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Epidemic confusions:
On irony and decolonisation in global health

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Abstract

The movement to decolonise global health is gathering pace. In its concern with the fundamental, distal causes of inequality and its call for social justice, the decolonisation movement forces us to question how global health works, for whom, where it is located, its funding practices, power asymmetries, cultures of collaboration and publication. This paper uses a new book by Harvard-based physician-anthropologist Eugene T. Richardson, *Epidemic Illusions,* as a point of departure for a broader analysis of the nature of global health knowledge, science, authorship, research and practice. Written in the 'carnivalesque' style, the book proceeds through a series of 'ironic (re)descriptions' to argue that global public health is an 'apparatus of coloniality'. In so doing, the book is generative of four 'ironic turns' that we explore through the themes of guilt, humility, privilege and ambiguity. In locating these ironic turns within the broader landscape of global health, we reflect on whether the *means* of such a book achieve the *ends* of decolonisation.

Keywords: global health, decolonisation, coloniality, irony, power

Introduction

The shift from 'international health' to 'global health' towards the end of the twentieth century – part temporal-technical evolution and part semantic attempt to dissociate the field from its colonial roots (Packard, 2016) – has long been marked by intense debate about what global health *is* and *should do* (Koplan et al., 2009; Beaglehole & Bonita, 2010). This debate has also been concerned with *where* global health is located and for *whom* it works (Crane, 2013; Herrick, 2017; King & Koski, 2020). The question of how those in global health work together, whether in partnership or collaboration, and the terms of these exchanges, has generated important insights into the vast power asymmetries in the field (Brown, 2015; Parker &

Kingori, 2016). Particular ire has been reserved for those research relationships deemed to be extractive or 'parasitic' (Smith, 2018; The Lancet Global Health, 2018), a situation that is irreparably worsened by cultures of publication within key medical journals (Abimbola, 2018; 2019) and funding structures for global health research (McCoy et al., 2009; Greenberg & Aggrey, 2020). The enterprise of global health thus presides over a fundamentally unequal world, but its architecture – funding, political priorities, grant themes, expectations of expertise, publication, protocols – more often magnify and entrench rather than unseat these inequities (Akugizibwe, 2020).

While criticisms of global health structures and infrastructures are longstanding, the movement to decolonise global health has only recently gained momentum. Accelerated by the West African Ebola outbreak, the killing of George Floyd, the ascendancy of Black Lives Matter and recognition of the deep racial disparities in the impact of Covid-19 in countries like the US, Canada and the UK, calls to decolonise global health are growing fast and getting louder (Abimbola & Pai, 2020; Büyüm et al., 2020; Lawrence & Hirsch, 2020). A central argument of the decolonising global health movement is that the enterprise itself 'focuses on consequences such as health inequalities and inequities rather than their root causes' (Affun-Adegbulu and Adegbulu, 2020, p. 3). Authors broadly concur that global health too often side-steps the origins of the poor health outcomes that it purports to improve and, in so doing, reinforces power asymmetries and does little to address the real causes of human suffering.

Perhaps unsurprisingly, there is less agreement about how decolonisation should proceed and what justice might look like (Abimbola & Pai, 2020). For example, on the questions of method, scope and objectives, Affun-Adegbulu and Adegbulu skirt prescription, instead arguing that, 'there can be no one-size-fits-all approach, as this would again mean (re)producing the universalism that is inherent to coloniality' (2020, p. 2). Abimbola and Pai, on the other hand, contend that, 'to decolonise global health is to remove all forms of supremacy within all spaces of global health practice, within countries, between countries, and at the global level' (2020, p. 1627). Thus, to decolonise, global health must become 'actively anti-supremacist, anti-oppressionist and anti-racist', offering the world 'a better version of itself' (Abimbola & Pai, 2020, p. 1628). Desmond Jumbam (2020) illustrates a number of concrete steps towards this end in his powerful satirical piece on 'how (not) to write about global health': the need to democratise and decentralise knowledge platforms; recalibrate flows of expertise and mutual learning; diversify global health leadership; and treat health as a human right rather than

'charity or saviorism' (Abimbola and Pai, 2020, p. 1628). Others critique how global health is taught, particularly the lack of attention to historical context, culture and political economy, the domination of biomedicine over the social sciences, and the privileging of certain types of Northern, Western, Eurocentric knowledge (e.g., Adams et al., 2014, 2019; Clark, 2014; Koris, 2020; Montenegro et al., 2020). Underpinning much of this movement are concerns with the apparent limits of global health equity frameworks, as well as efforts to highlight and tackle the origins and manifestations of structural racism across all domains of life.

