Rethinking Global Health

Frameworks of Power

Rochelle A. Burgess

CRITICAL APPROACHES TO HEALTH

'In this terrific, highly engaging book, Rochelle Burgess challenges us to think about what is global health without power, notably the power over who lives and who dies. This goes to the heart of every contemporary debate and policy practice and is thus essential reading for everyone working in global health. Burgess' command of stories that matter and scope of empirical cases combined with conceptual insight drawn from her years of expertise position this book at the heart of the global health canon'.

Professor Sophie Harman, *Professor of International Politics*
Queen Mary, University of London

'I want to place this book in the hands of every global health student, and everyone who has ever thought about, worked towards, or been on the receiving end of efforts to achieve health equity. The book puts the field of global health in its historical contexts, while brilliantly, sensitively, and inclusively pointing at what it could be; a field that lives up to its name'.

Dr Seye Abimbola, *Associate Professor of Health Systems*
University of Sydney, Editor BMJ Global Health

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

RETHINKING GLOBAL HEALTH

This book reflects and analyses the working of power in the field of global health – and what this goes on to produce. In so doing, *Rethinking Global Health* asks the pivotal questions of 'who is global health for?' and 'what is it that limits our ability to build responses that meet people where they are?'.

Covering a wide range of topics from global mental health to Ebola, this book combines power analyses with interviews and personal reflections spanning the author's decade-long career in global health. It interrogates how the search for global solutions can often end up far from where we anticipate. It also introduces readers to different frameworks for power analyses in the field, including an adaptation of Patricia Hill Collin's 'matrix of domination' for global health practice. Through this work, Dr Burgess proposes a new model of *Transformative Global Health*, a framework that calls researchers and practitioners to adopt new orienting principles, placing community interests and voices at the heart of global health planning and solutions at all times giving up their own power in the process.

This book will be beneficial to students and academics working in the global and public health landscape. It will also hold appeal to activists, practitioners and individuals invested in the discipline and in health equity around the world.

Rochelle A. Burgess, PhD, is a community health psychologist and scholar activist. She is an associate professor in Global Health at UCL, and Deputy Director of the UCL Centre for Global Non-communicable Diseases. Born in Canada of Jamaican heritage, she is currently based in the UK.

Critical Approaches to Health

Series Editors: Kerry Chamberlain and Antonia Lyons

The Routledge *Critical Approaches to Health* series aims to present critical, interdisciplinary books around psychological, social and cultural issues related to health. Each volume in the series provides a critical approach to a particular issue or important topic, and is of interest and relevance to students and practitioners across the social sciences. The series is produced in association with the International Society of Critical Health Psychology (ISCHP).

Titles in the series:

Selling Immunity
Self, Culture and Economy in Healthcare and Medicine
Mark Davis

Embodied Trauma and Healing
Critical Conversations on the Concept of Health
Anna Westin

Migration and Health
Critical Perspectives
Heide Castañeda

Rethinking Global Health
Frameworks of Power
Rochelle A. Burgess

For more information about this series, please visit: https://www.routledge.com/Critical-Approaches-to-Health/book-series/CRITHEA

RETHINKING GLOBAL HEALTH

Frameworks of Power

Rochelle A. Burgess

Designed cover image: Getty Images

First published 2024
by Routledge
4 Park Square, Milton Park, Abingdon, Oxon OX14 4RN

and by Routledge
605 Third Avenue, New York, NY 10158

Routledge is an imprint of the Taylor & Francis Group, an informa business

© 2024 Rochelle A. Burgess

The right of Rochelle A. Burgess to be identified as author of this work has been asserted in accordance with sections 77 and 78 of the Copyright, Designs and Patents Act 1988.

The Open Access version of this book, available at www.taylorfrancis.com, has been made available under a Creative Commons Attribution-NonCommercial-NoDerivatives (CC-BY-NC-ND) 4.0 International license.

An electronic version of this book is freely available, thanks to the support of libraries working with Knowledge Unlatched (KU). KU is a collaborative initiative designed to make high quality books Open Access for the public good. The Open Access ISBN for this book is 9781138653153. More information about the initiative and links to the Open Access version can be found at www.knowledgeunlatched.org.

Trademark notice: Product or corporate names may be trademarks or registered trademarks, and are used only for identification and explanation without intent to infringe.

British Library Cataloguing-in-Publication Data
A catalogue record for this book is available from the British Library

ISBN: 978-1-138-65315-3 (hbk)
ISBN: 978-1-138-65316-0 (pbk)
ISBN: 978-1-315-62378-8 (ebk)

DOI: 10.4324/9781315623788

Typeset in Bembo
by MPS Limited, Dehradun

For my mother, who first taught me that power isn't always loud.

For my father and my other ancestors, who survive through me.

For my students, who never realise how powerful they are.

For Theo, who taught me how powerful I am.

For E, who makes everything better.

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

CONTENTS

Series Editor Preface *xi*
Acknowledgements *xiii*
Note to the Reader *xv*

1 Introduction: Global health and its uncomfortable truths 1

2 Violence against women as a global health issue: Winners and losers in agenda setting? 24

3 Everyday interventions: Psychiatric power revisited in global mental health 44

4 Re-thinking the global health emergency: Power at work in making and shaping global health crises 59

5 Old becomes new: Haiti, Cholera and the matrix of domination in global health 72

Conclusion: A future better than our past in global health 93
References 106
Index 121

SERIES EDITOR PREFACE

Critical Approaches to Health

Health is a major issue for people all around the world, and is fundamental to individual wellbeing, personal achievement and satisfaction, as well as to families, communities and societies. It is also embedded in social notions of participation and citizenship. Much has been written about health, from a variety of perspectives and disciplines, but a lot of this writing takes a biomedical and positivist approach to health matters, neglecting the historical, social and cultural contexts and environments within which health is experienced, understood and practiced. It is time for a new series of books that offer critical, social science perspectives on important health topics.

The *Critical Approaches to Health* series aims to provide new writing on health by presenting critical, interdisciplinary and theoretical writing about health, where matters of health are framed quite broadly. The series seeks to include books that range across important health matters, including general health-related issues (such as gender and media), major social issues for health (such as medicalisation, obesity and palliative care), particular health concerns (such as pain, doctor–patient interaction, health services and health technologies), particular health problems (such as diabetes, autoimmune disease, and medically unexplained illness), or health for specific groups of people (such as the health of migrants, the homeless and the aged) or combinations of these.

The series seeks above all to promote critical thought about health matters. By critical, we mean going beyond the critique of the topic and work in the field, to more general considerations of power and benefit, and in particular, to addressing concerns about whose understandings and interests are upheld and whose are marginalised by the approaches, findings and practices in these various domains of health. Such critical agendas involve reflections on what constitutes knowledge, how it is created and how it is used. Accordingly, critical approaches consider epistemological and theoretical positioning, as well as issues of methodology and

practice, and seek to examine how health is enmeshed within broader social relations and structures. Books within this series take up this challenge and seek to provide new insights and understandings by applying a critical agenda to their topics.

In this book, *Rethinking Global Health: Frameworks of Power,* Rochelle Burgess takes us on a mission to consider new ways of considering, researching and responding to power as it is implicated in matters of global health. Drawing on broad scholarship as well as her own experiences working in global health, she argues that approaches to global health need to be more informed by the needs of citizens within local settings, and that we need new ways of thinking about power in global health concerns. Rochelle Burgess proposes a critical framework for examining the complexities of how power operates within global health settings. She achieves this by adapting and extending a previously proposed matrix of domains of power which covers structural, disciplinary, hegemonic and personal power and considers their potential effects.

This book delivers a critical account of how thoughtful consideration of the different domains of power expose the limitations of interventions in contemporary global health. Chapters in this book are crucially informed by salient case studies, including violence against women in Uganda, mental health interventions in South Africa and Colombia, the crisis on Ebola in West Africa and the cholera epidemic in Haiti. These case studies and their associated narratives provide a context for drawing out the major theme of the book – how various domains of power operate to shape, transform and often distort how health interventions designed to improve health function in these contexts, and how they frequently fail those they are intended to help. The discussions of these matters are wide-ranging, covering agenda setting in global health, the practices of medicalisation, the framing of knowledge production, subjectification, the logics of interventionism, the limits of humanitarianist interventions, paternalism, the inappropriate application of Western technologies and practices in non-Western and low resource settings, and community engagement. Throughout the book, there are compelling insights into how current practices of global health can unwittingly impact on and disenfranchise those on the receiving end of global health interventions.

This book concludes with a discussion of ways in which global health practices could be altered and improved to ensure that the voices of all involved are heard, along with a full consideration of the complex ways in which the various domains of power function. In undertaking this, Rochelle Burgess argues that we need to utilise more transformative paradigms and suggests that these could ultimately end the need for global health as it currently operates.

This book provides another important and timely addition to the *Critical Approaches to Health* series offering a critical discussion that has pressing salience for global health practices.

Kerry Chamberlain and Antonia Lyons

January 2023

ACKNOWLEDGEMENTS

Books do not write themselves. They are written, more realistically, in the conversations that happen between the writing. In the years spent writing this book, I have had dozens, if not hundreds of these conversations, that helped make and shape this book. I am grateful for each and every one of them, but in particular I would like to thank the following:

First, many thanks to colleagues and friends who have read earlier chapters of this work and provided advice and feedback, or a friendly shoulder to cry on about the anxieties that produced this book: Jeneveive Mannell, Jennie Gamlin, Ayesha Ahmad, Clare Wenham, Prof. Thea Hillhorst, Prof. Sarah Hawkes, Prof. Sophie Harman, Prof. Maureen Mackintosh – eventually your words and kindness sank in. Thank you for your belief in me and this project.

