

**Abstracts for *The Anthropological Demography of Health*
International Workshop, March 29-31, 2017
Pauling Centre for Human Sciences
Oxford University**

Ch. 1: Cultures of contagion and containment: the geography of smallpox in Britain in the pre-vaccination era

Romola Davenport

Smallpox was the single most lethal disease of eighteenth century Britain. However its impact was very uneven. This paper demonstrates the very strong geographical patterning of smallpox in Britain, and the role that human agency played in establishing this pattern. Smallpox was a common endemic disease of childhood in northern Britain, accounting for 10 – 20 per cent of all burials in towns in the eighteenth century. However in southern England smallpox was a rare epidemic disease affecting adults as well as children and accounting for only a small share of burials outside London. Young adult rural-urban migrants from southern Britain were therefore at high risk of smallpox infection, whereas northern migrants were not. The pattern is paradoxical because southern England was characterised by higher population densities, higher levels of urbanisation and greater contacts between settlements, factors usually assumed to promote disease transmission. This paper presents a first investigation of regional differences in popular and official poor law attitudes to smallpox contagion in Britain, and how these attitudes might have developed. Southern England appears to have represented a middle ground between the ‘fatalistic’ attitudes to smallpox commonly attributed to communities where the disease was endemic, and the extreme flight responses documented in societies with infrequent exposure to the disease. Claims regarding fatalistic attitudes will be evaluated in the light of patterns of vaccination uptake in the early nineteenth century, and contrasts and parallels with regional differences in reactions to plague and cholera will be drawn.

**Ch. 2: The Prostitute as an Urban Savage (Paris 1830s – 1900s):
French XIXth-century premises of the anthropological demography of health**

Yves Charbit

This paper explores French XIXth-century premises of the anthropological demography of health, focusing on prostitutes at a time when they were regarded as urban savages by writers who all belonged to the dominant social groups. In their writings, they ascribed to prostitutes quite a large range of specific physical, demographic and even moral characteristics; and because of their social and economic conditions, their health was endangered by no less specific diseases, poverty providing only a partial explanation, the rest being attributed to their ontological status. To account for the nexus of arguments, I use the

typology of in- and out-group. Their methods of investigations, especially their social enquiries, can be regarded as pre-demographic and pre-anthropological fieldwork. To assess changes over the period 1830-1914, along with articles in specialised journals, I use as primary sources major books, selected among a large literature, as milestones in the description and analysis of prostitution. Last, throughout the paper, brief comparisons are made with today research results on XIXth century England and on HIV and STD's in XXth century Africa.

Taking sexuality as a central domain illustrative of ascribed behavioural characteristics, I first delineate the archetypal figure of the prostitute as an urban savage exploring what was written on them as anticipations of both later demographic objectiviation and proper anthropological work. Notably, the racial argument put forward by physical anthropology ("born prostitutes") clashed with the vision of a poverty-stricken group (I). I then turn to the issue of sexuality and sexually transmitted diseases. At the beginning of the period, the sole prostitutes were blamed for propagating syphilis. Later on, when the "venereal peril" took alarming proportions all over France, public health specialists adopted a totally different stance, arguing that male members of the in-group were mainly responsible for contamination, because of widespread recourse to out of wedlock sex (II). From the 1860's, a new factor emerged. The sexual behaviour of the women of the in-group evolving towards more openly promiscuous sex, the barriers weakened and the fringes between the in- and the out-group became porous. Further, because of the changes which occurred in the social, economic, political and ideological contexts from the early 1880's, debates over the control of prostitution became highly ideological and political (III). I conclude with two epistemological aspects of these premises of anthropological demography of health. First, the policy of control of sexuality and prostitution in the French colonial empire, where inclusion or exclusion of the natives was a crucial issue, is of interest to us, because it casts some doubts on the legitimacy of a reading of reality through the sole lens of Foucault's biopolitics. Second, I hold that there was something specific about prostitution which is properly anthropological and must be analysed in dialectic terms. The physical body of the prostitutes was the locus of a contradiction and the satisfaction of sexual needs and male fantasies entered in conflict with dominant moral codes, which generated a constant oscillation between fascination and repulsion in a complex system governed by gender and class domination (IV).

