas, 1996). While some infectious disease specialists have stressed that it is not climate that is responsible for the prevalence of these diseases so much as poverty, the name has stuck, although so too has the description of NTDs as diseases of the "bottom billion"—referring to the world's poorest billion people (Feasey et al, 2009; Hotez et al, 2009). No one seems to question the term "neglected," but that framework is also erroneous: it is *exploitation* rather than neglect that has been at the heart of the social and environmental conditions of poverty.

Beyond the glitzy launches and high-profile partners, in 2009 IDB was also looking for countries to take their new NTD loans. The organization had recently contracted a Spanish consultant – a medical doctor with training in public health and epidemiology – to travel to several countries in Latin America and the Caribbean to evaluate possibilities for NTD programs. She identified an ideal candidate for IDB's first NTD loan component: Guyana had a recent history of efforts to eliminate lymphatic filariasis, and IDB was already in the process of developing a sanitation improvement program there. Improving sewage systems would address stagnant, high-organic waters that form breeding sites for the *culex* mosquitos that transmit filariasis in Guyana, and this could be combined with further population-wide preventative treatment. By the time of my fieldwork four years later, the Government of Guyana had taken an IDB loan for a lymphatic filariasis project, and was in the process of rolling out the program's "mass drug administration," as I describe below.

Throughout this dissertation, I examine the relationships of authority and value that shape health efforts across development bank networks. In this chapter I introduce the daily relationships at play in my fieldwork in Guyana and in Washington, D.C.,

highlighting the dynamics of expertise, nationality, gender, personal connection, and rumor that make up project life. I describe the role of healthcare workers, administrators, anthropologists, and development generalists, etc. in Guyana's Neglected Tropical Disease and nutrition programs, and I present an initial glimpse into the values revealed by project methods. I close the chapter by highlighting how the importance of quantitative and economic evidence amongst researchers at bank headquarters looks quite different from the relationships I described in the first sections of the chapter in bank operations, a topic I examine further in Chapter 4. To begin this exploration, I examine the interpersonal and interagency dynamics shaping my fieldwork with Guyana's Neglected Tropical Disease loan in 2013.

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Trained as a public health nurse in Guyana in the 1990s, by the fall of 2013 Nurse Jeffers had recently been appointed as the Ministry of Health's supervisor on the new IDB Neglected Tropical Disease loan. She had often spoken to me about how much she loved working on the Ministry's tuberculosis program before being transferred to NTDs, especially the close relationships with patients she developed as she conducted home visits week after week to observe patients' TB drug therapy. But as the NTD project was taking shape, she lamented that the project seemed to be mainly inter-agency wrangling. The Ministry's Chief Medical Officer was currently upset because no one from his team had attended a meeting on the NTD project held the week before at Guyana Water, Inc., the country's publically-owned utility company.

"Ravi didn't even mention the meeting to me," Nurse Jeffers told me, referring to the new IDB consultant on the project. As we grabbed a mid-morning snack from a stand in the Ministry's courtyard, Nurse Jeffers wondered aloud if Ravi's behavior was rooted in his "bigger issues" with the Ministry. I knew the rumors she was referencing. Many people in the Ministry believed Ravi—a Guyanese ethnomusicologist-turned-national development specialist—had gotten his position with IDB by fabricating stories about financial mismanagement within the Ministry, positioning himself as necessary to proper management of the loan. Ravi did seem to be able to transform himself endlessly. After a career as a musician, in 2010 Ravi Sigward had won a scholarship to study "Applied Community Change" at the Future Generations Graduate School in West Virginia and had since maneuvered into a variety of areas of public service supported by international development funding.

Ravi was one of the main reasons I was studying the NTD loan. A friend had introduced us the year before during one of my research trips to Georgetown, when I was trying to learn more about development agencies and public health in Guyana. During that first trip we'd spent many hours riding in the back of an open pickup truck to various project sites, discussing Caribbean activism, US politics, soca music and plans for the NTD project. But our relationship had rapidly deteriorated over the previous months, as the NTD project began to return poor coverage numbers, and as I grew closer with Nurse Jeffers and Ms. Mahmoud, the NTD project's supervisor and administrator at the Ministry of Health. As tensions between Ravi and the Ministry of Health heightened, he no longer wanted to chat with me casually about the project, often querying why I wanted to know about project details.

Ravi had arranged a meeting the week before at Guyana's government-owned water utility, which shares responsibility for implementing the NTD loan with the Ministry of Health, as well as the Ministry of Local Government, all overseen by IDB. The NTD project aims to eliminate lymphatic filariasis and control soil-transmitted helminths in Guyana both through environmental and preventative pharmaceutical interventions—combining major infrastructural interventions into Guyana's sewage system with a "Mass Drug Administration" program.

Prior to the IDB project, in 2003, the Government of Guyana had initiated a program to distribute salt fortified with diethylcarbamazine (DEC), a drug used to treat filariasis in many parts of the world since the late 1940s, which had just been added to WHO's essential medicines list in 2002 (Kimura, 2011). Guyana's DEC program had been heralded within the United States Centers for Disease Control and the World Health Organization as "the first program of its kind" pursuing the "unfulfilled potential" of DEC salt, offering the drug in the form of a food product akin to iodized salt, rather than as a pharmaceutical (Lammie et al, 2007). The Government of Guyana was even able to promote Caribbean business by negotiating with a company in Jamaica to produce the salt. While the DEC salt program was discontinued in 2007 after problems arose in the production process, the "Get on the BUS" (**B**uy DEC salt, **U**se DEC salt, **S**hare this information with family and friends) campaign had done a great deal to raise awareness of filariasis in Guyana—especially the idea that the permanent and massive disfigurations of the limbs associated with filariasis could be prevented (Persaud, 2013).

After visiting Guyana in 2009, IDB's Neglected Tropical Disease consultant suggested that Guyana would make an ideal candidate for IDB's first NTD loan, in large part because of the country's history of filariasis intervention. But rather than use DEC salt, IDB's program aimed to provide preventative medications to the entire population through a "Mass Drug Administration" of two drugs in pill form. The program would provide DEC and albendazole through a door to door distribution campaign conducted once annually for five years (IDB, 2010). Under a 1998 agreement, GlaxoSmithKline had agreed to donate enough albendazole to eradicate filariasis globally, as part of a longer tradition of corporate donation of anti-parasitic drugs (Ottesen, 2000: 592).

In the process of planning the IDB filariasis project, the goal of decreasing the prevalence of soil-transmitted helminths (STH) was added to the program because albendazole is also effective against these intestinal worms. Although filariasis is a mosquito-borne disease, it is caused by parasitic worms that are in many ways similar to hookworm and other soil-transmitted helminths: the microfilariae of lymphatic filariasis are transmitted via mosquitos, whereas STHs are most often transmitted either through vegetables grown in contaminated soil or through contaminated water (de Silva et al, 2003). And while STHs then infect the intestines, filaria causes permanent disfiguration when microfilariae block lymph channels and lymph fluid flows out into surrounding tissues.

During its implementation, this NTD project was overseen for IDB by an Italian environmental economist based in the Guyana Country Office. In IDB documents and external publicity materials, he often framed the project as a part of

IDB's focus on "multi-sectoral" efforts to "piggy back" health projects off the bank's more well-known expertise in large scale infrastructure (IDB, 2010). Here population-wide efforts in preventative medicine were supposed to capitalize on environmental interventions that would decrease the presence of filaria's mosquito vector, as well as STH contamination, by decreasing sewage overflows and drainage backups in Georgetown. The resulting project included involvement from IDB, Guyana Water, Inc., the Ministry of Local Government, Guyana's Regional Health Authorities, PAHO, Georgetown Public Hospital Corporation, the Ministry of Health's Division of Vector Control, and the Ministry of Education.

In the first months of my research, I spent weeks waiting for meetings that were constantly being rescheduled, or attending meetings where no decision could be made because the appropriate authorities were not present. One day near the end of my first five-month dissertation fieldwork stint Guyana, I attended an inter-agency meeting held in the main wooden building of the Ministry of Health, raised up by stilts like so many Georgetown buildings due to constant flooding and poor drainage. We met in the central board room, whose large stuccoed walls were empty apart from a picture of President Ramotar. I explained in my fieldnotes:

> Today we were finally able to meet with the Chief Medical Officer as part of the inter-agency steering committee, and the decisions we've been trying to settle for two months suddenly got decided in half an hour. The signs need to be large and orange, because Dr. Persaud (the CMO) says it is his favorite color. There was a lengthy discussion about the order of the institutional logos on the volunteer t-shirts, and the committee ultimately agreed that the logos would be presented in a square with IDB upper left, then the Ministry of Health, Guyana Water, Inc., and PAHO around clockwise. And the CMO wants there to be a jingle. He really liked the DEC jingle. But for me the most important part of the meeting was how the CMO treated Ravi. Sitting at the head of the huge rectangular table in the

> Ministry of Health's main boardroom, he constantly teased that "Ravi is angry because I've been taking so long" or "Ravi is angry because the coverage numbers have been bad." The CMO quickly enrolled other committee members against Ravi without leaving them space to disagree: gesturing "right, Dr. Ceron?" and moving on before the PAHO representative could speak up. Dr. Persaud stated clearly that Ravi should not have access to the full filaria survey and population data because "Ravi is a good boy right now, but who knows how things will be" (Fieldnotes, 18 Nov 2013).

My fieldnotes betray some frustration with waiting so long for what seemed a very simple decision about the design of t-shirts for project volunteers. For months prior to the steering committee meeting, Nurse Jeffers and Ravi had held numerous formal and informal meetings: Ravi would visit to the Ministry of Health and I would help the two of them as they worked to determine key campaign messages, plan trainings for nurses and project volunteers, and identify vendors to produce publicity materials. But we had to wait weeks to months on every tiny decision to get input from the CMO.

While international health analysts have often contrasted slow work rhythms in global health projects against supposedly Euro-American proclivities towards efficiency (World Bank, 2003; Chaudhury et al, 2006), the relationships of authority shaping this project's temporal dynamics are not unique to postcolonial contexts. Our waiting speaks to the authority that the CMO held in project planning and the ways it manifested in the life rhythms of his staff and collaborators. The Chief Medical Officer held no official position on the NTD project implementing team, but few project decisions could be made without his input. He had played a central role in appointing Nurse Jeffers as the Ministry of Health's representative on the project, and he was Nurse Jeffers' direct supervisor. It was a tough work environment, where miniscule pay often didn't come through on time, and vacation days often didn't come

through at all. Many Ministry staff spoke of their work as "tight-rope walking": any foul move and you could be sidelined despite years of service. But in their reference to the massive amounts of time devoted to t-shirt design, these fieldnotes also speak to the role that institutional branding plays in these development projects. Decisions about the layout of institutional logos were absolutely central to discussions throughout project planning.

The question of time and authority was also significant to relationships between the Ministry of Health and public medical clinics, whose staff were responsible for recruiting and coordinating teams of volunteers to distribute NTD medications door to door as the basis of the project intervention. Clinic staff often complained that the Ministry made unreasonable demands on their time, for example alerting clinics with only a day's warning that their staff would need to be present for a day-long training with the Ministry. While project administrators emphasized the importance of nurses being trained on the transmission and clinical effects of filariasis and soil transmitted-helminths, as well as the NTD project's methodology, clinic staff stressed that it disrupted work schedules substantially if nurses were meant to be in their clinics but were instead at a training. And while complaints about the Ministry often circulated amongst clinic staff, senior nurses also voiced their discontent directly to Ministry staff in inter-agency meetings and by visiting IDB project staff at the Ministry of Health to speak one on one.

After one such visit from a nurse regarding the project's organization and communication, I sat with Nurse Jeffers and Ms. Mahmoud, the project supervisor and its administrator, in the cool of their office as they lamented the

problems that seemed to pile one on the next. On top of the nurses being upset, there were still people clamoring that they had not been paid their small daily stipend for volunteering in the Mass Drug Administration on the East Coast several months before. Nurse Jeffers and Ms. Mahmoud shook their heads as they commented that the project couldn't even follow through to get these people a few dollars for transportation and for water during their work, when Ravi's IDB salary was "fat like hell." Like many of the volunteers, Nurse Jeffers and Ms. Mahmoud seemed to think Ravi was not managing project finances fairly, if not outright embezzling. Accusations of financial mismanagement often circulated in and around the development bank projects I studied, from Ravi's accusation of Ministry staff that supposedly got him his job with IDB, to accusations that Ravi wasn't paying volunteers, and claims of corruption in securing providers for IDB's Basic Nutrition Program, which I discuss below. But while the dynamics of patronage are an essential element in the health projects I describe (Chapter 4), the *accusations* of corruption are equally important: they reveal expectations of governance, and serve as a popular means of critiquing relationships of inequality and exploitation (James, 2012; Smith, 2007). In the following section, I demonstrate how such accusations of corruption have led to the early termination of Guyana's flagship nutrition program, even in the face of great accolades for the project and its data practices, as I highlight the values and knowledge practices at play in Guyana's Basic Nutrition Program.

Accusations, Data, and Guyana's Basic Nutrition Program

In 2007, the Government of Guyana and IDB initiated a USD $5 million loan project that aimed to address childhood and maternal malnutrition through the distribution of micronutrient and food supplements, and though nutrition education campaigns and surveillance. The project was designed as a form of wealth redistribution that would provide citizens in the country's poorest districts with income supplements in the form of food. But in addition to food supplements, the "Basic Nutrition Program" sought to distribute micronutrient supplements for consumption by pregnant women, infants, and young children. The project had obtained a license from Ped-Med Ltd. to produce the micro-nutrient "Sprinkles" that the small Canadian company had patented (Zlotkin et al, 2005). The IDB team chose to reformulate the content of the Sprinkles slightly to include iron, Vitamin A, Vitamin C and zinc for children, and folic acid, ascorbic acid and iron for pregnant women. Although previous nutrition surveys suggested that iron deficiency was the only micronutrient deficiency prevalent in Guyana, project planners decided that it was better to provide for possible unidentified problems than to go on a locally "evidence-based" approach alone, as the project's chief consultant phrased it. This was in stark contrast to the "data-driven" nature of the program broadly. As I describe below, the BNP mobilized data collection as a key tool to advance the project's profile internationally.

Income supplementation through food vouchers was a central aspect of the pilot Basic Nutrition Program as initially designed, but in 2012 the project began an extension that did away with the food supplements, leaving micronutrient Sprinkles

and education as the project's primary interventions. The sprinkles were produced under Ped-Med's license by a Guyanese company, the formerly public "Guyana Pharmaceutical Company," which had been privatized in 1992, and had been owned by local conglomerate leader Bobby Ramroop since that time. In early 2013, I visited the "New GPC" factory to see how the Guyanese company produced the Sprinkle supplements, on the encouragement of a friend who worked as an assistant to Ramroop. Just a few weeks after my visit to the factory, one of the country's most prominent newspapers -- *Kaieteur News* -- published a report accusing the Guyanese government of paying New GPC over a million US dollars-worth for drug products that had never been delivered (Kaieteur News, 2013). Rumors of corruption between the Ministry of Health under the People's Progressive Party and Guyana's New GPC pharmaceutical company had circulated for years, including accusations by the shadow Minister of Health who served during the PPP administration, and regular inquiries by *Kaieteur News.* That newspaper has examined several forms of corruption involving the two entities, including the Ministry of Health's nearly sole-sourcing of pharmaceuticals from New GPC, "grossly above-market" prices being paid by the government to the company, deliveries gone missing, and tax manipulation (Kaieteur News, 2016; Kaieteur News, 2012b). Based on these inquiries, *Kaieteur News* has been under libel suit for its accusations that New GPC's owner has colluded extensively with the PPP government headed by his close childhood friend, President Jagdeo, as well as subsequent PPP administrations (Kaieteur News, 2012).

Although New GPC produced Sprinkles for the Basic Nutrition Program, I never heard anyone at the BNP offices speak of possible corruption within New GPC

or the Ministry. This contrasted sharply with the way project staff discussed other failures of the Ministry of Health, for example when they argued that the Ministry had abandoned a nurse who had fallen ill, stressing that the Ministry would not look out for people who gave their lives to it. But the director of the Health Sector Development Unit, where IDB's Basic Nutrition Program was administered, was deeply embroiled with the PPP leadership, and staff were careful of criticisms that might implicate the director in any way. But in the months following the 2015 election, it became more and more difficult for BNP administrators to avoid the issue of the New GPC's dealings, as the BNP moved to the center of public rumor and accusation. Several news articles suggested that the Guyanese government might have to repay large portions of the BNP's 2010 loan-extension, as IDB was beginning an inquiry regarding funds that had not been accounted for (Balgobin, 2015; Kaieteur News, 2015). Under the new government, audits revealed large inconsistencies between the BNP's accounts paid and the supplies of micronutrient sprinkles delivered by New GPC. The sprinkles are a central aspect of the program, and the project's yellow and red sprinkle packets are a common feature in health centers, at health fairs, and at various public events, where they get handed out liberally alongside pamphlets on anemia, breastfeeding, and the role of fathers in childcare. Although the project began in a small set of health centers in districts with high poverty rates, the 2010 loan extension allowed the program to be expanded nationally. But following the post-election concerns about financial mismanagement, the Government of Guyana formally requested that the $3 million USD that had not been disbursed be

transformed into a project for "Sustainable Housing for the Hinterland," and the BNP was brought to an end (IDB, 2015).

The Basic Nutrition Program had received great accolades from the PPP government and from IDB, and had even been awarded a "Development Impact" award from the U.S. Treasury in 2012 (IDB, 2012). The program devotes substantial funds to monitoring and evaluation, which has helped provide the quantitative data on reductions in childhood and prenatal anemia, as well as overall malnutrition, that have formed the basis of this widespread attention. Research has been a major focus of Social Development, Inc., the Guyanese consulting firm that has coordinated the project: its principle investigators hold PhDs in nutrition and in cultural anthropology from Cornell and Cambridge. As a part of the Basic Nutrition Program, they have conducted research into rates and causes of malnutrition among indigenous Guyanese (see Chapter 5), measuring the impact of community nutrition counselors on breastfeeding rates, and investigating changes in young mothers' nutrition "Knowledge, Attitudes and Practices" based on different counseling approaches and printed publicity materials.

Research under the BNP has been used to generate several spin-off loans, including the World Bank-financed "Hinterland Feeding Program" initiated in late 2007. Both the BNP and the Hinterland Feeding Program attracted regular visits from researchers at IDB and the World Bank. In November 2013, for example, a group of IDB researchers from headquarters and from the Brazil country office came to interview project implementers in the clinics, the Health Sector Development Unit, and at the central Ministry of Health in preparation for a research report on IDB's

health initiatives. The team stayed at Guyana's Pegasus Hotel, a 1970s hotel that had not been much renovated, and ate at road-side stops and fish shops, welcoming me to join the team. The Brazilian physician and young Venezuelan health economist on the team set a casual tone for their visit, joined by the headquarters representative, an American straight out of his undergraduate degree in development studies. Their ways of addressing each other felt caring and sincere, without the glad-handling efforts at feigned informality I often felt at World Bank headquarters. Their visit barely made a ripple among BNP staff from the Ministry, who seemed happy to talk about the program, but quite unconcerned with the research. Although the visit from a group of foreign development agency staff and consultants was quite usual to Ministry staff, their visit struck me, as I mentioned in my fieldnotes:

> When they got to the gate of the Ministry of Health, Jonathan (the HQs rep) talked to the guard to sign them all in. Denise and Nancy stood aside, chatting in Spanish, positioned next to a sign explaining the Ministry's Dress Code. The sign read "LADIES NO: Short pants, armless dress or tops, thin straps, tights, midriff or tube tops, jerseys or t-shirts with indecent language or art" and below that "GENTS NO: Short pants, armless vests, jerseys or t-shirts with indecent language or art." Both Denise and Nancy were wearing sleeveless tops, but they strolled easily past the guards, no concern from either side. Of course, these rules are only for Guyanese. But there's been extensive public debate on the dress code since the reports that patients have been turned away from Ministry of Health properties for not passing the dress code. I saw a student-produced TV spot last week emphasizing the gendered and colonial roots of the propriety standards behind the dress code, which asked "Why does the Ministry of Health have a dress code when its toilet looks like a scene from Outbreak the movie?"[24]

Seeing Denise and Nancy next to the Ministry's dress code emphasized to me the different gendered standards at play between Guyanese women and foreign

[24] Fieldnotes, 12 November 2013.

development agency staff. But here "foreign" was not in the sense implied in Guyanese creole, where foreign refers solely to North America:[25] Nancy was Venezuelan of mixed indigenous descent, and Denise a tall Brazilian woman, although I would guess that she was rarely taken for Brazilian in Guyana. I had quite regularly been asked if I was Brazilian, and I understood the subtext that was often behind the inquiries; while there were some powerful Brazilian families in Guyana, Brazilian women with my skin tone had a reputation for working in nightclubs and various aspects of the sex trade. These dynamics of race and gender were significant for relationships of authority within development bank projects, and for my own interactions in my research. Northern economists often shared thoughts with me so much more readily than the Guyanese nurses who were rightfully concerned about how my work might affect their jobs and lives. While I was often read as Brazilian during my fieldwork in Guyana, I was not often taken as Guyanese; Nurse Jeffers was not the only one who suggested it was because of my light eyes: "Get some sunglasses from Giftland," Nurse Jeffers suggested, "and people won't know you're not a Putagee," referring to Guyanese of Portuguese descent. Many people told me it wasn't my skin tone or features that marked me as foreign, so much as a weariness in my eyes that would have marked me as Guyanese but which I was missing. And while amongst older white male development staff I operated as a young, mixed-race American woman, among Guyanese it was often my American identity that stood out

[25] Savitri Persaud (2015) has written of the difficulty of navigating the dual identities of being Guyanese, raised in "farren," describing for example the subtle comments of a taxi driver suggesting she wasn't really Guyanese, making her want to scream out: "I belong here! I am not just from farren! This is where my native string was cut! I am Guyanese and Guyana is my home! Mi belang hay!"

immediately. So when one of my closest friends, a Guyanese-Bahamian IT consultant, heard a man on the street call me "red woman," he teased that I could be happy the fellow had recognized my mixed African roots: red was a term for light-skinned black.

