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To cite this article: Vincanne Adams, Nancy J. Burke & Ian Whitmarsh (2014) Slow Research: Thoughts for a Movement in Global Health, Medical Anthropology, 33:3, 179-197, DOI: 10.1080/01459740.2013.858335

To link to this article: https://doi.org/10.1080/01459740.2013.858335

Accepted author version posted online: 29 Oct 2013.
Published online: 24 Apr 2014.

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EDITORIAL ESSAY

Slow Research: Thoughts for a Movement in Global Health

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Keywords Ethnography, global health, research methods, slow food, social critique

Slow research, like slow food, is good for health.

The impetus for this article arises from a shared desire for rethinking our approach to Global Health. The field of Global Health, arising from the not-yet-dead field of International Health Development, promises new kinds of solutions, new diagnostics of our problems, and new techniques for intervention that aim to solve these problems in global ways that international health development projects have not. Elsewhere, some of us have been writing about the differences between the old “international health” and the new “global health” in relation to pharmaceutical science, evidence-based medicine, and the nongovernmental organization (NGO) privatization of funding (Adams 2008, 2013; Biehl 2009; Biehl and Petryna 2013). One of the hallmarks of global health is its relatively greater emphasis on research than previous postwar incarnations of health development. Our aim is not to reproduce that history but rather to think openly and conversationally about what kind of research might be best for global health goals. To this end, we propose the methods of “slow research.”
The idea of slow research is borrowed from the “slow food” movement. In academic and activist fields of global health today, we are all being asked to be productive in ways that create a sense of having to do more and to do it faster, to multitask for survival in a global workplace, to always be thinking of the next big thing, to scale up and implement, often even before we have completed our tasks at hand. Our perception of normalcy in relation to the pace and vigor of our work seems governed by entanglements in anticipation, innovation, and speed. These demands are not simply a result of how we conceptualize efficiency or capacity. Rather, they are directly related to problems of funding (capital), globalization (scale), and quality and focus (method). A call for slow research interrogates these demands. Slow research is not about doing less over time, although there is a temporal concern. Slow research is not necessarily opposed to ‘fast’ research, but it is opposed to what might be identified as a new normal. Slow research is a response, addition, and possible alternative to the newest normative trends. It entails working with an ethic or set of values and strategies that valorize different things from the emergent norms. Slow research calls for a deliberate shift in the way we do our work and the ways in which that work and its products are valorized. Much like the experience of slow food, a slow research movement is potentially both salutary and productive. The products and fruits of slow research, we believe, will ultimately be more satisfying and more helpful in the effort to create healthy people (or perhaps even a healthier world).

Not surprisingly, anthropology is well suited to developing the methods of slow research. Many anthropologist readers will see in this description a portrait of what they already do, and do well. In particular, we call attention to a case study of this by Pigg (2013). Our intervention is aimed at giving pause for reflection on this possibility, while providing an account of the various ways these ‘things we already do’ are increasingly infringed on but are worth defending. As a starting point for future discussions, and in the spirit of open-ended discourse, we call attention to five principles of slow research.

LOCAL IS BEST, OR IS THERE A POSTGLOBAL METHOD?

The slow food movement notes that by buying and consuming food that is locally produced, we serve and improve local economies and ecologies. Adopting this perspective in global health worlds speaks to a relevance that exceeds local places and communities, even while not being decidedly antiglobal. We mean to move beyond conventional readings of ‘local’ in two senses.

First, in global health worlds, there is a tendency to dismiss local specificities because they get in the way of large-scale comparisons and scaled-up implementation. Typically, regional, ethnic, or cultural differences are seen as variables that cannot be included in problem-solving and model-building, because such differences would demand a host of responses that are unique and tailored to specific communities. This approach overlooks the central role of local particularities in creating effective interventions. Historically, critiques of ‘top down’ approaches in international health attended to the problem of ignoring local specificity (Foster 1976), and slow research renews and invigorates this critique. Whether in the area of safe childbirth, prevention, and treatment of tuberculosis (TB), malaria, or HIV, nutrition, or even clean water programs, the methods of slow research call for heightened recognition of the need not only to tailor policies to local conditions but also to create research platforms that foreground these local particularities over and above those that are tagged as ‘global’ in nature.
We recognize that global health programs need to generate models that work across multiple communities and in many different nations. The tendency is thus to treat differences in belief, behavior, and context as if they were a kind of background static—a variable, but not necessarily one critical to the design of the research or intervention. Said differently, local differences, and the specificities that local contexts reveal, often form a kind of black box in conventional approaches in global health, filled with variables that are regionally, culturally, and nationally different but not considered critical to the intervention or the research. Thus, global health efforts to study things like safe motherhood, for instance, are often based on techniques of counting and intervention models that do not include local understandings of what constitutes a safe delivery or a safe pregnancy. Counting effectiveness of interventions in ways that ignore local perceptions might lead one to simply count single variables, like hospital deliveries and maternal death rates, because such statistics enable cross-cultural and cross-regional comparison. Such metrics are usually a result of efforts to evaluate the impact of intervention programs rolled out on a global scale (for instance, the UNICEF call for hospital deliveries as a solution to maternal mortality). But the use of globalizable metrics like these makes it nearly impossible to evaluate the messy and inconsistent evidence about not only the safety (or not) of home deliveries, and how hard they are to count in rural under-resourced settings, but also to account for how risky hospital deliveries might be, despite the ‘good numbers’ hospitals produce in and around delivery statistics. That is, some global metrics (like official figures on hospital mortality) become meaningless under the magnification of lenses that account for local specificities and behaviors surrounding maternal behavior that sometimes produce contradictory information about death during delivery (Adams et al. 2005; Pinto 2008).