To Prof. Tim Allen, Director of the LSE Africa Centre, for giving me time, space and an academic home (and office!), where I wrote many aspects of this work in 2017 before the birth of my Son. Many thanks for your support and your inspiration. Much of the chapter on Ebola is informed and shaped by your teaching and our conversations over the years.

To the women I have met and who shared their stories of survival with me – in South Africa, Kenya, the Kingdom of Eswatini, Colombia and London. You have inspired me to write a book like this. I hope that our paths continue to cross I hope that the world becomes a place worthy of you, in your lifetimes. To the scholars, colleagues, activists who have allowed me to interview them for aspects of this work, some named, others who remain anonymous. Thank you for your time, your honesty and willingness to share.

To my fellow authors (though I still feel I remain unworthy of the title) – friends steeped in other traditions who encouraged me along the way; Laura Mucha, Lara Pawson and Jason Hickel. Thanks for not letting me give up, though the mood

often struck me. Most importantly, I want to thank my dear friend and writing mentor, Sarah Salway. You have pulled me out of a self-made malaise, for the second time in my career. You reminded me that I am a writer. I thank you and love you now and always.

To my family and friends who are too many to list, thank you for listening and always reminding me that the world needed this book, when everything in my being was telling me otherwise. I love, love you. A special thank you to Suzanne Smith, who came into our family like a gift from the heavens and helped create space for me to think, by loving our boy as much as we do. I am forever grateful

To Monica Gonzales-Gort and Farah Sheibani for being such supportive research assistants helping me carve out the final references needed to pull many of my arguments together in the final year. This final product is possible because of your hard work at the finish line!

My deepest thanks to my editors: Professors Kerry Chamberlin and Antonia Lyons. You believed in this book when it was an idea. You have had bottomless wells of patience as life dealt me various and consecutive losses, hardship and heartbreak. I am eternally grateful that you never gave up on me, or this book.

Finally, of course, there is no book, without Edward Reed – my partner, my love and a much better writer than I will ever be. You have listened while I talked my way in and out of intellectual rabbit holes for five years. You have taken 100-word sentences and made them into magic. You see in me what I do not see in myself, and for that I am eternally grateful. I hope that you are proud, and that you see so many of our conversations manifest in these pages. Thank you for always listening. Thank you for helping me stand (literally) at times when I could not. Thank you for loving me, at times when I could not. I love you completely, and eternally.

NOTE TO THE READER

It is hard to write a book about power. I discovered this about three and a half years into the writing of this particular book about power. The problem resides in the fact that we lack a single definition of what power is. Peeling back many theoretical framings to identify its source is to actually see power at work. Each definition reveals a new positionality, determined by, for example, the discursive power of the discipline within which each author finds themselves. Voices shouted back at me, page after page, demanding my agreement. Power is about the *law*; no, it's about the *patriarchy*; no, it's about *economic and financial and resources*; no, it's about *ideas*. Power is loud; no, it is quiet and invisible; it is never conceded without demand; it's available to us all.

I come to an understanding of power, as someone whose body has felt its unrelenting effects and consequences from the moment I came into the world. Whether we realise it or not, this is the case for all of us. Yet the body of a Black woman of Caribbean heritage, born of a lineage of bodies that travelled on ships against their will, I have felt power at work in my life in a particularly painful way at times. My positionality in this field is that I am of bloodlines rooted in the countries that Global Health praxis and engagement is 'about' and claims to be working for. So, hundreds of years later, my interest in understanding power in the discipline I call home comes from an acknowledgement that power operates 'on' me from all directions simultaneously. This is my history that is also the present (Sharpe, 2016), that is everchanging, but yet, heartbreakingly always the same.

So, for me, an inquiry into power is the only way to answer questions at the heart of global health inquiry: why do some bodies survive, and some don't? Why are some stories are heard, and others silenced? How have decades of global declarations, commitments and 'partnerships' made in the name of 'better health' still not managed to rid the world of millions of preventable deaths? Why do these

deaths always happen in the same countries? The countries where bodies and people who look like me, who share my linage, bear the greatest burden of preventable death? I have never seen it put as powerfully, or succinctly, as in the title of Social Psychologist Catherine Campbell's (2003) work on HIV: why are we 'letting them die'?

There are countless entry points in search of answers to these questions. For me, it began with the study of societal and community psychology; disciplines who view power as working through, and on individuals and collectives as they build their worlds and seek survival (Campbell and Jovchelovitch, 2000). These critical disciplines align with the work of Black and Southern scholars: Walter Rodney, Frantz Fanon, W. E. B. Dubois and Patricia Hill Collins. Each in their own way reminds us that survival is born of efforts to exercise ownership and agency in the face of what power produces in our lives. In International development, voices have also articulated the abuses of power within efforts aimed at health improvement. Arturo Escobar, Andrea Cornwall, Robert Chambers and David Mosse to name a few, remind us that the world and its inequalities have been produced through generations of uses and abuses of power. When pulled together, these scholars remind us of that good health and development demands a deeper understanding of how our world emerges as a result of various installations of relationships, structures and systems of governance.

The establishment of the global health landscape, as we know it today, is the cumulative impact of politics, resistance, resources and relationships working together *at all times* and *in all spaces*, as actors navigate their social worlds. And for this very reason, it is important to remember that this book can only be a starting point. It does not aim to be a definitive book on power in global health. But perhaps it will enable future books to be written that continue to tear down barriers seen and unseen, which limit our ability to imagine and implement a future in global health that is truly better than our past.

Rochelle A. Burgess

1

INTRODUCTION

Global health and its uncomfortable truths

Why do we need a book about power in global health? As a qualitative scholar, I will answer this question, with a story. This one, is about Bumi, who I spent the afternoon with during my PhD more than 10 years ago.

I met Bumi[1] in a part of South Africa (SA) you would only know about if you lived in this part of South Africa. The subdistrict shares an invisible border with Mozambique, recognisable only to locals, like my driver who joyously pointed out to me the precise moments we were in Mozi instead of SA. Our meeting was the third or fourth interview in my project studying women's mental health in the context of HIV,poverty and gender-based violence. Bumi and I spent the afternoon discussing the joys and sorrows of her life. We also discussed some of her answers which were reported on a screening tool linked to the larger study she was involved in, as they suggested she was living with depression.

She lived at the edge of an unmarked road, in a small house on the top of a small hill. There were children running around, and a group of men seeking refuge from the heat under a tree. She looked nothing like the depressed women I had met in my previous work as a mental health researcher – despite her scores on the screening tool suggesting otherwise. As we talked, mostly facilitated through my fantastic co-researcher and translator as my Zulu never improved as I had hoped – Bumi told me stories of struggle. She told me about her abandonment by her husband, and how poverty shaped every decision she made. When we discussed the origins of her depression symptoms, she listed worries about her children, their future and how the need to feed, clothe and pay for their education despite this poverty gave her sleepless nights. She framed this as a *sadness of the heart*, which was the closest you could get to something that matched the category of depression for people in this community (Burgess, 2014).

But these weren't her only stories. She also told me about how she mobilised, often on her own, to ensure the survival of her family. How she cobbled together

DOI: 10.4324/9781315623788-1
This chapter has been made available under a CC-BY-NC-ND 4.0 license.

multiple streams of income to ensure that there was nearly always something to eat. When we parted ways, she said a line to me, in broken English, that has stayed with me since. Words etched so strongly into my memory that some years later, I start my first book with her story. She told me, still smiling, that she thought I was coming to bring her electricity – because that was what she told the last researchers who she spoke to, that she needed. I spoke to 19 women, and they all told me something similar. They needed food, they needed water, they needed money.

> *You can't be free, if you don't have money. Money sets you free – am I wrong?*

In that moment, and now, I wonder how many researchers these women had said this to before, and since.

A brief history of global health: Definitions and uncomfortable truths

Global health is a discipline that, on paper, appears to exist for the purpose of responding to, and ending the struggles faced by women like Bumi, their children, families and communities. The desire to help is so strong that Development Assistance for Health (DAH) – the best metric available for mapping spending in global health – numbers in the billions. In 2020, DAH figures increased to 55 billion dollars, an increase of 14 billion due to financing earmarked for the COVID-19 pandemic response (IHME, 2021). But how such figures are put into action is often defined by others' far removed from women like Bumi's realities.

In 2009, Koplan and colleagues conceptualised global health as discipline and field that was as they noted 'fashionable'. This fashionability has not ebbed. If anything, it has increased. Ever expanding public debates, training programmes and sub-disciplines comprise the landscape. A recent review by Salm *et al.* (2021) on definitions of global health noted four broad themes reflected in the field's definitions, orienting around: practice to improve health, governance and ethics and broader tensions in the field. Beyond this, global health 'work' remains a central pillar of foreign policy within high income countries. For example, the G7 group of countries (G7) have made a series of global health declarations in the past 20 years. This includes founding the Global Fund in 2000 and the Muskoka Initiative in 2010 – which drove financial commitments needed for tackling health issues which captured the global imagination at the time: HIV/AIDS, TB and Malaria (Buse and Bertram, 2021).