That this research trip, led by two South American women, lacked the pomp of many other bank missions was not surprising to me. The visit of an IDB operations team later that year was a much more formal affair, enough so that I was not permitted to join for most of it. The day before the operations team visit, project staff were rushing around the BNP offices in the public hospital complex and at the Guyanese consulting firm responsible for implementing the project, whose offices were on the other side of town. Project staff were calling for reservations at various restaurants, making sure that meetings with senior Ministry leaders were set, and reviewing recent project reports. The BNP project team leader for IDB was based in Trinidad; he had grown up there, and had completed degrees in public administration, law, and business, before studying hospital administration and becoming a "social sector specialist" for IDB in 1998. Since he was meant to be the "on the ground" presence for IDB's nutrition project, he made visits regularly to Guyana, but the missions retained a feeling of stiffness each time – in dress, in speech, and in protocols.

But the more relaxed feeling of the fall 2013 IDB research mission does not reflect the identities of research and operations broadly at World Bank and IDB headquarters. At the World Bank, researchers are generally based at the D.C. headquarters, and make infrequent field visits. A greater percentage of IDB staff are based in country offices, as part of the institution's efforts to be "closer" to borrowing countries than are other financial institutions (Nelson, 1999). Operations staff from

both banks joke that the researchers are buttoned-up academics, out of touch with the daily realities of getting projects to work. Although there is often a light-heartedness to meetings of researchers, who laugh at their own self-described "wonkiness," there are markers of greater formality in their interactions: meetings planned with more advanced warning, more prescribed meeting agendas, etc.

Research divisions are also dominated by men. Observing a 2015 research meeting on conditional cash transfers held at the World Bank's main DC headquarters building, I remarked in my fieldnotes that all of the nine speakers were male:

> As the panelists took their places around the table, I couldn't believe that every single one of them was male. Perhaps my perspective is skewed after studying the banks in Guyana. The IDB Country Chief is a woman, the Ministry of Health's NTD coordinator is a woman, the vast majority of nurses and volunteers implementing both projects are women, etc. Certainly many of the most senior positions in Guyana's Ministry of Health are held by men, but that has not been the case with IDB and World Bank visiting consultants on the filariasis and nutrition projects, which have often been women with PhDs and other doctoral degrees.

I considered at that time whether my surprise at the all-male panel, heightened by the large number of panelists, was shaped by my recent experiences in Guyana. I must not have remembered the panel I had attended in that same building three years before, where the World Bank had co-hosted a panel with a DC think-tank, the Center for Global Development. That all-male panel had eleven members, although they were quite mixed in their national backgrounds: from India, the US, Botswana, the UK, Uganda, and Mali, plus introductory remarks by World Bank President Jim Kim, an American who had been born in Korea.

Beyond the gender dynamics at play, these two meetings were also significant moments in my research for examining the types of expertise and evidence that were valued in different spaces of the banks' networks. The first panel was a public event, held as part of the 19th International AIDS Conference, and framed as a debate amongst "development celebrities" (Over, 2012) regarding the following proposition: "Continued AIDS investment by donors and governments is a sound investment, even in a resource constrained environment." Before and after the panel, the moderator asked the audience for a show of hands in support of each side; based on these votes, at the end of the event the moderator declared those arguing against the motion to be the "winners" of the debate. Mead Over, a long-time World Bank health economist, later accounted his "win" to his mobilization of data against his adversaries, the well-known economist Jeff Sachs, and the UNAIDS Executive Director Michel Sidibé. Over argued that:

> The audience seemed to be moved by Michel Sidibé's argument that AIDS spending had engendered and subsequently fueled global social progress and tempted by Jeff Sachs' assertion that resources can be cajoled or wrested from the rich to meet all possible health needs. But neither of them adduced evidence to support the proposition at hand. In fact, both argued, Michel implicitly and Jeff explicitly, that the proposition be discarded so that the debate could be held on different premises and with different metrics. I suspect that many in the audience…were a bit put off by Jeff and Michel's decision not to play by the rules. This left an opening for Roger and me, which we had luckily prepared for: An evidence based argument. If Michel and Jeff had bombarded the audience with impressive statistics, like ART's 96% prevention rate of HIV-negative partners from the HPTH 052 trial or the Granich et al finding that AIDS could be eliminated in South Africa within "only" 40 years by a $100 billon test-and-treat program, the proponents would have held onto, and perhaps gained, adherents (Over, 2012).

Over's comments emphasize his own concern with statistics, and his perception, based on long experience at the World Bank, that efforts to reformulate a problem are largely unsuccessful in the face of such statistics, even when advanced by an economist with as much credibility as Jeffery Sachs. But such a concern with quantitative evidence was nowhere to be found in the relationships of project operations that I describe above and in the project planning and implementation I analyze in the following chapters. While many bank researchers advance an ideal of calculated, rational prioritization and project design, my own work highlights the personal relationships and dynamics of authority at play in development bank health projects beyond economic tools and market logics, like those I have begun to describe in this chapter.

In the following chapters, I further analyze the relationships among such researchers and operations staff in the World Bank and IDB, examining the knowledges and values at play in various arenas and how they come to interact in the planning and implementations of public health projects. First, in Chapter 3 I examine the ways that healthcare workers narrate the history of development bank-led reforms in the Guyanese health sector, highlighting how shared elements of socialist and neoliberal discourse underlie healthcare workers' tales of continuity.

CHAPTER 3

NARRATING HEALTH AND SCARCITY: GUYANESE HEALTHCARE WORKERS, WORLD BANK REFORMERS, AND SACRIFICE AS SOLUTION FROM SOCIALIST TO NEOLIBERAL GOVERNANCE

Sitting upstairs in the administrative wing of Georgetown Public Hospital Corporation—Guyana's largest hospital, Matron Williams spoke of the changes she'd seen during forty-five years working in the country's public health system. "Matron" was a title rooted in the British system, she reminded me, but everyone continued using it even after her position was officially renamed "Director of Nursing" over a decade ago. Names changed, she noted, sometimes reflecting more substantive changes than others. When she had first started volunteering at the hospital as a high school student, even Guyana didn't have its current title—it was still British Guiana, about to gain independence that year in 1966. Ten years later, Matron Williams had finished nursing school and was working in the trauma ward at Georgetown Hospital. It was a tough time for public health in Guyana, she explained:

> They were nationalizing everything and there was a lot less being spent…People were of course dissatisfied, we had a lot of migration. Once people could get out, they'd get out (AC Interview, 2015).

Matron Williams attributed tight public health budgets in the 1970s to socialist reforms focused on nationalization and cost control. However, she went on to argue that these were much like health system reforms initiated in the late 1980s under structural adjustment agreements with the World Bank, and Guyana's move from a

socialist to a market economy. She stressed that in both cases budgets were tight and her friends and colleagues continued streaming out of the country.

In this chapter I analyze how healthcare workers like Matron Williams narrate their experiences of Guyana's public health system from the country's socialist period through its market transition. While this process of "adjustment" involved massive cuts in public employment and spikes in poverty, healthcare workers surprisingly don't recall much change between socialist and capitalist systems; instead, they have emphasized continuity in public health governance across these periods. Does this framework of continuity simply reflect healthcare workers' efforts to provide a narrative arc to their lifelong careers, or do these narratives describe unexpected connections between socialist and neoliberal governance? In the case of the later, do such connections represent an encroachment of neoliberal values prior to the end of socialism, or do they reflect continuities in values across self-proclaimed differences in ideology? In what ways have healthcare workers' recollections aligned with the discourses of socialist officials and neoliberal reformers, and where have they differed? And how have these narratives and discourses varied in relation to material conditions in Guyanese public health? In order to examine these relationships, in this chapter I draw on oral histories with Guyanese nurses, physicians and health administrators, as well as archival records of socialist politicians and World Bank reformers, and various assessments of the Guyanese health system from the 1970s through the 1990s. I investigate how healthworker narratives, official discourses, and conditions of scarcity tell the story of the capitalist transformation of healthcare in Guyana led by development bank structural adjustment programs.

This chapter responds to literatures within political and medical anthropology STS, and sociology that have refined understandings of late capitalism by highlighting the often-surprising connections between neoliberal and socialist governance and knowledge practices (Bockman, 2011; Eyal, 2000; Kipnis, 2008; Brotherton, 2008). Johanna Bockman (2011) has demonstrated the essential role of socialist practice and economic theory in the development of neoliberalism through neoclassical economics, and Gil Eyal (2000) has emphasized the centrality of Czech socialist thought in developing neoliberalism's concern for civil society. A growing body of literature has suggested that tools and values integral to socialist systems have been taken up by reformers in the neoliberal tradition, and have played a central role in what Eyal has called the *bricolage* of neoliberalism (Eyal, 2000; Bockman, 2015; Collier, 2011). Similarly, scholars have shown that socialist systems often incorporated substantial elements of individualism, along with other values and methods associated with or rooted in capitalism (Lampland, 2016, 1995; Kharkhordin, 1999).

These literatures have focused primarily on intellectual histories of Eastern Europe. In this chapter I bring together analyses of governing discourses with narratives of experience to examine relationships between socialist and neoliberal governance in the global South. I situate this work between broad theorizations of neoliberalism which have paid little attention to the dynamics of location (Wacquant, 2012; Brenner et al, 2010; Brown, 2003), and the many theorizations of neoliberalism in specific sites (e.g. Ong, 2006). I draw attention to dynamics in Guyana that suggest very different dynamics of neoliberalism in the global North and South. I highlight differences in the ways that socialist and neoliberal public health have imagined

healthcare for Guyana's wealthy, but I emphasize how the context of material scarcity and histories of extraction have produced important continuities in governance, making the relationship between socialism and neoliberalism in Guyana and much of the global South differ significantly from that in the global North, where ideological changes enable much larger shifts in the resources made available for health programs.

Beginning from healthcare workers' narratives, in this chapter I highlight how ostensibly neoliberal values of efficiency and individual responsibility (Rose, 1999, 2007; Shamir, 2008; Zigon, 2010) have been key discursive tools for both Guyanese socialist politicians and World Bank reformers instituting market reforms.[26] I argue that recognizing discursive similarities helps interpret popular experiences of governance and the descriptions of continuity offered by Guyanese healthcare workers. I emphasize that in the face of ongoing scarcity and across major shifts in governance, Guyanese citizens continue to be offered a very similar recipe of sacrifice.

Oral History, Narrative, Experience

Within my research methods outlined in the dissertation's introduction, this chapter is based on oral history methods, including interviews conducted between 2013 and 2015 with forty-six health professionals and administrators (nurses, nurse's aides, midwives, and physicians) who worked in the health sector in Guyana during both the socialist period of the 1970s and after marketization in the late 1980s. I selected interviewees through snowball sampling focused on distribution in racial and

[26] While the Inter-American Development Bank did provide limited structural adjustment financing in Guyana, the institution's involvement in laying out specific policy prescriptions for Guyana has been much more limited than the World Bank, which forms the focus of this chapter.

regional background as well as professional path. My research has been based primarily in the capital city, where much of the country's healthcare system is focused, but I have also conducted interviews and ethnographic work in several small villages (St. Cuthbert's Mission and Yupukari), across the densely populated coastal areas outside of Georgetown, and in several larger cities (Linden, New Amsterdam). I also conducted interviews with Guyanese healthcare workers who emigrated to the US. From physicians to nurse's aides, and rural to urban settings, this group represents a wide range of experiences, but across these many sociodemographic factors, healthcare workers consistently narrate their experiences of public health governance over the last several decades through a lens of continuity.

This analysis does not interpret data from oral history interviews as a direct representation of the past or of Guyana's overall experience of structural adjustment. Healthcare workers' memories and narratives have certainly been shaped by their subsequent experiences, as well as the politics of collective memory (Bunzl and Berdahl, 2010; Cole, 2001; Watson, 1994). In the context of Guyanese public health, likening governance before and after Guyana's market transition is a recounting of the past and a political position that serves to discredit the current government's narratives of progress. And although my interviewees have experienced a wide array of backgrounds, these men and women's history of employment means they do not represent Guyana's poorest, who were certainly the most affected by the shifts of structural adjustment (Campbell, 2002). Nonetheless, these oral history interviews provide a significant window into the experience of Guyanese healthcare workers, and the frameworks through which they interpret and narrate their experiences

(Chamberlain, 2007; Hoffman and Hoffman, 2007). Focusing on healthcare workers allows me to examine experiences of health governance from the perspective of individuals who have engaged daily with Guyana's public health system over several decades.

Because people interpret their experiences through widely-circulating languages and frameworks, I couple my oral history with an analysis of official discourses drawn from archival sources (including annual reports, policy papers, strategic planning documents, topical reports, speeches, and news coverage) from the National Archives of Guyana, the holdings of the Pan-American Health Organization at the University of Guyana, and from the personal files of a variety of current and former high-level administrators in the national health system. These methods allow me to analyze themes in healthcare workers' recollections across political and racial affiliation, and to cross-reference lived experiences with themes emerging in archival documents. The discourses of public officials I highlight here are one of several factors influencing healthcare workers' narratives, including the effects of memory noted above.

In the first section of the chapter I demonstrate how healthcare workers have emphasized continuity across major shifts in governance taking place within their lifetimes. In the following section I demonstrate how Guyanese socialist politicians promoted efficiency, responsibility and sacrifice as key principles for public health, and I argue that these discourses have been reflected in the perspectives of healthcare workers—in the public health pamphlets they've developed, in their engagement with elected officials, and in oral history interviews. In the third section of the chapter I

show how World Bank reformers have mobilized languages framing sacrifice as a key to public health efficiency that are strikingly similar to the discourses of socialist politicians—discourses that shape healthcare workers' narratives of continuity in public health governance. But even as neoliberal reformers join in promoting the values of efficiency and sacrifice, they imagine a very different distribution of responsibility across Guyanese society, along with quite distinct visions of the past and ideal futures.

Shifting Governance, Continuing Scarcity

Standing under the floodlights in front of the grandstand at Georgetown National Park, waves crashing on the seawall not 300 meters away, Prime Minister Forbes Burnham addressed a large crowd:

> On this twenty-third day of February 1970, we become the first Cooperative Republic in the world. Four years ago we committed to build Guyana for Guyanese with our own hands. Now we commit to a new political and economic path (Burnham, 1970: 2).

That day Burnham officially declared Guyana a "Cooperative Socialist Republic," to be organized around agricultural and business organizations owned and run by their members. But the crowd was much smaller at a May Day celebration held two decades later in the same location, where President Hoyte declared that a new agreement had been signed with the World Bank supporting liberalization of Guyana's economy (Khan, 1990). This agreement was part of the World Bank's structural adjustment programs designed to confront the growing debt "crisis" (Roitman, 2013) through quick disbursements tied to large-scale adjustments in national economic systems—

especially marketization (Gershman & Irwin, 2000). But while these two declarations presaged very different periods of governance—between Guyana as a self-declared socialist republic and Guyana undergoing market reforms guided by international financial institutions, healthcare workers frame shifts between the two periods as having little real effect in their lives and in Guyana's health system, often voicing comments like the following:

> People say Burnham was a dictator, but not much changed after Burnham's time. Our salaries were still frozen, staff kept migrating, and there was never enough money to service regions outside of Georgetown. But we always made do.
>
> -Nurse Phillips, midwife

> They're the same policies over and over again. The government now promotes health fairs where you can take an active role in knowing about your health and taking care of your own health; it is the same as Burnham's old socialist self-help.
>
> -Dr. Singh, pediatrician

The continuity of frozen salaries, miniscule budgets, lack of staff, and a repeated turn to self-help before and after adjustment emerge constantly in healthcare workers' tales, in spite of the very real negative consequences of structural adjustment for health in Guyana—especially the rapid spike in poverty caused by monetary devaluation in the late 1980s (Campbell, 2002).

At one level, healthworker narratives reflect Guyana's unique experience of adjustment: while poverty and expenditure statistics have varied a great deal according to their sources (Thomas, 1993), it is clear that Guyana did not implement drastic cuts in its health budgets following the initiation of structural adjustment agreements with international financial institutions in 1989, as opposed to many other countries. Guyana's public health expenditures fluctuated slightly as a percentage of GDP

throughout the 1970s and 80s, correlating to overall growth in real per capita spending through the 1970s and decreases in the 1980s. However, health spending rose from the mid-1980s through the period of adjustment (Table 1).

Table 1. Selected Health Indicators, Guyana 1970-1995

	1970	1975	1979	1984	1987	1992	1995
Government Health Expenditure (%GDP)	2.33	2.15	3.22	2.79	2.09	3.2	2.5
Government Health Expenditure (per capita 1998 USD)	21.86	27.08	38.44	28.01	21.45	55.1	44
Physicians per 10,000 population		1.7	1	1.6	2	2	2.7
Infant Mortality per 1,000 live births	55.4	54.3	53.5	51.4	49.4	44.5	41.4

Source: PAHO 1992, 1998

The Guyanese government also avoided implementing some of the most detrimental policies associated with adjustment and health, such as user fees.[27] But Guyana is not the only country in the region that has been able to avoid massive cuts to its health budgets as a part of adjustment agreements; both before and after adjustment, the percentage of total government expenditure devoted to public health in Guyana was firmly in the middle of rankings in South America and the Caribbean (PAHO, 1998). Nonetheless, poverty and unemployment increased sharply in Guyana in the years following adjustment (Campbell, 2002).

At a deeper level, healthcare workers' narratives of continuity suggest that

[27] Public health scholars have consistently shown that charging people at the point of public health services in low-income countries excludes people from health coverage, even when there are fee exclusions for the poor (Nyonator and Kutzin, 1999; Kou, 1997; Gilson and McIntyre, 2005). While scholars disagree as to how healthcare should be financed, for example through tax-based as opposed to private healthcare insurance, there is quite str[28] This commonality speaks to Wendy Brown's arguments that, far from "hollowing out the state," neoliberal capitalism has positioned the state as a key actor in its systems of extraction (Brown, 2003).

even in the face of negative impacts of adjustment (Pfeiffer and Chapman, 2010) and across shifts in spending, funds and services have been extremely limited throughout the late twentieth and early twenty-first centuries, and governing actors have turned to similar discourses of responsibility, efficiency and sacrifice to narrate these limitations. But the importance of material scarcity does not imply that governing ideologies do not matter: activist challenges have continued to demonstrate that a turn to sacrifice and efficiency are not the only means of addressing such scarcity. Indeed, the distribution of these burdens looks quite different in the discourses of socialist politicians and World Bank reformers—as described below.

Socialist Narratives

Shortly after declaring Guyana a "Cooperative Socialist Republic," Forbes Burnham introduced a clause into the development of the new Republican constitution that would not only guarantee "the right to free medical attention" for all citizens, but which set out the *duty* of citizens "to participate in activities designed to protect the health of the nation" (Constitution of Guyana, 1970: ch. II, art. 25). That same year Guyana's Ministry of Health established a strategy for the upcoming decade, highlighting the provision of free healthcare as a fundamental principle of the new Republic (Government of Guyana, 1970). But rather than depend on the government for curative care, the strategy emphasized that the citizens of Guyana needed to embody the nation's central principle of self-help, in this case through preventative care. Nutrition and hygiene were especially important, including pre- and post-natal care to address the "unacceptably high" rates of infant mortality, which were the

highest in the Anglophone Caribbean. Malaria had essentially been eliminated with DDT spraying over the previous decade, the report noted, but diseases of infancy were a primary concern, as were pneumonia and bronchitis, diarrhea and enteritis.

This version of self-help was rooted in individual responsibility and autonomy, as Burnham explained in a 1973 speech: "the gospel of self-reliance, the unalterable aim to make the small man a real man – the arbiter of his own fate" (Burnham, 1973: 2). In discussing the 1970 health plan, Burnham argued that this self-reliance was crucial to improved public health:

> It was at first hoped and expected that, in constructing health facilities like those in Leonora and Corentyne, it would have been possible to provision more health posts. It was not possible, and we admit it. What has been done instead has been to encourage the villagers in all of these areas to indulge in self-help. The performance of self-help in this country has been a phenomenon (Burnham, 1970: 9).

Burnham stressed that in light of the government's inability to provide services, individual action would have to play a central role, and he encouraged Guyanese to engage in self-help both through direct self-care, and by joining together in projects to improve the physical infrastructure of health facilities and water systems. But party leaders stressed that self-help was not about government failure; it was about *efficiency*. The Minister of Finance, for example, argued:

> The criticisms about the health programme seem to imply that there must be some high cost prestige hospital and there must be a large number of specialist doctors running all about the country or deployed throughout the country. …What is needed is the training of local people to address and prevent ailments in their communities, who can provide an adequate and efficient service, which does not require the attention of highly skilled people (Hoyt, 2014 [1970]: 31).

Here self-help is presented as a value not only because of the autonomy it allows, but

also because of the efficiencies it provides.

Party leadership stressed that taking advantage of local resources was a crucial aspect of self-help. The Ministry of Health echoed this message, for example in a 1981 nutritional pamphlet that promoted the use of cassava instead of imported wheat products, arguing for a return to the country's Amerindian heritage as a model of lean living and good use of resources:

> Cassava has been a staple of the Amerindian diet for centuries, even before the arrival of Christopher Columbus in the Americas. It is a gift given to Guyana by the native people. Although cassava originated in Amerindian diets, today it is truly Guyanese. In Guyana's history, cassava came to be used by various plantation labourers including slaves, Indian indentured servants, and other ethnic groups brought to work on the plantations, making a bridge across these ethnic groups. Still today, cassava can be a bridge connecting all Guyanese (Kirkpatrick, 1981: 4).

The authors of this pamphlet promoted a nationalist vision of nutrition based on the idea of Amerindians as an ancient people whose customs could link Guyana to its pre-colonial past and at the same time provide an alternative to the impositions of plantation society. In this vision, sacrificing the now-standard comforts of imported wheat flour would help Guyanese learn to make more efficient use of resources; personal nutrition was to offer a crucial form of self-help for maintaining public health.