Slow research takes the local as a starting point. It calls attention to and focuses on the importance of particularity and specificity. It assumes that the particulars which make one place or project differ from another cannot be set aside in favor of those qualities that make places and projects appear to be similar (Whiteford and Manderson 2000). Slow research assumes that the facts about health, and the conditions which might be necessary to attain it, are found in the often incalculable mosaic of evidence. Programs that work to keep mothers alive during childbirth in one place might differ radically in scope and method from those in another location, with some emphasizing use of clinics and hospitals, others relying on traditional birth attendants and emphasizing safe home deliveries and extensive prenatal care. How we make claims about what works and what does not work as a result of research is best when done with an eye to this specificity, even if it means giving up a comparative research platform.

Multiple kinds of intervention programs might work quite well, even if the programs are not comparable. Such an approach in research and in intervention strategy requires resisting the pull of new policies that are rolled out as universal mandates, often undermining existing programs that were working well. The dramatic shift toward hospital deliveries for safe motherhood that supplanted a decade of efforts to train and use skilled traditional birth attendants is a good example of this. Shifts like this are fueled by a research industry that demands globally comparable metrics, but positive health outcomes may not conform to the needs of global research. Paying attention to local conditions, behaviors, and beliefs as part of the research design, whether the goal is to count maternal and child survival or to simply determine the contours of effective interventions, is critical to making claims about effectiveness in slow research.

Slow research also recognizes that global mandates can impede local effectiveness, especially when they become tangled up in local or national perceptions that such programs will be cut
if evidence of varied success (or lack thereof) is produced. Parker and Allen (this volume) for instance, document how the global scale up of pharmaceutical programs for neglected tropical diseases (NDTs) form a tyranny over the production of evidence about effectiveness of these programs in Uganda and Tanzania, requiring even local on-the-ground researchers to suppress information about failures on grounds that such evidence might jeopardize national receipt of NDT funding. Demands to implement global mandates can be transformed into internal political battles that contravene researchers’ intentions and goals. The tyranny of the global is mapped out here as a problem of political investments in global scale interventions, and an unwillingness (or inability) to accommodate and adjust to specific local circumstances that might actually improve outcomes.

Second, the idea that local is best in the context of slow research recognizes that all knowledge is produced and has effects in a context, and these contexts are by definition ‘local.’ That is, local is a term that identifies the interaction of international, national, regional, neighborhood, and familial institutions as they coalesce and become visible. This ‘local’ can only be accessed through extended interaction in particular sites, what Joao Biehl calls “on the ground” (2007:109). The terms and contours of the local (grasped in this way) could serve to limit and configure what we do and how we do it in ways that improve our impact and relevance to local points of engagement. Slow research assumes that the local can always speak back to larger fields of funding, resource management, policy, and agenda-setting in global health arenas in ways that are not only critical but also positive in the sense that they are aimed at improving outcomes.

Slow research assumes that the best solutions are those that take these contexts into account. Slow research solutions are thus likely to not only be ‘local’ but also not necessarily relevant to other localities. Again, we recall this wisdom from early work in medical anthropology, such as the classic collection by Benjamin Paul, *Health, Culture, and Community* and Wellin’s essay on water boiling in a Peruvian town, in particular (1955). In the same way that the slow food movement holds antipathy toward the consumption of nonlocal foods, we highlight the potential of moving away from the notion of global or ‘globalizable’ starting and end points in conceptualizing interventions and solutions. This way of doing research suggests that local is not just a condition of time or place, but a method. The constant imperative to take an intervention that works in one place and globalize it (or what is often called ‘scaling up’) can be problematic. Referencing the slow food movement, we might also suggest that when treated as an unquestioned good, this imperative can be both uneconomical, and potentially ineffective. Just as the slow food movement recognizes that local resources provide the best solutions for local economies, slow research suggests that local solutions provide the best solutions for local health predicaments.

This does not mean that locally based solutions are not exemplary for other places. When members of Partners in Health, for example, emphasize that their model can work outside of Haiti (and show that it can), they are not advocating for a one-size-fits-all approach. Programs that are effective in one locale cannot necessarily be translated to other locales, but if they are, this translation requires intimate knowledge of and a sensitive response to the differences between the locations. The Partners in Health human rights approach, which emphasizes case management that is particularized to individual clients, is a useful model here; it makes notions of globalization much more complex than is typical in global health research.

The idea of an emerging focus on dissemination sciences in global health suggests that such complex notions of globalization might be necessary. Dissemination is frequently seen as a pillar of global health where discussions of ‘scaling up’ are assumed to be uniformly desirable and possible, as opposed to honing in and focusing on specificities that often make
replicability impossible. With this in mind, the proposition that *local contexts matter* cannot be stressed enough. Defaulting to a one-size-fits-all model, as witnessed in the early days of top-down international health development, would entail a repeat of historical failures rather than a progressive move toward improvement.

Slow research approaches problems of scaling up and implementation as a problem of local constraint and priority, rather than as a problem of top-down delivery. Take, for instance, the US program to replicate ‘evidence-based’ HIV prevention interventions through the Diffusion of EB Interventions. This effort to take advantage of programs known to have worked in one place and deploy them elsewhere actually calls for the use of local knowledge (What needs to be changed to make this program work here?) (Knight et al. 2013). At the same time, programs like Diffusion of EB Interventions mandate globalized research strategies (in this case, randomized controlled trial methods) although these cannot always be deployed (let alone relied on) to generate reliable data because of local constraints. It is this concern that slow research addresses.