It is unsurprising then that specific definitions of global health shift to reflect the various positionalities of the actors, academics and policy makers working in these spaces. McCracken and Phillips (2017) provide a comprehensive genesis of the terms rise in popularity, noting its varied definitions within policy, research and practice.[2] They argue that what holds true across varied positions held by governments, academics and organisations such as the World Health Organisation (WHO) is an interest in health issues that transcend national boundaries which are believed to be solved through multi-lateral action in public and clinical spheres.

Koplan *et al.* (2009) define global health as linked to a similar interest in the health of publics, which anchor the field to previous generations of health engagement: international and public health. They argue that the three disciplines share an interest in prevention and population-based foci as well as underserved populations. Change is mediated through an emphasis on updating systems, and collaboration among stakeholders. However, they argue that global health is made distinct from other eras, through an overwhelming interest in fairness and a more direct response to health inequities. As stated by the authors:

> *The preference for use of the term global health where international health might previously have been used runs parallel to a shift in philosophy and attitude that emphasises the mutuality of real partnership … a two-way flow between developed and developing countries. Global health thus uses the resources, knowledge and experience of diver's societies to address health challenges throughout the world.*
>
> (Koplan *et al.*, 2009, p. 1995)

An earlier generation of critical scholars, such as Paul Farmer (2003), Arthur Kleinman (2010) and Joao Biehl and Adriana Petryna (2013), takes this notion of equity to the heart of their definitions of the field. For them, there is an agreement that global health is not a discipline or a field, but rather a constellation of problems, which disproportionally burdens particular parts of the world. Responding to these problems involves mapping partnerships, organisations and actors involved in efforts to solve them, identifying opportunities for advancing our efforts to achieve global health justice. Key actors include non-state institutions, such as private philanthropists, community-based organisations and non-governmental organisations working nationally and internationally (Farmer *et al.*, 2013). Critically, Biehl and Petryna (2013) focus on the the need for a deep interrogation of human, political and technical issues at play in the global health landscape. For them, a meaningful aspect of the drive for justice is embodied by the need for global health actors to witness and acknowledge the dignity of people's own struggles, placing this at the core of knowledge production in the field.

The language of justice and responsibility in the field is pervasive. Sridhar Venkatapuram's *Health Justice* (Venkatapuram, 2011) articulates the necessity of this approach to global health, arguing for the entitlement everyone has to the capability to be healthy:

> *Every human being has a moral entitlement to a capability to be healthy (CH), and to a level that is commensurate with equal human dignity in the contemporary world … . The entitlement is to the social bases of the CH … .individuals have a moral claim to the practically possible and permissible social interventions into those four determinates in order to produce a CH … . When* ***something is not immediately feasible whether locally or globally this gives rise to a claim for social policies that take steps towards***

> ***making the claim feasible.*** *This argument also limits the scope of social justice to what can be done by or through social actors … .*
>
> (p. 20, bold emphasis added)

The most important determinants to individuals achieving health capability are social in nature. If we follow Venkatapuram's argument, we all carry this responsibility for action. He calls us, perhaps more explicitly than others in the field, to actively respond to women like Bumi. As social actors in we must act within our own capacities to alleviate the past consequences of harm, and work to protect, sustain, promote and restore health capabilities. Such sentiments are part and parcel of arguments like those of Garcia-Basteiro and Abimbola (2021) who push us to consider that what global health may best be characterised as, is *health equity* research.

Yet, global health still manifests like a new label on the centuries old practice of foreign engagement in the lives of 'othered' populations. Global health scholarship and practice continues to grapple with the afterlife of colonialism. Keshri and Bhaumik (2022), for example, align global health to the feudal societal structures established during the colonial era. They argue that this ongoing tendency to defer to a small set of local actors who are socially positioned as more powerful, helps to maintain the colonial structures within global health infrastructure. The field is now inundadted with calls for decolonisation – a paradigm born in the freedom struggles of African and Latin American countries –. The journal *BMJ Global Health* published over 100 pieces on this topic since 2019.[3] Most of this scholarship is united in its demands for seeding the centre of imagination and action away from northern-derived scholarship and frameworks, towards southern and indigenous perspectives.

Still, in his history of global health, Packard (2016) states the only reliable change the field has seen has been the shifting of narratives that position certain challenges as 'priorities' over others. This is perhaps why, no matter how you slice the pie, women like Bumi are rarely given the opportunity to define for themselves what is needed to make their world better and to improve their health. She is heard, and simultaneously ignored. Instead, her narratives are filtered through methodologies and paradigms chosen by people who seek to help her, structured by knowledge systems anchored to prorities and societies beyond her. Boavenntura de Sousa Santos (2018) describes this process as contributing to the sustaining of the cognitive empire marshalled by western ideals. The consequence is that the speakers and claims which can trigger action or and be defined as 'true' are only valid when filtered through the lens of the global north[4] – vis a vis Eurocentric scholarship and positionalities (Abimbola, 2019). This process is how global health becomes embedded within cycles of hearing but not listening (Burgess, 2022).

The emedded nature of global health problems are inextricably linked to the wider problems of the development industry. There are scholars who view the current situation within global development practice as a purposeful production; that the notions of high/low income, developed/developing, are manifestations of efforts by rich, former colonial powers, to maintain influence in places once under their

dominion (Moyo, 2010; Hickel, 2016). Among the first to make this argument was Arturo Escobar. In his major work, *Encountering Development*, he argued that the establishment of the development industry in Africa, Asia and Latin America following World War II was a proxy for controlling and managing issues that would be a danger to western and European nations. Waves of independence meant that the era of development coincided with the waning of colonial powers, leaving the project of ending poverty in place of the project of colonialism. The result was the '*transforming [of] society by turning the poor into objects of knowledge and management*' (Escobar, 1995/2012, p. 22). Crucially managing poverty also demanded the management and delivery of interventions to improve '*health, education, hygiene, employment and the poor quality of life in towns and cities*' (Escobar, 1995, p. 23).

As such, if we also consider development as a site contributing to the making of global health, clear forms of power emerge, perhaps more clearly than if we are focusing on our links to 'international health' alone. For example, that of Economic power. NGOs and foundations whose main activities are most likely to include project development and delivery received 24% of DAH in 2018 (IHME, 2021). In the UK alone, International NGOs received funding worth more than 7 billion, 55% of the Overseas Development Assistance (ODA) in 2015 (Banks and Brockington, 2020).

These realities remind us that in global health, economic power cannot be underestimated. Social theorist Karl Marx viewed economic power and capital as a form of power continually manipulated and held by actors for their own gain. Across the global health landscape, it is clear that economic power is the bread and butter of the system, and those who hold it get to dictate the terms of engagement. For example, philanthropic entities like the Gates Foundation, who in 2020 donated 3.6 billion USD in DAH funding – more than France, Canada and Australia combined – have increasing scope to shape the parameters of global health action (IHME, 2021). Beyond this, the locus of global health research funding sits in high-income settings, mirroring old patterns of development and aid resource distribution (Keshri and Bhaumik, 2022; Abimbola 2019).

Economic power, is just the start. There are forms of power at work through processes of managerial control which set the rules and regulations of everyday global health practice. There is power at work in the production of interventions that organise bodies and actors in particular ways based on definitions of problems, and solutions. There is power at work, in setting the boundaires for how disease burden or poverty are defined and measuresd. These forms of power ultimatley determine how countries with economic power decide on what gains funding, and what doesn't.

To dig deeper is to find that there is never just one type of power at work. Take one example. In 2017, the Trump administration reinstated the *Mexico City Policy* or, as it is more commonly known, *the global gag rule* denying funding to international organisations that provided abortion services or advice, as part of reproductive health programming. The result was the stripping of funding for reproductive health. In 2020, allocating just 608 million out of a 9.1-billion-dollar

budget (IWHC, 2021), which cancelled entire programmes, creating gaps in care for women and children, including those who would have accessed abortion linked to rape and incest (IWHC, 2021). In this one act, we see the intersections of multiple forms of power. Economic power is clearly present, but decision-making powers are also shaped by other forms of power. For example, ideological power (based on a group's ability to shape norms that govern how others act – see Jones and Jones (2004)) give America the ability to establish normative frames to make decisions that affect the lives of others. This is enabled by the economic dependence that exists between low-resource countries engaged in aid relationships with the United States.

Despite this, somehow the study of power is not a mainstay in global health. Each year, high-income country institutions produce hundreds, perhaps thousands of people who emerge branded as specialists in the field of global health (Svadzian *et al*., 2020). Their goal? To design interventions and research programmes to 'fix' problems. To work on behalf of bodies and actors who are in the majority world. But very rarely they are taught to interrogate how the processes that will define their careers are anchored to power established historically and working continually often against the desired aims of women like Bumi. This is a reality that must change.

Where to begin? Grappling with power in global health

The current interest with power in mainstream global health discourses can perhaps be traced back to a commentary in the *International Journal of Health Policy and Management,* in 2015. Drawing on the work of Barnett and Duvall (2005), Jeremy Shiffman (2015) outlined two broad conceptualisations of power that are useful to global health: structural and productive power. Structural power calls attention to the forms of power that shape how we define ourselves in relation to one another; in ways that enhance the abilities of certain actors to act, while limit abilities of others. Structural power is typically wielded through the presence of actors, who determine the boundaries of action through their positions as 'experts' in various fields. As economists modelling impacts of social phenomena and costs to states, or as academics or advocacy experts who offer advice to governments as part of driving efforts towards improvement.

