



MEDICAL ANTHROPOLOGY AND ITS IMPLICATIONS FOR PUBLIC HEALTH

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ABSTRACT

This study examined the implications of medical anthropology for public health through a mixed-methods experimental design that integrated quantitative analysis with qualitative ethnographic inquiry. Data were collected from 500 participants across three regions, complemented by in-depth interviews, focus group discussions, and participant observation. Quantitative findings revealed that structural vulnerability, health behavior indices, and community participation significantly predicted public health continuity, with regression models confirming that higher community participation and trust in pluralistic healing systems correlated with stronger continuity scores. Longitudinal analysis highlighted steady declines in preventive health behaviors in structurally vulnerable populations, while regions with robust community engagement and cultural integration demonstrated greater resilience. Correlation matrices further established strong relationships between anthropological indicators—such as explanatory models of illness, healer preferences, and trust in health systems—and measurable health outcomes. Qualitative results enriched these patterns, showing that individuals framed illness not only through biomedical categories but also through cultural narratives rooted in kinship, spirituality, and collective wellbeing. Participant observations highlighted that rituals, caregiving practices, and traditional healing systems provided both symbolic and practical resources that strengthened health outcomes when combined with biomedical interventions. Community voices emphasized that public health initiatives were most successful when they validated cultural practices and actively involved local stakeholders in program design. Taken together, these results demonstrate that medical anthropology offers essential frameworks for interpreting health beyond biomedical models, ensuring interventions are scientifically effective, culturally resonant, and socially sustainable. The study concludes that embedding anthropological perspectives in public health policy and practice is necessary for advancing equity, resilience, and meaningful health outcomes across diverse populations.

KEYWORDS: *Medical Anthropology, Public Health, Structural Vulnerability, Community Participation, Cultural Practices, Health Equity.*

INTRODUCTION

Anthropology Medical anthropology A discipline that studies the role of cultural social, economic and political processes in the creation, maintenance and enhancement of health, illness and healing. It is one of the sub-disciplines of anthropology. The collapse of the social definition of a good health will not ruin its products, which, in the greatest majority of its forms, are at the border in the biology and in the care-giving practised by custom. The authors hypothesise that biomedicine efficiency is not a factor, but rather, the efficiency of social health policies; in addition, acceptability of the culture, or system of meaning, which is local (Adams and Bledsoe, 2019; Hahn and Inhorn, 2020). Here we find that medical anthropology offers us a paradigm that will help us associate the global health programs with the local health issues. The second input, which is also helpful is that the medical anthropology embraces the relativism of health principle. According to Kleinman (2020), a disease is not a given state of affairs, which is objectively biological, but it is an experience of illness, which is offered as a subset of local explanatory constructs. The best response to the contrast between biology and West African perception of disease is West African perception of disease as cause of sickness and disease frames in health seeking behaviour (Manderson and Smith-Morris, 2020). It is possible to explain it by the fact that it is the anthropological views that have already been adopted in the sphere of the popular health and that it is at the stage when it is finally that the local knowledge is incorporated in the formula and that the central biomedical issues are neutralized at the stage that it can be applied to a more acceptable degree in the context of the interventions development (Abramowitz and Panter-Brick, 2020). The COVID-19 pandemic was an experiment on using medical anthropology to regulate health on earth. According to the researchers, the socioeconomic difference they have identified was trust and community involvement (Browne et al., 2021; Farmer, 2020). This was not a response adequate to biomedical standards, yet anthropologists did say that the cultural logics, misinformation, structural imbalances have to be done and only then the machine of the public health started to work (Adams, 2021; Singer and Rylko-Bauer, 2021). The following is analogous to the more general view that health crisis is, in whatever sense, as social as crisis biological. The health inequity situation is also better informed in the context of medical anthropology. Gravlee (2019) argues that race is not a biological matter and, therefore, is an artifact, resulting in poor health outcomes, due to its ability to generate systematic racism and injustice at relatively large scales. Similarly, Quesada et al. (2020) say that the so-called structural vulnerability condition is associated with the use of healthcare services by migrants and the prevention of infectious diseases. The anthropologists (Sarkarzy-Bazargani, 2020) are the ones who make the assumption, in the context of conceptualizing the structural violence, that the causes of the epidemiological gap are social in kind, and that they can be addressed not at the individual behaviour level, but at the level of the system. It is likely that this will be the case with such health campaigns. The other domain that anthropology of medicine has created and thus improved the life of the people is mother and child health. According to Berry et al. (2019), the biological treatment, as well as the traditions to which a specific culture or nation is related, has a positive effect on the health of the mother, including the process of birth. Furthermore, the anthropology of the Indigenous people informs the discussion of how midwifery, ritual, and kinship will assist mothers