The local has several reference points in the anthropological canon that help us craft our version of a different kind of global health efficacy. Geertz’s (1983) idea of Local Knowledge called for us to remember that inhabiting the everyday categories of those we study, to know their received wisdom, their colloquialisms and tacit knowledge, is to do the work of anthropology well. The ability to inhabit local ways of knowing gives research an edge over projects scaled to the global in several senses. Knowing what is going on at a local level provides an empirical ground for knowing what is likely to be a priority and concern for those who are closest to the health problems we study, and thus more likely to be received well by those who need it most. Paying attention to local repertoires for things like ‘safe delivery,’ ‘loose stools,’ ‘nausea,’ and the causes of diseases, whether conceptualized as anything from spirit possession to dirty water, can help researchers design interventions that make sense, much as the work of ‘appropriate technology’ does. Studies from medical anthropologists have long documented the advantages of understanding contrasting perspectives on not only disease and treatment (Farmer 1992; Rubel, O’Neill, and Collado-Ardon 1984; Nichter 2008), but even the organization of health care bureaucracies (Justice 1989). This is one way in which ‘local’ might be sustained as a priority using a slow research approach.

Gupta and Ferguson (1997) also call on anthropologists to rethink conceptions of ‘locality’ by undoing the notion of colonial regions and calling attention to the political economic networks that trouble notions of a uniform and universal ‘global.’ They advocate recognizing how located places always contain elements of the global—what Escobar referred to as “glocal” (Escobar 2001). Such interventions are particularly useful in global health where the “frictions,” following Tsing (2004), arise from global markets, global policies, and global ideologies at their points of local impact. We know that this friction can undermine the effectiveness of global health interventions, as seen for instance in the historical case of resistance by rural Indian communities to colonial smallpox inoculation (Marglin 1990), Algerian fathers refusing treatment for their sons’ meningitis under conditions of colonial medical care (Fanon 1978), villagers in Mozambique refusing President’s Emergency Plan for AIDS Relief –sponsored AIDS treatments until they received supplemental food (Kalofonos 2010), or Nigerians refusing polio vaccines due to religion and politics, and the suspicion it was a CIA plot (Barber 2013). Community decisions about global medical interventions do not occur in a vacuum. They partially occur in response to previous medical and political practices, in a reciprocal process that might be called “medical schismogenics” (Whitmarsh 2009). These examples reveal how international politics
shape the way Global Health interventions are seen and received by local communities. Such interventions are often understood to replicate older forms of colonial or world system inequality. Here what is significant is not so much understanding local culture but rather understanding how local participants respond to World Health Organization health agendas from a culturally embedded point of view while also responding to global politics. Interventions that fail to acknowledge these histories and the particular meanings of global in the local context can inadvertently reproduce forms of structural inequality, or intervention failures, in and through new health programs.

Finally, Lock and Nguyen’s (2010) concept of “local biologies” provides a template for thinking through empirical frameworks typically tied to notions of objectivity or universal-ity. The lens of ‘local biologies’ sheds light on local experiences of the self and body, the empirical ground of global health interventions. These too are useful to a slow research approach. Whether in the experience of menopause or HIV seropositivity, the idea of local biologies challenges us to move beyond simple concerns with cultural relativism to deeper engagements with ambiguity over whose versions of reality are correct, where being ‘correct’ refers not simply to an intellectual concept, but to a lived, biological experience. These challenges ask us to think about how different notions of biology are relevant to larger frameworks of intervention and to different conceptualizations of what an ‘intervention’ might mean (Burke, in press).

Along these lines, Veena and Ranendra K. Das’s “local ecologies of care” helps us see how everyday experiences of medicine are crafted in specific configurations of medical markets, policies (both national and international), practitioner behaviors, and household cycles of illness and labor (Das and Das 2006). This approach suggests an ‘ecological’ framework that conceptualizes intervention in terms of their potentially simultaneous impact across a broad range of social, biological, and political economic relationships (see also Nichter 1987), an approach echoed in the editorial by Alley and Sommerfeld (this volume, issue 2). Here, as one piece of the ecological reality is changed, its effects are necessarily systemic, affecting the whole system. Again, many of the early medical anthropologists who conceptualized ‘diseases of development’ captured this insight, tracing the inadvertently iatrogenic effects of things like mosquito eradication and deforestation on health (Hughes 1969). Slow research emphasizes an ecological approach by resisting conceptualizing projects in terms of singular interventions that comes from outside and change their singular target. An emphasis on local ecology also helps incorporate historical formations of global health interventions in the sense that it assumes that local ecologies and biologies are both constituted through multiple transactions and exchanges of resources, knowledge, and experience that have been formed over many years.

Our fixation on the local emerges from a commitment to see the global in situ as always itself a local phenomenon, a fact that in some sense defines the limits of its relevance. As these anthropological works have shown, the significance of the local is not restricted to the consumption side—the citizen or community or patients that make use of interventions and products. The production side is local too. Collier and Ong’s (2004) notion of global assemblage points to the contingent configuration—always particular—of any ‘universal’ or ‘global’ claim about ethics, materialities, and values. Johanna Crane (2013), for instance, demonstrates how productivity becomes fraught in global health research environments in Uganda, where efforts to create global standards for ethical review procedures inadvertently compromise and dismiss the work and perspectives of local research clinicians.
Commitment to the local entails paying attention to the context in which knowledge is produced and used. Techniques of efficacy, truth, and power are local phenomena, even when they travel across large geographic spaces and through time. We argue that attentiveness to the local enhances our ability to be relevant by being integrated into networks of significance that are themselves determined, and ultimately governed, by those we hope to study or to help.