Productive power relates to how meaning is created in society, through the establishment of categories that shape the world through allowing us to think of the world, or imagine what is possible, in particular ways. In global health, this is embodied by various concepts, frameworks and paradigms that are put to work in the service of global health improvements: burden of disease metrics, interventions and beyond. A year later, Solomon Benatar's work on systems and frames in global health (2016) draws on this approach to power in making sense of how particular belief systems and frames shape reality in global health practice. He identifies structural and productive power as two different *forms* of power, while financial, knowledge-based and normative power are defined as *modes* of power.

Within these two well-cited pieces, collapse a multitude of pathways for engaging with power . The scholarship on power as a concept is quite expansive, and as such would be difficult to cover in its entirety here. Instead, I will focus on frameworks of power that have been helpful in supporting an engagement with the complexity of power as I have seen it in people's lives. Frameworks of power gain value in their ability to allow us to look at multiple forms or modes of power working together.

Conceptualising power in global health: Frameworks on action, decision-making, knowledge and resistance

A exerts power over B? Making sense of Dhal through Lukes faces of power

One of the most cited definitions of power is attributed to Robert Dahl (1957) whose work on power and coercion has informed many contemporary scholars in various fields linked to global health, particularly international relations (Moon, 2019). In his definition, he writes that power is conceptualised where A has the power of B, to the extent that they can get B to do something they would not otherwise do. There is no shortage of examples or mechanisms through which A gets B to act in particular ways. For example, the use of hard power – such as economic power wielded by states, corporations or physical power – can also trigger and enable the use of force, through militaries, police or other forms of conflict. However, Stephen Lukes, *faces of power* (2005) framework builds on the work of Dahl, supports the exploration of actors involved in these power relationships and considers the 'how' and 'why' of these relationships.

Decision-making face of power – A makes B do something they would not otherwise do

This face of power is the platform where power makes itself most visible. There are often very visible decisions, open conflict and observable martialling of resources. Lukes (2005) describes this as behaviour driven – where the self-defined interests of one group are clearly pitted against the self-defined interests of another. It shapes the way others act, through leveraging resources – in global health, one of the clearest of these resources is economic; where global health financing drives the will and whim of various actors within the global health space, who shift and change in response to funding priorities.

Agenda setting face of power – A prevents B from doing something they would otherwise do

This face of power, which is less visible than decision-making, allows us to understand the ways in which action, or the absence of action, is linked to the

power that groups can marshal visibly, as well as behind the scenes. This more hidden form of power is often described by Lukes as understanding 'who gets to decide, what is being decided?' Critically for global health spaces, this is of interest in coming to terms with how priorities emerge within a space; what drives an interest in one health crisis, and a disinterest in another? Another factor that is critical to note about power at work in such processes, is the ability for agenda setting to anticipate and block particular ideas from entering a debate or policy arena. This allows systems to be organised to exclude certain activities right from the start, such as the global gag rule which prevents the awarding of financing to women's organisations that fund abortion services.

Thought control power – A manipulates B into doing something that is against B's interest (but B does it voluntarily anyway)

For Lukes, this is the most invisible form of power, as the goal is to manufacture consent, without the necessary involvement of systems or structures, but through having actors believe that something is in their best interests. This form of power is rooted within the marshalling of other systems and 'hidden' forms of power that are less expected. Here, we consider power embodied in social norms, such as Pierre Bourdieu's notions of cultural and symbolic capital. Bourdieu (1989) who views power as exercised through various forms of capital held by various actors in the public sphere. Cultural capital is defined as the ability of people to align with the cultural markers within a society or space that is defined and viewed as having status and privilege. Symbolic power, or symbolic capital, is defined as the ability for certain groups – often those with cultural capital – to establish ideas as acceptable 'truths' that must be adhered to by others in a given context. To put this in a more concrete example, we can consider the Brexit campaign in the UK in 2014. The conservative party leveraged cultural and symbolic capital, in order to gain support for various claims, which have been proven false subsequently. The most famous of these was the claim that £350 million pounds were sent to the European union each week, and upon its departure, this money could be channelled to the NHS instead. This money has never materialised.

Knowledge and resistance dyad: Foucault's other contributions to global health

Power in global health is ultimately rooted in an understanding, either implicit or explicit, that the world is divided into two broad groups – those who have power and those without. These distinctions are often presented along reified dichotomies; reflected in language such as the 'third world vs. first world'; 'developed vs. developing countries'; 'high income vs. low income'. Each of these dyads invokes the afterlife of colonial legacies around the world (Benatar, 2016), and the common understanding that resources, wealth and ultimately power are held by some, but not others.

French philosopher Michel Foucault works to dismantle our interest in these absolutes and the belief that power is a zero-sum force (Hook, 2007). His work attempts to illuminate the diffuse way that power operates; how it becomes embedded within structures, ideas, knowledge systems and discourses. Crucially, he asserts that it is the power in these discursive domains that contributes to upholding systems and structures in the long term. As Derek Hook articulates:

> *Foucault is typically concerned with pining down the discrete procedural logic of power as it is manifest at a micro-political level … . if we are able to develop an adequate micro-political frame of analysis to trace what Foucault sometime refers to as the microphysics of power … then it becomes absolutely necessary to break from broader structural models that understand power in large scale and typically repressive juridical economic and ideological terms.*
>
> (Hook, 2007, p. 63)

Foucault also demands that we acknowledge the positive diemsions of power

> *What makes power good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says 'no' but that it traverses and produces things, it induces pleasure, forms of knowledge … . It needs be considered as a productive network … more than as a negative instance whose function is repression.*
>
> (Foucault, 1980, p. 119)

Arguably, Foucault's most popular contribution to global health derives from his interest in how the diffuse nature of power bestows on it the ability to define people and notions of personhood. Acting on them to control, manipulate and divide us – making us into subjects of particular ideas and concepts, operating through relationships, systems, knowledge and discourse. One of the most common themes is biopower, which is defined as the administration and regulation of human life and experience, which can occur at population and individual levels (Genel, 2006). This concept is what gives us the ability to see power in its totality – when we move away from a single type of power itself, or where it sits, and begin to focus instead on what it produces.

The power of discourse is most clearly conceptualised in the work of Stuart Hall (1994) who draws on Foucault in shaping his arguments. Hall defines it as the totality of what can be thought and known, about an entity. These knowing's shape action in relation to an object and ultimately ensure the reproduction of particular social systems and is a site where power is easily transmitted, transferred and produced. Hall's (1994) work on the power of the discursive space around the 'west' is particularly important to global health work; as the west vs. non-west remains one of the primary markers of global health interventionism. He describes four key functions of discourse that illuminate where power can be held or transmitted. First, it allows for the creation of categories – such as determining what

is and isn't 'western'. Second, it represents an idea that brings with it images and languages, an imaginary of a particular category. Third, it creates a standard for comparison – the ideal form, which others must aspire to. Finally, it establishes standards for measurement and evaluation against that ideal. Collectively creating new systems and structures to define the inclusion and exclusion of groups from that ideal, and as such, systems that manage everyday existence.

Absent in our discussion thus far are reflections on how we understand the capacity for power and agency among those on whom power typically act. In global health, the quest for social justice has, for the most part, positioned and established recipient communities as passive – to its own detriment as we will discuss in later chapters. Thus, global health scholarship also overlooks the forms and productive power among actors who live and survive at the coalface of various global health crises. This erasure is perhaps facilitated by an insufficient engagement with the corollary of power: resistance. Foucault argues that power does not exist in the absence of resistance – specifically, power only exists because of resistance. As noted by Hook: '*What else would drive the constant variations, the diversity of tactics, indeed the very plurality of power's forms, other than the need to surpass hurdles to its measures of control?*' (Hook, 2007, p. 85). For each point of power is a point of resistance, which has much to teach us in discovering the weaknesses of systems of power and sites for action.