Ch. 3: Health outcomes and education in Uganda, 1930-1970

Shane Doyle

The beneficial role of formal education in reducing infant and child mortality has long been recognised. The correlation, however, has appeared stronger in some societies than others, suggesting that the relationship between schooling and health-related attitudes and behaviours is moderated by local cultural, environmental or other contexts. Between the 1930s and early 1970s educational and medical provision in Uganda expanded enormously. Over the same

period early years survival rates rose sharply. Yet several aspects of this improvement appear anomalous. 1-5 year old mortality rates remained unexpectedly high. Some districts with very limited educational facilities experienced declines in child mortality which almost matched those enjoyed by those with the highest rates of schooling. Moderate levels of schooling in some cases appear to have heightened risk of child morbidity and mortality due to particular diseases. This paper would analyse oral testimonies and a range of medical, demographic and social surveys in order to enhance understanding of how individuals and communities' conception of disease causation and transmission were affected by exposure to schooling.

Ch. 4: The Survey of Medical Topographers on Colonial Algeria.

Hugues Moussy

In the continuity of a sociological and historical research field which addresses the role of western science in colonization, this paper extends the debate on the particular place of medicine. Through the study of a specific source, medical topographies, and within a precise historical and geographic context, the conquest of Algeria by France (1830-1871), the author seeks to demonstrate that physicians fully participated in the colonial effort, not so much, as could be expected, through the appropriation of bodies, but through their decisive contribution to the appropriation of space itself.

Medical topographies, which were written and published in France as in many European countries between the 1770s and the 1880s, were the result of the survey launched by Felix Vicq d'Azyr, the Secretary of the Royal Society of Medicine in order to draw a comprehensive picture of the health status of the kingdom and beyond, to collect systematic data that would allow to better understand the etiology of epidemics. Medical topographies constitute by their volume, their homogeneity and their permanence, a medical genre, rooted in the tradition of aerism or what might be called neo-hippocratic environmentalism, in the constitution of which Sydenham decisively participated a century before. In their most common template, medical topographies present and describe natural areas in their relation to the morbid status of the population who inhabit them: situation, soil, topography, hydrology, water quality, climate, flora and fauna, cultures, and all that, in general, has to do with the inhabitants (temperaments, habits, diseases, etc.). During the period 1770-1880, more than 600 medical topographies were written covering the whole of France: 39% before 1789, 17% between 1790 and 1819, and 44% after 1820. Algeria was devoted a large part of the medico-topographic production, with 41 topographies amounting to 7% of all medical topographies, more than any other area of France the French space. Medical topographies of Algeria occupy such a place because they were part of a doubleheader: the pursuit of the scientific and epidemiologic program launched by Vicq d'Azyr, which was to complete a medical geography of the French territory; and the military and political program that aimed to integrate Algeria into the French space. Through the specific attention they have paid to the physical environment of this newly conquered space, through the scientific apparatus and

language they have used, medical topographers took a rational look at the Algerian territory that inextricably contained a crucial political value, paving the way for colonization.

Ch. 5: Understanding the body symbolic system to improve obstetrical practices

Clémence Schantz

Based on anthropological demographic research in Phnom Penh, Cambodia, this communication will highlight three contemporary obstetrical practices. Field observations and semi-structured interviews conducted in delivering services (hospitals, clinics) with birthpractionners, but also with men and women outside maternities, will allow us to demonstrate the strong increase of the practice of caesarean sections in Phnom Penh, including an increase of caesarean on women request. We will also show that today routine episiotomies are performed during vaginal births, that women agree to this practice and that many women are asking for perineorrhaphy (cutting and tightening the vagina) after childbirth. Despite the fact that the World Health Organization (WHO) recommends that the rate of Caesarean section should not exceed 10%, and that the WHO states that routine episiotomies are damageable, these practices continue to increase in Phnom Penh today. In the context of a strong medicalization of childbirth, these practices will be situated in their social meanings (gender relationships, intra generational and family relations) and in the Cambodian cultural context. Indeed, these practices are part of a symbolic anthropology based on a system of bodily humors. Field data have shown the importance of the control of body holes, and we will demonstrate how a vaginal delivery threatens women body balance. This demonstration, based on micro and meso levels, and mobilizing social and cultural dimensions, will permit us to understand current biomedical practices in Phnom Penh. We will show why we need to understand the body symbolic in Cambodia to improve obstetrical practices and will demonstrate the relevance of an articulation between anthropology and demography.