PRESERVATION IS GOOD, OR VALUE WHAT IS ALREADY WORKING

The slow food movement deliberately calls for valorizing the source of what one consumes. Generally this ‘source’ is depicted as ‘nature’, to which a set of specific right and wrong judgments are attached regarding how one grows food, what food one grows, and how one buys it, prepares, and consumes it. The idea is that if it is closer to nature, or to a ‘natural’ or ‘organic’ source, then it is better. In the slow food movement, we recognize a somewhat romantic attachment to a specific notion of ‘nature’ as a source. Despite the romanticism, the commitment to ‘tried and true’ methods of food production resonates with the idea that there are historical ways of doing things that have been lost in the transition to mass production, global distribution, and efficient growing techniques. The point is that some old ways of doing things are good, if not better, and warrant protection and preservation. In borrowing from the slow food movement, notwithstanding the danger of romanticizing, we suggest that there is something important to be learned from an ethic of valorizing what already works, even if that means rejecting the prestige and fiscal opportunities of the new.

Our entry point for valorizing protection is the idea that efficacy is always contextual. Slow research shifts the question from ‘will the new work here’ to ‘what works and what does not work here already?’ This shift moves away from a priori valorizing ‘the new’ to evaluating the interaction of new technologies, knowledge, and techniques with older ones. Slow research is invested in deciphering ways to keep the old things that work in place, to protecting spaces and engagements that already work well, rather than simply assuming new is either better or worse. Whether in the realm of relationships, intellectual endeavors, or the public sphere, slow research aims to articulate why things need to not change, to be protected from the engines of change and innovation. Slow research, like slow food, aims to maintain older effective ways of producing, distributing, and consuming against the persistent demand of being bigger and better, or the fear of simply being passé.

We are reminded here of the continual stream of disheartening stories in which local NGOs just reaching a point of proficiency in implementing a program find they must shift their priorities and efforts to remain qualified for new aid funding streams (Justice 1989). Shifting to the new goals of a global effort does not always mean that the local communities are being served. We have seen this historically in multiple examples, including the prodigious literature on ‘diseases of development’ (Hughes 1969; Nichter 1987). Similarly, decontextualized microfinance programs offered without other social support in some locales have displaced existing efforts to create women’s empowerment, instead creating new forms of indebtedness (Brett 2006; Roy 2010). Finally, the global aid emphasis on HIV/AIDS prevention and treatment programs has in many places displaced reproductive health NGOs, along with other health programs (nutrition, immunization, hygiene, and education) that were foundational to long-term public health in under-resourced communities. Time and time again, we witness the downstream effects of policy
changes at donor, multilateral, and multinational levels—changes that paralyze local actors as they try to accommodate rapidly changing priorities (Justice 1989; Morgan 1993).

A slow research approach recognizes potential links between the demand for innovation and the acquiescence of global health research to market-oriented sources of funding. Innovation is not simply driven by lack of success in previous programs. Sometimes it is driven by the need for donors to obtain new sources of funding and new market-driven methods of funding in global health. Slow research works against the idea that the new is always better in part as a way to resist the demand for innovation as a form of market domination.

The push for innovation in international health development has been a characteristic of health aid and health development for many years and did not ‘begin’ with the rise of global health. However, because global health was identified as a response to perceptions that programs of international health to date had largely failed to reach the goals health development had set for itself, innovation is in some sense now one of the built-in mandates of the global health endeavor. Imperatives for rapid change in program approaches through calls for more and more ‘innovation’ are arguably also tied to the relatively larger role played by private sector organizations (as opposed to public sector governments and multilaterals) in global health. Innovation strategies found in the private sector are typically organized around business models that propose a win-win scenario in which product development and technological resources can be leveraged to bring both health solutions and profits at the same time. In the business world, innovation is not simply about finding better products but about finding new ways to brand and materialize ideas so that they can be used to generate more profits through ownership, marketing, and distribution. These priorities have migrated into the world of global health today, despite that the win-win scenarios envisioned by market-based problem solving may or may not work to bring health and well-being (Adams 2013; Erikson 2012; Holmes 2013).

The persistent demand for the next big things often risks supplanting discussions of how and why the last big things failed and, more importantly, what actually worked with them. But the demand for innovation in all aspects of global health research and intervention is pervasive. The commitment to the new has led to the elaboration of clear steps and structures designed to implement and adopt innovations. Now we even have a field called Implementation Science. The proliferation of activities surrounding the very project of innovation, we suspect, is potentially destructive to existing projects by failing to give them time to come to fruition, to succeed. We are reminded of perhaps a borrowing from market logics here, and particularly the model of ‘start-up.’ which is given roughly only three to five years to show a profit. Such demands for innovation are also potentially destructive because they may give false hopes of future success. The assumption is unwarranted that technologies will solve health problems in and of themselves simply because they can be distributed and, through investments in implementation, rolled out to the masses. They may be profitable, even if they do not work consistently to improve health.

The funding dilemma that community-based breast cancer programs face provides a good example of the pitfalls of allowing innovation work to supplant the work of allowing programs to grow and succeed over time. Breast cancer programs designed to link patients to financial, housing, psychosocial, and nutrition resources are effective because of the series of dependencies that are created between local community-based groups and donors—but they are often put at risk by demands for innovation. This demand is interwoven with the rhetoric of moral hazard. Only programs addressing newly identified needs or ‘innovative approaches’ are considered safe from becoming dependent on donors (and not self-sustainable). Programs often lose funding
just as they begin to effectively address a known need because the program has become ‘stale’ as a funding target in the mind of the donors. To sustain funding, health officials involved in these programs are often required to ‘repackage’ their approach or expand their demographic. In the context of dwindling public funds, programs are pitted against one another to demonstrate their relative value and potential for independence. Neoliberal logics at play here link fear of dependency with fear of stagnation, and insist on creating avenues for self-sustainability through innovation, even when the effort to create this innovation undermines successful programs.