Building in part on Foucault's work, James Scott (1990) has written extensively on notions of resistance, within investigations that centre the everyday resistance among marginalised groups. His positions are helpful in illuminating the importance of resistance in multiple forms including quiet resistance, countering assumptions that people who are the targets of power, are passive in their acceptance. He takes aim at scholars such as Gramsci, and his notion of hegemony and false consciousness – the framework that largely underpins Lukes third face of power. False consciousness is broadly interested in answering the question – why do people engage in actions that are against their best interests? According to Lukes (2005), the answer lies in the ways that symbolic and cultural capital can be leveraged to trick people into believing something as true (what Scott defines as a thick version of false consciousness). Critically, Scott rejects this notion, by articulating the strategic acts of playing into and choosing when, and what resistance looks like. Drawing on artefacts from communities who have experienced subordination, he highlights the transcripts of resistance within arts, music and oral histories. He notes:

> *The obstacles to resistance, which are many, are simply not attributable to the inability of subordinate groups to imagine a counterfactual social order. They do imagine both the reversal and negation of their domination, and most important they have acted on these values in desperation and on those rare occasions,* ***when the circumstances allowed****.*
>
> (Scott, 1990, p. 81, emphasis added)

Referred to in his work as 'hidden transcripts', Scott argues that visible action may make it seem as though power held by one group is secure and accepted. However, he contends that this itself is an action. All action, even those who seem to be acquiescing to power, may actually work to support survival in the here and now. An example from Scott illustrates this clearly:

> *Imagine someone appealing to his superiors in a capitalist firm for a raise ... So long as he anticipates remaining within the structure of authority, his case will necessarily be addressed to the institutional interest of his superiors. He may in fact want a raise to say, buy a car ... or help fund a fringe political group and feels he is entitled to it for having faithfully covered for his bosses' mistakes ... none of this, however, will make it into the official transcript. He will ... probably emphasise his loyal and effective contribution to the institutional successes of the firm ... Strategic action always looks upward, for that is frequently the only way in which it will gain a hearing ... . Most acts of power from below, even when they are protests, implicitly or explicitly, will largely observe the rules – even if their objective is to undermine them. The 'strange theatre' to which Foucault refers is deployed ... . often as a valuable political resource in conflict and even in rebellion.*
>
> (Scott, ibid, p. 93)

Other writers in international development draw attention to problematic notions of agency that overlook what happens in silence. Sumi Madhok (2013) articulates that agency itself is often approached in European dominated language that demands visible 'free action'. What their work on the dialogue between power and resistance provides is a clear drive to turn our attention towards the microcosms of power at work in global health. This type of lens provides much in the way of understanding what power means in the reality of people's lives as they negotiate for better health, in the face of complex realities.

Where power works: John Gaventa's power cube

A final framework of power that has been critical to understandings of power, particularly power in the form of resistance in global health, is Gaventa's (2006) Power Cube. Gaventa's cube considers power as operating at three faces, like the work of Lukes. *Visible power* is understood as observable decision-making mechanisms, and power at work where there are clear winners and losers. *Hidden power* is used to refer to agenda setting, and decisions that are made away from the public eye. Finally, *invisible power* includes social conditioning, ideology and notions of hegemony that come to bear on the practices and actions of others in more nuanced ways. His framework does the most to advance our thinking with the inclusion of the dimension of spaces and places, helping us to better locate opportunities for to drive change and resistance. Global, national and local places refer to the level of action, decision-making and the focus of interventions on planning. Global spaces would include organisations such as the United Nations and its associated bodies, or

other multi-lateral organisations within the global health landscape. National spaces include state systems of governance and operations, and often our forms of analysis explore their relationships to global as well as local spaces – which are those occupied by the everyday citizens and targets of interventions.

Notions of participation and ownership over action are critical to understanding health and development impacts. Drawing on the work of Andrea Cornwall (2002), Gaventa adds an additional dynamic of spaces to clarify that power ultimately works to open or close spaces to certain actors to engage in projects of change. Closed spaces, for example, are those where much action is fully hidden from the view of those who have vested interests in an outcome. The United Nations is an example of such a space; the closed nature of this space is moderated by a series of regulations and other disciplinary forms of action. Invited spaces are possible, when typically closed, spaces are opened to the participation of additional parties. In the case of the United Nations, this may take the form of events where sections of the public, such as NGO representatives, are invited to participate and deliver prepared remarks to inform decision-making of other actors. Finally, claimed and created spaces are those that typically centre coalitions acting to further resistance to the status quo, or decisions and actions of others. The clearest examples of these claimed spaces include resistance and advocacy groups.

The value of the power cube is that it provides us with the ability to focus on the diffuse nature of power, enabling us to think not just about locations of power but also about relations between the different spaces, places and forms of power at work in people's lives. Cruicially, it does this without minimising the capacity of 'bottom up' power to factor into and wield its own effects at various levels in search of change.

What next: In search of a power framework for the future of global health

In 2019, Suerie Moon suggested a typology of power within global governance spaces, using global health as the ideal example of a complex system. Her typology provides a useful summary of eight different types of power that are particularly helpful for our purposes. These types of power are used widely to make sense of phenomenon in global health research and praxis. In an effort to bring the frameworks discussed so far into alignment with some of the more typically discussed 'types' of power referenced throughout global health work, I adapt her table below. Table 1.1 maps the types of power across different frameworks allowing reflections on where types of power may be located within global health infrastructures.

It is my belief that, for global health to achieve its aims of social justice, engagements with power must attempt to embrace this complexity. This means an eschewing of engaging with power as it sits in a single space, place or actors, in favour of analysis *across* various levels of action attuned to how different types of power work together to produce particular outcomes. In global health analyses, there remains a preference for simplification, despite longstanding calls for

TABLE 1.1 Understanding power types and frameworks in global health

Type of power	*Actors*	*Theoretical foundations*	*Level/spaces of action (Gaventa, 2000)*	*Examples*
Physical power	Militaries, police; peace keeping missions	Dahl	National, global	UN peacekeeping missions
Economic power	States; philanthropic entities; corporations; transnational organisations	Marxism, Gramsci	Global, national	International monetary fund structural adjustment policies that demand low investment in social welfare sector (health)
Structural power	Governments	Barnett and Duval, Lukes	Global,national, local	Legislation on drinking age; abortion rights
Institutional	Organisations, government apparatuses	Lukes, Foucault (bio-power)	Global, national, local	Governance and management systems; policy frameworks
Moral	Public figures; traditional leaders	Bourdieu, Shiffman	Global, national, local	Bill Gates and similar actors who gain authority
Expertise (knowledge)	Academics, professionals, scientists	Foucault, Shiffman Freire; Fanon	Global, national	Academic publications
Discursive power	Media, academics; think tanks; journals; local leaders	Foucault, Shiffman	Global, national, local	Lancet Commissions
Networks	Individuals and collectives	Foucault, Bourdieu, Scott	Global, national, local	Treatment Action Campaign

complexity. For example, the syndemic approach coined by Merrill Singer in the 1990s argues that poor health is a result of complex relationships within biosocial contexts. Relationships between social and environmental factors can lead to the clustering of certain health conditions allowing us to hold within our view the impact of multiple social and political drivers of illnesses. A syndemic approach has gained much support in recent years, with many supporting its value in global health specifically (Mendenhall, 2017).

However, this analytical stance does not automatically lead to change in praxis relating to health and illness. As noted by Sangaramoorthy and Benton (2022) shifting praxis is better achieved by frameworks which centre the contributions of ideology, power and social categories – the factors that often put people within contexts that drive risk in the first place. As Table 1.1 illuminates, the categories that Sangaramoorthy and Benton direct us towards are always implicated within the workings of power. Yet rarely do we have the opportunity to work with all these categories at once in global health scholarship. However, this does not mean that others have not attempted to do so elsewhere.

Unsurprisingly, the relevance of power to health has been a longstanding focus for many Black scholars. For example, in *The Wretched of the Earth*, Franz Fanon (1963) devotes an entire chapter to mental health and the impacts of colonialism on psychiatry and psychology. He contends that the power of these systems can individualise the impacts war, including structural, political and psychological violences. Contemporary work by, Dorothy Roberts (1999), Alondra Nelson (2011) and Anthony Hatch (2016, 2019) show with painful clarity that Black bodies (in the United States in these works) are produced, constrained, manipulated and violated through multiple interlocking types and systems of power. Black feminist scholar Patricia Hill Collins has written extensively over the past two decades about the importance of engaging with complexity in making sense of oppression of marginalised groups, particularly Black women, in the United States (Collins, 1989, 2002; Collins *et al.*, 2021). Her renowned work, *Black Feminist Thought,* takes a much-needed intersectional lens to the analysis of oppression – or power – at work in the lives of Black women.

In this book, I hope to contribute to recent efforts to overcome an under-appreciation of Black scholarship in theorising in the global health space (Hirsch, 2019). In expanding Patricia Hill Collins reflections on power at work in the lives of Black Women, to exploring power at work within the global health – I also seek to acknowledge that our discipline is a space deeply concerned with the lives of Black and Brown people, and similarly marginalised bodies. Her framework *matrix of domination* asks readers to consider that power works, not through explicit types – but instead, domains where different types of power interact. In doing so, Collins directs us to the fact that power always works in multiplicities, rather than singularities, and orients us to the embeddedness of its workings. Her four domains – *structural, disciplinary, hegemonic* and *interpersonal* – allow us to recognise power in its full complexity.

Figure 1.1 displays my adaptation of her framework, titled 'The matrix of domination in global health'. Expanding on her domains, I include specific frameworks of power that are helpful in understanding her processes in global health spaces. I expand on the potential value of this approach in the following section.