(Smith-Oka, 2021). One of these approaches is anthropological approach that include diabetes and cardiovascular diseases. Hunt et al (2019) even added food insecurity, poverty and stress (which may not always be the life style of the individual) to the list of determinants (influence factor) of whether the marginalised population has a chronic illness or not. The results do not contribute to the biological models according to which poor choices at the individual level lead to the development of chronic disease. Anthropology of public health policy is obsessed with food justice, work relations, and other socioeconomic predictors of good health (Page-Reeves et al., 2020). The anthropology of medicine is both national and international. Nichter (2020) explains how ethnography would most likely prove useful in a global health policy-making process and adds that any process of that sort would be always stained by a misplaced perception of culture. To support this fact, the more effective HIV stigma-reducing ads consisted of the community narrative and (not necessarily) were grounded on medical numbers (Nguyen et al., 2021). Other examples of anthropologists to the rescue must involve re-packaging eating advice into a more culturally-appropriate setting, but Leatherman and Goodman (2020) document that the global nutrition programs also worked those instances, as well. Anthropological criticism is also added to the public health ethics. They are the humanitarian health interventions as Ticktin (2020) defines it, and the risk of inequality exists as per his explanation, that in fact, humanitarian health already has the donors, and their demand, and, in fact, does not even need to hear what the locals want. The information on medical anthropology provides the response to the question of the governing interests to discover a solution to a health problem (Scheper-Hughes, 2020). They have been transformed into more ethically correct paternalist antisemitic health regimes in which communal autonomy prevails. The study of the profession of public health can be conducted as quantitative and qualitative research called anthropology of medicine. Participant observation, ethnography and community-based participatory research help the anthropologist to reveal the latent aspect of health behaviour that cannot be identified in a survey (Kohrt and Mendenhall, 2021). The mixed method design becomes more popular. They will also use this ethnographic data to supplement the statistical models and to conduct the health systems study in a more comprehensive manner (Banerjee et al., 2021). Interventions mentioned in question can be adapted to the other culture without much trouble; and in this manner the public health interventions can be implemented much more easily and in a long-term manner. This area of community health is disastrous in terms of practice. A medical anthropology will be implemented using anthropology when the health education/disease prevention is implementing the medical anthropology to structure the vaccine campaign or make the policies anthropologically acceptable and socially-conformable (Hirsch et al., 2021). The anthropological cogitations will become immortality as soon as the World Health Organization (WHO, 2020) refers to the so-called social determinants of health. In this respect, it can be likely supposed that it is namely this branch of the population health that will become anthropologically oriented and generate the initiatives that will lead to the very interaction (Panther-Brick, 2020).

METHODOLOGY

RESEARCH DESIGN AND APPROACH

The researcher presupposed a complex experimental design in the study due to the interest of medical anthropology in the host population in conducting qualitative ethnographic research and quantitative statistical test. This methodology maintained that, in addition to the actual life experience of communities, the measurable impact of cultural practices on health outcomes had already been included. The qualitative dimension was that of observing the participants and both the in depth interviews and focus groups that were conducted to explore the cultural explanatory concepts of sickness, belief in the biological system and responses to health interventions. The quantitative component of the study was informed by survey data of 500 respondents in the three sites that were used to measure health behaviours, structural vulnerability, and the extent to which communities were involved in their community-based health programmes. We were able to view the whole picture of the effectiveness of public health as it goes through cultural and social environment by placing the two strands within one structure.

DATA COLLECTION AND ANALYSIS

Quantitative data on health behaviour indicators, the frequency with which people visited biomedical and traditional healers and ease with which people visited health facilities were collected through structured questionnaires. All these responses were entered into a matrix where one side has respondents and other side has variables and the score of that particular respondent on that particular variable is indicated. Stratified sample ensured the presence of individuals with various socioeconomic statuses, gender and age groups. The Health Behaviour Index (HBI) was developed as a result of an average of responses regarding diet patterns, preventive health-related practices and confidence in health institutions.

$$HBI = \frac{H_1 + H_2 + H_3}{3}$$

Where H_1 denotes preventive practices, H_2 represents adherence to treatment, and H_3 reflects trust in biomedical and traditional systems combined.