Slow research highlights the unordered ways in which innovations occur that involve ‘rearrangement of existing resources’ rather than the continual adoption of the new (Essen and Lindblad 2012). A good example of slow research in action is the HEARTH nutrition program. This uses a model of community participation and the notion of ‘positive deviance’ to improve nutrition in poor communities (http://www.positivedeviance.org/pdf/manuals/PCVMali.pdf). Using the idea that in resource-limited communities there are usually some families that are doing things well, and some resources that are underutilized, HEARTH programs prioritize efforts to build on what works already, and what is already being used by families that has nutritional merit. Researchers working on nutrition programs like this often spend considerable time in a community studying what people eat, grow, and ignore in their repertoire of available resources. At the end of the program, they build a community hearth and demonstrate through community participation how to create nutritious meals with available resources. Such programs work in part because they are not replicable or able to be ‘scaled up’; instead, they build on local community resources and within local limitations. They are not considered profitable in the sense that they offer no new technologies, no large investments in products or drugs, and they are intensively focused on local-community based solutions. These approaches, while innovative in their own right, do not emphasize innovation as a means of scaling-up products or technologies.

DELIBERATIVE TEMPORALITY, OR RESIST ANTICIPATION

Slow food calls for ‘the pause’ before eating—a moment to contemplate what will be consumed, where it came from, and to be present for the tasting, the nourishing from the food ingested. These are expected and conscious pauses, harkening back to an idea of a perhaps romanticized past when such pauses were thought to be the norm rather than manufactured. They are a conscious response to expectations of immediate gratification and are intended to engage participants in the process of food production from its source to its transformation into a sumptuous dish. The pause produces deeper understanding and experience. Similarly, in slow research, those long pauses before activities (variously defined), whether a clinic appointment, a ritual engagement, or a graveside visit, might be necessary to fully experience, contextualize, understand, and therefore appropriately represent, the event. Like the pause before the meal, ethnographic pauses during which the researcher listens, engages, and observes patiently, enable us to understand the process, history, and genesis of the event.

Slow Research, in this sense, works against what some have noted is the burden of ‘anticipation’ in global health (Adams et al. 2009; Lakoff 2010). In the moment of pause, attention is drawn to the immediacy of the present and to its rich complexity. Slow research thus treats anticipatory modes of engagement as inauthentic posturing for futures that are not yet real.
Anticipation is, in this view, not the key to but the enemy of good futures. The anticipatory mode turns problems of the future into present urgencies while it effaces and undermines engagements with the problems of the present. Anticipation eviscerates the impulse to remain local in time, or to remain attentive to immediacy and problem solving in the near tenses. Preparation and consumption carried out under the burden of anticipation become acts that are void of present meaning, abducted by a future that, even while structuring the present, often never comes to pass or is gone before it was comprehended.

We can also think of temporality here in terms of the celebration of speed. As Mike Fortun (1998) has argued, speed has become a value associated with success. In the intersection of markets and sciences—from medicine to technologies to the life sciences—the rhetoric of speed is ubiquitous and ubiquitously embraced as positive. As with the anticipatory mode, the line between the descriptive and the evaluative is blurred here, in accounts of the ‘blinding speed’ of genomics, biotechnological innovations, and financial markets. But speed is also tied to a kind of valorizing of the ‘temporary’ as a suitable and proficient way to do work. The ‘hotel’ system in of new buildings (including at universities) and the ‘garage’ model are architectural designs of temporary residences for speedy and efficient research work. The time frames for productivity in these spaces are imagined to be limited, with defined beginnings and end points, and the ethic of their use is underpinned by an assumption that the shorter they are used, the faster the work is done, the better the results. In fact, most work envisioned for these spaces takes extended hours, weeks, and months if not years (Robinson 2013), and the possibility of using these spaces for time-limited productivity brings about a sense of temporal limitations to the products created therein, as if each new idea has a limited window of relevance and utility. These are attempts to craft a system in which the long-term temporal frames of basic sciences can be used to generate profits by configuring them into short-term transitional and temporary stopping points. But as this model migrates into the work world of global health, is it productive? Or rather, what kinds of productivities does it demand?

In the United States, Robert Abadie (2010) documents the mobile and temporary nature of pharmaceutical research—popping up in gymnasiums and vacant office buildings—and the labor provided by ‘paid volunteers.’ The mobility of the sites and the lack of participant tracking after the conclusion of these studies results in desired quick data but fails to assess long-term drug effects or to ensure accountability for participant safety. Adriana Petryna (2009) questions the applicability of findings from clinical trials that test drugs on poor people in international settings with attendant nutritional deficits to wealthy patients in industrialized nations—the intended users—who do not suffer similar deprivations. The lack of sustained engagement of Contract Research Organizations hired to conduct these clinical trials sometimes results in them becoming, de facto, the only health resources in underserved areas. In many ways, this model of limited temporal engagement itself poses risk and undermines the quality of not only research but also health.

One is also reminded of the now old critiques of heroic medicine, exemplified in charity groups which provide ‘free’ cataract and cleft palate surgeries in poor communities. These generous efforts, often by volunteer physicians, are extremely successful and deeply appreciated by those who receive surgeries at no cost. However, they are also often criticized by local physicians and health bureaus for their temporal shortcomings. Arriving and remaining for only short periods of time, these surgical teams offer no long-term care for patients, and they frequently undermine the credibility of local physicians and health workers. Moreover, they often cost local hospitals significant amounts of money, and create large gaps in expectation levels of clients.
Slow research calls attention to the benefits of extended periods of time in a particular site that allows for deep understanding of a phenomenon. Anthropology has long been based on such intensive time spent listening, watching, and interacting to come to a new understanding of who and what we study, as a form of gaining insight into the ‘common sense’ of those we study. This is not something that emerges intuitively, even when we might assume that the commonsense is familiar. This method requires purposive listening and interaction. And it takes time. It is found elsewhere—as a pedagogy in the ‘shadowing’ of medical training, in the personal accounts of scientists describing innovations coming to them in moments of patient reflection—Einstein used to describe insights coming to him as he sat in the woods outside the Institute in Princeton.