Epidemic Illusions: On the Coloniality of Global Public Health, by the Harvard-based physician anthropologist Eugene T. Richardson (2020), is one of the latest entrants to this growing domain of scholarship and activism. Championed by medical anthropologists like Paul Farmer and Arthur Kleinman, and influential political commentators such as Cornel West, a review in *Africa Policy Journal* labels it 'one of the most bold, honest, and important reads of the year' (Arogundade et al., 2020). Such accolades are not restricted to academic circles – according to one Amazon reviewer, 'As Said was to Orientalism, Richardson is to global public health'. The comparisons don't end there: 'As Black Lives Matter is to white supremacy, *Epidemic Illusions* is to epidemiology', a *Counterpunch* reviewer recently raved (Yamada, 2021).

Given this widespread acclaim, we were intrigued to read a book that promised new insights into the coloniality of global health whilst pushing the boundaries of academic scholarship. However, in contrast to the careful analysis that characterises much critical social scientific and historical scholarship on global health (reduced to a two-page 'point of departure' in the book), *Epidemic Illusions* comes across as an often-flippant characterisation of a field warranting far more careful reflection and analysis. Given that its central hypothesis that global health operates as a tool of coloniality is non-novel (a point Richardson himself acknowledges) and has arguably been presented in a more convincing and nuanced fashion by others, its positive reception seems to be explained partly by Richardson's self-conscious adoption of a 'carnivalesque' style and 'ironist perspective' (2020, p. 14). Drawing inspiration from Richard Rorty's description of an ironist as someone who realizes that 'anything can be made to look good or bad by being redescribed' (Rorty, 1989, p. 73), the book thus proceeds through a series of 'redescriptions' that aim to reveal the underlying coloniality of global health.

A self-declared ironist perspective is an unusual choice for a book that asserts a series of truth-claims about the nature of global health, given that ironism – at least as Rorty defined it – is about unsettling certainty, not revealing truth (see Ryu, 2001). In other words, redescriptions are not a way of transcending appearances to reveal 'the real'; for Rorty, 'there is no answer to a redescription save a re-re-description' (1989, p. 80). This conceptual confusion in the book, as we will explore, thus engenders a series of further ironies. As Michael Lambek (2003, p. 2) notes, 'Irony can be located in many ways – as a feature of the world, as a rhetorical trope, as a kind of attitude'. Irony also raises questions of intention, with a distinction often drawn between intentional or performed irony that is 'made' by the author versus unintentional or inadvertent irony that is interpreted and 'found' by others (Lambek, 2003; Carrithers, 2014).

It is these latter, inadvertent, ironies that primarily concern us here. In what follows, we aim to draw them out as a contribution to ongoing conversations about what a decolonising agenda might look like and how it should – and shouldn't – proceed. This paper thus explores the ironies inherent within *Epidemic Illusions* as a purposefully critical point of departure for a series of wider reflections on the nature of global health knowledge, research and practice. We focus on four 'ironic turns' that emerge from the book: guilt, humility, privilege and ambiguity. In exploring and fleshing out the inadvertent ironies that emerge from Richardson's ironist redescriptions, we examine how this ultimately undermines what Moosavi (2020, p. 334) has described as the 'decolonial quest for justice and inclusivity'. The question that we therefore raise concerns *means* and *ends*, and whether the *means* of Richardson's 'mind bending' writing (Pai, 2021) will achieve his aspirational *ends* of 'epistemic reconstitution and improvement of human wellbeing' (2020, p. xxiii). Following James Ferguson (2010, p. 167), we ask 'what do we want?' of such political critique, and whether a book like *Epidemic Illusions* can deliver on the 'wants' of global health's decolonisation, or whether, as part of the 'decolonial bandwagon' (Moosavi, 2020), it may instead be closer to Rorty's understanding of ironism as the 'project of fashioning the best possible self' (Fraser, 1989, p. 98).