These public health narratives promoting self-help and the use of local resources also picked up on the recurring language of sacrifice in public discourse, reflected in fora such as Prime Minister Burnham's speech at Guyana's Fourth Republic Day, where he stressed:

> The times are serious. Not only have all of us, including the Prime Minister, to make the sacrifice of foregoing many a luxury to which we have grown accustomed, but which is unnecessary for living, but also we shall all have to bring our productivity in whatever task we are involved, to a new high... This is a period that will try men's hearts, limbs and energies… I can see the silver lining as the cloud begins to break, but a herculean effort, of which I know we are capable, is required to remove the dark cloud entirely and leave over us the clear sunlit sky of prosperity (Burnham, 1974: 7).

The Prime Minister invoked Biblical imagery to support the importance of sacrifice, hinting at the Promised Land hidden behind the current clouds of economic difficulty, and emphasizing that a temporary sacrifice would soon lead Guyanese to bathe in the warmth of prosperity.

But while socialist politicians offered this as short-term sacrifice, it was an ongoing message throughout the 1970s and 1980s. It was sacrifice offered in the name of efficiency: not just belt-tightening, this was learning to live better for the long-term. Almost ten years after Burnham's Republic Day speech, Prime Minister Ptolemy Reid offered a similar message:

> I hear Guyanese say they're starving. What he means is he's not getting a particular item he's become used to…Development has its pains. Unless we can appreciate the pains of development, we will all go around in the old ways and will remain with ignorance and poverty (Correy, 1982: 6).

Reid argued that the pains of sacrifice would help Guyanese move on from "the old ways" of colonialism and dependency, allowing them to turn to local resources and emerge a more efficient, and self-sufficient nation.

These official discourses are central to the recollections Guyanese healthcare workers offer of this period. Many nurses recall their efforts to improve public

nutrition in the face of national economic difficulties, and food import restrictions that the Guyanese government had put in place to promote local production, greater efficiency, and national sovereignty. These nurses often speak of developing Ministry of Health recipe books to help Guyanese substitute rice flour into dishes traditionally made with wheat flour, to confront restrictions on the importation of wheat. In a health system essentially devoid of pharmaceuticals and medical equipment, nutrition was the central tool available to healthcare workers, and today they speak of nutrition as a tool of self-help for public health.

Lorna Smith, for example, had gone to do her master's degree in nutrition at the University of London in the late 1970s, and she remembers returning to Guyana with enthusiasm for the nationalist project and her role in it as a member of Guyana's health corps. Nurse Smith hadn't grown up among Guyana's elite, but she had frequented the halls of Georgetown Hospital, where her grandmother was a laundress. "Two places I'm comfortable: hospitals and universities," she told me on multiple occasions. Nurse Smith grew up primarily with her grandmother, who she describes as a stern woman who dealt with innumerable challenges with her mixed Afro-Guyanese, Amerindian, and Chinese heritage. Lorna stressed to me that it was this spirit in the face of challenge that—even when she was a young, newly trained nurse—gave her the confidence to speak her mind to such influential politicians as Forbes Burnham. Upon completing her studies, Lorna wrote a letter to President Burnham stressing how nutrition could be used towards the sacrifices of development. She described to me:

> So I heard this rumor in the Ministry that they were going to export all the rice to get foreign exchange, and instead increase the production of provision [starchy root vegetables] and I said "this is gonna be crazy,"

> so I slapped my chest and I wrote a little letter to the President, Burnham, and I said to him, I understand the difficult position that he's got himself in, it is not the best idea to export the rice, but if he wishes to then he ought to supplement to make sure, because the provision doesn't have a high calorie density, so make sure that other things are available to increase the calorie density. For instance, make sure that oil is cheap so that we could at least fry. So I gave him a whole set of ways that he could possibly make it work (LS Interview, 2015).

For Nurse Smith it was clear that as a nutritionist—even one without high rank in the Ministry of Health—she could help make healthy life possible with limited resources. And indeed, President Burnham responded by requesting that she sit in on subsequent parliamentary debates regarding agriculture and nutritional policy. Years later in our interviews, Nurse Smith echoed official discourses in arguing that sacrifice was in fact generative, referring to the 1970s as the "Golden Age" of nutrition in Guyana, where people were willing to experiment with any and all ideas for new sources of calories and nutrients, food preparation techniques, etc.

Across lines of racial and political affiliation, the healthcare professionals I worked with in Guyana, and those who had emigrated, recalled nationalist pride in their work. However, the challenges of tight budgets were evident as well. Nurses consistently told me of washing, powdering, and repackaging latex gloves for re-use in the 1970s. Healthcare workers also recall how their salaries were frozen and collective bargaining was brought to an end during this period. While unions and the labor movement had played a central role in Guyana's independence efforts, Burnham's PNC government undermined the power of unions by promoting the doctrine of "party paramountcy." Under this 1974 policy, the party became the primary decision-making body in the country, above all state organs. Organizations such as unions were no

longer invited to contribute to negotiations and decision-making (Rose, 2002). And while many healthcare workers lamented a dwindling national spirit in subsequent decades, they also emphasized how the tight budgets, understaffing, and frozen salaries they associated with Guyana's socialist period persisted through the structural adjustment projects of the late 1980s and early 1990s, as I show in the following section.

Narrating Adjustment

In 1979 the World Bank established the structural adjustment loan as a new instrument meant to disburse money quickly to the many postcolonial countries where international economic recession and associated increases in oil prices were making it impossible to pay for crucial imports (food, medical supplies, etc.) with revenues from exports, let alone repay the large debts they had accrued from extensive lending by commercial and development banks during the 60s and 70s (Bockman, 2015). International financial institutions including the World Bank and the International Monetary Fund increasingly provided structural adjustment loans throughout the 1980s, with the largest number of them negotiated late in the decade, such as the one Guyana signed in 1989—four years after Burnham's death (Kapur, Lewis and Webb, 1997).

In negotiating adjustment loans, the World Bank required that countries fulfill policy requirements aimed at "macroeconomic restructuring," which were implemented as a fairly standard package focused on trade liberalization (eliminating subsidies for local goods and industries and reducing taxes on imports), monetary

adjustment (altering exchange rates, usually by devaluing currency), and the privatization of national holdings such as transportation or logging ventures. World Bank staff argued that these interventions would strengthen borrowing countries' economies, promoting efficiency in local industry through competition with foreign firms and through private rather than public ownership. Critics of structural adjustment, however, have made it clear that removing import taxes and devaluing currency in post-colonial and post-socialist countries undermined local industry by making goods from multinational companies much less expensive than those produced locally, that privatization often happened at public expense, that reducing the size of the civil service left huge numbers of people unemployed, and that adjustment programs on the whole did little to improve the economic situation in borrowing countries, in spite of the hardships they created (Sparr et al, 1994; Abouharb and Cingranelli, 2007; Stiglitz, 2002).

Throughout the 1980s the World Bank continued to revise its strategies and rhetorics supporting structural adjustment, but the institution's policy documents, loan agreements, and public statements continued to focus on the need to limit government intervention in light of the supposed greater effectiveness and efficiency of private systems for managing both economic and social issues. Accompanying this repudiation of government management, however, is a focus on government as the key site of solutions. Here World Bank staff converged with Guyanese socialist politicians in offering governmental budget management as an essential tool for achieving better

futures.[28] The World Bank often emphasized state policy as the essential variable for improving the health of Guyana's economy and its citizens. A 1995 World Bank report notes, for example: "By 1988, Guyana's economy was in dire straits. As a result of a long period of state intervention, mismanagement, and public sector domination, the economy had declined by about one-third in over a decade" (World Bank, 1995: ii). The report links public management with *mis*management, highlighting the two as the essential economic problem in Guyana. The authors then provide the solution of a structural adjustment loan focused on "liberalization of domestic pricing and trade policy, to improve climate for private investment," "streamlining of the civil service," "rationalizing investment programs of public enterprises," and "privatizing selected public enterprises" (World Bank, 1995: ii)—a standard package of liberalization and privatization.

World Bank staff also argued that individual action was crucial in the face of scarce resources. A 1990 report, for example, stressed that with overwhelming needs in the health sector "at a time when public spending in general cannot be easily increased—indeed, it must be curtailed…The Government needs to disseminate information and create incentives for efficient consumption and delivery of health services" (World Bank, 1990: 10). Here the institution's reformers stress that *individual consumption* of health services needed to be improved. World Bank staff and consultants offered individual action as the complement to "reducing government responsibility for the kinds of health services whose benefits are captured primarily by

[28] This commonality speaks to Wendy Brown's arguments that, far from "hollowing out the state," neoliberal capitalism has positioned the state as a key actor in its systems of extraction (Brown, 2003).

the recipients of the service" (World Bank, 1990: 11). That is, public resources should not be expected to cover health services for the benefit of individuals, including "monitoring the growth of infants, and much of antenatal and perinatal care" (World Bank, 1990: 11). And while this emphasis on government efficiency through citizens' self-help is reminiscent of Burnham's ideas on efficiency, the World Bank's version differed in one significant way: the World Bank framed this reliance on individual action through a market-based "willingness to pay"—that citizens would be willing to pay for health services that benefit them individually. The World Bank's framing of self-help through community action is even more in line with 1970s socialist visions; a 1991 World Bank report stressed that "individuals should take on a more proactive role through providing 'shared labor' in areas such as the maintenance of health facilities" – exactly the type of shared labor promoted by Burnham (World Bank, 1991: xii).

By the late 1980s the World Bank had acknowledged the negative health impacts often resulting from adjustment programs (e.g. Cornia et al., 1987), but the institution argued that these short-term difficulties were necessary for "long-term growth" (World Bank, 1986: 58). World Bank documents made clear that the devaluations and budget cuts involved in Guyana's adjustment program would most certainly make it more difficult for poor Guyanese to achieve adequate nutrition and environmental health. A 1992 report stressed that "macroeconomic stabilization processes are needed for growth" in spite of the increased poverty they would cause; the report suggested counteracting such negative effects by providing funds for health and nutrition in poor Guyanese communities (World Bank, 1992: 13). The "Social Impact Amelioration

Program" (SIMAP) that the World Bank financed was meant to "assist the Government of Guyana in cushioning the social costs of the adjustment process," allowing the government to implement politically unpopular reforms:

> It is understood that the adjustment process can entail adverse social impact in the short-run. Programs must be designed to serve priority needs of Guyana's most vulnerable population groups, especially in health, nutrition and social welfare… An infusion of resources in social services would improve the ability of the Government of Guyana to implement the difficult adjustment measures (World Bank, 1992: 12).

Here development is again presented as having necessary 'pains' – in this case short-term "adverse social impact." That is, World Bank programs were based on the idea that Guyanese would need to accept increased poverty in order to reach prosperity. And although government programs could work to counteract such pains, these difficulties were understood as inherent in progress towards a better future.

As in the 1970s and 80s, Guyanese citizens were told that these pains would be short-term, and that they were necessary for a good life. The Guyanese government echoed World Bank reformers, promising citizens that government austerity programs would lead to a better future, as in this 1992 government publication:

> the austere medicine of an IMF/World Bank Structural Adjustment Program is crucial for the movement of an economy from a state of crisis to one of recovery. However, not only is adjustment a crisis response, it is the very key to development (Danns, 1992: 17).

As Guyana's socialist politicians had promised, market reformers argued that this "austere medicine"—while painful at the time—would allow the country to reorient around efficient practices, leading to future prosperity.

But even as the discourses of socialist politicians and World Bank reformers converged on the values of efficiency, individual self-help, and sacrifice, they

diverged significantly in the ways they envisioned enacting these values. World Bank reformers sought efficiency not so much in the limitation of health services across society, but by promoting private payment, and their understanding of sacrifice fell squarely on the poor, who would shoulder the supposedly short-term burden of increasing poverty in the name of long-term macroeconomic growth. This differs substantially from Burnham's emphasis on shared sacrifice and lean-living for all Guyanese.

Currency devaluations and layoffs in the public sector under Guyana's Economic Recovery Program (ERP), as its structural adjustment effort was known, certainly made life difficult for many in the late 1980s and early 1990s (Thomas, 1993). One article on Guyana's adjustment process describes people "waking up one morning to find [their] savings virtually worthless and [their] jobs barely paying enough to put food on the table" (Meeker-Lowry, 1995: 33). The consumer price index multiplied more than ten times between 1986 and 1990, and efforts to 'streamline the civil service'—as bank loan proposals and project documents called the layoffs (e.g. World Bank, 1995: 2)—left many unemployed, especially since eighty percent of the country's jobs had been in the public sector prior to structural adjustment (Thomas, 1993). The effects of the Economic Recovery Program on nutrition were central to political debates in Guyana at the time, with street protestors carrying signs dubbing the ERP "Empty Rice Pots" (Ishmael, 2012).

These major shifts make it all the more surprising that healthcare professionals working in Guyana in the 1970s to the 1990s do not recall much change in the health sector with structural adjustment. As noted earlier, Georgetown Public Hospital's

long-time Director of Nursing—Matron Williams—highlighted similarities between austerity in the 1970s and under World Bank structural adjustment agreements. She stressed how in both periods she and her colleagues had to work hard to get even basic food items: in the 1970s waiting in distribution lines and bartering with neighbors, in the 1990s depending on family and friends in the US and Canada to send goods in cardboard barrels because prices locally were so high, making Guyana "the world's greatest importer of barrels," as people often joked (AC Interview, 2015). The healthcare workers I interviewed often likened tight budgets in the health system to their own home economies. Speaking of their frozen salaries, nurses and auxiliaries quickly moved to speak of the processes of acquiring "basic goods" like flour, emphasizing nutritional challenges for the population and likening them to limited budgets in the health system.

A 1993 World Bank report emphasizes that salaries grew both for upper and lower level nursing staff and physicians between 1985 and 1992, with an intermittent decline just after adjustment began in 1989 (Table 2).

Table 2. Monthly Health Sector Salaries 1985-1992 (1985 G$)

	1985	1991	1992
Medical Officer (physician)	2266	1715	4370
Ward Sister	1052	831	1212
Staff Nurse/Midwife	819	775	1037

Source: World Bank, 1993

Oral histories help place these numbers in context, emphasizing that in spite of these shifts, salaries were extremely low both before and after adjustment. Table 1

demonstrates a decrease in the number of physicians in Guyana during the 1970s, but an increase during the late 1980s and through the period of adjustment. None of my interviewees recall layoffs in the health sector in the late 80s or in the 1990s following structural adjustment. Instead, nurses, physicians, and administrators all stressed to me the difficulties with filling the positions that were open both before and after adjustment. Keeping healthcare professionals in the Guyanese health system has consistently been a problem, especially because both British and American governments have actively recruited healthcare workers from the Anglophone Caribbean since the 1970s (Bach, 2003). This migration happens at a major loss to the Guyanese government, which provides education for healthcare workers free of charge, in exchange for three to five years of service.

The Ministry of Health's former Director of Planning, Andrew Whitney, described Guyana's heath system to me as "training healthcare workers for export" throughout the late twentieth century. Mr. Whitney had worked in health human resources since 1972; he started work straight out of secondary school as a clerical officer in the Ministry of Health's Personnel Department. Mr. Whitney stressed to me: "in Guyana we've long been hemorrhaging our human resources, and training healthcare workers for export. Structural adjustment may have made it more acute, but it was the continuation of a long process" (AW Interview, 2015). He argued that although structural adjustment may have made it slightly more difficult to supplement staff in the 1990s, emigration and open posts were major problems reaching back in time well before the 1989 adjustment reforms.

Healthcare workers also spoke of continuities in tight budgets, but not in terms of

access to high tech machinery or instrumentation; securing such basic items as gloves and bandages has been a challenge. Nurses, physicians and administrators all emphasized the difficulties that arose in the late 1980s when they could no longer resort to washing and reusing latex gloves in the age of AIDS. Nurses also regularly referred to the difficulties they faced in implementing health programs both before and after adjustment, where budgets could not even cover petrol for transportation to run educational and vaccine programs outside of the capital city. These discourses, which focus on continuity in health system management, point to significant commonalities in the way healthcare workers have interfaced with systems of governance before and after adjustment, emphasizing how remote many healthcare workers feel from the policy decisions that affect their lives and work: they dismiss high level changes as simply 'more of the same.' But these narratives also reflect the continuities in official discourses on self-help, sacrifice and the pains of development described in this section, as well as ongoing challenges from activists and critics—as I discuss below.

Continuity and Critique

Official discourses of austerity have not been accepted quietly by Guyana's population. Both in Guyana's socialist period and during its market transition, critics have challenged limited social spending and associated emphases on self-help and lean living. In the late 1970s and early 1980s, opposition parties and trade unions criticized Burnham's austerity policies in their pamphlets and at rallies; well-known scholar and activist Walter Rodney, for example, highlighted how the government's approaches punished the poor and working classes for the mistakes of the wealthy. A 1982

pamphlet from the Working People's Alliance epitomized this, calling government representatives "local nabobs and parasites who advocated austerity and socialism from the roofs of their military guarded palatial homes" (Persaud, 1986: 63).

Similarly, members of Guyana's opposition parties were vocal in their critiques of the structural adjustment agreements signed with the World Bank by the People's National Congress (Ferguson, 1999). Cheddi Jagan, the head of the People's Progressive Party, rooted his critiques in his own experiences as Chief Minister of Guyana's first internal self-government beginning in 1961, where cost-control measures had led to rioting, a general strike, and the intervention of British troops in 1962. By the 1980s Jagan was reversing the logic that World Bank staff and consultants had used in promising prosperous futures for Guyana through the pain of structural adjustment. Jagan argued: "the macro-economic policies…virtually forced upon developing countries as part of programmes for stabilization and structural adjustment are geared to achieving a quick, short-term improvement in the balance of payments, safeguarding the interest of international commercial banks" (Jagan, 1996: 3). Jagan stressed that structural adjustment programs were not aimed at long-term growth at all, but at short-term protection of the interests of international banks. He went on to argue that in light of the long relationships of exploitation of the developing world, resources from imperial powers should be made available to improve ailing economies, rather than depending on reforms in post-colonial countries.

Guyana's economic situation throughout the late twentieth century left the country with few options aside from severe cost-control. But, like Jagan in the late 1980s,

critics have continued to argue that other responses are possible, and that Guyana's hardships are rooted in international economic systems that extract raw goods, as well as people and labor, from the post-colonial world, for example through policies that attract healthcare workers from Guyana to the US and UK. These actors have advocated a response to international economic exploitation that does not simply resort to policies of sacrifice in the post-colonial world, but which would target the roots of exploitation by reforming international policies on trade and access to capital. Members of Guyana's governing socialist party joined in these critiques at an international level in the 1970s and 1980s, promoting a reorganization of trade relations through such bodies as the United Nations Conference on Trade and Development (Brotherson, 1989). However, these international discourses diverged from those through which party leaders narrated limited spending to the Guyanese population—through an emphasis on efficiency, responsibility, and sacrifice.

Conclusions

In spite of the major shifts involved in Guyana's transition to a market economy in the late 1980s, Guyanese healthcare workers today emphasize continuity in the Guyanese public health sector before and after structural adjustment; they speak of tight budgets and limited staff, but they also highlight the similarities of official discourses promoting lean living and self-help. These narratives of continuity are shaped by experiences of ongoing scarcity: while public health budgets have fluctuated, Guyana has continued to deal with extremely limited resources and a marginalized place in the world economy. Successive governments have turned to a

language of sacrifice to legitimate limited social services, offering Guyanese citizens instead the moral values of efficiency and self-care. However, activist challenges have continued to highlight that such discourses of sacrifice and efficiency are not the only means of governance in the face of material scarcity. Indeed, even as socialist politicians and World Bank reformers have turned to similar discourses, their visions of sacrifice and efficiency have been built on very different distributions of responsibility.

The continuities in discourses and narrations of health governance that I describe here speak to Sean Brotherton's (2008) examinations of socialist and capitalist forms of healthcare in Cuba. Brotherton argues that in twenty-first century Cuba, private forms of capital are not creeping in from the margins to undermine socialism, but are instead *an essential part of* Cuba's contemporary *socialist* healthcare. Policy debates have often centered on whether similarities in socialist and capitalist systems arise because one of the two systems has been incompletely fulfilled (e.g. Rodney, 1990). My focus has not been on such ideal-types, but on the discourses and narratives of governance in *self-proclaimed* socialist and capitalist systems. Discursive convergences here should not be taken as the incomplete enactment of socialism, or the encroachment of neoliberal values into socialist Guyana; instead, they reflect significant overlaps in concepts and conditions that often exist between socialist and neoliberal systems, shaping continuities in lived experiences under diverging forms of government.

Examining recollections and discourses of governance in Guyana's health system from its socialist period through its transitions to a market economy

emphasizes that, throughout the late twentieth century, various actors have attempted to sell Guyanese citizens on the idea of short-term struggle towards future prosperity. Burnham's socialist party promoted the idea of sacrifice towards a future of communal solidarity, whereas structural adjustment was rooted in the idea that short-term increases in poverty would allow for long-term economic growth through integration into international markets. In both cases, these visions promoted the idea that short-lived pain would teach Guyanese to lead better, leaner, independent lives—and that government programs would provide the pathway to these imagined futures. In both cases, sacrifice is offered as a means towards long-term efficiency—not only a stop-gap measure. Here the values of individual responsibility and efficiency reach back beyond twenty-first century neoliberal austerities. The contexts of extraction and material scarcity in the postcolonial world shape such historical convergences in ways unlike the history of governance in the global North, where public resources have been much more expansive. Socialist and neo-liberal discourses of self-help have certainly diverged in their imaginations of autonomy: the former has promoted individual responsibility as a means of avoiding reliance on the imperial North, whereas the later has advocated individual autonomy in avoiding citizens' reliance on the state. However, in Guyana these discourses have converged in promoting individual autonomy as an inherent moral value in the face of a state deemed unable to provide expansive health services. But activists have continued to demonstrate that local cost-control and self-help are not the only solutions to exploitative international economic systems; redistribution of wealth and far-ranging reconceptualizations of trade, responsibility, and international relations are possible.

Development banks themselves have transformed many of the health policy proscriptions they advances in the 1990s. In the following chapters I further explore the nature of development bank health interventions in Guyana and internationally in more recent years: in Chapter 4 I show how the World Bank and Inter-American Development Bank have promoted economic tools and analysis for global public health, but I argue that the use of such tools has been rooted primarily in aspirational discourses of the institutions' research divisions, which do not align with the knowledges and values at play in operational divisions and negotiations with Guyanese healthcare workers and government representatives.