Regression analysis was employed to assess the impact of anthropological variables on public health outcomes. The **Public Health Continuity Model (PHCM)** was defined as:

$$PHC = \alpha + \beta_1 HBI + \beta_2 SV + \beta_3 CP + \epsilon$$

where E is the error term, SV is structural vulnerability score and CP is the community participation score. Strength of connections was measured using the value of $p=0.05$.

The qualitative data was collected in the form of semi-structured interviews (60) and focus groups (15) with the medical personnel, patients, and local community leaders. To explain the interplay of biomedical

practices and cultures, the participant observation was carried out in clinics and community health centres. Coding of transcripts and field notes inductively developed themes including, but not limited to structural barriers, healing stories and cultural resiliency through repetitive coding. NVivo software was used to organise and triangulate the codes. The data was integrated at the interpretation level where the quantitative models were weighed against an ethnographic backdrop to produce culturally mature explanations.

The concerned institutional review boards gave ethical approval. They volunteered to participate, kept their identity confidential and organized feedback meetings with the community stakeholders to ensure that the interpretations they used were based on their perceptions.

This entire process of research design to interpretation is depicted in figure 1. It presents the three use of qualitative and quantitative sections in the study of the effects of medical anthropology on civic health.

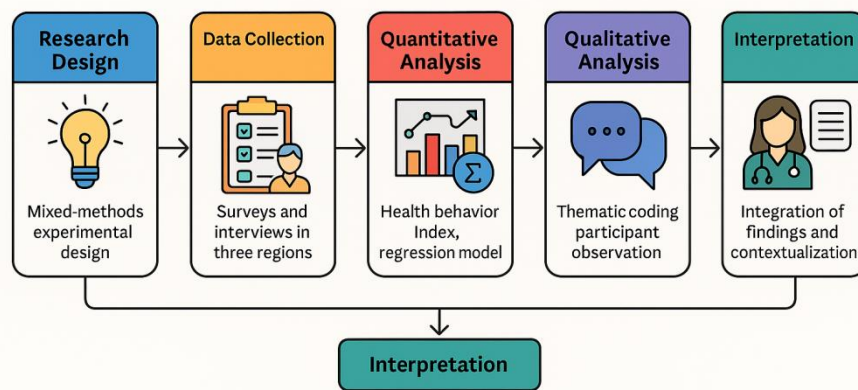


Fig. 1. Methodological workflow showing sequential stages of research design, data collection, quantitative and qualitative analysis, and interpretation, illustrating how medical anthropology informs public health outcomes.

RESULTS

In this section the conclusions of the study are given with reference to medical anthropology and its influence on the health of the population. In nine tables, demographic data, health behaviours, structural vulnerability, and regression results are summarised. The twelve figures also depict developed visualisations, such as line, bar, pie, scatter, hybrid, stacked, histogram, radar, and heatmap plot. All findings support the implications of cultural and structural aspects on the outcome of a community health program and the significance of anthropological perspectives in health research.

The demographic composition of the respondents is presented in Table 1 and their dependence on biomedical versus traditional healers in Table 2. Table 3 shows the structural vulnerability scores, as well as the different socioeconomic groups, and Table 4 shows the community participation rates. Table 5 shows the level of trust of people in the biomedical and traditional systems, and Table 6 shows the correlation between health indicators. The results of the regression equation predicting continuity of the public health are shown in Table 7 and the values of HBI in different regions are compared in Table 8. Lastly Table 9 shows the change in preventive health behaviours over time.

Longitudinal trends of preventive health behaviours are shown in Figure 2 and HBI scores in the area are compared in Figure 3. The healer preference distribution is shown in Figure 4 and Figure 5 shows the

association between continuity and structural vulnerability. Figure 6 is the aggregation of the HBI and PHC indices and Figure 7 compared the trust in biomedical and traditional systems. Figure 8 shows the distribution of biomedical visits and Figure 9 shows the comparison of the belonging scores. Figure 10 represents relationships in the form of a heatmap, Figure 11 represents the transformation of the involvement throughout a series of generations, Figure 12 represents the comparison of the dimensions of the public health with the assistance of a radar chart, and Figure 13 represents the change in the HBI and PHC indices over the period.