Irony 1: Epidemiology, the guilty disciplines and the importance of history

A central thread in *Epidemic Illusions* is that epidemiology and its models 'serve as an ideological apparatus of imperialism by shielding the structural causes of health inequities in the global south' (2020, p. 46). Richardson contends that the methods and ideologies of epidemiology hold a monopoly on global health truth via the discipline's ability to sanction certain accounts of disease causation, which then become 'reified as commonsense' while other

perspectives are ‘marginalized’ (2020, p. 5). To address this, Richardson argues that ‘breaking up the Global North’s monopoly on truth will transform global health by transforming its representations’ (2020, p. 10). While sympathetic to his frustration regarding the disproportionate authority granted to epidemiologists and their often widely inaccurate models, we were nevertheless perturbed by the book’s characterisation of epidemiologists (see also Agaranov, 2021; Pai, 2021), who are condemned wholesale as having ‘had their moral outlooks stunted by coloniality, which delimits how they gather facts’ (2020, p. 92). This not only underplays (and obscures) the sub-fields of social and political epidemiology and the debates among and between them (Amon, 2014; Krieger, 2011), it also ignores the overt historical, political and economic causal explanations inherent in the ‘social determinants of health’ research tradition (see Herrick & Bell, 2020).

While the inaccuracies and forms of knowledge built into (and transmitted through) Ebola modelling is a core focus of Richardson’s disquiet, he also takes aim at the discipline in far broader terms. The institute of Health Metrics and Evaluation (IHME) and, relatedly, their Global Burden of Disease (GBD) study, for example, are called out for their ‘hermeneutic injustice’ in reifying ‘downstream risk factors as determinants of morbidity and mortality’ (2020, p. 85). Richardson accuses IHME of being more than just ‘prisoners of the proximate… rather they become the apparatchiki of global apartheid by decoupling analyses of power from disease dynamics’ (2020, p. 87). In the context of such charges, it is important to pause and put contextual flesh on Richardson’s claims regarding the GBD and IHME. We therefore want to tease out two inadvertent ironies that emerge from Richardson’s characterization. These are especially marked given the importance Richardson himself places on the distal, historical drivers of the present. But, perhaps most importantly, these details are deeply consequential for how we know and understand the global health inequities that drive so much of the work undertaken in the field.

The GBD study has grown from the early work of Christopher L. Murray, Alan Lopez and Dean Jamison on the World Bank’s 1993 *World Development Report* into a global enterprise funded by the Bill and Melinda Gates Foundation (Shiffman and Shawar, 2020, p. 1455). Just as Richardson writes of his ‘insane experience’ (2020, p. 5) at the frontline of global health’s humanitarian emergencies, the IHME’s director, Christopher L. Murray, could also lay claim to similar experiences. As his biography makes clear, his parents’ annual trips to Africa with their four children to work in what Paul Farmer terms the ‘medical desert’ inspired Murray’s

later application and admission to Harvard Medical School. Here, he befriended Paul Farmer and Jim Yong Kim, both of whom would go on to found Partners in Health (PIH) – for whom Richardson has worked for alongside alongside Murray's sister, Megan B. Murray. Murray's early PhD research was presented in colloquia to Harvard faculty Arthur Kleinman and Amartya Sen. Both academics fundamentally influenced Farmer's own understanding of human suffering and, therefore, cannot be detached from the genesis and language of *Epidemic Illusions.* But, it is crucial to remember – especially given Richardson's characterisation of IHME and the GBD – that their perspectives equally shaped the trajectory of Murray's own work and his aim, just like his friends Farmer and Kim, to 'improve the lives of the world's poorest people' (Smith, 2015, 59).