CHAPTER 4

ASPIRATIONS AND ECONOMICS: COST-EFFECTIVENESS ANALYSIS, PATRONAGE POLITICS, AND GLOBAL PUBLIC HEALTH

> "Health care policy making has become increasingly dominated by economic perspectives, to the point that some health ministries are run by economists rather than public health specialists!"
>
> -Anne-Emanuelle Birn, *Textbook of International Health (2009)*

> "I think the 1993 WDR changed the conversation between ministries of finance and ministries of health by suggesting to the ministries of finance that this ministry of heath was not just a black box and that there could be a dialog with respect to how efficiently the money was being spent and the ministries of finance had legitimate grounds to ask questions about whether the ministry of health was getting its priorities right."
>
> -Long time World Bank health economist on the World Bank's 1993 World Development Report (WDR) *Investing in Health*

In the late 1980s, Rafael Nunes became the first Brazilian to receive a PhD in health economics, and he returned from his doctoral studies in the US to begin teaching courses in health finance at the University of Sao Paolo's medical school. When I met him in Washington, D.C. twenty-five years later, he had spent most of his career working as a health economist for the World Bank and the Inter-American Development Bank, and he stressed to me how much he felt these institutions had contributed to transforming global health during this time—a transformation in the very intellectual bases of global health, especially the centrality of economic concepts, he noted. He spoke of his early years teaching health economics in Brazil, when students and health professionals often argued that his work went against the

fundamental principles of medicine by prioritizing economic efficiency over human life. But Nunes contrasted this with what he called the subsequent "universalization" of health economics in medical education internationally, arguing that students around the world now clamor to get a space in the economics courses for health practitioners offered by the World Bank.

Nunes' claim that tools and methods from the field of economics have become increasingly influential in global health is borne out by analysis of global health research and policy literatures, which now abound with discussions of opportunity costs, cost-effectiveness analysis, and demand modeling (Reubi, 2013; Adams, 2013). Some analysts have critiqued the use of such economic tools as a reductive and profit-driven approach to public health, whereas others have heralded it as a crucial move for efficiency, but both groups have attributed the prominence of economic expertise to the new centrality of the World Bank and other international financial institutions in setting international health priorities and in implementing global health interventions (Adams, 2013; Thomas and Weber, 2004; Birn et al, 2009; Jamison et al, 2006: 2015). These claims have been based largely on the involvement of development banks and their staff in international meetings, publications, and other global health forums, where development banks have often promoted the importance of economic tools and rationalities for public health. But how do economic tools operate in the *practice* of development bank health projects and programs? How do they enact and shape the relationships of power at play in the institutions? These questions are essential to understanding how economic tools and rationalities are impacting global health projects and the lives of the people ostensibly meant to benefit from them.

In this chapter I examine these questions by focusing on the set of economic tools most commonly used in public health, investigating how they operate across development bank networks. Health economists refer to this group of tools, which includes cost-benefit and cost-effectiveness analysis, as simply "economic evaluation" or "economic analysis." These tools present methods for analyzing the economic efficiency of health interventions, and since the early 1990s many development banks have advocated their use for prioritizing which health programs should be funded both publically and privately.

Cost-benefit analysis is a well-known tool that requires comparing project costs and benefits in the same metric – most commonly monetary value. For every dollar spent on preventative medication for cardiovascular disease, for example, how much money does one save by averting the cost of treatment and lost days of labor on the part of a patient? With cost-effectiveness analysis, however, costs can be measured against a health outcome; for example, one could measure how much it costs to avert a case of malaria (the health outcome) through the distribution of insecticide-treated bed nets versus through case-management with chloroquine (Morel et al, 2005). Health economists have long recognized the moral and practical obstacles in putting monetary values on human health, challenges which make cost-benefit analysis for health quite difficult. By comparing costs against specific health outcomes, cost-effectiveness analysis avoids the need to attribute such monetary values to health benefits, and for this reason it has been the most common of these economic analyses used in public health over the past several decades (Drummond et al, 2005).

In this chapter I trace the role of economic expertise through networks of the

World Bank and Inter-American Development Bank by focusing on the discourses and practices surrounding economic evaluation, examining how and where these tools get mobilized and towards what ends. In doing so I examine the *politics of expertise* in these networks; that is, I examine the forms of expertise that come to be prioritized in various spaces, the processes through which this occurs, and the actors and values that get privileged or sidelined along the way. I move across several organizational divides within development banks: from headquarters to country offices in Guyana, and research to operations, highlighting the very different ways and extents that economic analysis gets used and produced at different points in these networks.

This analysis responds to literatures in "critical global health" emphasizing that technical tools—especially tools of economic calculation—are an essential site for investigating the values governing today's public health and international development. This chapter speaks directly to Vincanne Adams' (2013) assertion that the use of randomized control trials and other tools of "evidence-based global health" has transformed healthwork from a relationship of care to one of "buying and selling truth and reliability" through neoliberal economic rationalities (Adams, 2013: 55). Are development banks similarly commoditizing global health through cost-effectiveness analysis? This chapter also responds to David Reubi's call "for researchers to go beyond neoliberal structural adjustment policies and start telling other, different stories about the economisation of global public health" (Reubi, 2013: 223). Reubi emphasizes that logics of market competition, economic efficiency and individual entrepreneurialism operate far beyond the privatizing measures of structural adjustment. But what role do economic tools like cost-effectiveness analysis play in

enacting such logics within global health? Reubi's work has emphasized that the intellectual lineages of taxation in public health do not match standard stories of neoliberal privatization, but this chapter highlights a different mismatch: between the ways that development bank researchers and policymakers have promoted cost-effectiveness analysis for public health, and the near absence of these tools from the practice of project planning at both the World Bank and the Inter-American Development Bank. While both banks have policies requiring the use of such economic analyses, projects are consistently approved without them, and operational teams have often sidelined economic analyses in setting priorities for health lending. This contrasts with the use of economic analyses in the banks' more traditional infrastructure sectors, where cost-benefit analyses are judged to provide essential information for operational practice.

In emphasizing the differing ways that economic analyses have been valued across bank networks, my analysis speaks to the work of STS scholars such as Sheila Jasanoff (1990, 1990b) and Shobita Parthasarathy (2017), who have highlighted the very different kinds of knowledge that come to be valued in various arenas of governance. My analysis also speaks to development studies literatures on the seemingly fundamental contradictions inherent to the idea of international development—for example those emphasized by Dan Smith (2003) between the goals of development funders and implementers, or those described by Richard Rottenburg (2009) between "official" representations of the sovereignty of borrowing governments and the "unofficial" control exerted by development banks. But rather than focus on how alignment across difference (Smith, 2003) or the work of

consultants (Rottenburg, 2009) allows development actors to continue their efforts towards divergent goals, I focus on the divergent knowledges and values operating in specific spaces of the banks' networks. That economic analysis is surprisingly absent from the banks' practices of planning, implementing and evaluating projects leads me to examine in greater detail exactly how economic expertise is being mobilized across these networks and how the power of economic expertise is intertwined with other forms of power, such as electoral politics and the politics of race. In doing so, this chapter brings together the above literatures in development studies and STS of institutions with the work of medical anthropologists and sociologists such as Ruha Benjamin (2013), Ian Whitmarsh (2008), Duana Fullwiley (2011), and Anne Pollock (2012) showing how health and medicine continue to operate in constructing relationships between race and nation.

In this chapter I examine the pathways of cost-effectiveness analysis through both the research side of the World Bank and Inter-American Development Bank and through the operational divisions where the planning and implementation of projects is based—moving between fieldwork at bank headquarters in Washington, D.C. and with the banks' country offices and Ministry of Health in Guyana. In the first section of the chapter I demonstrate how bank publications and policies since the early 1990s have prioritized economic analysis as a key form of expertise for global public health. In the second section I show how this emphasis on economic analysis amongst the banks' research divisions has contrasted with the priorities of operations divisions and the implementation of projects in Guyana, where democratic politics have been given greater credence, even as projects move into the realm of patronage politics. In the last

section of the paper I argue that the aspirational visions of economic calculation advanced by bank researchers in the face of operational practice highlight the very different entanglements of racial, electoral and expertise politics across the banks' networks.

Cost-Effectiveness Analysis as Public Health Message

Early in 1994 Dean Jamison received a phone call in his UCLA office: it was a colleague from Cape Town telling him that perhaps he should reconsider his upcoming talk at the university there. "Look, they really don't want you, they don't like you here," she said, explaining that he wasn't much welcome, considering the World Development Report that he had directed for the World Bank the year before (DJ Interview 2015). Jamison was then a professor of public health at UCLA, and had already been receiving intense criticism throughout the previous months from many of his closest friends and colleagues regarding the report, which was widely received as a conservative manifesto for international health—advocating a more prominent role for private health providers and a reduced set of services to be provided by national governments. Jamison had completed his PhD in economics at Harvard under the so-called "father" of health economics, Kenneth Arrow, before going to work at the World Bank in the mid-70s, and had recently taken part-time leave from the World Bank to pursue this professorship at UCLA. But in 1992 Jamison came back to work full-time at the World Bank on the report – the first and only time this flagship annual World Bank publication has focused specifically on public health.

The 1993 World Development Report *Investing in Health* has become one of

the most well-known and controversial publications in global health in the last several decades (Sridhar, 2007; Jamison et al, 2013). The report presented economic arguments for seeing public health as a "productive investment" (e.g. through improving worker productivity) as well as economic methods for determining how to best invest private and public funds in this area, although the report focused largely on the later. Jamison and his team advocated using cost-effectiveness analysis to "maximize efficiency in purchasing health" (DJ Interview 2015) by identifying interventions which would return a great deal of 'health' in relation to their cost. This would be measured by comparing the cost of various interventions against the numbers of years of life that the interventions would save, according to the calculations of public health experts. In order to take into account interventions that improve quality of life without extending it, however, the report advocated using the metric of the Disability-Adjusted Life Year (DALY). This metric takes into account total years of life saved as well as years lived with chronic pain or other "disability."[29] Calculating the effect of an intervention in DALYs involves a weighted measurement in which non-lethal disease states (e.g. neck pain) are measured as a percentage of a year of life lost, and then added to the total number of years of life saved through interventions in lethal diseases.

Both in criticism and praise, many observers have credited the World Bank for development of the DALY, although the metric was mainly developed by Chris Murray—a health economist and physician at Harvard at the time, and Alan Lopez—a

25 The DALY arose in close relationship to the "Quality Adjusted Life Year" (QALY) in a period when debates regarding definitions of quality of life were central to bioethics literatures, but before "disability" had become a broadly politicized term.

demographer at WHO (Brennan et al, 1993; Barker and Green, 1996; Misra, 2006). It was, however, the World Bank's 1993 World Development Report that first popularized the DALY, leading to extensive debates in international health circles regarding the measurement and its associated assumptions as to the value of various forms of life. What percentage of a year of life lived with a missing limb, for example, would be equivalent to a year of disease-free life? Can one really rank certain forms of human life as more valuable than others, and try to transform these value judgements into quantitative measures? For example, the 1993 World Development Report advocated weighting the economically "productive" years of life (i.e. when people are generating income) as more valuable than years of life saved for the elderly, which was a highly controversial stance (Sayers and Fliedner, 1997; Arensen and Nord, 1999).

The 1993 World Development Report added intellectual support to ideas that had been circulating within the World Bank for some time. As early as the mid-1970s, when the World Bank was first considering lending for health projects, internal bank reports had argued that public health interventions often produce financial returns outweighing initial investments. Since the late 1970s the World Bank had also been supporting the idea of selective primary healthcare, advocating that governments provide a small set of basic health services rather than aiming to provide a large array.[30] Similarly, the DALY built closely on the "Quality Adjusted Life Year," a

[30] In response to the 1978 Alma Ata conference where governments declared their commitment to broad public provision of primary healthcare and to "Health for All by the year 2000," the World Bank and the Rockefeller Foundation organized a 1979 conference held to consider a more circumscribed provision of public health services. The conference was based around Julia Walsh and Kenneth Warren's now well-known paper advocating selective primary healthcare involving a limited package

measurement that had been in use since the 1970s in the field of health economics. However, the 1993 WDR circulated widely outside of both the World Bank and the field of health economics, bringing the debate on DALYs and cost-effectiveness analysis into the broader field of international health policymaking where such specific concepts from health economics had not much entered previously (Barker and Green 1996, Misra 2006).

The World Bank published several other reports alongside the 1993 World Development Report that have also been foundational in the growth of cost-effectiveness analyses in global health research. While working on the 1993 World Development Report, staff in the health division at the World Bank were also preparing the report *Better Health in Africa*, which likewise promoted the idea of a basic package of health services that governments and international donors could provide at low cost – a series of health interventions that would be selected based on their economic efficiency (World Bank, 1994).

In 1993 the World Bank also published the first edition of the Disease Control Priorities (DCP) in Developing Countries report, which presented cost-effectiveness analyses of numerous health interventions in an effort to help priority setting in "highly resource-constrained low- and middle-income countries" (Jamison et al, 1993). The DCP has become the central reference on cost-effectiveness in global health, although in large part based on its second edition, which was developed as follow-up collaboration with the World Bank, the World Health Organization, and the United States National Institutes of Health. This report set out a list of the 'top ten best

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of services that would be more 'practical' regarding the health services that governments could provide (Walsh and Warren 1979).

buys' in global health, identified as the most cost-effective interventions in terms of cost per DALY averted.[31] While the list included long-time essentials of primary health care such as immunization, nutrition, maternal education, and monitoring child health, it also included quite a distinct set of priorities including traffic regulations to divert injuries from road accidents, a focus on comprehensive HIV prevention and treatment, and tobacco taxation.

The World Bank produced numerous such reports and also events (conferences, workshops, etc.) in the mid 1990s promoting the idea that governments and donors should use cost-effectiveness analysis as a primary means of determining which health interventions to fund. However, this idea was not without resistance even within the World Bank. During the writing of the 1993 World Development Report, several World Bank economists argued that the report's use of cost-effectiveness analysis countered the idea of free-market economics. In their view, it was not the place of policymakers to determine spending based on an explicit process of prioritization among health interventions; a policymaker's role was to establish a financial architecture that would guide people's behavior and health expenditure. Some World Bank economists even argued that the 1993 WDR represented a Stalinist approach to health because it advocated determining priorities through central planning rather than market mechanisms. That report's lead author explained:

> So all I tried to say is "look if it is Stalinist, we tried to make it an intelligent Stalinism, but central planning is the right way to think about resources in the health sector." That group of people thought, "you get the prices right, the institutional arrangements and the economy right

[31] Because the measurement of DALYs is based on calculations of how many years of life would be lost without intervention, health interventions are measured for how many years of lost life are "averted."

> and everything will work itself out for health, you don't need to *plan* what interventions to buy, the system makes you do what's best, you don't as a central planner know what's best." But the left buys into this argument as much as the right. The right puts it forth as a free-market argument, the leftists all talk about it as "communities know what's best, you don't need technocrats at the center telling communities what to do." The right-wing people say "individuals" – they're not inclined to say "communities" – "individuals know what's best for them; empower individuals and you don't have to get your central planning apparatus in place to tell individuals what to do." So the left and right come out in very much the same place (DJ Interview 2015).

Jamison noted that the World Bank's approach was criticized from many perspectives; while numerous observers have described the report as a conservative, economistic force in global health (Chapman and Pfeiffer, 2013; Adams, 2013), many economists within the World Bank actually criticized the report for lacking sufficient backing in free-market economics.

Jeff Hammer has been one of the most vocal critics of the World Bank's promotion of cost-effectiveness analysis as a tool for setting priorities in public health spending. In the early 1990s Hammer was an economist in the World Bank's division of Health, Nutrition and Population (HNP), and he was a member of the team responsible for the first edition of the Disease Control Priorities (DCP) in Developing Countries report. However, Hammer opposed the very basis of the idea that cost-effectiveness analysis should guide government investment in health. The DCP, he explained:

> had nothing to do with markets, had nothing to do with market failures or anything an economist would look at. It was counting up pros and cons (which would be the costs), and then they made up something about the outcome – it wasn't benefits – it was a health outcome, which was so *anti-economic* (JH Interview 2015).

Hammer argued that basic principles of economics would lead governments to

examine markets as a way to guide investment. These principles would also emphasize the benefits that people have expressed through their health behavior (i.e. where they have actually chosen to spend their money), rather than health outcomes arbitrarily determined by physicians and other "experts." And governments ought not necessarily devote their investment in health to the *least expensive* interventions, he argued, but to those where private systems failed; it might actually be the most expensive interventions where insurance fails, for example, in which case that would be the best site for government intervention.

Both within the World Bank and in subsequent publications, Hammer criticized the "cost-effectiveness thinking" laid out in documents such as the 1993 WDR and DCP for not prioritizing public goods (Hammer and Berman 1995, Hammer 1997). For example, leukemia treatment is more *cost-effective* than environmental control of dengue, even though Hammer stressed that any economist should see that leukemia treatment is a completely private good in that its benefits "accrue to the individual," whereas the environmental control of dengue is a public good that benefits anyone in areas that have been cleared of the mosquito vectors. Hammer has argued that the failure to recognize such basic tenets of economics has been characteristic of the World Bank's approach to global health, where he suggests that physicians and other health professionals have tried to harness the credibility of economics without knowing its basic principles. Economists who have been based in the World Bank's health division have been pulled away from mainstream economic thinking, he stresses, and have not been able to impose reasonable applications of basic economics. Rather than using economics to make specific decisions about

particular situations and contexts, these practitioners have attempted to use economistic language to promote broad conclusions about which health interventions should be priorities internationally.

In the early 1990s Hammer tried to rally economists outside of the World Bank's health division to counter the World Bank's growing focus on cost-effectiveness analysis. But while many World Bank economists disagreed with the health division's use of economic principles, they were on the whole unwilling to take on a major battle with the health division over how to handle a health topic.[32] Throughout the 1990s the World Bank continued to push for setting priorities in global health based on the most cost-effective interventions. This focus on cost-effectiveness analysis for public health also grew within other international institutions, including the Inter-American Development Bank (IDB), which in 1996 hired one of the principal authors of the 1993 World Development Report to lead IDB work on cost-effectiveness and priority setting (Bobadilla 1998).[33]

The reports and events that the World Bank and Inter-American Development

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[32] Hammer explained: "The trouble I had at the Bank, I would say things even simpler than this and my economist colleagues would say 'well yeah, who would say anything other than that' and therefore they didn't get excited about it. And so they would just let the health people say anything because they didn't know anything about health… LP was representing the chief economist's office and I went and said 'they don't do public versus private,' which is really 'why does the government get involved in anything, why is the market failing' – people maybe rely on that a little too much as a baseline, but government is there to do collective action that people can't do on their own, that's the whole point of government as far as I can see, and that is the basis of a lot of economics and I said 'they just do these silly mechanical calculations' and LP said 'boy the guy seemed like he was smart but he must be really off the wall because no one would say this kind of stuff,' and then he read it and said 'oh my god, that's what they're saying,' and that's when we started becoming friends" (JH Interview).

[33] Early in the following decade the World Health Organization also began to make cost-effectiveness analysis central to its approaches to public health, for example through its CHOICE program, which aims to help countries set priorities by using this economic tool. The program's guide to cost-effectiveness analysis has become a central reference used in the global health literature, especially as the standard setting the threshold at which interventions should be deemed "cost-effective" (Edejer et al, 2003; Marseille et al, 2015).

Bank have produced over the past twenty-five years regarding cost-effectiveness analysis have been led by staff in research divisions of the banks' Washington, D.C. headquarters. However, the practices and priorities of these researchers differ quite substantially from bank staff, consultants, and government officials working in operations both at bank headquarters and in borrowing countries. Although some staff do move between positions in research and operations, many researchers have never worked in operations, and have quite a different outlook than the operational staff who actually plan and implement loans. In the following section I look to the relationships surrounding cost-effectiveness analysis in operations, focusing on prioritization and project planning in Guyana. I start with a scene on an August 21013 day at Guyana's Ministry of Health.

Operations, Economics, and Democratic Politics?

Sitting in an air-conditioned meeting room, blue-tinged neon lights overhead and the sound of soca music on the radio of a car passing by on Brickdam Street, the directors of the Ministry of Health's seven program areas jotted notes on the consultant's presentation.[34] Guyana's Ministry of Finance had arranged an initiative with the World Bank to implement a new software tool meant to help governments plan their health budgets by prioritizing spending on the most cost-effective health interventions.

After the World Bank consultant – an older Pakistani economist in a crisp white shirt and dark suit – finished his presentation on the results of the budgeting

[34] This scene is drawn from fieldnotes August 18, 2013.

exercise, the director of the Health Ministry's Disease Control Program spoke up. The middle-aged, Afro-Guyanese physician began: "Can you please go back to your slide regarding the demographic information you've applied through the software?" The consultant flipped back to a slide with two charts. The first listed Guyana's racial breakdown: 43.5 percent Indo-Guyanese, 30.2 percent Afro-Guyanese, 9.1 percent Amerindian, 16.7 percent Mixed. The second presented historical population information as well as a forecast of population growth, covering together the period from 2006 to 2026.

The Disease Control Program director continued, "I have to say that your population predictions don't seem at all likely." They were based on an out of date census, she noted, and a series of flawed population studies by Guyana's Bureau of Statistics. The racial and electoral politics of her claims were not lost on those in the room. Although she did not mention it explicitly, it was clear that she referred to widely-circulating accusations that the People's Progressive Party (PPP), popularly understood as the party of Indo-Guyanese, was manipulating population statistics to obscure rapid emigration. Many people outside of the PPP argued that the true statistics would reflect the scale of discontent with PPP governance during the past nineteen years during which the party controlled Guyana's executive branch. And the PPP was in a particularly tenuous position at the time. While the PPP had won elections by large margins in the late 1990s and early 2000s, in 2011 the PPP was only narrowly able to retain control of the executive branch despite losing the popular vote, because the majority vote was divided among opposition parties.