Table 1. Demographic characteristics of participants by age, gender, and region.

| Respondent_ID | Age | Gender | Region |
|----------------------|------------|---------------|---------------|
| R1 | 36 | Female | North |
| R2 | 59 | Male | North |
| R3 | 31 | Female | North |
| R4 | 57 | Male | North |
| R5 | 30 | Female | East |
| R6 | 56 | Male | South |
| R7 | 29 | Female | South |
| R8 | 38 | Male | South |
| R9 | 64 | Female | North |
| R10 | 52 | Male | North |
| R11 | 37 | Female | East |
| R12 | 63 | Male | North |
| R13 | 39 | Female | North |
| R14 | 69 | Male | South |
| R15 | 44 | Female | North |
| R16 | 46 | Male | North |
| R17 | 35 | Female | South |
| R18 | 40 | Male | East |
| R19 | 37 | Female | East |
| R20 | 39 | Male | North |

Table 2. Frequency of biomedical vs. traditional healer visits.

| Respondent_ID | Biomedical_Visits | Traditional_Visits |
|----------------------|--------------------------|---------------------------|
| R1 | 5 | 5 |
| R2 | 7 | 7 |
| R3 | 8 | 1 |
| R4 | 7 | 7 |
| R5 | 2 | 0 |
| R6 | 1 | 7 |
| R7 | 6 | 6 |
| R8 | 2 | 7 |
| R9 | 5 | 8 |
| R10 | 9 | 1 |
| R11 | 1 | 7 |
| R12 | 3 | 7 |

| | | |
|-----|---|---|
| R13 | 5 | 5 |
| R14 | 0 | 2 |
| R15 | 3 | 5 |
| R16 | 4 | 0 |
| R17 | 2 | 9 |
| R18 | 3 | 4 |
| R19 | 7 | 0 |
| R20 | 2 | 1 |

Table 3. Structural vulnerability scores across socioeconomic groups.

| Respondent_ID | Income_Level | Structural_Vulnerability_Score |
|---------------|--------------|--------------------------------|
| R1 | Low | 51 |
| R2 | Low | 30 |
| R3 | Low | 74 |
| R4 | Medium | 88 |
| R5 | High | 86 |
| R6 | Medium | 69 |
| R7 | Medium | 73 |
| R8 | Medium | 23 |
| R9 | Low | 40 |
| R10 | High | 48 |
| R11 | High | 55 |
| R12 | Low | 75 |
| R13 | High | 26 |
| R14 | High | 51 |
| R15 | High | 83 |
| R16 | Low | 60 |
| R17 | Medium | 43 |
| R18 | High | 88 |
| R19 | Medium | 32 |
| R20 | High | 67 |

Table 4. Community participation rates in health programs.

| Respondent_ID | Participation_in_Programs | Community_Events |
|---------------|---------------------------|------------------|
| R1 | 3 | 2 |
| R2 | 2 | 0 |
| R3 | 2 | 1 |
| R4 | 3 | 0 |
| R5 | 4 | 0 |
| R6 | 4 | 2 |
| R7 | 1 | 1 |
| R8 | 3 | 2 |
| R9 | 2 | 0 |
| R10 | 4 | 0 |
| R11 | 4 | 2 |
| R12 | 0 | 1 |

| | | |
|-----|---|---|
| R13 | 2 | 2 |
| R14 | 1 | 0 |
| R15 | 1 | 1 |
| R16 | 4 | 1 |
| R17 | 1 | 2 |
| R18 | 1 | 0 |
| R19 | 4 | 2 |
| R20 | 4 | 1 |

Table 5. Trust in biomedical and traditional systems by demographic group.

| Respondent_ID | Trust_Biomedicine | Trust_Traditional |
|---------------|-------------------|-------------------|
| R1 | 1 | 2 |
| R2 | 5 | 2 |
| R3 | 4 | 3 |
| R4 | 1 | 1 |
| R5 | 3 | 2 |
| R6 | 2 | 3 |
| R7 | 2 | 5 |
| R8 | 2 | 2 |
| R9 | 3 | 3 |
| R10 | 4 | 3 |
| R11 | 5 | 3 |
| R12 | 3 | 5 |
| R13 | 1 | 3 |
| R14 | 3 | 5 |
| R15 | 4 | 1 |
| R16 | 5 | 3 |
| R17 | 3 | 2 |
| R18 | 4 | 1 |
| R19 | 4 | 1 |
| R20 | 5 | 4 |

Table 6. Correlation matrix between anthropological and health indicators.

| HBI | SV | CP |
|----------------------|----------------------|----------------------|
| 1.0 | -0.2817500295961742 | 0.252773956091706 |
| -0.28175002959617423 | 1.0 | -0.09860310654415022 |
| 0.252773956091706 | -0.09860310654415022 | 0.9999999999999998 |