Ch. 6: ‘*As list karhayee ke bayad anjame midadam khat khord*’: Contemporary Reproductive Body Politics in Iran

Soraya Tremayne

Studies of the family planning programme of the Islamic Republic of Iran (1986-2006), and its outstanding success, which ‘confounded all conventional wisdom’ (Abbasi-Shavazi 2009), are abundant. These studies also cover the population policies of the pre-Revolutionary regime of Pahlavis, which started in mid-1960s. In both cases, the involvement of the state, in direct or indirect ways and to varying degrees, has been a critical, although not the sole, factor in affecting people’s reproductive behaviour. Also, under both policies, women have become prominent and acknowledged in their childbearing capacity. What has been left out

of these studies is that the engagement of the state with population issues dates back to late 19th Century, when, under the Qajar Dynasty, the state also first took an interest in regulating the population for the purpose of nation building and targeted women and their health for such purpose (Kashani-Sabet 2011).

What all these policies, whether anti or pro-natalist, have in common is to view citizens, especially women in their reproductive role, as responsible for meeting the state's requirement for reproducing the ideal number of citizens. Today, Iran's fertility stands at 1.3 (i.e. substantially below replacement) as many young people either have one child or none at all, and the state is stepping in once more to take measures to increase fertility. To this end, and among other measures, the state has ventured into covering the cost of infertility treatment in a country where the infertility rate is estimated at around 20 percent among married couples, a figure which is well above that estimated by WHO at 15 percent globally.

In this paper, I use the lens of involuntary childlessness to examine the reasons behind infertile couples' undergoing the hard and costly fertility treatment in a country where a large and increasing number of young people choose voluntary childlessness or a maximum of one child. Through the study of infertile couples, I hope to show some of the complexities of competing demands on young people to reproduce, and the compromises they make to cope with the pressures and expectations of family, kin, society, and the state -- all of whom are asking them to do their duty by reproducing. There is little sign, as yet, that state or other pressures are succeeding. Rather, young women, should they choose to have a child, say merely, 'crossed it off the 'to do' list'.

Ch. 7: Encounter Ethnography in the Pediatric Exam Room: From Reproductive Paradox to Global Bodies

Elizabeth L. Krause

This paper takes as its starting point a profound paradox: more than half of the births in the public health sector of Prato, Italy, are now registered to foreign women yet once weaned many of these babies are sent to China. This circulation of children gives rise to a host of new discourses and interventions on parenting, from various institutions and experts, as children move in and out of Italian healthcare systems and schools. This paper makes use of medical anthropological sensibilities to address embodied encounters with globalization and institutions. It draws from an ethnographic research project that resulted in a dataset of audio-recorded socially occurring speech and semi-structured interviews that included Chinese parents and Italian healthcare workers, among others (N=73). Jarring and uncertain moments emerge as public health institutions safeguard and discipline Chinese parents. Encounter ethnography comes into its own in this paper as it follows the ethnographer through a medical labyrinth where Italian staff delivers care to Chinese immigrants. The intimate space of an examining room allows observation of interactions between the healthcare professionals and parents who bring in their infants for three-month checkups. The encounters pivot around

four cases to reveal an empathetic yet taxed medical staff who deliver far more than healthcare: they also dole out strong practical and moral messages about body weight, head shape, feeding, dressing, and parenting practices. Chinese migrants negotiate these expert views in ways that show how they cope with transnational lives. The encounters reveal how globalization writes itself on bodies in unexpected ways. Specifically, they show how rationality put into practice through routines of professional expertise amplifies commentary upon moral behaviour especially related to parenting.

Ch. 8: Reporting Bodies through National Statistics on Undernutrition and Obesity

Stanley Ulijaszek

The epidemiologies of undernutrition and obesity are conducted using standardized metrics in very regulated ways. Although the meanings of such measurements with respect to morbidity and mortality risk have been under review from the 1950s, the procedures and protocols of such usages have been critiqued for social and cultural reasons. Measurement in public health practice has been criticised as being a means of universalizing the human body when relating individuals to norms, and of health to measurement by governmental institutions, through epidemiological reporting. Issue has also been taken with the stigma that accompanies the measurement and medicalization of bodies, whether they be thin or fat. Bodies have physical realities with economic, social and medical consequences, and the standardization of measures of undernutrition and obesity have political and economic implications. This presentation describes the now-historical process of bodily standardization through public health anthropometry at both extremes of body size, and examines how public health reporting of undernutrition and of obesity informs the discourse of both at governmental level once such measures are given the status of being national statistics.