Gina Arjoon sat close to the presenter during the 2013 meeting on health prioritization. She had just graduated with her master's in health economics from the University of York, making her the only person with a degree in health economics out of the 751,223 residents of Guyana – if the World Bank and the Guyanese government's numbers were to be trusted. Gina had returned from England to work in Guyana's Ministry of Health, and she had been placed on the project team implementing the World Bank health budgeting software tool. But in spite of the cachet of the World Bank and the group of foreign and Guyanese economists on the project team, Gina explained that the team "could never get the buy-in from the Ministry of Health program heads; they didn't believe the output of the tool" (GA Interview 2015). In subsequent conversations and correspondence, the World Bank project team stressed to the Ministry of Health program heads – most of them physicians and epidemiologists who had completed advanced degrees in Cuba and Russia – that the tool had been tested internationally and that it incorporated the most up to date expertise in health economics. The program heads, however, questioned the numbers and the assumptions on which the economic tool was based. The directors disagreed both amongst themselves and with the project team on the birth-rate projections necessary to planning future health services, and they strongly disagreed with the priorities that resulted from the tool's implementation: that non-communicable diseases needed to be prioritized more in relation to the Ministry's current focus on HIV/AIDS, tuberculosis and malaria.

The process of running the budgeting tool and debating its results fulfilled requirements contained in two World Bank and Inter-American Development Bank

loans. These loans required that Guyana's Ministry of Health have a mechanism for incorporating best practices and cost-effective measures into its strategic planning. But while both of the banks had planned for this health sector prioritization process to inform their priorities for upcoming loans, the lack of credibility of the tool amongst the directors of the Ministry of Health meant that its results were by and large left aside; as Gina Arjoon described it "it just sort of fell off the map." This suggests the important role that Ministry of Health representatives can play in setting priorities for loans, although all development bank negotiations are coordinated through Guyana's Ministry of Finance, who serves as the country's representative to the development banks. But health professionals have expressed concern that the Ministry of Finance has negotiated loans directly with health staff in the banks with little input from the Guyanese Ministry of Health.

Close to the time of the prioritization exercise, the Government of Guyana was developing a national development strategy focused on environmental sustainability, in concert with a $250 million agreement with the Government of Norway that would provide compensation for keeping deforestation in Guyana at a minimum. This "Low Carbon Development Strategy" (LCDS) came to serve as the platform of the incumbent People's Progressive Party (PPP) in the 2013 national elections, and although it stated that "investing in healthcare" was still a government priority, many members of Guyana's public health community feared that health spending would be minimized in efforts towards green development.

While the World Bank health prioritization exercise rooted in cost-effectiveness analysis didn't get the "buy-in" of Guyanese health officials, the PPP's

Low Carbon Development Strategy became the basis for planning loans with both the World Bank and Inter-American Development Bank (IDB) over the next several years. In the case of the later, the LCDS became the guiding principle for the "Country Strategy" that IDB develops every four years with each country that it lends to, laying out the sectors and projects that will be the focus of loans during the upcoming four years. Although the health sector has been a central pillar of every Country Strategy in Guyana since the mid-1990s, the 2012-2016 Country Strategy moved to a focus on energy and natural resources rather than public health. The director of Guyana's IDB Country Office explained:

> It was an easy decision since we have limited resources, we cannot do a bit of everything, and doing a bit of everything would give us a weak portfolio. It doesn't mean that it's not important; it means it is not what is prioritized with our resources…So we were able to have a very focused approach on energy, because government has requested us to focus on energy and we really felt it was important, and the board has commented on that, that it was in line with what the country was doing with the LCDS. We did not want to have something that was not in line with the orientations that the government was giving, so natural resources was a natural movement. Then we have the dialogue sectors, which are water, transport, etc., which were chosen based on how relevant they are to the LCDS and to past work we have done (SM Interview, 2013).

Here the IDB Guyana director – a Haitian education specialist – argued that the LCDS was representative of what the Government of Guyana had prioritized, and she suggested that the government's electoral mandate gave these priorities democratic credibility. However, in a published evaluation of Guyana's programs, IDB headquarters had already criticized the Guyana country office for not incorporating economic evaluation into planning its Country Strategy. This led to a major disagreement between IDB's evaluation division, its board, and the Country Office;

the Guyana office had argued there that the broad lines of lending need to be based in the program of the country's government rather than the bank's growing emphasis on economic projections. But the country office was eventually overruled when IDB established new institutional guidelines for developing country strategies, which formalized and underscored the institution's policies requiring economic evaluations in the planning of country strategies (IDB Office of Evaluation and Oversight, 2012). The fact that the director of the Guyana Country Office continued to stress electoral accountability so strongly even after her office had been publically rebuked by IDB's management points to the very different ways that expertise and electoral politics are intertwined in different spaces of bank work. While bank researchers and evaluators can recognize the importance of democratic priorities and move between emphasizing economic evaluation and political context, people working in operations confront the daily exigencies of negotiating loans with governments, keeping racial and electoral politics front and center – as the following section highlights. But this difference between bank publications and operational programs does not represent a simple disjuncture between discourse and practice. Rather, it reflects the very different ways that expertise politics play out across bank networks. To examine this further, I start with one of my first outings with the Neglected Tropical Disease project team in January 2013.

Patronage Politics

We arrive in a vehicle marked with a large government seal.[35] The Ministry of Health driver lets the eight of us – me and several volunteers and staff members from the Ministry of Health – unload from the minibus, all wearing t-shirts marked with government seals. We've arrived in Mahaica, a town on Guyana's coast about a 45-minute drive east of the capital. Over the next four hours we will visit each of the wooden houses on the town's quiet roads, speaking to citizens about the dangers of lymphatic filariasis and soil-transmitted helminths, distributing preventative medications to anyone over the age of two willing to consume the pills in front of us, and recording the name, age, and gender of each person who does. Volunteers have packaged individual doses of albendazole into small plastic bags, but they are sure to carry the bottle emblazoned with the GlaxoSmithKline label. The diethylcarbamazine citrate tablets come in a blister pack, foil marked with Sanofi's logo.

As we spent hours packaging the doses the week before in the airless annex building at the public hospital complex, a young member of a church group had commented that these were expensive medications, and an older Red Cross member laughed that for once you can get something other than paracetamol from the Ministry of Health. The international brands of the medications are central to the credence of the project, but the most important branding is most definitely that of the Government of Guyana. Between volunteers' shirts and bags, the program banners, and the arrival of teams in government vehicles, the outreach efforts are a carefully-orchestrated effort to ensure that citizens feel the presence of the incumbent government. That has been clear in planning meetings at IDB and at the Ministry of Health in previous

[35] Taken from fieldnotes January 13, 2013.

weeks. When the chief IDB staff contact on the project, casually remarked that a newspaper article covering the Mass Drug Administration did not even mention IDB, the Chief Medical Officer snapped that this was rightly so – this was a Government of Guyana project, with support from IDB, he stressed. The Minister of Health grumbled in a meeting several weeks later that this was something the government had been able to accomplish in spite of the obstructionism of the opposition party.

Under the IDB-financed project, the Government of Guyana aims to distribute these preventative medications for "neglected tropical diseases" to every one of its citizens over the age of two, starting in the capital region. In this election year, the incumbent People's Progressive Party highlights the work it has done to provide for the health of its citizens – *all* of its citizens, it stresses in pointing to the house-to-house campaign. But there is a relationship of exchange, the campaign suggests: it is the obligation of Guyanese citizens to contribute not only to their own health, but to that of their compatriots by taking the pills and thus removing the reservoirs of this "secret infection" that lie within the bodies of four percent of the Guyanese population. At the volunteer trainings held with various community groups in the weeks leading up to the MDA, trainers stressed the importance of making it clear to every home and every citizen: even if you feel healthy, you can be infected, and you can spread this to others. In national news media, the head IDB consultant on the project, the Ministry of Health coordinator, and public officials all argued that the project should be a national communal effort: everyone has to join in for the health of the entire nation (Grainger, 2014; Stabroek News, 2011b; Government Information Agency, 2016). These messages draw on early twentieth-century public health

messages emphasizing the new germ theory (Leavitt, 2014), and equally long-standing efforts to promote health and medicine as a central form of citizenship and national participation (Chakrabarty, 1992; Prakash, 1999; Bashford, 2004).

However, the rhetoric of national unity through medicine in Guyana's NTD project contrasts with very regular accusations that the People's Progressive Party has for the past twenty years funneled the benefits of development projects to Indo-Guyanese, who form the party's base in a highly racially-stratified electoral system. Across these divides, the incumbent government attempts to make foreign medical expertise packaged into tablets serve as electoral currency. Government representatives will come to your door and provide you free of charge with top-grade medications that will save you from disfiguring disease, the campaign stresses (Haynes, 2016). This is framed through a language of cleanliness: pairing cleanliness of environment with cleanliness of body. While project materials stress that the city's "insanitary state" makes it a literal breeding ground for *culex* mosquitos, the project's managers mobilize internationally-circulating public health discourses as they speak of "mop up" efforts to return to areas of low coverage: the image is one of project staff cleaning up remnants left behind in initial efforts. The branding of the project as an offering from the Ministry of Health has been the most consistent concern throughout project planning, and publicity materials have been at the center of project planning discussions much more often than strategies for avoiding re-infection, transmission between dyssynchronous waves of the project in neighboring regions, etc.

But how do bank staff and consultants make sense of these dynamics in the face of claims regarding the importance of economic calculation? In the following

section, I argue that analyses of power offered by development bank staff themselves are an essential aspect of how economic knowledge operates in development bank health projects.

Legitimacy, Aspirations, and Constructing Global Health

Economists at World Bank and IDB headquarters have often argued that party politics like those described above distort the use of government and donor funding, directing money away from the most economically efficient projects and towards those which elected officials anticipate will win them the most votes. While this framing of party politics as "distorting" is common in the institutions' publications, at times the banks' researchers acknowledge the importance of democratic politics in setting public health priorities, and they suggest that such expressions of popular opinion need to be weighed against the results of economic analysis. In this section I analyze how economists at the banks' headquarters move between these two discourses—a "technocratic" versus a "democratic" vision of project planning, on the one hand presenting electoral politics as a corrupting force in project design and on the other hand presenting these politics as the rightful context within which democratic priority-setting must be conducted. My informants have shifted between these discourses in ways strikingly similar to what Ashmore et al (1989) have described of British health economists as early as the 1980s. I argue that these discursive moves regarding the relationship between economic analysis and electoral politics present a significant aspect of how economic tools are being used in the health work of these

banks: in constructing and reflecting understandings of the possibilities of global health.

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Like many of his IDB colleagues, Gabriel Jackman presents a technocratic vision in stressing the importance of economic evaluation for countering simple political calculus in development bank projects. The Trinidadian economist – trained in the UK and the US at the University of Kent and at Georgetown University – has been working in various capacities at IDB since 1980. He argues that without economic analysis, project planning amounts to borrowing governments conducting political analyses of the following sort: "Is my populace asking for healthcare? Will I get more votes from healthcare or a metro, or from balancing my budget and controlling my spending?" (GJ Interview 2015). Significantly, he emphasizes electoral *calculus*: these too are forms of knowledge and calculation. Mr. Jackman argues that loans have often been planned based on implicit vote projections by incumbent governments. But cost-effectiveness analysis, he notes, allows both governments and development agencies to make decisions based on economic evidence and explicit priorities in order to achieve the greatest overall benefit for money spent.

Economists like Mr. Jackman continue to echo frameworks presented over the past twenty years in World Bank and IDB publications promoting cost-effectiveness analysis for health. A 1998 IDB report, for example, noted:

> The current decision-making process in the public sector, which is based on implicit criteria, is unsatisfactory because of a lack of transparency and distortions in the allocation of resources. With few exceptions, establishing priorities is heavily influenced by political pressures and delegated to health managers who often have serious

> conflicts of interest. Such is the case of hospital managers who want to expand the degree of sophistication and size of their medical facilities, but have no incentives to use hospital resources to provide the most cost-effective services to their patients. Moreover, in many countries, public sector health institutions spend most of their money in urban areas, often at the expense of the rural populations' access to health care. A more subtle way of setting priorities is through the underfunding of recurrent and maintenance costs which leads to deterioration in the quality of care (Bobadilla, 1998: 4).

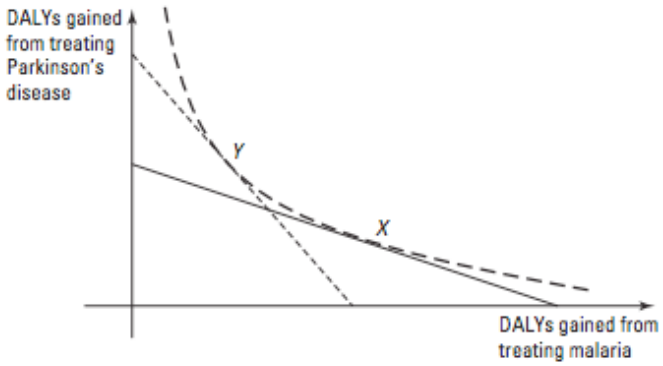
The report argues that cost-effectiveness analysis makes the criteria for decision-making explicit, as opposed to political decision-making processes – both in terms of electoral politics (with the undue influence of urban voters) and the politics of personal and professional advancement (healthcare professionals setting priorities in their own interests). These technocratic ideas appear again and again in bank publications, such as the 1993 World Development Report, which explained:

> There are several reasons why developing countries fail to allocate sufficient resources to cost-effective health interventions… At a fundamental level, the distribution of political power explains much of the misallocation of government resources for health. The urban population is better organized than rural groups and more vocal in demanding health facilities and services. Similarly, middle-class workers in wage employment, who frequently belong to powerful trade unions, are more effective than self-employed farmers and workers in the informal sector in lobbying for government-subsidized health benefits. Health professionals are also often better organized than the population they serve, and in promoting their own interests they may make the health system less efficient. Despite these problems…success can be accelerated, as newly available information makes it clear how costly misallocation is" (World Bank, 1993: 69).

This foundational World Bank document stressed that electoral politics are often responsible for "misallocation," understood as the dedication of public funds to health interventions with low cost-effectiveness. The report's authors highlight the lobbying power of interest groups such as labor unions and healthcare professionals as a crucial

aspect of such politics. Cost-effectiveness analysis, the report argues, allows decision-makers to avoid such party politics and instead prioritize the greatest social good for money spent.

But in light of broad criticisms by public health practitioners regarding the banks' economistic approaches to decision-making, both the World Bank and IDB have increasingly presented another "democratic vision" of project planning, acknowledging the importance of democratic politics and preferences in setting public health priorities. The 2006 edition of the Disease Control Priorities in Developing Countries report, for example, notes that "a frequent, often justified, criticism of cost-effectiveness analyses is that they address only one of many criteria that could be used to evaluate health interventions;" the report goes on to argue that cost-effectiveness analyses have to be weighed amongst "epidemiological, medical, political, ethical, and cultural factors" (Jamison et al, 2006). The DCP presents the graph below to demonstrate how cost-effectiveness analysis can be combined with the priorities of policymakers for serving different constituencies, using the Disability-Adjusted Life Years (DALY) measurement discussed above.



Source: Jamison et al, 2006

The authors propose preparing an "indifference curve" to describe political preferences. For example, if deciding between funding Parkinson's disease treatment and expanding malaria programs, the indifference curve would represent the "willingness of policymakers to trade off health improvements in children (malaria) versus the elderly (Parkinson's)" – represented by the dashed curve above (Jamison et al, 2006). The indifference curve can then be combined with cost-effectiveness ratios to determine optimal levels of government investment in each intervention:

> When the price of buying a unit of health to treat Parkinson's is relatively high in terms of cost per DALY averted, the relatively flat (solid) budget line applies, and the optimal balance of investment in the two interventions is at point *X*. If the cost of buying a unit of health to treat Parkinson's is relatively low, then the steeper (dashed) budget line applies and the relative allocation of resources is represented by point *Y*. Therefore, policy makers would allocate relatively more resources to treating Parkinson's when the price of buying a unit of health through this intervention is relatively low, and they would allocate fewer resources when the price of health obtained through this intervention is relatively high (Jamison et al, 2006).

Here, the authors acknowledge that cost-effectiveness analyses should be weighed against the specific preferences of policymakers who have been vested with democratic authority. However, the authors attempt to frame such political preferences within a highly calculated, quantitative model. This vision contrasts markedly with the visions of planning advanced by the banks' operational staff, such as the director of the IDB country office in Guyana discussed above, who frames project planning as a flexible and ongoing negotiation centered on the goals and values of the governments to which IDB makes loans.

Beyond their publications promoting the importance of cost-effectiveness analysis for public health, both IDB and the World Bank have *policies requiring*

economic evaluation in project planning. Over the last several decades both the World Bank and IDB have received severe criticism regarding the extent to which they have been able to achieve their own goals of economic and social development. In order to demonstrate and attempt to ensure the effectiveness of their work, these institutions have established rules and procedures meant to guarantee the appropriate design of projects. Such rules have made up an essential aspect of attempting to convince donor countries to continue providing funds. For example, in preparation for an upcoming request to donors for a "replenishment of funds and increased capital for lending" in 2009, the IDB worked to create a "Results Framework" emphasizing development effectiveness (IDB, 2009b). As a part of these efforts, the IDB established new rules for evaluating projects in their planning phase, which introduced a requirement that all projects present an economic analysis before they can be approved. Although IDB had had requirements for economic analysis previously, ensuring the use of cost-effectiveness or cost-benefit analyses before project approval was not standard practice throughout the late 1990s and early 2000s (RI Interview 2015).

Members of the committee responsible for elaborating IDB's new rules stressed to me that they had envisioned a more flexible set of standards than those eventually made official policy. The institution's internal planning group had recommended a system in which loan proposals would receive points for various analyses conducted during planning, and proposals over a certain point total would be financed. The planning group felt that this system would have allowed space for each project team to determine the most important analyses for each specific project. However, when the policies went for approval by the institution's Executive Board,

IDB's US representative pushed for a requirement that every project include a cost-benefit or cost-effectiveness analysis prior to approval. Although this became official policy, it hasn't been much put into practice. Likewise at the World Bank, economic analyses have long been officially required for project approval, but managers and senior leadership within the institution have not enforced these policies. Officially projects must contain either a cost-benefit or cost-effectiveness analysis, but projects are consistently approved without either (World Bank IEG, 2010 – see discussion below).

Although economic analysis policies were initiated as part of the push for "results" to ensure ongoing funding of development banks, there is more at play in the banks' promotion of cost-effectiveness analysis than a straightforward search for legitimacy in the eyes of donors. These economic analyses are central to how economists at the banks understand what they can offer to global health, and what they enjoy in it. Cesar Ezra, for example, has worked as an economist for the World Bank and IDB since the 1990s. He explains:

> I would say that a good summary of what I do is that I help governments prioritize investments. As you know, probably, this applies also to the US, but as you know in developing economies everything is a priority, so if you talk to a water expert, health specialist, education specialist, private sector expert, whomever you bring to the table, they would be able to give you convincing arguments that their field is or should be the priority and therefore decision-makers when they receive all this information it is a problem because when everything is a priority nothing is a priority and nothing gets done, so my job is to use the tools of economics to try to bring to the table some evidence-based information that helps you make decisions, so I like to think of myself as someone who can give you a good idea of trade-offs and opportunity costs, right, 'if you do this, you stop doing that' and from that perspective cost-benefit analysis is one tool, one

> powerful tool that helps you provide that evidence-base (CE Interview 2015).

Cesar considers cost-benefit and cost-effectiveness analyses a central aspect of what he can offer to international development as an economist. Many bank economists also describe the joy they take from conducting such analyses, noting the intellectual stimulation of trying to consider how these economic evaluations can be done better, especially in light of limited data. For example, how should one extrapolate data between countries? What should count as a benefit? However, these practitioners argue that project timelines and the politics of developing projects mean that economic analyses don't have much space to influence project design. Two economists in IDB's health division explained to me:

> PI: The government and the bank join to decide "we're going to do a 50 million dollar health loan in Jamaica" and most likely the government of Jamaica will know that they want to build two hospitals in Kingston, so it is going to be very hard to do an economic analysis that says "you shouldn't," or that "you should do *one* in Kingston and one in another place," or that instead of building hospitals you should invest in primary healthcare. That's very, very hard. So at the end of the day I think ninety plus percent of economic analysis have been to justify what has already been decided.
>
> DP: I would say, if we're being so honest about it, it is more of an academic exercise to have some support for your argumentation and to fulfill our requisite rather than really influencing any decisions.
>
> PI: In that sense, as an academic exercise, we've been having a lot of fun in saying "ok, how do you think we should go about doing the economic analysis: which benefits do we count" for example… But I don't think we can say any project has really changed because of the economic analysis; it's the other way around (PI and DP Interview, 2015).

Pablo and Diana stress that although economic analysis doesn't have much power at the level of planning projects, the two of them continue to enjoy the process. Diana

has even started an initiative to establish specific guidelines for economic analysis in the health sector, since she finds that IDB's standards for economic evaluation in health and education remain too aligned with the standards for infrastructure and transport: financial benefits are more central to analyses in those sectors, she suggested.

Economists at World Bank and IDB headquarters not only see economic analysis as a crucial aspect of what they can contribute to global health, and it is also something they enjoy in their work. Economic analysis forms a central aspect of how health economists at the World Bank and IDB envision the possibilities of global health; one of the key roles it plays in these institutions is in creating and reflecting these aspirational visions. And as the banks' health economists often lament that economic analyses do not have much power to substantively shape the process of project design even within their own institutions, they stress the influence of party politics, but also the rapid cycle of projects and a lack of data and funds for economic analysis. A 2010 report by the World Bank's Independent Evaluation Group bemoaned the absence of economic analysis in project planning, and attributed this specifically to the rise of lending in health and associated sectors, where the report suggests that cost-benefit analysis is difficult. The opening lines of the report read:

> Cost-benefit analysis used to be one of the World Bank's signature issues. It helped establish the World Bank's reputation as a knowledge bank and served to demonstrate its commitment to measuring results and ensuring accountability to taxpayers. Cost-benefit analysis was the Bank's answer to the results agenda long before that term became popular (Independent Evaluation Group, 2010: ix).