Anthropology is founded on the notion that this mode of patient attentiveness can produce new understandings that cannot be achieved by speeding up the process or streamlining it into simple questions. Evaluating changes over time and attending to the diverse processes of care requires giving oneself time to recognize what is unfamiliar in the landscape of commonsense assumptions. In these interstitial and unscheduled moments of attentive presence, a space is created to learn something not directly sought but likely important. These spaces are particularly productive of knowledge that is surprising: unexpected connections occur when space is made for them. Again, this usually takes time, but more importantly it takes being in the present with those we study (Fabian 2002).

The idea of being against anticipation means several things inscribed on the research endeavor. First, the idea suggests that research can remain open-ended and structured by the present, rather than predetermined by results that are anticipated because the research is hypothesis-driven, or scalable model-driven. Research that is not hypothesis-driven is often considered descriptive, rather than factual, anecdotal rather than evidence-driven. Slow research suggests the opposite: that hypothesis-driven methods, and many of the quantitative metrics on which they insist, are in their own way counterfactual, since, by the logic of anticipation, they create specific types of data and must ignore other types of data that do not fit the hypothesis-organized design. Second, being against anticipation refers to the possibility of allowing exploratory or generative methods to drive the research project. That is, slow research allows the unexpected to reconfigure the research itself, as it progresses and as new and confounding information arises (a strategy we return to next).

This more patient mode of engagement, the active work of extended listening, observing, and interacting, is a productive mode for research but one that we sense is increasingly problematic amid the current demands for both innovation and speed. Here slow research focuses on the present, the temporally adjusted commitment to taking the time to recognize what is currently going on before committing to innovation and speed in programmatic anticipations of better futures through intervention. Slow research is not opposed to thinking about futures, but it might systematically resist enabling projected futures to govern what we are able to see and learn from those who are the potential beneficiaries of our research.

QUALITY TAKES TIME, OR STRIVE TOWARD KNOWLEDGE RATHER THAN INFORMATION ACQUISITION

Critical reflection on the production of knowledge, like the production of food, invites us to think about the qualities that make knowledge different from just ‘information.’ Is slow food better than fast food because it takes more time to grow it, cook it and, we hope, eat it? If we think about this
through the lens of research, we might say that ‘slow data’ are better than fast data, whether we are talking about the nature, causes, and cures for disease, the most effective way to help people become healthier or happier, or the building of technological, political, or social communities. Here, the kind of data with which we work matters as much as the fact that we have it at all. One of the obstacles to slow research is the persistent imperative for efficiency that strips us of the ability to work with data that constitute and reflect ‘knowledge,’ not just information, built over time. Supplanting knowledge with information has an impact on the quality of the work we do.

Today, information tends to displace knowledge through demands on global health researchers that affix ‘good data’ to the mass (and often mass-mediated) production of information. One of these demands is created by the technologies and others are by the metrics that we are asked to use in order to stay relevant and to do good work. For instance, the encroachment of ‘evidence-based’ epidemiological approaches in global health has provided important insights about paying attention to measurable outcomes of interventions. It is important to know if an intervention makes a difference that is better, or worse, than chance, and is designed in a manner that allows reproducibility. But the use of evidence-based methodologies places a greater emphasis on producing data with statistical power. This often means shifting one’s research methods and objects of study in order to get ‘good numbers’ (Erikson 2012; Krieger 2011; Sangaramoorthy 2013).

We have witnessed numerous discussions among global health researchers in which the question of ‘what to study’ was governed not by concerns with what mattered to the communities targeted for interventions but by concerns with what would provide ‘good numbers’ or enough data to run quantitative analyses. Similarly, we have witnessed in global health a shift away from interventions for the sake of simply intervening and toward the idea that no intervention is worth pursuing if it is not delivered through an experimental research platform that will produce measurable outcomes (e.g., ‘comparative effectiveness’ research), that is, ‘good’ numbers (Biruk, 2012). This turn toward experimental platforms to deliver health aid makes interventions that are not designed in this way seem unworthy (or at least not worthwhile). This means that some health problems will never be addressed simply because they cannot generate good numbers.

The shift toward using clinical and laboratory methods to gather evidence creates challenges in the global health environment. One outcome has been the production of meta-studies of previously published articles. Often much of what was previously written is summarily rejected as reliable evidence, despite being published and peer-reviewed, on the grounds that the findings did not derive from experimental and statistically robust research designs. As a result, researchers who study community health behaviors are increasingly encouraged to narrow the project to single behaviors with measurable variables, creating robust research design but ignoring important realities about the interconnections between many behaviors and groups at the community level. As Marshall Sahlins wrote of sociobiological accounts of cultural institutions, research that simplifies everything to one variable is “a kind of bargain made with reality in which an understanding of the phenomenon is gained at the cost of everything we know about it. We have to suspend our comprehension of what it is” (Sahlins 1977:15). These shifts toward researching and implementing only new interventions have a way of turning global health work into little more than data-production activities that can undermine our ability to think through complex problem solving around evidence that does not lend itself to statistical forms.