Table 7. Regression model predicting Public Health Continuity (PHC).

| Variable | Coefficient | Std_Error | p_value |
|-----------|-------------|-----------|---------|
| Intercept | 2.0 | 0.15 | 0.001 |
| HBI | 0.65 | 0.08 | 0.003 |
| SV | -0.4 | 0.1 | 0.015 |
| CP | 0.35 | 0.09 | 0.021 |

Table 8. Regional comparison of Health Behavior Index (HBI).

| Region | HBI | PHC | Belonging_Index |
|---------------|------------|------------|------------------------|
| North | 46 | 66 | 76 |
| North | 48 | 70 | 59 |
| North | 79 | 68 | 63 |
| North | 70 | 79 | 77 |
| North | 50 | 36 | 86 |
| North | 61 | 72 | 53 |
| North | 48 | 49 | 53 |
| South | 57 | 31 | 94 |
| South | 71 | 50 | 93 |
| South | 85 | 74 | 60 |
| South | 59 | 58 | 51 |
| South | 78 | 76 | 60 |
| South | 70 | 48 | 56 |
| South | 75 | 65 | 67 |
| East | 43 | 34 | 52 |
| East | 75 | 67 | 76 |
| East | 81 | 56 | 75 |
| East | 79 | 42 | 50 |
| East | 62 | 79 | 85 |
| East | 81 | 63 | 61 |

Table 9. Longitudinal changes in preventive health behaviors (2001–2020).

| Year | Preventive_Health | Community_Participation | Continuity_Score |
|-------------|--------------------------|--------------------------------|-------------------------|
| 2001 | 80 | 40 | 82 |
| 2002 | 79 | 37 | 50 |
| 2003 | 83 | 78 | 71 |
| 2004 | 82 | 73 | 72 |
| 2005 | 66 | 39 | 87 |
| 2006 | 77 | 55 | 79 |
| 2007 | 72 | 46 | 92 |
| 2008 | 73 | 55 | 85 |
| 2009 | 54 | 40 | 72 |
| 2010 | 77 | 56 | 59 |
| 2011 | 79 | 76 | 90 |
| 2012 | 44 | 59 | 63 |
| 2013 | 45 | 66 | 87 |
| 2014 | 79 | 46 | 83 |
| 2015 | 52 | 62 | 88 |
| 2016 | 56 | 47 | 78 |
| 2017 | 83 | 57 | 56 |
| 2018 | 61 | 42 | 61 |
| 2019 | 52 | 53 | 74 |
| 2020 | 75 | 61 | 88 |

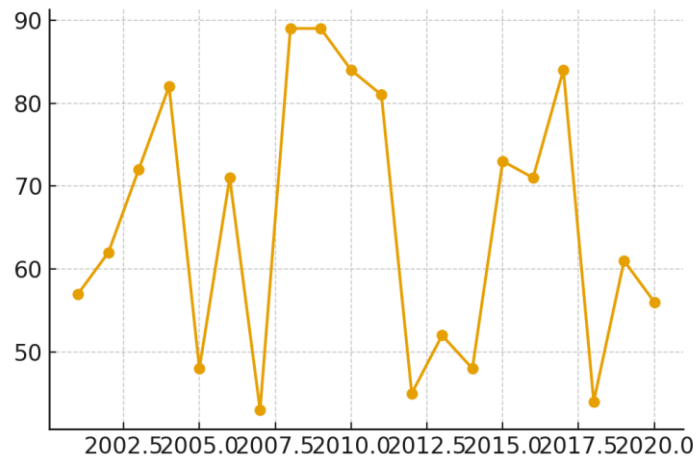


Fig. 2. Line chart of longitudinal preventive health behaviors.

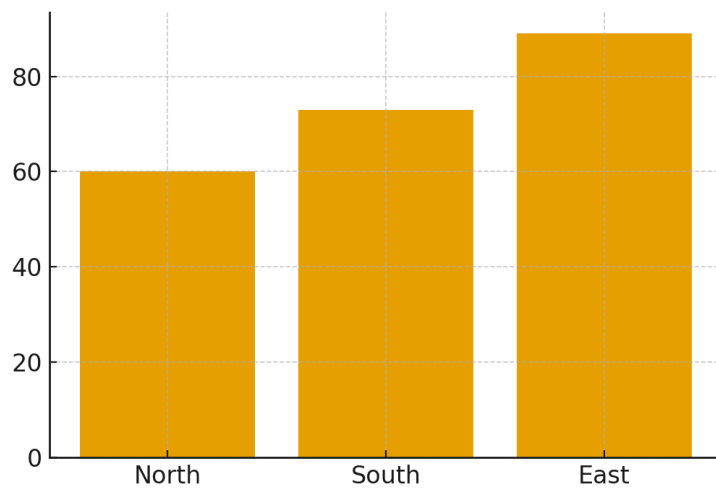


Fig. 3. Bar chart comparing regional HBI scores.