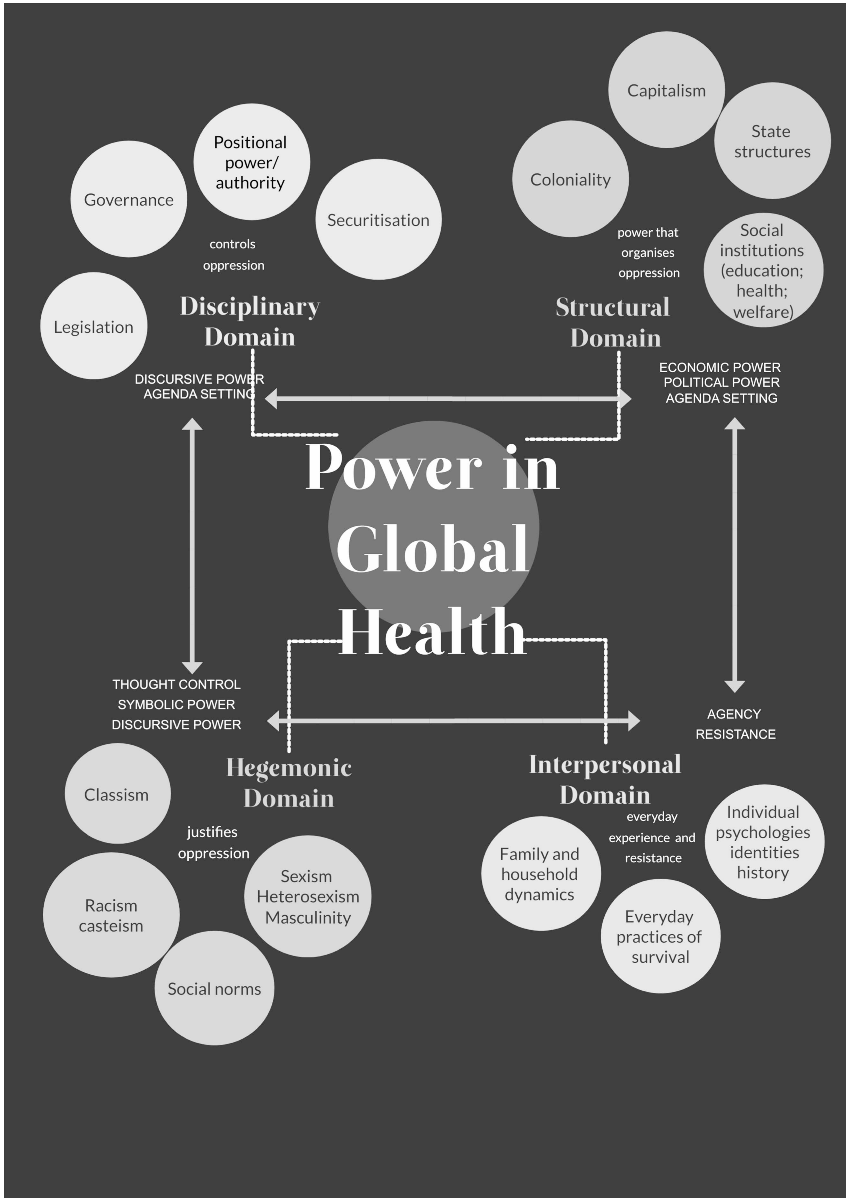

FIGURE 1.1 Matrix of domination in global health: maintaining space for complexity, adapted from Collins.

A power framework for our times? A matrix of domination in global health

In the *structural domain* of power, Collins draws our attention to how wider social and public institutions and their policies are organised to reproduce the oppression and subordination of various groups over time (Collins, 2007, p. 295). Crucially, she highlights that such institutions often work in overlapping ways, shaping the totality of systems that organise our lives: education systems, health systems, welfare systems, to name a few. While she focuses primarily on these systems as they operated at the level of the nation state, to increase the paradigm's relevance to a global health framework, we must also acknowledge how these systems are global in scope. Thus, we acknowledge that state infrastructures are bound to others through systems of globalisation, coalitions of global actors, which collectively contribute to states of oppression – operating through the martialling of economic and decision-making types of power.

For example, the endemic poverty that remains at the heart of many struggles to improve health outcomes is linked to intersecting social institutions that operate at both national and global levels. One classic example of such relationships are structural adjustment policies, enforced by the World Bank and International Monetary Fund (IMF) in the 1980 and 90s. Such policies demanded that countries across the global south pull funding from social institutions, such as health and social welfare and enforce strict periods of austerity that deepen the impossibilities of improving health and wellbeing. Other international forms of infrastructure such as the World Trade Organisation (WTO) also carry the ability to establish rules that structure systems which can exacerbate poverty. For example, Singh and Gupta (2016) discuss mechanisms through which WTO negotiations are driven. Various national and international alliances between rich countries and other coalitions based on trade have had little positive impacts on the Farming Sector in India. Earlier work by Oxfam on the textile industry (Barber, 2004) highlights how negotiations on tariffs in this industry continually favour rich countries. This has contributed to the pervasive poverty seen in nations where textiles are contributors to industry, such as cotton-producing countries 40 billion dollars per year in lost exports during the 1990s and 2000s.

Furthermore, it could be argued that poverty itself becomes a structural form of power within this domain, operating as a form of productive power (Shiffman, 2015) in people's lives through the organisation of various social systems. Once individuals fall into states of economic precarity, the social, economic and political systems around them are often designed in such a way that moving out of poverty is nearly impossible. So, not only do systemic structures make people poor but they also *ensure* that they can also never leave poverty. For example, a recent UNDP report for the European Union, noted labour market resources, access to social care and other forms of support are the scaffolding required to enable people to take up employment opportunities, and escape poverty (UNDP, 2017). However, it is well

known that poor people, particularly women, are also less likely to have access to these resources, making them increasingly vulnerable to falling deeper into states of poverty once exposed (Weyers *et al.*, 2008).

For Collins, the *disciplinary domain of power* is defined as the mechanisms and functions of power through which structural forms of power are managed (Collins, 2002, p. 294), and begin to filter into the everyday lives and experiences of people. Foucault's work on disciplinarity and its ability to define relationships between subjects clarifies the importance of this domain. In 1973 lectures, he remarked that disciplinary power '… is a total hold, or at any rate … an exhaustive capture of the individual's body, actions, time and behaviour … *every disciplinary system tends, I think, to be an occupation of the individual's time, life and body*' (Foucault, 1973, pp. 46–47, emphasis added). The totality of disciplinary power is achieved through the operation of procedure, a state of continual observation of various actions, in the hope that observation eventually is no longer needed – as actors reach states of self-management, or habit (p. 75). In her reflections on the role of the disciplinary domain on the lives of Black women in the United States, Collins draws our attention to the specific function of bureaucracies. She notes how the organisation of systems, institutions and states develops policies and practices that can discipline and controlling their workforces or citizens. As she aptly notes in her descriptions of the systems, Black women surviving poverty must endure the multiple ways that 'occupation' of women's bodies and behaviours is clear:

> *Whether the inner-city public schools that many girls attend, the low paid jobs in the growing service sector that young black women are … forced to take, the culture of the social welfare bureaucracy that makes Black mothers and children wait for hours … the goal is the same – creating quiet, orderly, docile and disciplined populations of black women.*
>
> (Collins, 2002, p. 299)

The intersectionality that Collins describes above is a key feature of disciplinary domains of power. Foucault notes that various disciplinary domains can bleed into one another – that once a person has been identified and shaped by one disciplinary system, their engagement and connection with other systems will be continually shaped by the original. This is critical to understanding how global health challenges persist.

The *hegemonic domain of power* can be understood as types and forms of power that help to maintain power at work in structural and systemic domains. They do this, through shaping consciousness, by providing a cognitive framing that often justifies and enables oppression, in the minds of various actors who work within disciplinary and structural domains. Collins (2002, p. 302) argues that these forms of power justify oppression and exclusion through controlling our patterns of thinking about and seeing the world – similar to the forms of power that Stephen Lukes (2005) describes as mind control:

> *A may exercise power over B by getting him to do what he does not want to do, but he also exercises power over him, by influencing, shaping or determining his very wants; Indeed, is it not the supreme exercise of power to get another or others to have the desires you want them to have – that is to secure their compliance by controlling their thoughts and desires … . thought control takes many less total and more mundane forms, through the control of information, through mass media and through the process of socialisation.*
>
> (Lukes, 2005, p. 157)

Forms of symbolic power presented in Bourdieu's work highlight the ability for intangible systems to impose particular visions of the world and naturalise particular ways of working and being in the world. As noted by Collins: '*The significance of the hegemonic domain of power lies in its ability to shape consciousness via the manipulation of ideas, images, symbols and ideologies*' (p. 304). It is ultimately the domain that links together what happens at structural and disciplinary domains; the ideas that justify the means.

Finally, Collins' most important contribution is her refusal to overlook the level of the individual. At the outset of her work, she notes much scholarship on power creates a false separation in our analysis of subjective power relationship. Referring to power and systems that act on people to oppress them, and dialectic power relations which explore power and agency relationships in the face of oppression (Collins, 2002, p. 292). By refusing to see these approaches as mutually exclusive, we hold close the everyday impacts of power on the lives of everyday people. This domain enables us to maintain the dignity, agency and capacity for resistance among individuals and collectives to exercise power in their own right on their own terms. This is a critical aspect of scholarship in a quest to push global health praxis beyond its failings of the past: a reminder that analysis, and systems occur alongside people who in the face of interlocking systems of oppression at the structural, disciplinary and hegemonic domains, *survive*.

This is achieved through analysis of power in the *interpersonal domain*, which focuses on day-to-day practices manifest in how people treat and, how we imagine our own capacities in relation to one another. For example, internalised, psychological practices can shape how people think about their own capacities. As systems replace local and cultural ways of knowing with ideologies of dominant groups, People come to utilise or adhere to norms created by dominant groups, sometimes without knowing. This form of self-policing is central to the ways in which actors view themselves in relations to others, and among typically excluded groups is a part of how action is hindered or enabled. For example, W. E. B. Du Bois, an African American scholar, articulates clearly how individuals can internalise systems of their own oppression:

> *This sense of always looking at once's self through the eyes of others, of measuring one's soul by the tape of a world that looks on in amused contempt and pity … . He simply wishes to make it possible for a man to be both a Negro and an American, without being*

> *cursed and spit upon by his fellows, without having the doors of Opportunity closed roughly in his face.*
>
> (Du Bois, 1996 [1903])

Attention to this domain also highlights the importance of appreciating the multiple forms that resistance takes; why some groups actions to challenge structural, hegemonic or disciplinary forms of power are more overt, and others are quieter. As Collins states: '*what remains less visible … . Are the myriad ways in which ordinary individuals from all walks of life work for social justice in small yet highly significant ways'* (p. 307).