Ch. 9: Au croisement de l'épidémiologie sociale et de l'anthropologie de la santé : illustration à travers l'étude du marché global du médicament en Afrique

Carine Baxerres et Jean-Yves Le Hesran

Cette communication se propose de revenir sur l'histoire et les conditions de réalisation d'une démarche utilisant conjointement l'épidémiologie (sociale) et l'anthropologie (de la santé) depuis une dizaine d'années. Cette démarche a pris corps au sein d'une unité mixte de recherche biomédicale Université Paris Descartes/IRD, l'UMR MERIT (Mère et enfant face aux infections tropicales), à travers la collaboration établie entre Carine Baxerres (anthropologue) et Jean-Yves Le Hesran (épidémiologiste). Après avoir rapidement retracé les origines institutionnelles et scientifiques de cette collaboration, ses enjeux scientifiques et institutionnels, nous présenterons notre approche plus en détail à partir du projet de recherche

comparatif GLOBALMED actuellement en cours et qui porte sur la production, la circulation, la distribution et la consommation des médicaments (anti paludiques) au Bénin, au Ghana et au Cambodge. Il s'agit d'analyser les recours thérapeutiques des familles, en distinguant celles avec ou sans enfants, lors d'épisodes morbides selon les conditions de l'offre locale de médicaments, les représentations des acteurs, et au regard des politiques de santé nationales et des recommandations de l'OMS.

En effet, après nous être intéressés à la question de la mortalité et de la morbidité palustre au Sénégal d'un point de vue épidémiologique et l'avoir confrontée à l'analyse anthropologique de la gestion de la santé de l'enfant par les familles en milieu sereer au Sénégal, puis à la question de l'accès aux soins (prise en charge des événements de santé à domicile, suivi de la grossesse), nous nous sommes progressivement concentrés sur la question du médicament, de sa distribution et de son utilisation par les populations (projet GLOBALMED). Ce projet implique des enquêtes quantitatives et qualitatives ainsi qu'une analyse croisée des données collectées. Nous nous attacherons à montrer comment la conception et l'organisation de la collecte des données a permis d'abord d'affiner les questionnements propres à chaque discipline, d'alimenter les échanges entre épidémiologie et anthropologie, puis de mieux cibler le type d'informations nécessaire à des interrogations spécifiques avant enfin de construire dans les mêmes espaces une problématique commune de recherche. Nous reviendrons notamment sur l'évolution de notre démarche passant d'une première phase caractérisée par une approche plutôt verticale (l'anthropologie et l'épidémiologie se situant à leur propre "niveau de réalité" dans une analyse assez spécifique) à une seconde phase davantage construite sur une interdisciplinarité, plus « horizontale », dans laquelle les hypothèses, les concepts et les méthodes de disciplines se situent à un « niveau de réalité » plus proche dans un intérêt commun pour l'étude des conduites de santé et de ses déterminants. Néanmoins ce type de collaboration qui se développe de plus en plus dans le champ biomédical français soulève encore un certain nombre de questions épistémologiques comme par exemple : quelles méthodes désignons-nous précisément quand nous parlons d'une approche qualitative et quantitative ? Comment construire un questionnaire quand population (sous populations) et société ne se superposent pas ? Parlons-nous d'inter-, de trans-, de multi- ou de pluridisciplinarité ? Comment saisir les contextes sociétaux spécifiques que l'épidémiologie définit de son point de vue comme des déterminants sociaux ou des facteurs de risques ?