The report argues that economic analysis was once central to the World Bank's

identity, but that these tools have been used decreasingly over the previous several decades. In spite of Word Bank policies requiring economic analysis in project planning, the report found that the number of projects completing economic evaluations dropped from seventy to twenty-five percent of all World Bank projects between the early 1970s and the early 2000s. The report also found that during its one-year sample period in 2008, of all the projects that cited cost-effectiveness as the standard for approval (versus cost-benefit analysis), not one project conducted an actual cost-effectiveness analysis. The report stressed that while infrastructural projects continue to conduct cost-benefit analyses, health projects referenced cost-effectiveness analyses but did not actually make use of them. The report caused a major stir at the World Bank, and rumors flew that its author was pushed out of the institution as a result of revealing the "public secret" of the lack of economic evaluation in World Bank projects.

The 2010 Independent Evaluation Group report did not much examine *why* economic analyses weren't being conducted, beyond citing the difficulty of cost-benefit analysis in "health and the social sectors." However, my discussion above emphasizes that operational staff often feel they don't have time or money to conduct the analyses. One World Bank consultant stressed:

> Team leaders are given a budget for project preparation—about US$90K for most projects. With this budget they have to do everything—paid for consultants that help design the projects, travel, environmental impact, and the CBA among more uses of funds for project preparation. A proper CBA could be very expensive if primary data is needed. For this reason, Bank projects seldom collect primary data for the CBA. In the private sector due diligence of a project is between 2-3% of the project cost, for the current health project that would represent US$4-6 million, which as you can see does not compare well with US$90K.

Ironically, then, the tradeoffs of economic analyses (i.e. the economic benefits that such analyses could yield) don't appear to hold weight across projects and their various stages; the benefits that could arise from implementing more cost-effective projects can't get a project planning team any more money for their task. Many project planners feel it just isn't worth putting a lot of money into an analysis that isn't going to change which projects get financed, since project planners don't see these economic analyses as crucial for the actual design and implementation of projects. From my observations of inter-sectoral meetings within bank headquarters and country offices, and my interviews with bank staff who have moved between sectors, it appears that health project planners see the quantification of effectiveness in this sector as elusive, whereas infrastructure planners generally see cost-benefit analysis as offering broadly faithful representations of reality that are significant for daily operational decisions.

These implicit calculations shape the valuing of economic tools in the project planning stage, where project planners and the institution's senior management have by-passed official policies requiring cost-benefit and cost-effectiveness analyses. These operational calculations are distinct from the great importance placed on economic analyses by the banks' researchers, but also from the priorities of country office representatives negotiating loans with the Guyanese Ministry of Finance and Ministry of Health. In these spaces, different knowledges and values come to be seen as relevant.

Conclusions

Since the early 1990s, both the World Bank and Inter-American Development Bank have led major efforts advocating for the use of cost-effectiveness analysis in setting priorities for public health spending in poor countries. In publications and at conferences and workshops, development bank researchers have argued that cost-effectiveness analyses allow both governments and development agencies to prioritize health spending on the interventions that will yield the greatest improvements in health for the least amount of money. Publications and initiatives led by the World Bank and IDB have played a major role in the growing centrality of cost-effectiveness analysis in global health literatures, from academic journals to development blogs.

Over the last several decades, staff and consultants at these two development banks have promoted the use of cost-benefit and cost-effectiveness analyses for guiding the design of health projects in part as a way of legitimizing the institutions' health programs in the eyes of the banks' donors, using such calculations to argue that the banks make good use of their funds in pursuing only the goals with the greatest return on investment. However, the promotion of economic analysis as a decision-making tool is also driven by the *aspirations* of global health practitioners and especially the hopes and visions of health economists employed by the banks. In spite of these two banks' repeated emphasis over the last quarter century on the use of economic evaluation for decision-making in global public health, my research reveals that even within the Word Bank and IDB, cost-effectiveness analysis does not play a major role in planning and implementing the institutions' loans.

Ashmore et al. have emphasized that the "successful application of health economics depends on acceptance by, and support from, non-economists within the

system of health care" (Ashmore et al., 1989: 10). That is, health economists have to convince healthcare providers and administrators that the tools of health economics can actually be helpful, in order for these economic tools to be applied in practice. Health practitioners in Guyana, however, resisted the authority of economic analyses for health priority setting. But this difference between bank publications and operational programs does not represent a simple disjuncture between discourse and practice. Rather, it reflects the very different ways that expertise politics play out across bank networks. In Guyana, health officials took issue with the assumptions and conclusions of the World Bank's economic planning software. Rather than focus project prioritization on such tools, the IDB Country Office in Guyana emphasized planning projects based on the priorities of the incumbent government, which included a form of patronage politics, enrolling foreign medical expertise packaged into pills and distributed in an effort to win votes. But my research at bank headquarters emphasizes that economic tools are not used any less in Guyana than in other country offices and operational projects. And while the patronage politics I describe are part of a problematic system of electoral politics that has concentrated wealth in very few hands in Guyana, I do not argue that the presence of these politics has necessarily resulted in *worse* programs than would result from greater reliance on economic or other expertise. I do not interpret these politics as a corruption of expert negotiation. Rather, I see the interweaving of racial and expertise politics in Guyana as an ideal window for examining how these forms of expertise interact more broadly.

Researchers at bank headquarters offer economic analysis as the answer to party politics, offering a technocratic vision in arguing that these tools allow them to

identify the projects with the greatest benefits across society – without the undue influence of interest groups. In reports, in blogs, and in interviews these practitioners often present economic analysis as the rational, scientific remedy to the irrational politics of international development. However, health economists working in these two banks also move between framing politics as a corrupting force and as the rightful context within which cost-effectiveness analyses must be weighed against local values and priorities. I have argued that these discursive moves are a significant aspect of how economic tools are being used in the health work of these international financial institutions: economic expertise operates as a tool in constructing and reflecting understandings of the possibilities of global health.

At times researchers acknowledge that democratic politics ought to be taken into account when considering how to weigh the results of cost-effectiveness analyses, but development bank staff and consultants most often envision a highly calculated field that contrasts markedly with the visions expressed by the banks' operational employees. Staff and consultants in operations consistently highlight the importance of making loans work in close collaboration with borrowing governments that have their own politics, priorities, and approaches. These visions speak to very different knowledges and values at play across development bank networks, even within a single project. Amongst the institutions' researchers, economic analysis holds great sway. But economic analysis does not hold the same preeminence in operations, where economists regularly lament the absence of economic evaluation, despite the banks' policies requiring these analyses. In operations, party politics are front and center. This is not to say that "traditional Politics" have no place at development bank

headquarters; the strong influence of the banks' US representatives in developing the institutions' policies makes that clear. Nor is it to say that economic analysis has not influenced the banks' operational priorities at a broad institutional level, shaping the areas of intervention that the organizations see as institutionally significant. It does, however, highlight a very different intertwining of expertise politics and electoral politics across the banks' networks that goes beyond a straightforward power of either the one or the other, and it suggests the importance of examining the differential intertwining of these forms of politics within various spaces of global health.

While economic expertise has become incredibly powerful in many spaces of decision-making in global health and more broadly, economic tools have been mobilized to quite different extents and towards very different ends in different sites – including within the work of such centers of economic expertise as development banks. But while economic knowledge has not been as central to health projects as one might expect from the histories and discourses of development banks, the banks' use of anthropological expertise has been equally surprising. In the following chapter I show how anthropologists—in spite of their sensitivity to dynamics of power—have played a key role in the continued marginalization of indigenous Guyanese through bank health projects.

CHAPTER 5

BIOLOGIZING CULTURE, RACIALIZING INDIGENEITY: ANTHROPOLOGICAL AND LEGAL EXPERTISE IN GUYANA'S BASIC NUTRITION PROGRAM

In the previous chapter I argued that, amidst tensions surrounding the authority of economic calculations and government priorities, IDB's Neglected Tropical Disease program has constructed its "Mass Drug Administration" as an act of national unity, bringing together all Guyanese to care for themselves and their fellow citizens by eliminating parasite reservoirs hidden within and among them. I argued that the incumbent People's Progressive Party mobilized the project in direct opposition to claims that their party had cared only for Indo-Guyanese; the project instead promoted a form of patronage politics offering benefits to the entire population across racial groups. The NTD project operates at the national level, but it is focused on the capital and coastal regions, as project planners have argued that filariasis is not a problem in Guyana's "interior." However, over half of the health loans provided to Guyana by the World Bank and the Inter-American Development Bank in the last ten years have focused specifically on "Amerindian health" in the Southern and central regions of the country that coastlanders call "the hinterland." In this chapter I examine the knowledges and values underlying this focus on the health of indigenous Guyanese. Does such attention simply reflect high rates of poverty and health problems among indigenous Guyanese? Is it an enactment of a new development focus on indigeneity (Hodgson, 2001; Shah, 2007)? Or an example of internal colonialism (Moore, 1970;

Stone, 1979; Gutierrez, 2004)? And how has such disproportionate focus on indigenous Guyanese affected relationships of power in Guyana?

Building on the work of Michel Foucault, STS scholars have emphasized the role of scientific analyses and public health interventions in constructing populations, which are essential tools of governance. Jenny Reardon (2004), for example, has emphasized how racialized populations and forms of governance have been coproduced through the Human Genome Diversity Project. But while biologists have often argued that racial categorizations simply read social divides onto biology, such racial categories continue to play a central role in medical and public health research and practice. In this chapter I examine how development bank nutrition projects in Guyana have constructed indigenous health and nutrition as a problem: I investigate the dynamics that shaped this problematization (Foucault, 1997; Lakoff, 2008; Hodžić, 2016), and the ways these constructions in turn shape racial dynamics in Guyana. I argue that this focus on indigenous health is rooted in the interaction of two legitimacy problems across development bank networks: the first surrounding social justice and focused on bank headquarters, and the second rooted in the expertise of Guyanese electoral politics. I highlight the ways in which anthropological and legal knowledge, and also expertise in the racial codes of the Guyanese state, get mobilized in addressing divergent legitimacy problems, and I emphasize the role of these knowledges in the ongoing biological racialization and marginalization of indigenous peoples.

This analysis speaks to the work of STS scholars and political theorists such as Shobita Parthasarathy (2017) and Jacqueline Best (2014), who have emphasized how

international institutions respond to challenges to their legitimacy through efforts to reformulate their knowledge practices. Here I turn to the work of both historians of science and critical race theorists to conceptualize the ways in which various forms of expertise have been mobilized in addressing legitimacy problems through indigenous health programs. Critical race theorists such as Dolores Delgado Bernal (2002) have argued that knowledge and experience of dynamics of race in various contexts operate are forms of expertise that are often unrecognized. I build on this work to emphasize the importance of reading the *expertise* involved in the deployment of state racial politics alongside the *values* inherent in the mobilization of more codified forms of expertise such as anthropology and law. To investigate the later, I turn to the work of historians of science such as George Stocking (1968; 1987), Thomas Trautmann (1997), and Helen Tilley (2007), who have emphasized the essential role that physical, linguistic and cultural anthropology have played in creating racial categorizations in many parts of the world since anthropology's earliest developments in the mid-nineteenth century. The histories of anthropometry (Bates, 1997), and the treatment of culture as a biological phenomenon (Kevles, 1985), are front and center in the Basic Nutrition Program that I analyze in this chapter. In examining the mutual mobilization of anthropological and legal knowledge, this chapter speaks as well to the work of anthropologists and legal scholars Annelise Riles (2001; 2006) and Sally Engle Merry (2003) on the interfaces between law and anthropology.

In this chapter I examine the knowledges at play in the problematization of indigenous health in Guyana. In the first sections of the chapter I demonstrate how expertise in Guyanese electoral politics became influential in IDB health project

planning, moving IDB's Basic Nutrition Program away from initial analyses that emphasized high malnutrition among the incumbent government's main voting bloc. I show too how indigenous history has been a key tool of legitimacy in Guyanese electoral politics. I then show how international challenges to development banks' treatment of indigenous peoples have led IDB and the World Bank to seek anthropological and legal knowledge on indigenous peoples. In the final section of the chapter I demonstrate how these forms of expertise operating across the banks' networks have aligned in promoting a focus on Amerindian nutrition, and in constructing indigenous Guyanese culture as a biological risk.

Selective Racialization and Guyana's Basic Nutrition Program

In late 2002, the Government of Guyana signed a five-million-dollar loan agreement with the Inter-American Development Bank in support of a large-scale national nutrition program. The Basic Nutrition Program (BNP), as the project was known, aimed to provide the central elements of a nation-wide nutrition program focused on women and children. Its planners argued that malnutrition was especially damaging for these groups, leading to life-long effects on children's immunity and health, as well as a heightened risk of maternal hemorrhage—the leading cause of maternal death globally (IDB, 2002: 2).[36]

The program aimed to address malnutrition in Guyana through national educational campaigns, paired with the distribution of food and micronutrient supplements, and the implementation of national data systems for nutrition and growth

[36] Throughout the project, women and children were offered as a pair, with women taken as key caretakers and the categories of "women" and "pregnant women" often freely interchanged.

surveillance. While both the World Bank and IDB had been involved in nutrition efforts in Guyana since the early 1990s, project planners emphasized that the BNP was the first stand-alone nutrition project financed by either bank in Guyana. Previous projects had created structures to distribute food supplements along with other social services, and had not been integrated into the Ministry of Health. The BNP, however, emphasized the importance of treating nutrition as a public health issue and integrating nutrition programs with primary healthcare and health education (IDB, 2002: 8). The program's original loan proposal attributed past project failures to a lack of such integration, and emphasized that nutrition is an essential driver of health, "associated with up to 56% of all childhood mortality" (IDB, 2002: 2).

The production of such loan proposals is an essential element of the work of project design: in this process the framework of project goals and methods emerges, and in these documents the project's explicit and implicit logics become evident. The BNP loan proposal was prepared by a project team of four economists and one legal specialist – one from the Guyana country office and the rest based in Washington, D.C. Although all of the economists were "social sector specialists" who had worked in various areas of food policy and welfare programs, only one was a health economist by training. For specific area expertise in nutrition, the team enrolled several nutritionists as consultants during project design, and based the loan proposal closely on the consultants' reports. Their final report followed the standard structure of IDB loan proposals, opening with a discussion of Guyana's "macroeconomic context." The team's economists argued that liberalization and privatization had bolstered the country's economy in the 1990s, but they suggested that "development has been

recently held back by external shocks and political problems," including "a 66% government sector salary increase triggered by a major public service strike" (IDB, 2002: 1). Here project planners' visions of social justice begin to reveal themselves: living wages for government workers are framed as an impediment to economic growth, rather than an essential aspect of social solidarity. But even as project planners dismissed the needs of government workers, they demonstrated acute attention to a different set of justice issues that had become popular in development circles: the distribution of the benefits of national economic growth. Project planners stressed that marginalized peoples are often excluded from the gains of national economic expansion, and that special attention to "vulnerable populations" is thus necessary.

In addition to this "macroeconomic context," the loan proposal presented an analysis of "national nutritional context." Amongst the principle factors shaping nutrition, the project team first emphasized the importance of ethnicity, which they argued was one of the most central factors impacting nutrition in Guyana. The proposal argues:

> Ethnicity appears to be a decisive factor; overall malnutrition is greatest among the Indo-Guyanese and least among the Amerindian populations, attributable to the duration of exclusive breastfeeding and infant feeding practices (IDB, 2002: 3).

Drawing attention to ethnicity as a "decisive factor" in nutrition, the proposal highlighted nutritional problems especially among Indo-Guyanese; the authors contrasted this with the nutritional status of indigenous Guyanese, whose levels of overall malnutrition were the lowest in the country.

But in spite of this initial framing, the project did not ultimately focus on Indo-Guyanese during its implementation. Instead the project's implementers chose to study

and target Amerindians, the group with supposedly the lowest rates of overall malnutrition in the country. From the original 2002 Basic Nutrition Program loan, over the next eight years, project implementers came to worry about the ways that "Amerindian culture" was being translated—through nutritional practices—into bodily difference, including "poor mental development" among indigenous Guyanese (e.g. IDB, 2008). To understand this transformation and its selective racialization, I start by examining how the loan proposal's initial framing of Indo-Guyanese nutrition arose.

Project Planning and Indo-Guyanese Ethnicity

In its original loan proposal, the Basic Nutrition Program drew attention to nutritional problems among the country's Indo-Guyanese majority: a framing drawn directly from a consultant report produced during project planning. One year prior to completion of the BNP loan proposal, in 2001, IDB had hired a consultant to begin conceptualizing the central elements of a large-scale nutrition program that was to become the Basic Nutrition Program. IDB's Social Protection Division had hired Dr. Emilio Alcaide, a Chilean nutritionist, to review the extant data and identify the key nutritional issues in Guyana. After a review of data quality from several World Bank, WHO and UNICEF studies, Dr. Alcaide concluded that "the prevalence of malnutrition in Guyana presents a *clearly atypical distribution*, which is different than that observed in the immense majority of countries" (emphasis in original; IDB, 2001: 6). He stressed that in Guyana the rate of acute malnutrition was extremely high in relation to chronic malnutrition, and he suggested that the country's unique ethnic composition might explain this.

In his analysis, the Dr. Alcaide made use of three measures of malnutrition: weight for age, weight for height, and height for age. He explained that these were the most up to date international standards, as opposed to the fragmented systems used in the Caribbean up through the 1980s – including Boston and Iowa tables from the US, England's Tanner system, and the Sempé system from France. While weight for age reflects broad trends in malnutrition, he noted, low weight for height reflects acute nutritional shocks. A child may have had excellent long-term nutrition and good growth, but short-term lack of nourishment can lead to a low weight in relation to the child's height. Height for age, alternatively, can reveal chronic malnutrition, where long-term lack of nutrition leads to what nutritionists call "stunting" – when a child does not grow to heights deemed normal for their age. To evaluate "normal" growth, nutritionists typically measure height against international standards, as I discuss further below.

Based on his revisions of the World Bank, WHO and UNICEF data, Dr. Alcaide compared Guyana's rates of malnutrition first to selected countries in central and South America, then to Caribbean countries, and finally to selected countries in Asia and Africa, each time focusing on countries with gross national product similar to that of Guyana. Dr. Alcaide stressed that in all these comparative cases, the rate of chronic malnutrition has been much higher than acute malnutrition, always at least two-fold, but in many of cases chronic malnutrition outweighed acute malnutrition by five or ten times. Most of the South American comparators had numbers similar to Ecuador, where acute malnutrition was measured at 2.3% of the population and chronic malnutrition at 26.7%. According to all three of the studies conducted in

Guyana over the previous ten years, the country's rates of both chronic and acute malnutrition hovered around 11%. In countries with levels of acute malnutrition similar to this, such as Indonesia or Kenya, the levels of chronic malnutrition have been much higher – 42.2% in Indonesia and 33.6% in Kenya, the consultant report stressed (IDB, 2001: 6).

Dr. Alcaide recognized that errors in measurement or analysis could explain Guyana's unique situation, but he suggested it was unlikely that three studies would come up with such similar numbers erroneously. Instead, he emphasized the importance of ethnicity, which he argued was the strongest variable explaining malnutrition rates in Guyana. He noted that on all measures, Amerindian populations had the lowest rates of malnutrition. In addition to ethnicity, Dr. Alcaide analyzed the effects of sex, age, and geography – including costal/interior and rural/urban divides. Out of all of these demographic factors, and across all malnutrition measures, the strongest effect ($p<0.02$) was in ethnicity, where Indo-Guyanese had almost five times the rates of overall malnutrition compared to Amerindian populations (IDB, 2001: 11).

In his preparatory report for the IDB, Dr. Alcaide made use of ethnic categorizations from a 1994 World Bank report on nutrition and poverty in Guyana. These categories included: Indo-Guyanese, Afro-Guyanese, Amerindian, Mixed, and Other (World Bank, 1994b). However, Dr. Alcaide also used the raw data set that had informed the 1994 World Bank report. That data set was drawn from the 1993 Household Income and Expenditure Survey and Living Standards and Measurement Survey conducted by the World Bank, in conjunction with Guyana's Statistical Bureau and the United Nations Development Program. The original 1993 survey reported data

according to slightly different categories – termed "race" (as opposed to "ethnicity") and divided among: East Indian, Negro/Black, Chinese, Portuguese, Amerindian, Mixed, Other (HIES, 1992). This classification is much closer to the popular racial categorizations underlying common reference to Guyana as the "Land of Six Peoples" (see Chapter 1), although it omitted the distinction between "Portuguese" and "European" rooted in divides between Portuguese indentured servants and European colonists.

However, Dr. Alcaide presented his report in Spanish, and translated "Indo-Guyanese" from the 1994 World Bank report to "Hindu" in his own 2001 report. Indo-Guyanese are most certainly not universally Hindu, even by family tradition. Almost a fifth of the Indo-Guyanese population identify as Muslim, in addition to substantial numbers who are Christian or do not identify with any sect (Guyana Bureau of Statistics, 2016). The 1993 survey from which Dr. Alcaide drew his nutritional data *did include* data on religion, in addition to race/ethnicity. But Dr. Alcaide did not choose to analyze the nutritional data according to religion. Here and at many other points in the project, it was not religious difference, so much as ethnic difference that was deemed relevant: first by World Bank staff reporting on the 1993 study (World Bank, 1994), later by Dr. Alcaide (the IDB project design consultant), and consistently throughout the project's implementation. In spite of data on religion being provided alongside the source of his data on nutrition and race, Dr. Alcaide chose not to include religion in his analysis of demographic factors. This is surprising, as religious practices can affect people's decisions regarding nutrition, for example through fasting practices and food norms.

The IDB loan proposal completed the following year replaced the term "Hindu" with "Indo-Guyanese," but the proposal did retain Dr. Alcaide's emphasis on ethnicity as a "decisive factor" to be taken into account in project planning. Dr. Alcaide's framing of ethnic stratification in malnutrition, with Amerindians consistently having the lowest rates of malnutrition, is reflected directly in the loan proposal, as are several sentences taken directly from the consultant report, although it is not standard practice to cite such reports when using their language in loan documents. But Dr. Alcaide's inattention to the ways that ethnic categories obfuscate patterns that are likely to affect nutrition (e.g. through religious practices), and his reference to Indo-Guyanese as Hindu, both reflect a limited familiarity with social relations in Guyana on the part of the IDB consultant. This lack of expertise is not consistent across IDB consultants: in the following section I demonstrate how other IDB consultants mobilized expertise in Guyanese social structures and state racial norms to reformulate the project away from its initial framings.