As such, working through or analysing actions in this domain demands appreciation of family and household dynamics, individual psychologies and everyday practices of survival. This illuminates how power impacts on us and also who individuals and groups use it to serve social justice causes. For example, Catherine Campbell's (2014) discussions on the future of social mobilisation points to the 'micro-social partnerships', or the individuals or small collectives that sustain and support meaningful action in people's everyday quests for survival.

In thinking about partnerships, Collins reminds us that people gain access to various forms of power despite being oppressed or limited in particular domains. She calls us to be sensitive to how the power actors do have is used in other spaces:

> *In essence, each group identifies the oppression with which it feels most comfortable as being fundamental, and classifies all others as being of lesser importance … these approaches fail to recognise that a matrix of domination contains few pure victims or oppressors – each individual derives varying amounts of penalty and privilege from the multiple systems of oppression which frame [our] lives.*
>
> (Collins, p. 308)

When these domains are considered together, the entrenched nature of inequality, exclusion and oppression begins to make sense. The totality of power takes on a whole new meaning as it intersects across levels, space, time, practices, imagined and contemporary selves. But what might such a matrix mean teach us in the context of global health? Does it open up new ways to build solutions? This book continues, with an attempt to answer these questions, using each domain as a platform to drive later chapters in this book.

How to understand this book

This book was written with the hope of taking the reader on a journey to illuminate the complexity of power as it works within global health. I write it from the position of a community health psychologist; a discipline of alliances designed for the explicit purpose of transfer of power as praxis and practice (Nelson and

Prilleltensky, 2010). It is community psychology that has seeded my dissatisfaction with global health, and power analysis in our field. As a discipline, community psychology unsatisfied with approaches that deny the role of oppression in establishing health outcomes. It is unsatisfied with approaches that draw on singular disciplines to understand how people relate to society. As a result, it draws on elements from other disciplines including the political sciences, public health, cultural and social psychology (Marsella, 1998). Importantly, it is global in nature, although community psychology's place in global health scholarship is relatively underappreciated, to the field's own detriment.

Each chapter that follows, reflects on a different global health space. Some where I have worked directly for many years, others that I have come to learn about through activism and interest in social change. Where the varied contexts converge is that in each case assumptions viewed by community psychology as fundamentally harmful are made. In Table 1.2, I summarise this, linking each global health space to

TABLE 1.2 Assumptions in global health – mapping their location in practice and the book

Locations of assumptions and key practices	*Traditional (health) approaches*	*Case study global health issue (chapter)*
Defining the 'problem'	Individualist philosophies (can result in victim blaming, separation of groups with shared adversities)\	Violence against women and the alignment to a health discourse (Chapter 2) Global mental health interventions to address the treatment gap (Chapter 3) Ebola and emergency discourses (Chapter 4) Cholera and Haiti (Chapter 5)
Focus of intervention or research	Deficits and problems – health challenges; resource deficits and gaps	Global mental health interventions to address the treatment gap (Chapter 3) Ebola and emergency discourses (Chapter 4) Cholera and Haiti (Chapter 5)
Goals of intervention or research	Reduction of behaviours deemed 'maladaptive': reducing risky behaviours, promoting healthy behaviour	Global mental health interventions to address the treatment gap (Chapter 3) Ebola and emergency discourses (Chapter 4) Cholera and Haiti (Chapter 5)
Role of 'client' or participant	Compliance with treatment regimens, compliance with interventions	Global mental health interventions to address the treatment gap (Chapter 3) Ebola and emergency discourses (Chapter 4)

a problematic assumption. The analyses in each chapter seek to understand how-workings of power drive these assumptions and what is produced in the lives of others as a result.

As such, this book also provides evidence for the necessity of power analysis to every global health space, whatever the task, whatever the disciplinary focus. This call to arms is taken from Michel-Rolph Trouillot (1995, p. xi) whose seminal work in Haiti, power and history reminds us:

> *The ultimate mark of power may be its invisibility, the ultimate challenge, the exposition of its roots.*

My work in the pages that follow is some of these exposés – created through my own interpretations of scholarship on power from a range of fields and disciplines. They represent particular angles that could be taken in trying to understand how and why things are as they are. They are produced with the hope that these analyses will develop and trigger new ways of thinking about our field that are more sensitive to how power dynamics transform a field committed to social justice into one which appears overly committed to a bureaucratic self-sustenance. Analyses in the following chapters also seeks to contribute towards broader efforts to make global health a discipline where we promote logics of care that push into and respond to the complex social worlds that produce and reproduce health challenges in the first place (Burgess, 2022).

Chapter 2 begins with a case study of the Marriage and Divorce Bill in Uganda, which first came to wide public knowledge in 2014. This pro-women legislation was publicly rejected by women themselves, leaving many to wonder why, given violence against women remains a priority issue globally. The case study illuminates that where agendas are set in the absence of everyday people, they often present incomplete pictures of what is required for change. From this starting point, this chapter presents an analysis of agenda setting within global health, specifically looking at what is gained and lost in the faming of violence against women as a global health issue. By focusing on different forms of power at work within the disciplinary domain it interrogates how processes at the core of global health praxis – knowledge production through scientific special issues – can move us further from the types of action needed to implement change. Using a 2014 Lancet series on violence against women as one such example, I suggest that when this type of power is leveraged, actors and movements simultaneously help and hinder the achievement of their own desires.

In Chapter 3, a similar interest in the unintended consequences of external involvement drives an exploration of the space of mental health interventions. The story of South African and Colombian women at the heart of work I have conducted elsewhere brings into focus the potential consequences of interventions designed to focus on deficits and gaps, without an eye on complexity. Following a brief overview of the movement for global mental health's aims, this chapter explores the consequences of extending the arm of psychiatric power in the majority world. Drawing on the connections between the structural and disciplinary

domains, exploring the productive power of structural violence alongside subjectification suggests that many of today's interventions can contribute to complacency and acceptance of fractured social worlds, and what this means for global mental health more broadly.

In Chapter 4, we turn to a global health crisis which feels as though it occurred in another lifetime: Ebola. In making sense of the 2014–2016 west African outbreak, this chapter asks the question of whether humanitarian approaches to global health crisis are fit for purpose. It begins with Marc's story a humanitarian worker who arrived in Sierra Leone after the pandemic 'ended'. This chapter makes sense of the afterlife of the pandemic, by exploring what is produced by the global health emergency discourse – a rallying cry for many in our field. Delving into how power works within the intersections of the disciplinary and hegemonic domains, this chapter explores how cognitive framings which leverage the space of humanitarian responses to crisis leave the door open for further emergencies.

In Chapter 5, the 2011–2020 Cholera epidemic in Haiti is brought to light, through the story of Ramsey, a development professional directly involved in the implementation of the Cholera response, and the much-overlooked community led strand of the UN's flagship programme. In making sense of Haiti's challenges in this context, this chapter uses the matrix of domination in its entirety to examine how multiple domains of power work simultaneously to limit the possibility of health in Haiti. In each overlapping domain, narratives and logics of interventionism are maintained, with the production of partial solutions to complex problems. In truth, the story of Haiti could be the story of global health working many places in the majority world; it describes a country brought to its knees in part by the same forces of intervention that aimed to save it.

This book concludes with a search for opportunities move beyond these realities. The community framings suggested throughout are revisited alongside Southern decolonial scholarship to explore community psychology's ability to take seriously longstanding calls for independence from the majority world. The chapter suggests that to take the matrix of domination seriously necessitates the application of transformative paradigms (Mertens, 2001) across all disciplinary approaches in the field. Through efforts that centre the transfer of power transfer and solidarity in short- and long-term praxis, global health could emerge as a space determined to put itself out of existence by ending the need for global health as we know it.

Notes

1 This name and some details of the narrative have been changed to protect the participant's identity.
2 It is beyond the scope to provide an account of the history of this term but for those who are interested, see chapter 1 in McCracken and Phillips, which accounts in detail how ideas and concerns about globalisation fed into the establishment of this particular discursive space.

3 Based on search on *BMJ Global Health* journal, with key word 'decolonisation' on 15 December 2022.
4 Throughout this book, the use of the terms global north and global south is in line with Boaventura de Sousa Santos. He views the concepts as encapsulating a collection of states and environments who are at the receiving end of the violence of neoliberalism (Global South) or perpetrators of that violence (Global North). In such a definition, he includes the shared positionality held by oppressed peoples within the geographical north, who often experience shared fates – such as higher mortality and morbidity – with those in the majority world. At the time of press of this book, allegations of sexual violence by Santos came to light. I stand in solidarity with his victims.

2

VIOLENCE AGAINST WOMEN AS A GLOBAL HEALTH ISSUE

Winners and losers in agenda setting?