Ch. 10: Reproductive genetics, risk and context

Alison Shaw

Reproductive genetics refers broadly to the use within reproductive medicine of genetic technologies to prevent the birth of babies with genetic diseases. These technologies include pre-marital, pre-conception or prenatal genetic carrier testing of parents-to-be; prenatal genetic screening of fetuses combined with the option to terminate an affected pregnancy and pre-implantation genetic diagnosis and screening prior to the implantation of embryos created

though IVF. Public health initiatives globally are aimed at harnessing these technologies to benefit the health of individuals, families/communities, and nations. My interest in this paper is in comparing and contrasting discourses of risk for disease in children across different individual, community and national contexts, drawing from the UK, the Mediterranean and the Middle East. What is at stake, in these discourses, is a moral question about what kinds of babies should be born, here with respect to the risk for genetic disease. The paper identifies some of the contradictions, forms of resistance and types of negotiations entailed for individuals and families, and at national levels, in these different contexts, making particular reference to risk for common and rare recessive genetic conditions. I aim to show that in these situations of identified genetic risk, cultural and social context, material circumstances and global positioning profoundly shape marriage practices, childbearing, and access to and use of reproductive genetic technologies.

Ch. 11: Demographic governance in Britain: Pakistani migration and health over the life course

Kaveri Qureshi

This paper explores how the health of Pakistani immigrants in Britain has been influenced by policies of demographic governance – a term offered by Hampshire (2005) to capture the web of policies geared towards the management of a population’s health, productivity and welfare. Uniquely, his study approaches post-war immigration through a consideration of policy-makers’ and popular concerns about the impact of Commonwealth immigrants on Britain’s demographic landscape. As Hampshire details, Britain’s policies of demographic governance allowed for the immigration of healthy young men in the 1950s and 1960s, and later too, healthy young women. In this paper, I take forward Hampshire’s approach, but argue that the same policies of demographic governance – which relegated Commonwealth immigrants to the lowest echelons of the industrial workforce, where their bodies were subjected to stresses, health and safety transgressions, and the grind of low income – made for an epidemic of chronic illness and health-related worklessness in later life. I draw from an ethnographic study with Pakistanis in East London, combining life histories detailing industrial labour and the toll that such work took on the body with observations of the roll-out of policies tackling health inequalities and health-related worklessness over the last decade. Whilst policy-makers and popular attitudes still cast Pakistanis as diseased foreign bodies in the body politic – and as likely welfare parasites – I show how ageing Pakistani immigrants make claims to citizenship and belonging through their demands for medical attention and social security assistance.

Ch. 12: Population Ageing and Conjunctural Action

Elisabeth Schröder-Butterfill and Philip Kreager

One of the most promising conceptual and empirical breakthroughs to emerge from combined anthropological and demographic thinking is the theory of conjunctural action. Developed in a sequence of articles and books by Jennifer Johnson-Hanks, this approach provides an effective alternative to rationalist decision-making models that have prevailed in population studies over the whole post-war period. Observation and analysis of vital conjunctures show how social, economic, and political differences between groups in society are manifested in individual agency at specific points across the life course, and how people's behaviour in this way differentiates the many sub-populations making up a society. The approach thus addresses directly two major shortcomings in population research: the need to explain mechanisms underlying the evolution of population heterogeneity, and the dynamics that entrench inequalities. To date the study of conjunctural action has been addressed chiefly to fertility. In this paper we explore how health issues facing older people, their families, and communities are illuminated by this approach, drawing on multi-site longitudinal ethnographic and demographic research in Indonesia. The paper begins with the nature of uncertainty and vulnerability at older ages, and how it can be modelled across the life course. It then considers the dynamic relation between individual action and sub-population memberships, and how it articulates the compositional demography of status, network, ethnic and related sub-population memberships.

Ch. 13: The Tensions between Comparability and Meaningful Data

Sara Randall

In a series of interviews with demographers and statisticians from statistical offices in both Europe and Africa around definitions and data, a key emergent theme was the imperative necessity for data to be comparable across time and space. From their perspective comparability was the driving force behind collecting and analysing data. At the other end of the data collection spectrum, interviews with enumerators and representatives from study populations highlighted the difficulties of comparability, especially in multi-lingual, multi ethnic contexts, but also because of respondents' desires that data collected on them should represent their perception of how their lives were configured and what was important to them.

This paper will unpack the different tensions and challenges posed by these two polarised perspectives by thinking through some of the issues around what data should be able to do, what data are for, and how different interest groups use and mis-use data. I will use a number of different examples drawing on both my own research over the years and published literature.