Second, compounding the irony of Richardson's attack on the IHME and GBD, Paul Farmer's endorsement on the back cover of Murray's biography describes the vital statistics of the GBD as telling 'mortal dramas'. This is an important irony – and even more so originating from Farmer – which forces us to question the utility of characterising, as Richardson does, IHME and the GBD as mere 'transfer mechanisms for the neoliberal ideology of predatory individualism' (2020, p. 85). Notably, one of the main aims and outcomes of the 1993 *World Development Report* was to render visible previously hidden or unknown burdens of disease in lower-middle income countries, and, with it, recalibrate the global health endeavour (Gaudillière & Gasnier, 2020). As Wahlberg and Rose assert, the GBD was hugely significant for 'making non-fatal outcomes calculable' and thus uncovering mental disorders and noncommunicable diseases as the major global cause of disability (2015, p. 4). For policy makers, the GBD was envisaged as a tool for better decision making (Smith, 2015), enabling limited resources to be invested in those areas of greatest need, not just among those advocacy groups shouting the loudest (Cohen, 2012; Vogel, 2012). This was especially important, given that Murray's work had shown that only 10% of global health funding was going to diseases that affect 90% of the world's population (Smith, 2015). Of course, many have justifiably critiqued the IHME's monopoly on data for eroding the statistical autonomy of countries of the Global South (Tichenor & Sridhar, 2019). But to dismiss, as Richardson does, the entire endeavour as 'unradical' is to de-contextualise and a-historicise the origins and objectives of the GBD in a way that sits uneasily with the central conceptual tenets of the decolonial movement.

Irony 2: Humility, meta-narratives and the tyranny of detail

In an interview with Madhukar Pai (2021), Paul Farmer argues that the decolonisation agenda requires that 'we dig deeper into the historical record'. Given the interlinkages between Richardson's and Farmer's work, reading the latter's most recent book – *Fever, Feuds and Diamonds* (2020) – alongside *Epidemic Illusions* is an interesting exercise in cross-referencing and calibration. Doing so also reveals the inadvertent ironies that emerge through the kind of detailed analysis called for by Richardson, but largely absent in his book. In illustrating the coloniality of global health, epidemiology and public health, *Epidemic Illusions* proceeds through generalisations and assertions that stand in marked contrast to the ethic of humility that pervades the decolonisation agenda. This is especially ironic given Farmer's assertion that, 'every generalization risks washing away the messy details of social life and social history, and should be corrected by the specificity of historical and ethnographic accounts and informed by the lived experience and clinical condition of the sick' (2020, p. 183). It is to the humble necessity for detail that we now turn.

Farmer's contention that 'there was too little *T[reatment]* in the Ebola Treatment Unit' (p.xiii) is a refrain that carries right through its dense 526 pages. Richardson echoes this point, but contrasts the 'control over care' paradigm favoured by the WHO with the approach adopted by PIH's Ebola response in Sierra Leone. This instead operated under the 'twin mandates of prioritizing patient care and government involvement', allowing this exceptional 'warrior caste' to 'work under conditions where other tribes would not' (2020, p. 36). The 'therapeutic courage' (2020, p. 30) of PIH during the West African Ebola outbreak is thus presented as a moral outlier vis-à-vis the far more 'extractive… travelling circus of humanitarian relief and epidemic research' (2020, p. 39). This fetishisation of the PIH response (see Agaranov, 2020) is given crucial nuance – that gives far more insight into coloniality at work – by Farmer's account of the difference between Sierra Leonean and expatriate healthcare worker treatment and survival rates. He devotes significant text to exploring the difficulties and dismay of having to medevac an American PIH staff member back to the US (who was cared for by none other than Dr Anthony Fauci) when they contracted Ebola in Port Loko. Thus, while the question of the gulf between the treatment and care afforded West Africans compared to their Western counterparts runs throughout both books, Farmer's reflections shed light on the dynamic and relational geographies of the Ebola epidemic and its global health interventions. By contrast, *Epidemic Illusions* – in a powerful example of performed irony producing inadvertent ironies – reinforces a far more simplistic and dualistic vision of the world and its geographies.