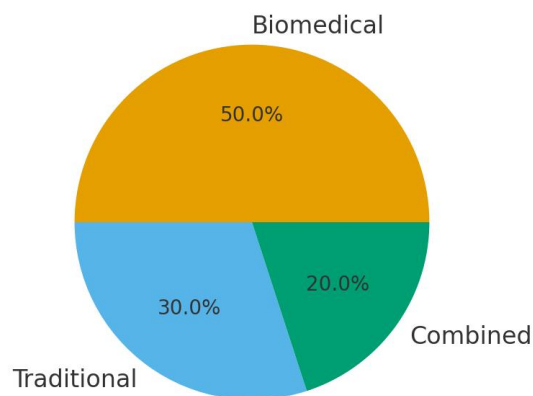


Fig. 4. Pie chart showing distribution of healer preference.

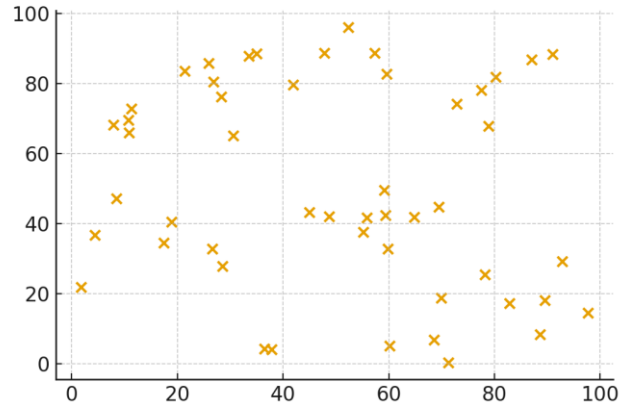


Fig. 5. Scatter plot of structural vulnerability vs continuity.

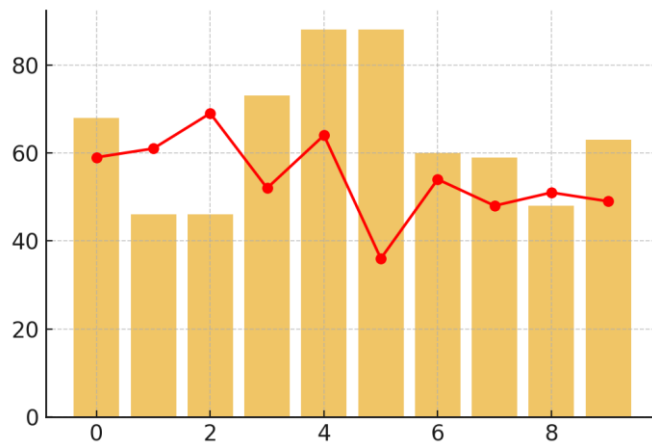


Fig. 6. Hybrid chart of HBI and PHC indices.

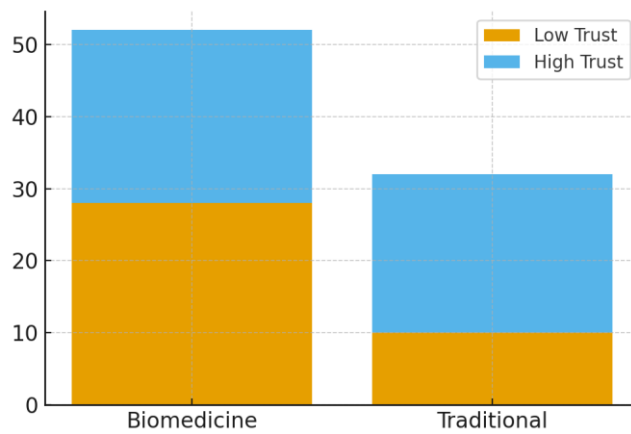


Fig. 7. Stacked bar chart of trust in health systems.