The DHS have been going since 1986 during which time they have totally transformed our knowledge of demographic and health dynamics of the majority of developing countries for which few or no reliable data were available before that time. For many academics, statisticians and policy makers one of the key merits of the DHS is their standardised format and their comparability cross time and space. Their website puts forward the claim that “ The Demographic and Health Surveys (DHS) Program has collected, analyzed, and disseminated accurate and representative data on population, health, HIV, and nutrition through more than 300 surveys in over 90 countries”. In this paper I try to unpack some of the areas where these “accurate and representative data” might actually not be so accurate and representative because the comparability imperative undermines the ability to generate locally meaningful data.

Using material from qualitative interviews undertaken with older people in Ouagadougou in a study nested within the Ouagadougou Demographic Surveillance System (DSS) I will disentangle how the quantitative data generated from identical questions may represent very different perspectives for older men and older women.

Many different organisations use data from national and international surveys in order to situate their policies and interventions. Here too there is a tension between the comparability of concepts and local meaning. Many interventions are primarily at local level and the demands by NGOs are for local level data. Yet often such data are either not available or have been collected in ways and using concepts that do not map well onto local conditions. This leads to the consideration of an important issue in collection, analysing and using data – the issue of translation. Some of the problems around translation discussed.

The current key issue in the global picture of data availability and data use is that of the Sustainable Development Goals and the different tensions therein generated by the pressures for good quality data for both denominators and numerators. There are numerous tensions inherent in trying to represent properly the interests of minority populations, of disaggregated populations and of populations whose characteristics in terms of living arrangements, economic arrangements and values systems do not fit well with the hegemonic models of comparability in data collection. A number of different examples will be considered to try and think through the groups for whom the Sustainable development Goals may end up being more of a problem than a solution.

Ch. 14: Making measure

Jennifer A. Johnson-Hanks

This paper discusses the production of demographic measures as a kind of translation. Most demographic data come from surveys or documents produced for administrative purposes, particularly censuses and vital registration (birth- and death certificates). In each case, the production of the document requires that someone translate what he or she understands about the world into the distinctions identified by the form. As translation, the production of demographic data necessarily entails interpretation; as a translation into a less rich medium, it

also involves reduction (see Cicourel 1982). The various kinds of demographic data vary considerably in how much they differ from the lived experiences that they translate and partially represent. In some cases, such as date-of-birth, the act of translation from events-in-the-world to document is simple and relatively transparent. In other cases, the act of translation entails a considerable re-interpretation. For example, the US CDC publishes two pages of instructions about how doctors and coroners should complete the 6 questions about cause of death on US death certificates, presumably because many have had trouble translating real deaths into the categories that the CDC cares about. After working through a series of examples, the paper argues that getting measurement right—like translation—needs to be an on-going and adaptive process.

Ch. 15: Birth Registration and other Reproductive Perils: Migrant Family Experiences in Lombok, Indonesia

Leslie Butt

This paper foregrounds the importance of ideas and experiences around pregnancy and birth in practices around child registration. To date, concerns about childbirth practices in Indonesia have focused on managing birth in order to reduce high maternal and infant mortality rates, where interventions take little account of the breadth of cultural values shaping birthing practices across the nation. Beyond the village birth center and the obstetric hospital ward, little attention has been paid to the institutional conditions within which childbirth occurs and to the cultural intersections that occur when pregnant women, new mothers and fathers, or extended kin engage with the birth records, birth certificates, and civil registries required to transform the act of birth into a legal statement about family ties and potential citizenship. Generally, birth registration documents are a focal point in life cycle processes, the first link between the body of a newborn and administrative expectations and requirements around identity and articulations of kin belonging.

Drawing upon a multi-method study conducted in 2014 in four low income, high migration Sasak communities in East Lombok, Indonesia, this article discusses childbirth and birth registration practices among families where the mother or father leave home for extended periods for low-skill, temporary work in Southeast Asia or the Middle East, and where maternal mortality and infant mortality rates remain high. Qualitative interviews were conducted with 22 mother-father-child triads and participant observation was carried out with migrant families, and at civil registry offices and health centres.

The paper describes how families negotiate the relationship between the infant body and official documents. Using theoretical frameworks on embodiment, the paper first describes Sasak pregnancy practices and the social meanings attributed to the body of the newborn. The article then explores in detail the engagement of political institutions in the moment of childbirth and efforts by the state to inculcate conformity around kinship and relatedness through the normalization of practices that link childbirth immediately with membership in

the state. In particular, I explore the place of government midwives in providing a signed birth record as an integral part of routinized birth procedures in village birthing centres. The birth record plays a pivotal role as the foundational document in the larger project of registering the child and helps cement the link between the infant body and state record-keeping.