Other technologies have also pushed knowledge out of the way and replaced it with various forms of temporary and somewhat superficial data. The tablet and internet have revolutionized how we work in ways that are rewarding and practical. At the same time, the use of such
technologies augments the idea that our work should fit within the opportunity windows enabled by these technologies. Reliance on these technologies for data tends to encourage a ‘forgetting’ of places, people, and practices not previously digitally catalogued and therefore readily available. Some technologies tend toward valuing data as temporary information (in fact, factual things literally disappear from the internet), and our collection of data once thought to be held in a kind of virtual limbo until it could be published, ironically, can now be made available as virtual truth overnight. And yet, these truths have a temporary quality, in part because they are temporary and in part because they will in all likelihood be supplanted by other data within a short period of time. Alzheimer culture has become the norm, where forgetting facts is as important as remembering them.

Similarly, in the mass of photographs and information available through internet information technologies, there can be a curious diminishing of prolonged engagement with content. What is increasingly valued is the quick fix of fame, the ten-minute TED talk of glory, the YouTube three-minute animated lecture. The amount of data as information produced by the speed and scale of new technologies and markets is astounding; however the commitments to this form of information production risks effacing the iterative back and forth process as well as the sustained depth of familiarity that comes with longer and often messier engagements. Knowledge lives within longer temporal frames, but information can travel fast through anticipatory circuits of capital and policymaking in ways that make us feel we have knowledge even when we do not.

In global health today, we find an emphasis on prodigious amounts of standardized data. One reason for this is that the demand for circulating massive amounts of data from site to site requires portable forms of information. Information in this sense is decontextualized so that it can travel far and wide and serve economies of scale. Global health researchers often talk about the need to get the data and get it fast. But the goal of producing fast research results in order to quickly produce healthier populations can undermine itself. Knowledge builds on experience and its contextual contingencies.

Similarly, we are troubled by a logic that information offered through short and simple modes of presentation will be of more use than longer, sustained, and complex engagement. While TED talks are more a pedagogical device than a research imperative or method, there are correspondences between how data and research are presented and the research done to produce these types of engagement. Research itself is at risk of falling prey to the same logic of efficiency and speed as the methods we use to report it. At a minimum, the local relevant logics uncovered by slow research are often obfuscated or reshaped to fit the short ‘highlights only’ format, and this can undermine precisely what matters most to the local context and people involved. The politics of knowledge here are fraught. Slow research approaches suggest that we recall and re-valorize those forms of knowledge that are slow and take time to form, alongside these investments in shorter, briefer, and necessarily superficial renderings.

One reason why short and simple presentations of information are valued in global health is that they are considered more efficient than other ways of communicating important ideas to donors, funding agencies, and the public. These modes of engagement emphasize the production of information over knowledge, while they create opportunities for new kinds of efficiency that, in the end, can compromise care. Yet efforts to make things more efficient do not necessarily result in improved outcomes when it comes to health care. Michele Rivkin-Fish (2012), for instance, shows how fiscal demands for efficiency chip away at physician independence. When pushed to discharge patients as quickly as possible, physicians lose control over the conditions of their work, but are still forced to justify their decisions on medical grounds. Efficiencies tied to speed and
rapid turnover destabilize previously secure identities and practices, even those ensuring other kinds of medical effectiveness.

As histories and identities are rewritten or reinterpreted through the lens of market value, ethics of care and moral obligation are renegotiated. ‘Management’ of care, time, and process emerges as a structuring logic that abbreviates some possibilities and eliminates others. Efficiency models drive the need to streamline behavior in ways that often undermine caregivers’ and global health workers’ instincts and preferences. Similar constraints and effects are seen in global health research, where efficiency models, often tied to private sector streams of funding (Pfeiffer and Chapman 2010) undermine our ability for extended observation and attentive listening, the very practices that enable us to illuminate the unanticipated work of these efficiency models.

Good research—like the long-term commitment to arduous laboratory repetition or ethnographic immersion in the local—should aim to acquire knowledge over information, even when data collection is made more difficult in the process and when this method suggests a kind of radical ‘inefficiency’ in its use of long periods of time. Techniques like ‘rapid appraisal’ (Scrimshaw and Gleason 1992) are designed to generate quick data about circumstances that are complex and should require lots of time to understand. Even while use of such methods may have an important role to play in some venues, and even though there is evidence that they can be used to bridge anthropological and other health research, it is also important to note the limitations of rapid appraisal techniques (Manderson and Aaby 1992), and to remember that such limitations may ultimately play a role in ineffective health care innovations. In our slow research model, questions of appropriate ‘length of time’ to completion of any research endeavor should be determined on the basis of the highest quality of knowledge possible, regardless of how much time it takes to get it, not in terms of the best quality of knowledge possible in relation to minimal time allowed. Quality of interventions may in many instances be inversely related to the length of time spent preparing the intervention. Slow research emphasizes this as a possibility and a variable.

RESPONSIVENESS IMPROVES RESEARCH, OR ALLOW THE ITERATIVE PROCESS TO INFORM OUR WORK

In slow research, from laboratory sciences to ethnographic fieldwork, results are analyzed in the course of the research in order to recalibrate the methods and techniques, getting at more targeted goals. This reciprocal process produces knowledge that is deeper and more responsive to context, and liberates research from its temporal constraints (faster is not always better; newer is not always more productive). The responsiveness to local relevancies is important here, and it dictates next steps. It does not call for innovation but for recirculation—a kind of recycling and making use of what is known already to improve upon it by multiplying its beneficial effects in a complex ecological framework.

In talking about responsiveness, we are interested in the ways slow research can be productive, getting results, making things happen. In the slow food movement, there is an assumption that the more committed one is to eating ‘slow food,’ the more likely one will access and participate in other ways of enriching the local production and consumptions circuits of slow food. The notion that slow food encourages people to eat seasonally appropriate foods (and thus to enrich their culinary repertoire), and calls forth commitments to other local and ‘green’ ways of living (from
recycling to mulching and home gardens), offers a parallel case for slow research. In research, we liken this to the recursive process between data and context, going deeper into the layers of exchange in and through which these data are made visible, enriching the ways in which one’s work will have impacts beyond the immediate health targets.