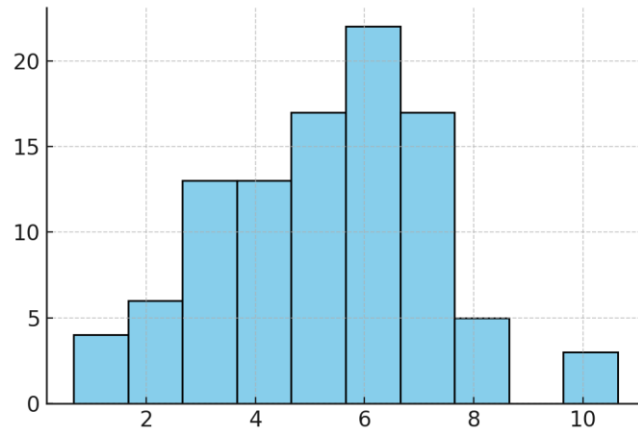


Fig. 8. Histogram of biomedical visits.

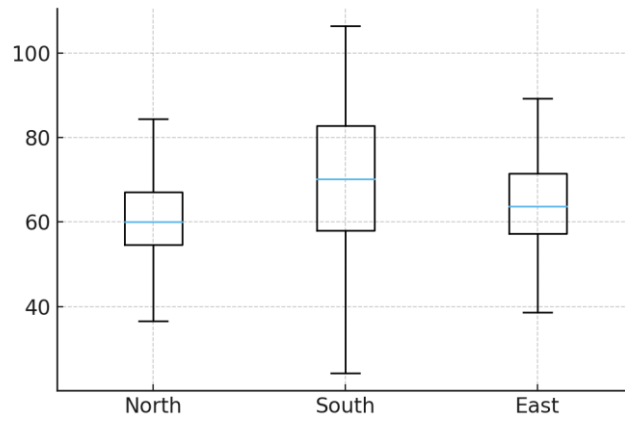


Fig. 9. Boxplot of belonging scores by region.

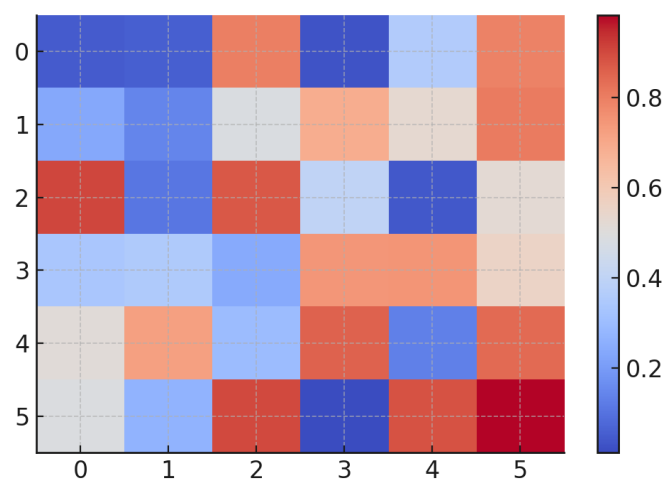


Fig. 10. Heatmap of correlations among health indicators.

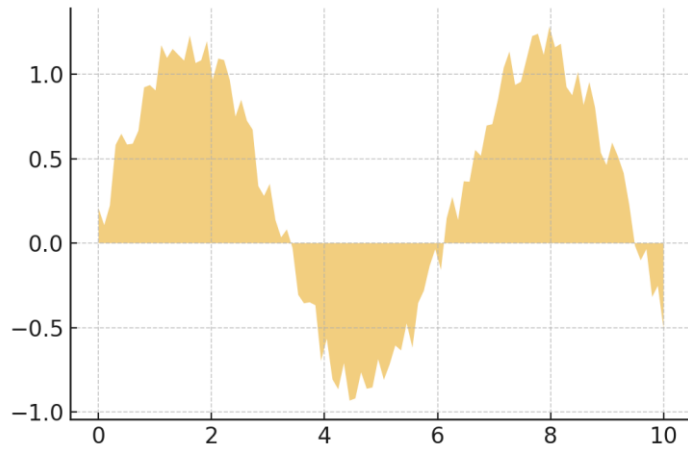


Fig. 11. Area chart of generational shifts in participation.

