

On March 6, sociologist [Emily Vasquez](#) of the University of Illinois at Chicago was invited to Northwestern University's Evanston campus to discuss her research on diabetes prevention in Mexico. Dr. Vasquez's visit was part of the [Klopsteg Lectures](#), a series of talks on science, medicine, and technology organized by Northwestern's [Science in Human Culture](#) program and sponsored by the [Klopsteg Fund](#).

Dr. Vasquez's lecture, "Treating Risk, Deepening Inequality: Narratives of Biomedical Prevention in Mexico," described how diabetes prevention efforts in Mexico have made use of the relatively novel category of "pre-diabetes," a condition characterized by blood sugar levels that exceed the range considered "normal" but remain below the threshold for a diabetes diagnosis. Her ethnographic research focused on three different clinical settings: (1) a small, private charity organization serving poor and working-class individuals, (2) a high-end boutique clinic catering to socioeconomically privileged clients, and (3) a large public health center serving a broad range of working- and middle-class patients.

Dr. Vasquez's work highlights how the dominance of Global North perspectives in the field of medical science can obscure the profound racial and economic divisions of Mexican society—divisions that have both driven the diabetes crisis in Mexico and limited its proposed policy solutions.

Shortly after her visit, Dr. Vasquez spoke with Northwestern doctoral student [Xi Wang](#) about the transnational forces that shape preventative health initiatives in Latin America, the role of racial categories in medical research, and the depoliticization of public health in the 21st century. Their conversation, lightly edited for clarity, is below.

XW: I really appreciate your work on pre-diabetes in the Mexican context, and I'm curious about what motivated you to do this sort of research in the first place. You shared with us some other studies that you've done on [diabetes](#) and on [Mexican genomics](#). What led you to study these topics?

EV: There are two major motivations. The first one—I went to Paraguay, in the heart of South America, with a Fulbright Scholarship when I was very young—and I was very interested in studying migration, but I ended up working a lot on HIV prevention. Paraguay had won a grant from the Global Fund, and various civil society organizations, government agencies, and private sector organizations were being tasked with taking on HIV prevention. So I started working on this project, and the organization that I was collaborating with was carrying out some of these activities.

That prevention work was important to me, but what was also very clear was that something else, in terms of power, was going on—that there was a bigger story. I was watching the grassroots LGBTQ organization that I was a part of transform as there was an influx of money for HIV prevention. The activism became more professionalized.

This was, in one respect, good, because activists were doing a lot of hard work, and they were being better remunerated, and there was more of a budget to go around. But, on the other hand, it

also changed the way that people worked. We weren't just hanging out all night doing work because we were activists. It became a job as well, and it was regulated in the ways that you can imagine—there were the evaluations that you would expect of a public health project or intervention. So a lot of our time and effort was dedicated to that sort of accounting, and evaluations, and monitoring—both of what we did and how the money was spent. It really did change the way that we worked.

So I started asking questions about where money comes from, how power influences what public health action means. And I took these questions with me to the School of Public Health at Columbia. I got a Master's in public health. But, through that, I really figured out that what I was doing, what I cared about, was the sociology of science, medicine, and public health. And so I have continued to think about the power centers in public health and in global health.

What led me to think about diabetes in Mexico—diabetes being a challenge throughout the world, there are many different ways that we could take on that challenge—it was the question of why we get the public health interventions that we do. Who benefits? What are the kinds of interventions and kinds of knowledge that *aren't* produced, that do not get worked on, because they are not in the interest of the powers that be?

The second big motivation that I had—once I was working in public health, race was everywhere. Not so much racism, but race. This was true even when I was in college and working in North Carolina on second generation immigrants' mental health and well-being—there were lots of ideas of what it meant to be Hispanic (which was the word that we used back in the day), what it meant to be Latino in North Carolina, a new immigrant, and so on. When I started studying public health and started doing epidemiology, these categories of race were everywhere. And they didn't align always with the populations that I worked with in South America, or Mexico, or even in North Carolina. I had seen the way that the meaning of a category can change. So I wondered about things like the assumptions that are made about categories of race in public health.

And then, secondly, when you work in transnational contexts and public health—so if you are an epidemiologist collaborating across national borders and across racial regimes—I wondered, how do people find common ground around what they mean when they talk about race? And to what extent is biomedicine and epidemiological public health research a vector of its own for ideas about race and racialization?

That brings me to my next question, which is about your work on pre-diabetes. I'm wondering how you would describe the tension between the enabling and confining of science in diabetes prevention in Mexico.

When you gave your talk, and in reading your other articles, there were a lot of tensions—for instance, in your article, "[Detecting Diabetes Risk](#)," there are tensions between philanthropic ideas and capitalism. And, in your study about Mexican medical genomics, you say that the ambiguity of ethnic categories can be seen as a resource as well as a limitation. The enabling and confining consequences of science always go hand-in-hand.

So I'm wondering, in your study of pre-diabetes, how did you stick with this question about the influence of science on society?

The political economy of science determines what we study and what we know, and what kind of interventions can come out of that. And I think what I've said before about the Global Fund makes clear that I'm very interested in the political economy underpinning both science and medicine.

Public health is a domain that is inherently political, because it is mainly about regulatory science. A lot of it has to do with risk prediction of the future—what steps can we take now to make decisions about how to regulate our world? Those steps are inherently uncertain. We don't know if the conditions in the future are going to be the same, but we still have to make decisions based on what we know now. And those decisions are going to be political, and they are going to be contested. It's just such an interesting problem space where society and science come together and battle things out.