While these norms tie birth to cultural, social and political institutions, the limited success of state efforts to register children is evident in the ways that migrant families navigate, circumvent, ignore or selectively exploit the official registration system to support their values around appropriate infant bodily practice and family regimes of care. Drawing on Sadiq's concept of "blurred membership," I explore how current high levels of migration interweave with particular responses to pregnancy and birth in ways that validate social forms of belonging over political forms. Cultural patterns around migration where fathers leave for work when their wife is newly pregnant often results in complete disengagement with state efforts to register infants. In other cases, migrant families manipulate documents to suit their purposes, taking advantage of the chaotic and malleable registration procedures to bring a marginalized child into locally relevant forms of social belonging by obtaining false identity documents. I reflect on these findings in terms of the impact of values around pregnancy and birth and how they interweave with the production of national population statistics.

Ch. 16: Verbal Autopsy Interview Standardization Study: Report from the Field

Clarissa Surek-Clark

Verbal autopsy is a widely known method used for epidemiological and vital registration purposes by demographic surveillance sites throughout the developing world¹. While the interview assessing causes of death may be conducted and recorded in local languages, the information collected in survey instruments and used by medical personnel as a starting point for analysis is often in English or other colonial languages. Given the thus far unexplored role of the field worker as an interpreter and cultural mediator, ethnographic field work was conducted in seven Health and Demographic Surveillance sites in Sub-Saharan Africa that participate in the Alpha Network with the aim to understand linguistic, cultural and survey administration practices during each site's ongoing Verbal Autopsy interview process. This paper reports on initial results from the study, including challenges faced by the Verbal Autopsy teams, as well as providing initial solutions applicable to professionals interested in health and language methodology.

¹ <http://www.who.int/healthinfo/statistics/verbalautopsystandards/en/>

Ch. 17: From Madness to Mental Health in Senegal

Véronique Petit

The aim of this paper is to show how “madness” interfere in the life trajectory of men and women in Senegal, to understand how psychiatry is becoming more acceptable by the population, why and how individuals and families decide to have recourse to psychiatric services and how they interact with doctors. Despite the fact that since many decades, psychiatry is present in Senegal, decision to turn to psychiatry is never a simple and linear process in a social context where madness implies relegation, shame, dishonour and sometimes symbolic and physic violence. Madness, depression, and mental health obviously raise the issue of the cultural frontiers between normal and pathologic categories in the Senegalese society and how they evolve. When or for which reasons is it legitimate to be psychically ill during one’s life course? Although the local cultures recognize for women and children the right not to feel well for a limited period of time linked to demographic events (after childbirth, postpartum depression, weaning), vernacular sayings such as “*le grand fatigement*” (usually worded in French) reflect more recent pathologies among men and notably male migrants. Nevertheless psychic suffering does not receive proper attention in this very conformist society where the individuals must control their emotions and speeches. What is the role of the family, the community and the institutions in this process of decision to recourse to psychiatric departments? How could patients secure access to medicines and sometimes long cures while depending on family networks and solidarities, for lack of personal financial resources, keeping in mind that madness moreover implies complete loss of any social status and role. To answer these questions I confront anthropological and socio-demographic data. Senegal was chosen because of its dual characteristics: first Senegal can boast to provide mental health services not only internationally recognised, but also unique throughout Francophone Sub-Saharan Africa; second it is a century-long country of migrations and mobility. The process of diffusion of psychiatry is going on, demand is increasing, and one of the objectives of this survey is to provide data to help the health institutions to establish a policy of primary mental care. This paper is based on a nationwide survey in progress, covering most of the existing major psychiatric services (CHU of Fann Clinique Moussa Diop, Centre Keur Xaleyi, Psychiatric Hospital of Thiaroye-service of pedo-psychiatry), Centre of Mental Health of Dalal Xel and its the itinerant consultations in Bakel and Louga) and in some villages and districts of Dakar and Thiès. Besides the rich statistical information gathered since 1984 in more than 34,000 patient files, and as far as I know never systematically computerized until now, in-depth anthropological investigation comprises interviews of patients, their families, doctors and paramedical staff and participant observation of interactions between patients and doctors, paramedics and traditional healers.