For example, Richardson actively sets apart his 'colleagues in the Third World/Global South' as if they occupy a separate category of readership weighed down by their 'experience of epistemic violence' (2020, p. 13). Throughout, an amorphous and geographically mysterious Global South is juxtaposed against an equally geographically mysterious Global North. More than this, in the book's empirical focus on West Africa, the region appears as the synecdochal referent for the totality of global health in the Global South. In so doing, Richardson falls into the trap highlighted by Moosavi (2020) of the 'decolonial bandwagon' too often essentialising the Global South. Richardson's use of the Global South descriptor is often far more absolute than might be expected for a book whose foreword takes the reader on a global tour of 'the plagues he's battled' across the world (Richardson, 2020, xviii). The Global South instead becomes, 'a drastically simplified notion which mimics the crude geographical categorisations that colonialism was built upon' (Moosavi, 2020, p. 344). More problematically, in setting the global health enterprise of the Global North against the surprisingly stymied voices of Ebola 'patients, survivors and their close contacts' (Richardson, 2020, p. 98), it does little to expand out the geographical terrain or imaginations of the global health field. For, as Moosavi has equally argued, 'instead of essentialising the Global South, it should be understood that the Global South is such a vastly diverse entity that it can never be said to have a single essence that can be discreetly conveyed' (2020, p. 344).

While Richardson obviously opposes the fixing of much of the Global South's dependency and vulnerability through the coloniality of global health science, he does little to unsettle the North-South dualism and intense power asymmetries that, it must be remembered, so many others have ably critiqued in the practice and imperfect partnerships of global health (see Brada, 2011; Crane, 2013). Here, we agree with the *Lancet* commentary by Fitzgerald et al. (2017) published in reaction to Richardson and colleagues' paper 'The Ebola suspect's dilemma', which calls it out for 'framing the outbreak within the trope of African subjugation or passivity in the face of international colonialists' (2017, p. E659). Richardson et al.'s response does little to reassure the reader that this critique has been subject to the kind of critical reflexivity that the decolonisation agenda actively calls for and that its author impresses upon others so forcefully (2020, p. 136). Little appreciation is also given to the tranche of multidisciplinary work that has long aimed to decentre knowledge through its privileging of theory from the South (see Connell, 2014, for an overview). The geographical and historical nuance of modes, experiences and practices of colonialism, post and de-colonial trajectories, and the 'baroque' nature of the complex 'ideological and cultural relationship which sub-Saharan Africa has with

the rest of the world' (Bayart & Ellis, 2000, p. 251) are barely acknowledged in the book. Nor are ever-increasing South-South relationships in global health or the extractive relationships between Africa and countries such as Brazil and China (see Allotey, 2021). Even 'the destitute sick' –as Richardson labels his interlocutors – are not given a direct voice. Returning to Jumbam's (2020) recent treatise on how (not) to write about global health, Richardson's book ironically falls into the trope trap of, 'lots of poverty and death, helpless people, corrupt national or local governments, something about colonialism, and oh yes, weak health systems' (2020, p. 1). The point here is that even the purest of decolonial ambitions can inadvertently reinforce the very same coloniality that they decry.

Irony 3: Power, privilege and priorities

In some of the book's most widely quoted passages, Richardson owns his considerable privilege. 'My ideas on the coloniality of global public health come from engagements as a privilege-exerciser (white upper-middle-class male settler-colonist) in the Global South and its spigots in the Global North' (p. 4), he informs the reader in the introduction. He continues in this vein in his 'Redescription 1: Colonizer, interrupted' – a fictionalised '*bildungsminiroman*':

> We begin with a white upper-middle-class male settler-colonist privilege-exerciser called Quesalid, after the famous shaman of the Pacific Northwest (settler-colonists have no qualms naming people or places after human groups they've decimated). His childhood was typical – summers in Rangoon, luge lessons (p. 42)… It suddenly dawned on Quesalid that as a white male citizen of the First World, his privilege derived from a racialized, patriarchal, hierarchical, asymmetrical, imperial, heteronormative, neoliberal, and Euro-American-centric order. 'You are a colonizer through and through,' he thought (p. 19).