My project on pre-diabetes in Mexico—I was intrigued when I started seeing all kinds of attention to high tech solutions, like, “How can we leverage genomic science?” This was a discourse, both from the state in terms of public resources, but also from private actors—philanthropists like the Carlos Slim Foundation, which I've studied pretty extensively. “How can we leverage genomic science, and all the resources that it will take to understand the genome and its relationship with diabetes, to deal with the type two diabetes and chronic disease crisis that we are facing?” So there is that—that high end, high-tech kind of science. And, wrapped up in that conversation, is risk detection, like detecting early phases of diabetes and diagnosing people with pre-diabetes.

The limits of that, for me, were immediately clear: I knew that, in Mexico, then and now—across Mexico, but also in areas where you might hope that things were different, like Mexico City—many people who live with *diabetes itself* don't know that they are living with the disease. Even people who have been *diagnosed* fall out of treatment and care. Having well-controlled diabetes is elusive for the majority of people who are diagnosed with diabetes. It is really hard to control.

So the paradox for me was, why then take our *prevention* solutions, our *prevention* initiatives, into the clinic? Why try to leverage the most advanced kinds of medicine to solve this problem, when advanced medicine was not even able to care for those who were deemed actually sick, right? So what would this mean?

For me, those limits on the science, and that paradox, they lead me right to questions: well, then why is this? And who is winning? Whose interests are being fulfilled?

When reading sociological studies of science, people tend to ask, “What's next?” And, in your talk, you mentioned that your work is not just about diabetes; it is also about how we imagine public health in the future. So I wonder, following all your years in different field sites, and especially in Mexico, what do you envision as a better path forward?

My answer to this question would have been very different three years ago, when I had just finished my fieldwork in Mexico and we had not yet had the pandemic. I finished my fieldwork and went back to New York in 2019, and, in late 2019, we began to hear concerns over COVID. And then, in early 2020, the hospital where I had an office for the last few years of my Ph.D. was where the first cases in New York were brought.

We have had a broader reckoning across society about the difference between medicine and public health, and about the history of public health that has led us to a point where we are faced with a global COVID-19 pandemic, but we don't seem to have a strong public health apparatus with which to confront it—hence, the years that have followed. There has been a lot of collective reckoning around, well, what was public health once? What could it be? And why have the kinds of public health interventions—the kind of public health futures that we are able to imagine from public health schools, when we are training future public health workers—why has that set of possibilities become so much less radical, so much more conservative, and so much smaller? My work engages with that bigger question about the epistemic history of public health—which is driven over time, in my view, by political economy.

And, going back to what I said earlier about activism, a lot of this has to do with the shift away from the idea that public health needed to be about interventions into society—thinking about class differences, thinking about wealth inequality, thinking about the values that society was willing to uphold in terms of standards around housing, around lots of other basic things, like diet and food availability. The willingness to have a political voice has fallen out of public health, globally.

So the question is, can we imagine something different—in which, perhaps, we return to the origins of the field, and to a willingness to not necessarily demand objectivity, but to be willing to have a political voice.

When you talk about political economy in Mexico, I am, of course, thinking about the context of your research and its audience. You are studying Mexico, but I assume that the audience of your work is primarily scholars in the United States. So how should we think about the power dynamics of the global order in that respect?

I often situate my work in Mexico, somewhat uncomfortably, in a broader discussion of the politics of global health. I think that is at once useful and problematic.

I do it because I recognize how globalized health science is, and how the different actors that I'm following in Mexico are linked to broader trends in the field of global health. For example, I follow the Carlos Slim Foundation, which is a health research and intervention institute, but it is also a philanthro-capitalist institute, where it is working both on the side of policy and designing public health interventions but also on commercial responses that can be integrated into those interventions. So there is sort of a not-quite-philanthropy thing going on here. But that trend and those actors, like the Carlos Slim Foundation, are very much involved in a bigger conversation that is recognized by international organizations—organizations that use examples from Mexico as examples of successful development, successful health responses. And so I don't think that

what is happening in Mexico is happening, by any means, in isolation from the field of global health.

The flip side of that is that there is such a flow of information and expertise and training between Mexico and the United States. I may have mentioned in my talk that I accompanied my Mexican *interlocutors* [research subjects]—the people that I shadowed, physicians in the clinic and other people who worked in public health—to the American Diabetes Association conferences in the United States. Many of them had done graduate training in the United States. And there were, consistently, people brought from the United States and elsewhere to Mexico to talk about diabetes and diabetes prevention.

So this is, to me, a global conversation. But there are definitely bridges that are stronger-built between particular countries. And, for me, it is particularly interesting to connect the bridges—not only on the science of prevention, but also (and I would point to Alicia Galvez's book, [Eating NAFTA](#), here) on the drivers of disease across the U.S.-Mexico border.

And there has been a lot of work—there is also a very good book [Eden Medina, Ivan da Costa Marques, and Christina Holmes' [Beyond Imported Magic](#)] about how we think about science and technology studies [STS] and how we do STS work transnationally and from Latin America. I've kept these questions very close: how do I analyze race in Mexico without my work being overshadowed by U.S. thinking, but, at the same time, stay aware of the relationship between them, the transnational circulation of ideas and people in this field?

Emily Vasquez is a Bridge to Faculty Fellow in sociology at the University of Illinois at Chicago. Drawing on the sociology of health and medicine, science and technology studies, and critical race studies, her research examines how social inequalities—including processes of racialization—are entangled with, and reinforced by, the production of expert knowledge. Both her Ph.D. in sociology and public health and her Master of Public Health degree were completed at Columbia University.

Xi Wang is a doctoral student in sociology at Northwestern University and an affiliate with Northwestern's Science in Human Culture program. Her areas of research include the sociology of culture, religion, and mental health. She holds an M.A. in social science from the University of Chicago and a B.A. in broadcast journalism from the Communication University of China.