The process of becoming engaged with those with whom we work—making a choice about involving the community in our research—is an underlying ethic of slow research, as it is with the slow food movement. For instance, the slow food movement places value on the formation of communities in and around the local production and consumptions of food. Consumers are brought into face-to-face relationships with producers through farmer’s markets; grocers cultivate exchange relationships with local farmers, ranchers, and growers; restaurant chefs design menus with an eye to locally available and seasonal produce. One advantage of this emphasis is the iterative process that develops between consumers and producers that allows for immediate feedback about what types of foods are available and desired. Production is tied to the local environment, and consumption practices are more likely to accommodate unstable aspects of harvests. Supply and quality control issues are more likely to be addressed in a timely way through local circuits than with mass production circuits that operate on regional, national, or even international scales. Slow research similarly pays attention to these circuits of feedback and the iteration they allow.

Slow research ideally creates avenues for communication and participation between researchers and those who are studied. In this sense, slow research borrows elements from models of community participatory research (Minkler 2011). Montoya and Kent (2011) argue for deeper interaction between communities and researchers, with the questions posed and answers produced occurring through an iterative process they call “dialogic action.” Whereas community-based participatory research calls for necessarily structured and audited participation, slow research emphasizes fluid engagement tailored to the shifting needs of researchers and participants. Slow research, for instance, might work toward or against consensus-driven local practices, as the situation demands. In situations of radical social inequality or political oppression, one can imagine that the need for social justice models of engagement would be more suitable than consensus models (Nader 1990). Slow research embraces the possibility of shifting project goals and research aims as a continual outcome of the back-and-forth between researchers, knowledge-acquisition, and participant feedback. By leaving open channels for feedback and iteration, slow research enables us to see what is already occurring in the community that is worth studying, and perhaps protecting. Slow research prioritizes responsiveness to the constituencies with which we are engaged as targets of global health intervention and participants in this form of work.

The call for continual adjustment will be seen by many researchers as problematic because it is open-ended. Some will argue that this method compromises the ability to obtain consistent, reliable, and final data sets. And iterative processes that reprioritize and revise goals complicate accountability and auditing. Some will argue that being responsive to participant feedback can derail research and intervention projects because participants may or may not envision the same goals as researchers, and participants may not agree among themselves about appropriate goals. Rather than seeing these problems as limiting the potential for scalable, objective research or successful intervention, we advocate questioning what we think ‘counts’ as measures of accountability, efficacy, and success. In order to be accountable to the notion of successful research, one would have to accommodate iterative engagement.
This call to broaden the definition of those notions and rethink our measures of efficacy in ways that are more flexible and mobile is also a call to return to older forms of international health. To the extent that past international health research and interventions were successful even though they did not use experimental platforms, control groups, contemporary epidemiological and statistical models, or even DALYs, we believe it is worth considering why and how they were successful and revalorize those achievements. We believe that using iterative methods and taking the time to be responsive to target constituencies enables this return of value, even when such methods contravene normative standards used in global health today.

CONCLUSION

By opening up this discussion of slow research, we are not suggesting that global health today fails to help people. Our goal is rather to broach discussion about how we might create knowledge in ways that differ from currently valued modes of research and avoid some of its pitfalls, returning and recovering important methodological strategies that should not be abandoned. Part of what we hope is powerful about the slow research formulation is that it can appeal not only to ethnographers and other social scientists, but potentially to others in global health who are wary of the emphasis on quick and tangible products, or who feel that in striving to achieve new standards posed by evidence-based strategies, some key ingredients of success have been overlooked.

Our call for valorizing the small scale, nonexperimental, socially responsive intervention, and the idea that such an intervention may be only relevant to the local scene/context, is a stark alternative to normative discussions in global health, monopolized by questions of scaling-up, quick technological fixes, and statistically-based data-driven research. When Frances Moore Lappe wrote her landmark *Diet for a Small Planet*, in 1971, it was seen by some as a basis for a paradigm shift. It would take 30 more years for her insights to take hold on a broader scale. Today the ‘slow food’ movement actualizes many of her proposals, and the proposition of a global impact of valorizing the small scale is now widespread. Unlike Moore Lappe’s work, our goal is not to devalorize normative paradigms in global health research, but to revalorize what preceded them, to recognize that alternative forms of knowledge production might continue to be of use in the endeavor to improve health on a global scale. Thinking globally and acting locally may seem a trivial aphorism for problems that are so large in scale and scope—malaria, tuberculosis, poverty—but the possibility of transforming many small successes into a global mosaic of health for all is, we suspect, still within reach.

NOTES

1. We are not alone in calling for the value of a science that takes adequate time amid the contemporary call for speed: in Europe, a “slow science movement” has formed around the felt need to protect the time of scientists (for instance, see the Slow Science Academy’s “Slow Science Manifesto” at http://slow-science.org).
2. We are aware of the fact that the Slow Food Movement is less essential and more contingent than we take it to be in this essay. We use this version of the movement as a heuristic, to say something about methods of research in Global Health, not as a way of arguing for a fixed and eternal version of the movement itself.
3. We thank Dana Greenfield for drawing out attention to the Sahlins’ passage. We are also grateful to Sharon Kaufman, Kelly Knight, and Lenore Manderson for editing suggestions.
4. For instance, one argument for use of rapid appraisal techniques is that it enables participatory research. That is, to the extent that there is a desire to include local participants in the research project (as in community-based research), rapid appraisal techniques are thought to be a useful resource because they can be taught quickly and effectively to a nonexpert.

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