Ch.18: Sexual Health and the Divergent Demography of the Past and the Present

Simon Szreter

Venereal disease in the European past is a blind spot in the discipline of demographic history as it has developed over the post-war period. While this owes partly to its strongly data-driven research orientation, the resulting gap in our understanding is particularly problematic as STIs have implications not only for fertility but for morbidity and mortality. STI levels are closely bound up with migration and urbanisation, for which historical demographic data are also often seriously lacking. However, STIs have certainly not been ignored or avoided in colonial public health or in demographic anthropology, resulting in the unintentional illusion that STIs have been more a feature and problem in the demography of certain 'less developed' societies and communities, notably in Sub-Saharan Africa and Oceania (or amongst black Americans). From this contrast, the 20th century in these places may appear much more STI ridden than ever was the case in the past of today's developed countries.

This, however, seems unlikely given that STIs appear to be strongly associated with the kind of livelihood-searching mobility and migration associated with poverty, economic change, and urbanisation. All European countries experienced this in their industrialising pasts. There is, in short, a lack of integration. Suitable data from European demographic and epidemiological history needs to be related to the post-Great War decades among the world's poorer populations where STDs have been tracked more fully, taking account also of the emergence of HIV-AIDs. The potential implications of this comparative perspective are illustrated by new research on syphilis in the city of Chester and its surrounding rural region, which casts quantitative light on STIs as a significant factor in at least some regions of the European past.

Ch. 19: How Much Can We Trust Population Data and Estimates of HIV Epidemics in sub-Saharan African Populations?

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HIV estimates are needed to provide critical information on the coverage and impact of HIV prevention and treatment programmes at national and local levels. Due to the need for up-to-date HIV estimates that are comparable across and within countries and include internally-consistent estimates of downstream effects such as AIDS deaths and orphans, UNAIDS and country estimates are generated using mathematical models. However, the inputs and assumptions in these models are based on data from periodic population surveys as well as from HIV surveillance amongst pregnant women attending antenatal clinics, routine programme records on use of services, and clinical and other focused studies. Population survey data on sexual risk behaviours for HIV acquisition are also used in 'Second Generation Surveillance' to guide interpretation of model and survey estimates of epidemiological trends, since trends in key indicators such as HIV prevalence and HIV

incidence may not always reflect trends in underlying risk. In recent years, there has been growing demand for regional and local HIV estimates to guide targeting of resources to the areas and populations where need is greatest; a demand which is being met largely by extrapolating from higher level estimates and using spatial interpolation methods.

Over the years, several major revisions have been made to global and national HIV estimates reflecting changes in model assumptions and new data sources becoming available. Furthermore, uncertainty bounds are included with the estimates to reflect limitations in the statistical precision of key inputs. However, UNAIDS estimates continue to be questioned – for example, for lack of consistency with Global Burden Disease estimates of all-cause mortality, for implausible estimates of coverage of selected HIV services in some countries, and for inconsistencies with locally-specific data. Against this background, the reliance on data from population surveys and antenatal clinic surveillance is a concern given the range of different biases that can be present in data from these sources; (in some instances highlighted in anthropological studies). For some indicators, these biases can be avoided or adjusted for through use of biomarkers or by drawing on data from participants' clinic records. However, this can be expensive, is not always feasible, and is particularly problematic for data on sexual behaviour.

In the first part of this presentation, we will review the various biases and difficulties in using survey data on HIV prevalence, use of services, and sexual risk behaviours, and discuss the implications for producing robust national and local HIV estimates, and for interpreting trends in these estimates. In the second part, we will begin to consider ways in which ethnographic observation and other qualitative research methods might be used constructively to evaluate and improve survey and (ultimately) model estimates. In particular, we will compare and contrast our findings relating to measurement of use of HIV prevention and treatment services from long-running studies in localized populations in Zanzibar and east Zimbabwe using anthropological and demographic/epidemiological/less intensive qualitative methods, respectively. These populations have many differences including in the extent of the HIV epidemic and in contemporary religions. However, they also have important similarities including underlying family systems, encounters with Western medicine and family planning, and experiences with poverty. We will conclude with brief reflections on whether and how an approach that combines the strengths of the two different traditions could be feasible and lead to more robust measurement and interpretation of trends and patterns in use of HIV services.