While the tone is supposed to be playful and ironic, it's unclear whether he is symbolically excising his privilege or satirising wokeness (a point we will return to below). Elsewhere, Richardson frames himself as a champion for the oppressed – or, in his words, 'the Havenot-isteme' (p. 6). His aim, he tells the reader, is to reclaim 'Havenot-istemic knowledge production – that is, subjugated ways of interpreting phenomena that do not become hegemonic, owing to the social position of their creators and their often-destabilising ramifications for global elites' (p. 6). The scene is set a few pages later, when Richardson castigates James Ferguson's *The Anti-Politics Machine* for its similarities to Kwame Nkrumah's *Neo-colonialism: The Last Stage of Imperialism*. Richardson continues, 'Once I observed how coloniality permeates even the most ostensibly progressive echelons of academia – where privileged scholars appropriate the intellectual property of thinkers from the Global South and gentrify it – I began to recognize it in global health praxis' (p. 10).

There is no question that Richardson cites many non-dominant voices throughout the book, and that is surely a welcome development. However, given that these voices are mostly either name-dropped *en masse* (p. 10) or relegated to chapter epigraphs, one could question the depth and breadth of engagement with this literature. More detailed encounters, such as 'Redescription 2: The Allegory of the Warren', do little to reassure the reader. Consisting of a hypothetical conversation between the American semiotician Charles Sanders Peirce and the Ghanaian philosopher and leader Kwame Nkrumah, the dialogue bears little resemblance to the voices of either – other names could be readily substituted with little impact on the dialogue itself. It is not that we object to the strategy, which has been used to superb effect by Steve Woolgar (1993), among others, but that we would expect someone so willing to call others out for their intellectual appropriation of Nkrumah's voice to be more careful in commandeering it themselves.

For us, a central inadvertent irony in the book is Richardson's seeming obliviousness to the ways in which his observations about 'how coloniality permeates even the most ostensibly progressive echelons of academia' (p. 10) apply equally to himself. We are therefore reminded of Claire Wendland's (2019) reflections on scholarship by physician anthropologists, where she observes that,

> Much of it is powerfully compelling work. Much of it rings with moral authority. And while that moral clarity is galvanizing... it also calls for an exercise of caution. In clinical settings, physician authority has its dangers. It can mean that potentially useful interventions and observations by other professionals, such as nurses and social workers, go unnoticed or unheard; it can impede creative thinking; it can lead too easily to a speaking-for rather than a speaking-with position; it can leave physicians blind to their – our – own privilege (Wendland, 2019, p. 199).

Indeed, rather than *excising* privilege, the very existence of the book seems an *exercise* in it. Would this book, in this form, have been published by MIT Press if written by a scholar from either Beni or Addis Ababa – the locations from which Richardson (ironically) informs the reader that he has written the introduction and afterword? Given the harms caused by the 'predatory publishing' discourse to scholars in sub-Saharan Africa (Mills et al., in press), we suspect that any African academic book publisher would be immediately discredited for publishing a book by an African scholar that chose to similarly approach topics 'heuristically, rather than via linear argument or conventional ethnography' (Richardson, 2020, p. 12). Clearly, this kind of writing experiment is one that very few academics can afford to take – at

least, if they are to stand any chance of successfully getting published. Likewise, for such an experiment to be taken seriously, both the authors and publishers willing to take such 'risks' must have considerable symbolic and cultural capital.

In fact, we can think of little better illustration of the coloniality of knowledge production about global health than the book's publication itself. The *Global Health 50/50 Report 2020* (aptly sub-titled 'Power, privilege and priorities') notes that '85% of global organizations active in health and health policy are headquartered in Europe and North America' (2020, p. 16). This spatial concentration of power and influence is further evidenced by the fact that 80% of global health leaders are nationals of high-income countries and 92% obtained their degrees in high-income countries (*ibid*). It is of particular note that 8% of global health leaders obtained their degrees from Harvard – the same as the proportion of those with degrees from all lower-income countries combined (see also Greenberg & Aggrey, 2020; Plancikova et al., 2020). Given these dynamics, that a book about the coloniality of global health written by a Harvard academic and published by MIT Press has been touted as 'game-changing' is obviously ironic. That the foreword is also written by a Harvard colleague rather than the 'colleagues in the so-called Third World/Global South' (2020, p.13) to which Richardson expresses his gratitude for their accompanying of his 'unlearning' is only rendered more ironic for the book's same calling out of other global health practitioners for not having African co-authors. These forces coalesce to magnify, in both advertent and inadvertent ways, the politics of privilege in the context of scholarly knowledge production, by doing little to attend to the question regarding the extent to which the subaltern can speak, and, equally importantly, who can speak for the subaltern (Spivak, 1988).