Contextual Expertise and Justice

As the Basic Nutrition Program loan agreement was nearing closing in 2002, IDB contracted another consultant to prepare the implementation of the project. Like Dr. Alcaide, this consultant was also a nutritionist by training, but she had deep and long-term connections and expertise in Guyana. Dr. Irfan ran a consulting firm based in the country, and she had lived in Guyana on and off since the 1970s, although she was born in the UK. During this period she had developed nuanced expertise in

Guyanese electoral politics, working closely with Rupert Roopnaraine throughout his political career, from Working People's Alliance activist to long-term parliamentarian.

While Dr. Alcaide, the Chilean consultant, had emphasized Indo-Guyanese nutrition as a problem area, Dr. Irfan saw Indo-Guyanese ethnicity as simply "too politically charged" to focus on in the Basic Nutrition Program (SI Interview, 2013). She remembers emphasizing this to the team at IDB headquarters after she reviewed Dr. Alcaide's report and the loan proposal. By 2002 the People's Progressive Party had held control of the government for ten years, and had regularly been accused of funneling development aid to its Indo-Guyanese base. The Guyanese government wouldn't be open to orienting a health program around ethnicity so explicitly, Dr. Irfan argued, since it would play into existing challenges to the government's legitimate representation of the entire Guyanese nation. Nor should IDB put itself in the position of promoting racial division, she suggested.

Dr. Irfan didn't see this concern for popular politics as something to tiptoe around: it was one of the first things she shared with me when we first spoke in the fall of 2013, as my research on the BNP was just beginning. At that time she was briefly away from Guyana consulting for a nutrition program in Zambia; she spoke to me from a sparse living room of a second residence she was maintaining for her ongoing work there. All three members of her British-Guyanese nuclear family work in international development, moving regularly across the former British empire, but also throughout Latin America, Eastern Europe, and Central Asia. And while Guyana has been Dr. Irfan's most central home for quite some time, she has often established such second residences for long-term consulting in other sites; her work regularly takes her

around the globe. The BNP kept Dr. Irfan in Guyana regularly after many years primarily abroad: a large project in her exact area of expertise, in the country where she had raised her son.

As the BNP was beginning, and Dr. Irfan argued that racial politics in Guyana were far too sensitive to guide project planning, she argued instead that the Basic Nutrition Program should be targeted *geographically* by providing services to health centers in the districts deemed the poorest in a recent poverty survey (IDB, 2002b). During a mission of IDB team members to Guyana, Dr. Irfan noted that geographic targeting based on poverty maps would allow the BNP intervention to function as an income supplement for low-income families, and she stressed that this was a worthwhile goal to consider. She followed up on this point by email soon after, arguing that although this approach would lead to a greater number of program beneficiaries – and might thus be more difficult for the government to support long-term, this focus "causes least dissatisfaction/disruption within communities, since whole communities covered by a health center are included" (IDB, 2002b). That is, rather than risk controversy within neighborhoods regarding who has access to the program, it would be best to include more people in the program's coverage. Furthermore, geographic targeting would be administratively simple, avoiding the difficulties of screening for project beneficiaries: anyone receiving services at health centers in the poorest districts would be able to access the program. Although Dr. Irfan's plan for geographic targeting presented a substantial reformulation of the project, the rest of the project team accepted her proposal without discussion (IDB,

2002b), deferring to her combined expertise in Guyanese politics and international nutrition.

Dr. Irfan also expressed concern that the project planned to make use of imported pre-mixed foods to provide the key nutritional source for weaning infants. She proposed that the project instead make use of local goods and distribution systems, stressing that such an approach would allow the project's resources to benefit local food producers rather than international companies. Throughout the project, Dr. Irfan's progressive approaches have been consistently informed by leftist perspectives on both international and local power dynamics and justice. But in order to advocate for the use of local production to her colleagues at IDB, she did not use a language of justice. Instead, Dr. Irfan based her argumentation on administrative cost, logistical difficulties, and educational benefit. She argued that providing vouchers that could be exchanged in local shops for cereals and dried milk to make porridges would allow the project to avoid creating its own distribution systems, making it more administratively simple, and less expensive. Dr. Irfan stressed that using pre-mixed foods does not allow mothers to learn about providing appropriate nutrition for their children through food preparation, and she pointed to the success of voucher systems in the US, Jamaica and Sri Lanka. Furthermore, Dr. Irfan argued that the voucher system could be tied to required visits to health centers, which would promote broader use of health services. And while she argued for distributing food vouchers at post-natal counseling sessions, she did not root this approach in much-discussed data emerging at the time regarding conditional cash transfers like Mexico's Progresa program. Rather than framing the provision of food vouchers through market languages of "incentivization,"

she stressed wealth redistribution. But again, IDB staff accepted her local expertise, combined with her direct references to recent international conferences and expert panels she had participated in; the IDB staff who initially conceived of the project were willing to significantly reformulate the program to base it on a food voucher system rather than the distribution of imported pre-mixed infant formula.

Dr. Irfan's resort to languages of administrative efficiency does not mean that other project planners and implementers were not interested in justice: local food production, "empowerment," and a focus on vulnerable populations are all widely espoused values within IDB. However, Dr. Irfan's success in reformulating the project from food distribution to a voucher system, and in stressing that the project must avoid future references to the Indo-Guyanese population, does provide insights into the dynamics of expertise and evidence at play in planning the Basic Nutrition Program. Dr. Irfan was able to situate herself as an international nutrition expert who also mobilized personal expertise in the specifics of racial and electoral politics in Guyana. But while Dr. Irfan dismissed a focus on Indo-Guyanese ethnicity in the project, she often spoke of Amerindian ethnicity as a structuring factor in project planning. For example, in her note about vouchers, she stressed that the system could be extended to "Amerindian communities" with little adjustment (IDB, 2002c). Rather than continue her focus on geographic targeting by using regional classifications, she used an ethnic classification. The conflation of geography and ethnicity is foundational to race relations in Guyana (Jackson, 2013), and represents a central tension in the Basic Nutrition Program, as I discuss below. But first, in the following section I elaborate on the Guyanese electoral politics shaping Dr. Irfan's discussion of Amerindian

communities, examining the ways in which indigenous histories and communities have long been mobilized as a symbol of legitimacy in Guyanese governance.

Amerindian Ethnicity and Racial Codes of the Guyanese State

As Dr. Irfan suggested, Indo-Guyanese ethnicity holds a primary place in popular and scholarly representations of electoral politics in Guyana, which focus on ethnic divides between Indo- and Afro-Guyanese and very rarely make reference to indigenous Guyanese (Bartlett, 2005; Kean, 2006; Wilson, 2012; Bissessar and La Guerre, 2013). Shona Jackson has eloquently shown how in the post-independence period both Indo- and Afro-Guyanese have constructed "modern labor" of enslaved Africans and indentured East-Indians as the key to national belonging, from which indigenous Guyanese have been excluded (Jackson, 2013). But at the same time, Amerindian ethnicity has long been mobilized as a symbol of national unity in the face of racial divides, and to shore up the legitimacy of the Guyanese state against claims of racism, both by Indo- and Afro-Guyanese (Forte, 1996; Bulkan, 2013). Both of the major parties have mobilized language emphasizing that Amerindian heritage links modern Guyana to its pre-colonial roots, providing a way forward from plantation society and the ethnic divides that it generated. This framework of unity is a common tool in Guyanese electoral politics, promoting the idea of a legitimate government that represents the nation, rather than a single racial segment.

In 1970, as the largely Afro-Guyanese People's National Congress was being accused of discrimination against the Indo-Guyanese population, party officials announced that celebrations of Guyana's independence would now be celebrated

under the name "Mashramani," which is ostensibly an Amerindian term for festival, although it appears the term has had little meaning for any of Guyana's indigenous groups (Danns, 2014). In recent years, several newspaper editorials have made reference to the idea that the word "Mashramani" was a fabrication with little connection to indigenous history, but these accusations have not caused much of a stir, as they have not challenged the central dynamic mobilized by the naming of the festival: "Mashramani" was marshaled more as a symbol of the *idea* of Guyana's Amerindian roots uniting the new nation than to connect on a deep level with the experience of indigenous Guyanese (Taylor, 2015).

Guyana's independence celebrations under the name "Mashramani" were a key symbol of the new republic, as was the expansion of the British colonial Aerodrome into an airport that would represent the modern independent Guyanese nation.[37] At the opening of the new airport expansion in 1969, Prime Minister Forbes Burnham noted that the name that had been chosen, Timehri International Airport, was based on the Amerindian rock paintings in Guyana's interior, which he emphasized had been created long before British colonialism; this Amerindian heritage was essential to the idea that the country could be new and modern, but at the same time ancient and preceding European arrival in Guyana (Bulkan, 2013).[38] In addition to the Mashramani festivities and Timehri Airport, the PNC government continued to promote unity through Amerindian symbolism throughout the 1970s, for example through the construction of the Umana Yana unity building in the capital in 1972. But

[37] Large infrastructure projects have often been mobilized by post-colonial governments as signs of the modernity of the new state: see, for example, Prakash, 1999.
[38] Navigating this tension between the modern and the traditional has been a central dynamic for post-colonial states (Prakash, 1999; Anderson, 2002).

in the 1990s, as the People's Progressive Party government was being accused of discriminating against Afro-Guyanese, they too turned to indigenous histories to promote current unity and government legitimacy. In 1995, Cheddi Jagan officially established September as Amerindian Heritage Month. At the opening of the first Heritage Month celebration, Jagan emphasized that Amerindian history formed the basis of Guyana's contemporary diversity, the wealth of the united Guyanese nation which he had been charged with leading (Moreno, 2009).

These symbolic actions of naming festivals and celebrating indigenous history are key aspects of legitimacy in Guyanese electoral politics, a means by which each party emphasizes their ability to represent a unified nation beyond their racialized voting bloc. But even as they mobilize such indigenous symbols, Guyana's main political parties have consistently worked to undermine the emergence of indigenous Guyanese as political actors. For example, Janette Bulkan has demonstrated that legislation denying government funding to third parties was specifically aimed at undermining indigenous political agency (Bulkan, 2014). Since 1992, the People's Progressive Party government has created a series of spaces for indigenous engagement which have consistently channeled participation along the priorities and policy lines of the government, while at the same time denying these bodies any substantive power in Guyanese electoral politics (Bulkan, 2013). Both the PPP and the PNC have preferred to maintain indigenous Guyanese as symbols of unity, rather than political actors in their own right.

Along with this symbolism, development projects focused on "Amerindian communities" have framed indigenous Guyanese as atavistic and impoverished (see

discussion of BNP below), emphasizing to coastlanders that they are much better off and more developed than their Amerindian brethren. These programs project the beneficence of the governing party, while also seeking votes from indigenous Guyanese in exchange for program resources. Over the last decade, as indigenous Guyanese have come to represent increasing percentages of the population (see chapter 1), the Guyanese government has also devoted more international development funding and financing for projects in this growing voting bloc (Bulkan, 2013). But these electoral politics do not alone explain the focus on Amerindian nutrition within IDB's Basic Nutrition Program. In the following section I demonstrate the key role of IDB indigenous specialists that have played on the racial politics I have been describing, and I show that popular challenges to the legitimacy of development banks have been essential in bringing such specialists in law and cultural anthropology to the institution.

Justice Challenges, Indigenous Specialists, and Banks' "Social Knowledge"

Kathryn Bowdin was an IDB social development specialist who was assigned to the Basic Nutrition Program team in 2002, brought on to the project as a generalist in "social issues." The BNP was coordinated through IDB's Division of Social Protection and drew on their body of social development specialists, who worked on projects across the health and education sectors. Although Kathryn was working on the BNP as a generalist, she had been hired at IDB earlier that year specifically for her *Canadian expertise* on indigenous peoples. She was a lawyer from a First Nation in Canada, who had studied and published on aboriginal law, and had been running an

indigenous peoples' organization for several years. Although IDB's Basic Nutrition Program initially framed indigenous Guyanese as having the lowest rates of both chronic and overall malnutrition, Bowdin pushed for specific attention to Amerindians in the project. She was able to mobilize her own expertise and that of a cultural anthropologist she brought on as a consultant in arguing for specific studies and interventions focusing indigenous Guyanese. That focus fit smoothly into the racial codes of the Guyanese state, which have turned to Amerindians as objects of development, but not as political actors.

But why was IDB seeking to hire a Canadian expert on indigenous peoples in 2002? By the early 2000s, both IDB and World Bank had been subject to major international activism regarding the negative impacts their development projects were having on indigenous peoples through deforestation of indigenous lands and through forced relocation (Fox and Brown, 1998; Sarfaty, 2004; Rich, 2013; Goldman, 2005). Making use of social and environmental surveys conducted by development agencies, as well as independent anthropological studies, activists stressed that the banks' infrastructure projects for dam and highway construction had led to the displacement of over a million people between the 1950s and early 1980s, and that these projects had led to large-scale destruction of wetland, riverine and forest habitats and associated flora and fauna (Scudder, 1989; World Commission on Dams, 2000).

While critiques of development bank projects and their impacts began largely with international environmentalist NGOs and organizations of indigenous peoples in Latin America, by the early 1980s such critiques were being launched by mainstream political actors within the US government, especially within the US Congress. In a

much-publicized Congressional hearing in June of 1983, anthropologist David Price testified that the World Bank had "watered down" his negative assessment of the impacts that a proposed highway project in Brazil was likely to have on indigenous communities—with horrific consequences, Price argued. A Congressional inquiry was launched in response to Price's testimony, which appeared to further jeopardize US appropriations for development banks, which that had been increasingly contested within Congress since the late 1970s (Charnley and Durham, 2010). The inquiry led the US Congress to adopt several sets of recommendations for multilateral development banks to improve their handling of environmental and indigenous rights issues, including a 1985 report making US contributions to the banks dependent on improved management in these areas (Keck and Sikkink, 1998).

In response to such large-scale challenges, both the World Bank and IDB sought solutions to improve their image and legitimacy as essential arbiters of international development. One such response was enrolling cultural anthropologists and sociologists to help improve the design of development banks' projects. In 1972 the World Bank had commissioned two external consultants to study whether and how anthropology could contribute to the organization's work (Cernea, 1996). Although the World Bank did not implement the consultants' recommendation that the institution make extensive use of anthropological and sociological expertise in the design of its projects, the World Bank did create the position for a staff sociologist, and it hired its first employee under this title in 1974—the Romanian rural sociologist Michael Cernea. Over the next several decades Cernea played a major role in expanding credibility within development banks for what he referred to as "social

knowledge"—a phrase he has often used in World Bank publications to describe the expertise of both sociologists and anthropologists (Cernea, 1984; Cernea and Freidenberg, 2007). Drawing on emerging academic debates, Cernea argued in World Bank meetings and internal publications that development banks needed to pay more attention to "local social organization" when they designed projects; Cernea argued that this would require the expertise of sociologists and anthropologists to be valued as much as that of economists (Cernea, 1996). Although World Bank management dismissed such a vast role for qualitative knowledge as far from realistic, the institution's growing focus on "poverty alleviation" yielded some space for applying "social knowledge," as bank projects increasingly needed people who could identify and help target marginalized groups within borrowing countries (Cernea, 1982).

Projects involving "involuntary displacement and resettlement" of indigenous peoples were one of the first areas where development banks sought anthropological expertise, both through the use of external consultants and by hiring anthropologists to work internally. In the late 1970s, the small group of anthropologists who had been hired full-time at the World Bank began to push the institution to adopt an official policy on resettlement; they put together extensive background papers and proposals, advocated with colleagues, and lobbied the Executive Board in a concerted effort for almost two years until an operational policy was adopted in 1980. That policy required any project displacing people from their homes and territories to make arrangements for "resettlement" (World Bank, 1982). The World Bank's in-house anthropologists also pushed for a specific policy on indigenous peoples; in 1982 the World Bank adopted an operational policy requiring that any project on indigenous lands provide

safeguards to mitigate negative effects on "tribal peoples" (World Bank, 1982b), but this policy has been heavily criticized by activists and scholars as highly integrationist—pushing indigenous people to integrate more fully into mainstream capitalist social structures.

In promoting policies on resettlement and indigenous peoples, anthropologists contributed to institutionalizing their expertise within development banks. With the creation of "social safeguards," as these policies were called, the need for anthropological expertise in project appraisal was inscribed in World Bank policy. In order to guarantee that "tribal peoples" were not being harmed, projects now needed to conduct assessments of initial social conditions and the likely effects of proposed projects.

In the 1980s, the World Bank also confronted a series of legal issues in implementing its new "tribal peoples policy," especially issues relating to traditional land title and community property in projects involving the resettlement of indigenous peoples (Macedo, 1990; Shihata 1993). In addition to anthropological and sociological expertise, the codification of indigenous peoples policies also led the World Bank to enroll legal expertise on indigenous issues, both through training of existing legal staff and hiring of staff with legal expertise on indigenous issues (Escuerdo, 1988). In the early 1990s, the World Bank's Legal Department became increasingly involved with indigenous issues and using legal solutions to address "problem projects," as bank staff termed infrastructure projects that were generating widespread activism like the Polonoroeste Project in Brazil and the Sardar Sarovar Project in India (Davis, 1993). Subsequent operational directives made the need for legal expertise regarding

indigenous peoples into institutional policy. The World Bank's 1991 operational directive on indigenous peoples, for example, required that projects affecting indigenous groups conduct an assessment of the legal status of indigenous groups in the borrowing country, as well as an analysis of land rights and legal recourse of indigenous peoples in defending their rights to natural resources (World Bank, 1991b). As opposed to policies for economic analysis (see Chapter 4), activists and scholars have closely observed the World Bank's implementation of these policies requiring anthropological and legal analyses regarding indigenous peoples, and development banks have closely followed their own policies.

But while the World Bank codified policies regarding indigenous peoples in the 1980s and 1990s, IDB didn't adopt an official policy on indigenous peoples until 2006. As it was developing that policy, IDB looked specifically to Canada's experience with First Nations as an example, in spite of broad critiques regarding Canada's own marginalization of indigenous peoples (Tang and Brown, 2008; Regan, 2010; Neu and Therrien, 2003). But IDB's recourse to Canadian expertise was supported in part through a trust fund established with the Canadian government. In 2002 IDB put out a call for a Canadian expert on indigenous peoples, and eventually hired Kathryn Bowdin. Although Bowdin was involved in Guyana's Basic Nutrition Program as a generalist, she played a key role in establishing the project's focus on indigenous peoples. In project team meetings, she advocated for conducting research into how the project was affecting indigenous communities, which were eventually carried out by a Guyanese cultural anthropologist working in Dr. Ismail's consulting firm, with funding from the BNP. As Bowdin met with staff in Guyana's Ministry of

Health and at the IDB country office during site visits, she stressed the importance of having specific procedures in place for nutrition in indigenous communities; with the research that the BNP funded, these discussions eventually led to two subsequent World Bank loans for indigenous nutrition and an expanded focus on indigenous communities in the 2010 BNP expansion. Bowdin's own background in indigenous studies fit well with racial codes in Guyana, and with two sets of legitimacy politics across the banks' networks: the challenges regarding indigenous rights at bank headquarters, and those regarding representation by the Guyanese state.

Challenges to the legitimacy of development banks have led them to hire specialists in indigenous studies such as Kathryn Bowdin, who have in turn pushed for a focus on indigenous issues in a wide range of projects, such as Guyana's Basic Nutrition Program. A small percentage of IDB's nutrition loans have developed such a focus, but many World Bank nutrition loans in Latin American and the Caribbean in recent years have focused specifically on indigenous peoples (Marini and Arias, 2016; World Bank, 2013). Attention to indigenous health and nutrition has arisen in Guyana in the interaction amongst these legitimacy politics, across the growing role of indigenous specialists at bank headquarters and the importance of expertise in Guyanese politics for project planning. But this construction of indigenous health as a problem has in the process constructed damaging representations of indigenous Guyanese as bound by traditional cultures and suffering from racially-based biological problems, as I discuss below.

Biologizing Social Life

Lethem is a town of just over a thousand people, but it is the capital of the Upper Takutu-Upper Essequibo region of Guyana, and a hub connecting Guyana's southern regions with the capital city both by overland and air routes. These connections played a central role in making Lethem's regional hospital one of the first "Amerindian Centres" to be included in the Basic Nutrition Program; while nurses would have to make the long trek to the capital by minibus for trainings and other meetings, researchers would be able to travel by air from the capital city to Lethem from time to time to study the project's implementation.

Lethem's hospital resembles the lower level health centers through which the BNP operated in the coastal regions: a small, yellow cement building where staff offers mostly preventative care. Although it has a theater for surgery, the hospital has few rotating physicians and surgeries most often have to be referred to the capital. As a part of its primary care efforts, prenatal counseling had been a focus of the hospital's services for some time, but the BNP brought new emphasis to maternal and child nutrition here. A large, glossy banner hung outside of the hospital advertising free food coupons for young children if mothers registered for the BNP, and women often came into the hospital inquiring about how to be involved. In the hospital waiting room, four short films produced by the BNP showed on a new color TV procured through the program. The TV set had been delivered with much fanfare: a representative of the People's Progressive Party government offered it to the hospital's director in a ceremony covered at length by local news and on the BNP's social media accounts.

By the fall of 2013, only one nurse from the Lethem hospital had attended the Basic Nutrition Program training in Georgetown; she held BNP pre-natal clinics on Tuesday mornings and infant nutrition clinics in the afternoons. She offered extensive prenatal care for women in the program, providing prenatal vitamin packs as well as in-depth counseling on personal nutrition, anemia, and preparation for breastfeeding. For caretakers of children between six and twenty-four months, Nurse Patterson provided training in weaning and complementary foods, again with a focus on anemia. In the early years of the program, she'd provided food coupons to these caretakers as well; now she had to repeatedly tell people that the food coupons aspect of the program had been discontinued, offering them instead micronutrient packets for young children. But she was sure to tell her patients that the project had been awarded a prize by the U.S. Treasury because of how much these micronutrients helped improve child health in Guyana.