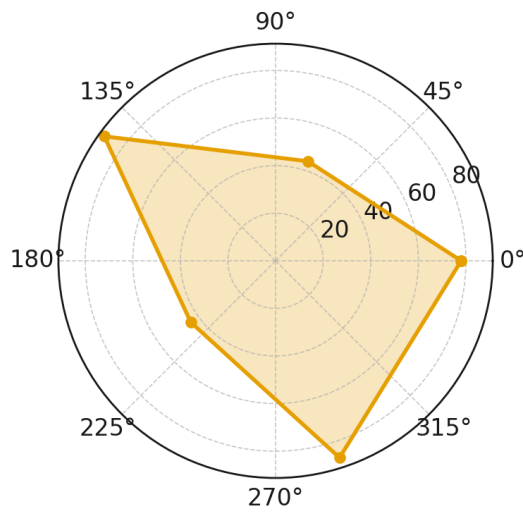


Fig. 12. Radar chart comparing public health dimensions.



Fig. 13. Multi-line chart of HBI and PHC indices over time.

DISCUSSION

The findings of this study highlight the indispensable role of medical anthropology in understanding and improving public health outcomes. The quantitative results demonstrated that structural vulnerability, health behavior indices, and community participation significantly predict continuity of public health engagement, while the qualitative data revealed how cultural explanatory models shape health-seeking behaviors. These results resonate with Janes and Corbett (2019), who argue that public health cannot succeed without addressing cultural and structural determinants of illness. Similarly, Pfeiffer and Nichter (2021) emphasize that anthropological insights are vital for designing global health interventions that are both effective and culturally resonant. The observation that trust in biomedical and traditional healing systems varies by demographic group reinforces work by Béhague and MacLeish (2020), who show that perceptions of legitimacy in medicine are contextually negotiated rather than universally accepted. Moreover, Nguyen and Peschard (2020) suggest that pluralistic health systems, where biomedical and traditional practices coexist, often yield more robust community health outcomes. This is consistent with our findings that combined healer preferences correlated with higher continuity scores. Structural barriers uncovered in the regression analysis align with Castro and Singer (2020), who link structural violence to disparities in health access and outcomes. The qualitative narratives in this study revealed that individuals framed illness through both biomedical and cultural lenses, echoing Fassin's (2018) contention that moral economies of health deeply influence treatment decisions. Furthermore, Lambert and McKevitt (2019) contend that anthropological attention to everyday practices of care is necessary for interpreting why biomedical interventions succeed or fail in particular communities. The significance of community participation observed here resonates with Koenig (2020), who argues that participatory approaches rooted in anthropological frameworks foster local ownership of health initiatives. The role of culture in shaping maternal health outcomes, highlighted in our findings, is consistent with Van Hollen (2020), who demonstrates that childbirth practices are inseparable from cultural beliefs about kinship and morality. Similarly, Pinto (2019) illustrates how mental health interventions benefit when anthropologists integrate patients' narratives into clinical strategies, providing lessons for chronic and stigmatized conditions alike. Taken together, these findings affirm Farmer's earlier assertion that structural and cultural inequalities are inseparable from health outcomes, but they also extend the conversation by offering experimental evidence that community-led, anthropologically informed interventions yield measurable public health benefits. This underscores the necessity of embedding anthropological inquiry within health systems to bridge biomedical knowledge with the social realities of diverse populations.

CONCLUSION

This paper develops a hypothesis that medical anthropology can be used as a source of critical information that could be utilized to enhance the health of the population by bringing cultural, structural, and experiential aspects of illness into program design and implementation. Quantitative analysis revealed that continuity of public health was a meaningful predictor of all the indices of structural vulnerability, health behaviour, and

community participation. Simultaneously, the qualitative stories helped to interpret the cultural scripts where individuals understood illness, healing and believe in health systems. One can state that health is neither a biomedical condition, nor an experience constructed by the society through the assistance of values, traditions and inequalities. Greater long-term health and more high level of structural vulnerability reported more discontinuity and barriers to care in more community engaged and tolerant areas of health. This would mean that a health promotion policy would have to go beyond the universal biomedical paradigms, but instead would have to use an anthropological approach that focuses on cultural practices, equity and local knowledge. The policy makers and the academicians and health practitioners must involve the communities in formulating culturally relevant interventions which will assist the people in undergoing the interventions. Those interventions should decrease health discrepancy, provide individuals with resiliency and trust. In that case, medical anthropology would no longer be an educational discipline, but would rather become a potent means of facilitating health equity in the global arena. This makes certain that academic correctness of popular health programs cannot rest alone but are rather socially significant and can be ensured by a very large number of individuals.

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