Irony 4: Irony, ambiguity and double-edged swords

Having said much about the inadvertent ironies the book engenders, we want to come full circle to consider its intentional, performed ironies. Richardson describes the book's ironist style as 'an approach that intends to destabilize and question hegemonic modes of knowing' (2020, p. 2). However, while presented as an experiment in decolonising academic writing, the book is hardly accessible to a non-specialist. This inaccessibility is summed up in one of the rare critical Amazon reviews of the book. Titled 'Written for pompous academics', the reviewer rants, 'Impossible for a normal person to read. Who writes like this?' In our view, those trained outside the humanistic social sciences (and potentially within them) would struggle to wade through the arguments. Indeed, its style seems designed to alienate the very audience that

Richardson suggests the book is intended for: global health practitioners. It is unclear how 'presenting their intellectual categories in potentially novel fashion' via ironic 'redescriptions' (p. 14) will serve to convince 'those global health practitioners who have not [already] been convinced' (p. 12). This raises larger questions about who the book's intended audience is and what its ironism really accomplishes.

Although Richardson represents carnivalisation as straightforwardly subversive, a vast body of literature has highlighted the ambiguous relationship between the carnivalesque, parody and the status quo. As Mark Burde (2014, p. 556) observes, 'A recurring conundrum in carnival studies is how to evaluate consequence and political valence. Is any given festive or ritualistically parodic production innocuous or antagonistic toward the power hierarchies in which it operates and whose language it often appropriates?' Take, for example, Horace Miner's 'Body Ritual Amongst the Nacirema' (1956), which Richardson treats as a straightforward satire of Americans, using it as the basis for his 'Redescription 3: The Pacification of the Primitive Tribes of Lake Geneva' – a Nacirema-esque takedown of the World Health Organization. However, as Burde (2014, p. 550) notes, the Nacirema can be read in multiple ways – as either a satire of American culture, or a parody of anthropological writing conventions and the interpretive risks run by the 'zealous and overearnest ethnologist'. These radically different readings speak to the ambiguities of satire, parody and irony itself, and the challenges these genres pose to any straightforward reading of authorial intention.

An illustration of this problem can be found in the satiric scholarly article 'Maternal kisses are not effective in alleviating minor childhood injures (boo-boos): a randomized, controlled and blinded study' (SMACK Working Group, 2015). Ostensibly authored by the Study of Maternal and Child Kissing (SMACK) Working Group, the paper satirises the paradigm of evidence-based medicine in a manner that amusingly illustrates its limitations. However, to the author's surprise, it was quickly taken up as a 'real' study, despite its obviously satiric intent. As he reflected in a subsequent letter to the editor,

> Satire, no matter how ridiculous or unbelievable an author may find it to be, will be lost on some… Not only did many of these posts and comments take the study to be real, but they imbued it with qualities that supported their own biases and causes: waste of government money, an attack on the values of mothers and the family, a piece of mind control propaganda or a demonstration of the worthlessness of science (Tonelli, 2016, p. 141).

Further complicating the use of irony, parody and satire in academic scholarship is the existence of Jeffrey Sokal-style hoaxes (see Sokal, 2000) by self-styled Defenders of Science aiming to parodically expose the lack of intellectual rigor in fields such as cultural studies, and the role of ideological faddism in what gets published. A recent example can be found in the 'conceptual penis as a social construct' hoax, which claims to reveal the 'extreme ideologies' in gender studies by 'carrying out their arguments and rhetoric to their logical and absurd conclusion' (Boghossian & Lindsay, 2017). While based on several questionable assumptions, the very existence of this genre poses challenges for a book like *Epidemic Illusions*, because of the ways in which Richardson's self-conscious use of ironism seems to unintentionally echo their satiric intent. This problem is exacerbated by the unevenness of the book's tone, so that it is occasionally unclear what, exactly, is being parodied. Read with a jaundiced eye, the whole book comes across as a satire in precisely the Sokal vein. Indeed, Richardson's ironist redescriptions lend themselves to ironist re-re-descriptions such that *Epidemic Illusions* can be readily interpreted as an experiment not in decolonising academic writing but in demonstrating how thoroughly colonised it remains, especially given the book's glowing reception.