By 2013, the Basic Nutrition Program had transformed substantially from its beginnings six years prior, both in its methods and its focus. In the initial phases of Guyana's Basic Nutrition Program, planners and implementers often spoke of geographical factors that affect nutrition. In presentations for planning meetings and in the projects' original planning documents, project staff emphasized that poor road access makes it difficult to transport fruits and vegetables to the country's Southern regions from the coastal areas where they are farmed, thus presenting nutritional challenges in Guyana's interior regions from the lack of fresh foods. But throughout the project, implementers increasingly linked geography with Amerindian ethnicity, stressing the predominance of Amerindians in the "hinterland." By the end of the

project, implementers had begun to speak of the nutritional effects of Amerindian ethnicity beyond geography.

For example, a project report submitted by the project's chief nutritional consultant to IDB in fall 2008 compares several health indicators amongst Amerindian and non-Amerindian children living in the same communities in the interior. By comparing across groups within the same location, the report attempts to isolate the effects of ethnicity. Based on this analysis, the nutritionist drew attention to substantially higher levels of stunting (low height for age) among Amerindian children as compared to non-Amerindian children in the same communities. She provided the following table to support her comparison of Amerindian children against "other children", citing 30.9 percent of Amerindian children as severely stunted against 12.1 percent of "other children" in the same communities.

Table 3 Severe stunting and ethnicity in Amerindian communities

	Percent of samples severely stunted	
	Amerindian children	Other children (*)
Baseline sample	29.6	9.6
Final sample	31.8	15.2
Total	30.9	12.1

(*) Includes mostly children of mixed ethnicity (see Table 1), all living in Amerindian communities.

While highlighting high rates of stunting among indigenous Guyanese, the report stresses that the "consequences of stunting include poor mental development and poor school achievement" (Ismail, 2008: 11). This "poor mental development" became a

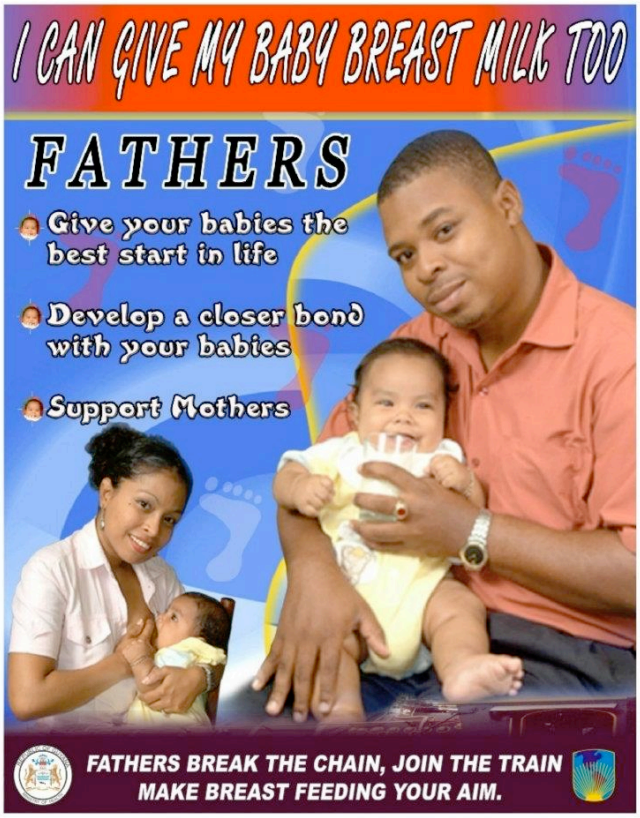
central theme in the project, a key message for nutrition counseling and a key indicator used to measure the success of the project's communication efforts. Progress reports from the project consistently offer data on the percentage of mothers that understand poor mental development as a consequence of malnutrition, and how that has improved (or often not) through the program.

The 2008 project report attributes stunting to "Amerindian cultural norms" which supposedly lead women to breastfeed for longer than the WHO-recommended six-month period, and introduce solid foods later than international standards. The report notes that there had not been an improvement in stunting in spite of the program's nutrition counseling, food coupons and micronutrient supplement interventions. The report's author attributes the lack of improvement in indigenous nutrition to both cultural and economic factors. She argues:

> Behaviour change and the translation of knowledge into good practice is challenging, especially when both culture and economic or physical access to the full range of nutritious foods are constraining factors, as they are in Amerindian communities (Ismail, 2008: 4).

The report places Amerindian *culture* on the same plane as "economic and physical access" to nutritious foods in "constraining" Amerindian nutrition. In doing so, the report, and project interventions focusing on Amerindian culture, undermine the gravity of economic exploitation in shaping opportunity in Guyana. And beyond the homogenizing representation of a singular Amerindian culture, the focus on culture represents indigenous ways of life as malignant. Women are represented as the guardians of this culture, passing knowledge about breastfeeding between generations in female spaces of the home. Another BNP study by a Guyanese cultural

anthropologist argued, for example, with regards to breastfeeding guidelines, "key informants pointed particularly to the negative influence of other household members, especially senior women" (Ismail and Roopnaraine, 2008: 45). This contrasts with the focus on the role of fathers in breastfeeding promoted in the project's publicity materials and campaigns in the capital region, like the poster included here. While most BNP trainings for nurses and counseling sessions for project participants emphasized the role of mothers as the essential guardians of child nutrition, this poster promoted the possible role of fathers even in providing breastmilk. But this message didn't much transfer to project sites in the interior, where trainings were much more focused on communication among women.



This focus on culture as an explanatory factor diverges markedly from the project's efforts to avoid representations of race-based *genetic* difference. In the decades after World War II, biologists worldwide denounced such biological concepts of race, arguing that these interpretations not only opened space for biological discrimination, but imposed social categories onto biology (Stepan, 1985). In avoiding such constructions, several BNP reports emphasize that the problem with stunting is

not genetics. Dr. Irfan's 2008 report argued, for example: "what is important with stunting is not the fact of being short, but rather the failure to achieve one's full growth potential, and why this failure has occurred" (Ismail, 2008: 12). Dr. Irfan stressed that the problem is not genetics, but environmental factors that inhibit growth: "the fact of being short" is not a problem if that is your genetic "growth potential." Dr. Irfan calculated stunting rates by comparing children's heights against "international reference standards obtained from healthy well-nourished populations" (Ismail, 2008: 11), in this case WHO's 2006 reference standards. These standards were developed based on a sample of approximately 900 children living in circumstances with "no environmental restrictions on growth", drawn from Brazil, Norway, the United States, Ghana, India and Oman (Ziegler and Nelson, 2012: 301). The IDB report stresses that such height comparisons can be made across countries because of the effects of nutrition beyond genetics. It notes that "ethnic groups, such as Indian, Chinese and Japanese, traditionally considered to be of short stature, are now achieving heights comparable to those found in European and North American populations," especially when they "migrate to the States or Europe" (Ismail, 2008: 11). Here the report argues that environmental factors are more significant than genetic ones in shaping height and stunting.

But while the report avoids a genetic view of racial difference, the project adopted a cultural view of racially-based bodily difference, offering "Amerindian culture" as the cause of racial differences in height for age. Those same cultural factors were then also held responsible for "poor mental development," and "Amerindian culture" came to be a risk factor imperiling the possibilities for health.

But the report makes no reference to the BNP's original framing of Amerindians as having the lowest levels of malnutrition in the country, or the five studies used to generate that analysis. Nor did it reference the findings of the consultancy report produced the year before by the Guyanese cultural anthropologist, which stressed that Amerindian culture had positive impacts on nutrition, as there weren't taboos or fasting practices that would negatively impact child nutrition (Ismail and Roopnaraine, 2007).

Although some BNP reports recognize the many different cultures among indigenous Guyanese, both in the capital region and throughout the rest of the country, project planners and implementers most often referenced "Amerindian culture" as a monolithic impediment to health. This was the case at a BNP training for nurses held at the Regency Suites in the capital in the fall of 2013. Nurses had been bused in from across the country, including a fifteen-hour minibus ride for several nurses from the Southernmost regions. At the training, there was a special afternoon session devoted to "The BNP in Amerindian Centres." An instructor from the nursing school argued that "Amerindians have a very strong culture" and that it was important for nurses working in "the hinterland" to understand why Amerindian breastfeeding practices were a problem. Whereas many Guyanese don't breastfeed for long enough, she suggested, in Amerindian communities the problem was the opposite: breastfeeding alone beyond six months after a baby's birth would not meet a child's nutritional needs; it was essential to introduce complementary foods.

While indigenous activists in Guyana have often pointed out the very different ways of life amongst indigenous Guyanese, for example among Warau living in

Guyana's Northwest and Macushi living in the country's South, the idea of a singular "Amerindian culture" has become so normalized in Guyanese development discourses that this framing didn't seem surprising even to Lea, a Macushi nurse attending the 2013 training. Lea and several other indigenous nurses were in the difficult position of representing the "modernity" of health programs planned in the country's capital against Guyana's "problematic Amerindian culture," and finding a space for themselves between.[39] In the year leading up to the 2015 general election, the BNP's emphasis on its offerings of modernity felt especially acute, as project administrators drew attention to the technology the project was bringing to rural communities, posting photos on social media of government representatives offering laptops to indigenous leaders in front of BNP banners. However, indigenous nurses were among the strongest proponents of special attention to Amerindian communities, which brought resources to their clinics even as they furthered images of "backwards" indigenous practices.

The framework of a malignant Amerindian culture has formed the basis of several subsequent IDB and World Bank loans, which advance representations of "Amerindian culture" as presenting a biological risk to intelligence and health. Even as a focus on indigenous Guyanese could be a progressive act of social justice through attention to the unique histories of Amerindian oppression, these projects instead construct indigenous Guyanese as unmodern, they build a biological basis for discrimination, and they rob indigenous Guyanese of personal agency. And while indigenous Guyanese have not publically countered the Basic Nutrition Program's

[39] Saida Hodzic has analyzed a similar dynamic at play in campaigns against female genital cutting in Ghana (Hodzic, 2016).

representations, the maintenance of forms of life – to the frustration of BNP planners – is certainly a form of resistance.[40]

Conclusions

Amongst the often-cited "tapestry of races" in Guyana (Guyana Chronicle, 2013; Stabroek News, 2016b), development banks and the Guyanese government have singled out indigenous Guyanese alone as appropriate subjects of health interventions based on race. As I have demonstrated in this chapter, project designers have argued that Afro- and Indo-Guyanese ethnicity are simply "too political" to form an explicit variable in project planning, but project staff have repeatedly turned to indigeneity as a key program framework. The banks' projects selectively racialize indigenous Guyanese, representing Amerindians as subject to a single, fixed culture that manifests as racialized biological difference. Attention to the specific histories of oppression of indigenous Guyanese, not only by colonial powers but also by Guyanese elites (Jackson, 2013), is certainly essential to promoting more just distributions of wealth and opportunity today. But even as development bank projects aim to address such relationships of wealth and power, they have been rooted in, and have promoted, negative visions of indigenous Guyanese as diseased and culture-bound—representations that are choices rather than simple reflections of reality.

While other development agencies have also implemented projects targeting indigenous Guyanese, the legitimacy problems shaping development bank projects have been especially acute because of the large-scale popular mobilizations and

[40] Such resistance is a "weapon of the weak," in James Scott's terminology (Scott, 1985).

activism that have targeted the banks' treatment of indigenous peoples. In this chapter I have focused on IDB's Basic Nutrition Program as a key site in the construction of Amerindian nutrition as a "problem area" in Guyana. The dynamics that I have described have solidified into a much broader focus on Amerindian nutrition in both World Bank and IDB programs in Guyana, which has major impacts on public representations of indigenous Guyanese. These programs continue to stress the obduracy of Amerindian culture, framing it as an impediment to good health and mental development. In these programs the banks' indigenous specialists have continued to push for a focus on Amerindian nutrition, which has knit smoothly into national racial and electoral politics in Guyana.

Two legitimacy problems converge to produce this selective racialization of Amerindians. In the first, development banks have mobilized indigenous specialists in response to activist challenges, marshaling anthropological and legal expertise as key forms of knowledge for creating just and effective programs. In the second, the Guyanese state has turned to Amerindians to demonstrate its ability to represent the full range of its citizens, and expertise in Guyanese electoral politics has become a key to designing development projects. But in their convergence on Amerindian nutrition, these politics have led to representations of Amerindian ethnicity as shaping biology, through culture, in ways that endanger health and mental development. These projects construct Amerindian ethnicity as uniquely relevant to health, portraying Amerindians as both biologically inferior, and exterior to the nation. I have shown here that this representation was far from foregone, constructed through a series of assumptions and choices that draw attention to Amerindians as opposed to other demographic

groupings, that construct stunting as a major problem as opposed to nutritional characteristics among other populations, and allow race to overshadow geography and economics.

CONCLUSION

GLOBAL HEALTH UNDER LATE NEOLIBERALISM: PUBLIC RELATIONS AND SOCIAL JUSTICE

In this dissertation I have analyzed the relationships of power that underlie and result from public health efforts of the World Bank and the Inter-American Development Bank, especially in Guyana. In this conclusion, I briefly discuss the main arguments of the dissertation, before reviewing the implications of these arguments. This dissertation has highlighted how, in attempting to reform their own practices of marginalization (displacement of indigenous peoples, further impoverishment of the poor, etc.), development banks have continued to inscribe state racial codes in the bodies of Guyanese citizens through the institutions' health programs. I have highlighted the intellectual and economic continuities shaping these histories (Chapter 3), but I have also emphasized the institutions' surprising departures from their past reputations and their own self-representations. While development banks have struggled to reform themselves, the practice of their health programs differs substantially from how the institutions have been imagined both by scholars and development practitioners. I have argued that even as economic knowledge has been minimalized in development banks' operational practice (Chapter 4), anthropological and legal knowledges have played a central role in shaping health programs (Chapter 5). While development banks are known for their economic rationalities, it is through the work of anthropologists – brought to development banks for their "cultural sensitivity" – that many of the banks' disenfranchising effects have operated in health projects in Guyana. My argument here is not that development

banks have simply enrolled anthropological and legal knowledges towards the banks' own ends; I emphasize the active role that anthropologists and legal specialists have played in shaping development banks' contemporary practices of marginalization, even as these specialists have become entangled with the banks' institutional histories. And while I emphasize that development banks have mobilized health programs in an attempt to remake the institutions' neoliberal reputations, I also highlight the marginalizing effects that bank projects have had even when the institutions have sought to substantively alter their practices rather than simply undertaking reputational repair work. In the process, development bank health projects in Guyana have constructed "indigenous culture" as homogenous and malignant, even when these representations counter the banks' own nutritional statistics.

I have emphasized that the banks' ongoing projects in Guyana have not served primarily as a means of neoliberal privatization and individualization, in spite of the World Bank and IDB's long-time promotion of market mechanisms as the solution to development problems. For example, even as the IDB Neglected Tropical Disease loan mobilizes drug donations from large pharmaceutical companies, it does not construct corporate power as the primary route to better health. The project focuses on a combination of environmental and medical preventative measures (Chapter 4). The project's donations of albendazole are not set up to create infrastructures that then make it difficult for Guyana not to purchase the drug when donations come to an end: the albendazole donation covers drug administration until lymphatic filariasis is eradicated globally. Rather than a route to selling more of this specific drug, the donation is a part of efforts towards "corporate social responsibility" that are rooted in

improving the company's image, and thus its sales, not so much in Guyana as globally. But even more than positive PR for pharmaceutical companies, the NTD project aims to create positive public relations for development banks themselves: it is part of efforts to remake the image of development banks away from the neoliberal exploitation for which they have been so widely criticized.

In the early 2000s, development banks' nutrition programs in Guyana began as a limited form of wealth distribution through food vouchers (Chapter 5), although that element was eliminated with the expansion of the Basic Nutrition Program in 2010. I have argued throughout this dissertation that health justice relies on greater wealth redistribution, both through health programs and through broader development policy – which should include trade and intellectual property regimes (see Chapter 4). However, IDB and the Government of Guyana agreed that in order for the government to "take ownership" of the BNP project and support nutritional efforts with minimal bank loans, the food vouchers would need to be eliminated – they were understood as pushing the project over its possible budget, in spite of their benefits. The resulting national project, supported by a new IDB loan, provided only micronutrient supplements, along with a substantial amount of surveillance and operational research. The data that results from such efforts play a significant role in the banks' position in global health and international development. Development banks have branded themselves as "knowledge banks," and their control of extensive data sets allows them to be a reference point in framing the vast majority of development analyses (Goldman, 2005). The banks conduct substantial research through their own operating budgets and through "technical collaborations," which development banks provide in

the form of grants, usually creating data that forms the basis for further loans. But the data created through loan operations is also central to the banks' positioning as centers of knowledge, and bank management has consistently pushed operational divisions to collect more data through their projects (World Bank, 2009; World Bank, 2012; IDB, 2015b). As low- and middle-income countries can increasingly borrow on commercial markets, both the World Bank and the Inter-American Development Bank emphasize their knowledge resources as their "comparative advantage" (World Bank, 2012; IDB, 2013). This knowledge-base is subsidized by borrowing countries, who repay the costs of research financed through loans, plus interest.

Quantitative data on reductions in anemia produced through the Basic Nutrition Program's research and surveillance efforts in Guyana allowed the program to receive international attention, especially through a prestigious "Development Impact" award from the US Treasury. Although data generation is highly significant within both the World Bank and IDB, not all loan projects place the same emphasis on data collection: project teams determine the allocation of resources, and some team leaders prefer to use project funds on other operational elements, such as medical supplies or training. However, research can be a key means of recognition and personal advancement within development banks. Staff and consultants at both the World Bank and IDB use an entrepreneurial model in explaining relationships within the institutions: they describe how people must promote and sell their various services

(research design and evaluation, anthropological knowledge, etc.) to other divisions within the banks in order to be deemed worthwhile.[41]

This differential approach to quantitative data across bank projects points to a key insight of this study: the patchiness of late neoliberal management. While scholars such as Vincanne Adams (2013) and Manjari Mahajan (2015) have pointed to global health's neoliberal practices of quantification, tied up in the search for scientific management tools drawn from business and the private sector, the use of these tools continue to be patchy even in the supposed heart of neoliberal practice – international financial institutions. While I set out to study neoliberal practices and knowledges in global health, it was not in rationalized, privatized, or self- management that I found these logics. Instead, late neoliberalism emerged as an explicit quest by financial institutions to remake their neoliberal reputations. The valorization of private management here exists alongside its public denouncement by development bank senior leadership, and health projects become a site to reform the bank's image.

These tensions are an essential aspect of development banks' global health work. In this dissertation, I have drawn attention to the differing standards of values and knowledge at play in various spaces of the banks' work: from operational health divisions to research collaborations or negotiations between country office staff and government representatives. In Chapter 4 I emphasized that while researchers at the banks' headquarters place great value on cost-effectiveness analyses, these economic calculations haven't held the same sway in the operational negotiation of projects. And while researchers have recognized the importance of local priorities expressed through

[41] David Mosse has picked up on this language, describing the ways that anthropologists have made their expertise "salable" within the World Bank (Mosse, 2005).

democratically-elected governments, electoral politics have been much more consistently valued in operational practice. In Chapter 5 I showed how increased attention to anthropological expertise within bank headquarters has aligned with legitimacy politics of the Guyanese state to promote projects focused on indigenous Guyanese. But I highlighted how the resulting projects have constructed indigenous peoples as bound by a "culture" that translates into biological risk and difference. And in Chapter 3 I argued that the values of efficiency and individual responsibility have held great value across spaces within the banks and the Guyanese government through time, mobilized in different versions as part of very different discursive packages.

The differential entanglement of knowledge and popular politics across development banks' networks helps explain tensions between the institutions' operational practices and their self-representations; these representations are produced largely through research and policy at bank headquarters. But while development banks have long sought to reform the practices of borrowing governments, I have highlighted how these financial institutions' efforts towards self-reform have continued to enact institutional histories of marginalization. I have emphasized how, in responding to critiques of their coercive practices, development banks have turned to discourses of "country ownership" and "participation;" however, the importance of such democratic priorities in bank operations has run up against the prescriptions of research divisions for using economic expertise to define project priorities. In the process, bank projects have come to promote a form of patronage politics under the guise of democratic priorities, and their neglected tropical disease programs in Guyana have sought to bridge Afro- and Indo-Guyanese in a form of national unity through

medicine. At the same time, development banks have enrolled legal and anthropological knowledge in responding to critiques of the banks' treatment of indigenous peoples, continuing to marginalize indigenous peoples by singling them out as uniquely "racial citizens" whose ethnicity is uniquely dangerous to their health.

Considering how knowledge and values are entangled differently across networks of the banks' work helps understand the power dynamics that contribute to and result from the banks' health projects. The banks' health projects not only affect the health of millions of people around the world, they reflect and reproduce the very relationships that govern broad aspects of human life: between wealthy and poor countries, wealthy and poor people, national governments and private industry, elected officials and technocrats, as well as the daily relationships among healthcare workers, patients, volunteers, and government representatives in Guyana. In the dissertation's Introduction, I described the larger system of extraction within which the projects that I study operate. I emphasized that global health programs allow for broader forms of exploitation, in which wealth continues to travel on balance from the global South to the global North. While I expected my research to reveal the daily exploitative practices that make up this larger system of oppression, instead my work pointed to gaps in the system – the ways in which financial institutions work to maintain their centrality by responding to academic and popular criticism. These are projects where activist efforts have had a real impact, pushing development banks to avoid privatizing and individualizing practices. Understanding these dynamics points to sites of disenfranchisement, such as the ongoing marginalization of indigenous peoples as they are singled out for development, but it should also give hope for the possibilities of

expanding social justice; activist efforts and critiques of development banks have fundamentally shaped the relationships of legitimacy at play in some of the world's most powerful institutions, encouraging activists and scholars alike to imagine routes to other stories and other worlds.

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