This is not to suggest that irony and ironism have no place in critiques of global health – as Jumbam's (2020) recent paper illustrates, they can be used to powerful effect. Moreover, the concepts of parody and irony have, of course, been critical to the decolonisation movement itself, given the central role they played in the thinking of some of its most influential forebears (e.g., Fanon, 1970; Bhabha, 1984). But their intrinsic ambiguities, which have only been magnified in the culture wars of the 1990s and post-truth era of the present, are such that without due care in their deployment, they have the potential to discredit the very ends they aim to accomplish.

Conclusion

As we have explored, *Epidemic Illusions* is a provocative book whose carnivalesque narrative style singles it out as deeply original within the global health canon. Yet, and crucially, its lack of empirical depth and flippant generalisations risk foreclosing the kind of nuance and reflexivity that the decolonising movement rightly calls for. It is also important to highlight that while Richardson lays his privilege bare on occasions – or at least struggles with it – the book also derives from and reinforces it in ways that come across as somewhat tone deaf. For example, despite proponents of decolonising global health decrying 'white saviour' narratives (Koris, 2020), Paul Farmer's foreword offers no less than a *grand tour* of Richardson's

international educational accolades, humanitarian endeavours and consultancy work. Further deepening the saviour trope, Farmer writes that Richardson has chosen 'tending to the sick as his praxis' (2020, p. xii). The juxtaposition of this with the condemnation of the 'coloniality' of global health is a substantial - albeit inadvertent irony - given the book's imbrication within the tight knots of Harvard's global health machinery. But these ironies, like the others we have explored in this essay, demonstrate something exceptionally important – how difficult it is and will be to effect significant change within global health through an intellectual project alone.

While global health enjoyed a 'golden age' of funding in the first decade of the twenty-first century, with Covid-19 shaping the financial priorities of donor countries and the philanthropies, a question mark now hangs over the enterprise at a time of unparalleled human need (Cousins et al., 2021). Indeed, as we write, the UK's 'massive global health cuts' mean that, to cite just one example, the UK's contributions to UNAIDS will be reduced by 90% as part of a reduction in the aid budget from 0.7% to 0.5% of GDP (Zarocostas, 2021). These cuts are replicated across vast swathes of global health and development spending among some of the world's most vulnerable people. This moment of rupture arguably necessitates reflection on the extent to which how we *write* about global health is intricately entwined with how it is *done* (Büyüm et al., 2020). On that note, while we were writing this paper, we both received emails from Harvard Medical School suggesting that we 'enrol now!' in their 'Effective Writing for Health Care programme'. This year-long programme costs USD$14,900 (although a fee reduction of 25-50% for LMIC applicants at best still leaves USD$7,450 to find) and aims to help applicants write funding applications and publications for (Northern) international medical and scientific journals. That Harvard Medical School charges significant sums to help applicants break into the very echelons of coloniality that one of its faculty so decries in *Epidemic Illusions* suggests that this book presented a real opportunity to interrogate the architecture of global health from within – to shatter the illusions even. Doing so would necessitate dwelling, in empirical depth, on the tensions and contradictions (Fassin, 2020) of Richardson's 'insane experience' of global health (2020, p. 5). A more detailed – and ethnographically grounded – journey through those 'insane experiences' would perhaps have been a better starting point for a project of intellectual decolonisation than the 'ironist' perspective favoured by Richardson. We leave the final word to Rorty himself:

> [W]hat the ironist is being blamed for is not an inclination to humiliate but an inability to empower… She cannot claim that adopting her redescription of yourself or your situation makes you better able to conquer the forces – which are marshalled against you (1989, p. 90)… These distinctions help explain why ironist philosophy has not done,

and will not do, much for freedom and equality. But they also explain why 'literature' (in the older and narrower sense), as well as ethnography and journalism, is doing a lot (p. 94).

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