> *You know, sometimes some of the husbands may not be necessarily violent, but due to peer pressures, where they work, and they talk to others about how they iron out issues with their wives they get ideas. 'You know when my wife comes back late, I slap her', or 'if I come back and she doesn't welcome me, so – I don't buy food for the next two days'. There are those small violences that are not always looked at in violence against women – leaving home without leaving money for buying food … .*
>
> – Gender Community based organisation staff member, Uganda. Interview, 2014

A dream deferred: Uganda, violence against women and the MAD* bill

The world is in agreement that the levels of violence that women and girls face is a problem – one with wide reaching impacts for health (WHO, 2013a) and wider processes of development (Krug *et al.*, 2002). Thirty percent of women globally have experienced either physical or sexual violence at the hands of their partner (Devries *et al.*, 2013) and 7% of women worldwide have experienced some form of sexual assault at the hands of a man who was not their partner (Abrahams *et al.*, 2014). The health impact of these experiences cannot be understated – notwithstanding the physical impact of physical forms of violence, the emotional consequences for individuals and families is also well documented (Adams, 2006; Satyanarayana, Chandra and Vaddiparti, 2015; Oram, Khalifeh and Howard, 2017).

Where the agreement ends is on the best route to take to bring these experiences to an end for women globally, with many arguing for the importance of state-driven interventions and the increase of women's participation in society. In 2003, the Ugandan parliament resumed its efforts in this vein, through pushing a

DOI: 10.4324/9781315623788-2
This chapter has been made available under a CC-BY-NC-ND 4.0 license.

collection of pro-women legislation, whose roots dated back to the 1960s and the establishment of President Museveni's new government. Originally titled the Domestic Relations Bill, it was developed in response to the Kalema Report (1965) which highlighted the poor treatment of women within marriages, and the limited rights available to victims of abuse.

Despite an active women's movement in Uganda dating back to the early 1960s (Tripp, 2004), the process, like so many others, is marked by complexity and contradiction in its search for women's equality. For example, despite Uganda's place as an initial signatory to the Convention on the Elimination of All Forms of Discrimination against women (CEDAW), a 2006 survey (Speizer, 2010) indicated that around 70% viewed domestic violence as justified under certain circumstances (i.e., burning a family meal, neglecting children or visiting friends without a husband's permission).

Violence against women also exists within the public sphere. Feminist icon, Dr. Stella Nyanzi, has suffered a string of arbitrary arrests for her government resistance, linked to multiple public critiques against President Museveni as part of her 'radical rudeness' campaign. Her crimes? Calling him a 'buttock' in her poetry collection (published while in prison), public nudity. Recent policy developments in the country highlight the continued polarisation of views with regards to women's positions in society. In 2014, the passing of the highly contested Anti-Pornography bill (SIHA, 2014) acquired the popular name of the mini-skirt ban, when women's rights groups protested the presence of a clause that sought to legislate the length of women's skirts (Gander, 2014).

Against this background, the Domestic Relations bill spent more than 20 years in the processes of consultations and redrafting, driven by wavering levels of political support. In 2010, the bill was split into two parts, including the Domestic Violence Act (2010) which successfully made violence against women illegal in certain forms. The remaining clauses, most of which revolved largely around women's rights in marriage, were rebranded under the Marriage and Divorce (MAD) bill, which remained under parliamentary debate until being shelved 2014. In late 2019, a second reading of the bill was postponed again, in search of further consultations. Finally, in 2022, it was reintroduced to parliament, under a new name 'The Marriage bill' by MP Hon. Sarah Opendi (Parliament of the Republic of Uganda, 2022).

The most contentious point of this bill's history was the period from 2012 to 2014, when it reached unprecedented heights of media attention domestically and internationally. What remains the most striking aspect about the bill was its efforts to engage with structural and symbolic vectors of violence that contributed to women's reduced status in society. Standing at 85 pages and even more clauses, the 2014 version of the bill revolved around some of the most contentious issues at the heart of Ugandan culture – in particular, Polygamy and bride price. The bill aimed to make bride price optional and make it illegal for it to be refunded at the dissolution of marriage. It also recognised the rights of women to have access to property and assets upon the end of a marriage, including access to children. Such a move effectively reduces the economic and social barriers to divorce for many

women, where previously women would have had to leave children behind (often to be looked after by unsupportive stepmothers) and have no access to land or their economic contributions to the family home during the marriage. If the bill had passed in that form, a first wife in a marriage would have been entitled to 50% of the household's worth – with legal recognition for cohabiting partners as well. The current revision maintains its focus on these issues – and proposes that gifts should not be a requirement for marriage and criminalises a spouse who demands refunds of marriage gifts.

In 2014, public consultations required MPs to go to their local constituencies and hold public debates on the bill. This resulted in a widespread rejection of the bill, particularly among women in rural areas of the country that were viewed to have the most to gain from the passing of the legislation into law. Findings from my research into this topic (Burgess and Campbell, 2015) explored understandings – or discourses – that drove the bill to this outcome. In doing so, we observed the effects of a modern feminist discourse that in seeking to tackle violence overlooks the realities of the many violence(s) that women experience in their lives. As noted powerfully by Mary, during focus group discussions in northern Uganda:

> *I would say that this law does not give empowerment to the women; it does not help us because as women if our dowry is not paid to our parents then we don't feel happy and we always feel insecure. Maybe this law would be beneficial in the long run but as of now in its starting point, it will not empower us as women in this village. For example, your father has raised you through sweat, he has paid your school fees though you might have dropped out of school, or you completed studies, but you have not got a job which could earn you money to be able to support your father, then the only consolation would be the payment of bride price when you are married.*
>
> *Secondly if you have bought something you will treat it with dignity but if man marries you, he has not paid anything on you then he will decide to throw you out of his house anytime he likes. He will say that after all "I did not pay anything for your dowry what will I lose?". This non-payment of dowry will make you to get married in one home and you return, you get married in another home and return so you will just be rotating like that. This means that us as women we shall be taken for granted by the men and we will lose value and respect in the community because a woman can marry different people 5-6 times so this does not bring respect for her.*
>
> – Mary, Community Focus Group discussion, 2014

Mary highlights the complexities of intersecting forms of women's oppression, and also the ways in which women can potentially etch out power within places where their oppression is assumed. To have a bride price associates a woman with value in ways that society does not automatically allow – in a way that remains largely uncontested within male-dominated spaces in the country. Her assertions draw our attention to the intersectionality in the domains of power from our power

in global health framework (PGHF) at work in women's lives. Though legislative action would seek to create action in a structural domain, Mary argues that this will not translate to other areas of importance in her life. The hegemonic domains – where cultural norms work to shape the realities of the interpersonal domain of power – where men wield financial and normative power in women's lives. There are no discussions for how these laws will change the way her father acts towards her, or how a husband would attribute value to women.

In taking Mary's demands seriously, we also take seriously scholars such as Collins (2002), Scott (1990) and others, who demand that we view the actions of oppressed groups as purposive (Madhok, 2013). The complexities of her existence in the short and mid-term seem at odds with a long-term goal of giving women equal power within society. In seeking and securing survival, it makes more sense for women to reject processes that are viewed as helping them in the long run, if in the immediate spheres of their lives, there is no change. In framing the response within the structural systems and disciplinary domains – much is lost within efforts to address the violence she faces.

Though Mary's story does not speak of health directly, this case study is important for two reasons. First other study participants including the NGO staff member quoted at the start of this chapter point to violences which have direct action on health outcomes – such as the denial of food. These realities are among those which contributed to the growing interest in addressing violence against women by placing its health consequences as a priority area for global health.

There are surely positives to be gained from aligning the violence against women movement with a global health project – particularly when global health is taken as a social justice project. In doing so, a potential platform emerges to engage with the wider structural and contextual realities of the violence that faces women. For example, drawing us to acknowledge that opportunities for health are inseparable from the opportunity to live a life free of violence. But it remains a possibility that when drawing violence against women discourses into the global health paradigm, critical aspects linked to the long-wave processes for ending violence against women, are overlooked. As noted by Mary, empowerment of women is not so easily achieved particularly when the 'how' is framed, prioritised and developed from the outside.

This chapter explores how violence against women and girls is conceptualised and approached within global health spaces, to understand the impacts – intended and unintended, when policy and research frame the experiences of women like Mary as an object for action. In this context, how do our conceptualisations of what counts as violence in the lives of women align with how *women* see violence in their own lives? What is the impact of our efforts to do good in policy and research spaces? Using the landmark 2014 *Lancet* commission on violence against women as an example of framing and policy power at work in global health, this chapter focuses on power within the disciplinary domain. Using Carol Bacchi's policy analysis method, I explore what the framing of the violence against women agenda

as a global health issue achieves and loses in this process. It also suggests what steps could be taken to draw on the positive opportunities created by this current attention to debates on gender inequality globally.

Productive power in the disciplinary domain: Agenda setting and making claims (on behalf of others)

In 2014, Jeremey Shiffman (2014) drew attention to a need to acknowledge the normative power at work within agenda setting. Drawing our attention to two collectives of actors: the Institute for Health Metrics (IHME) and *The Lancet*, he sought to problematise how agenda setting in global health occurs. *The Lancet* medicals journal, with its global reach and a large involvement in global health issues since the 1990s is widely respected and as such a platform for scholars to express their ideas on what the world *should be doing* to solve health challenges (Shiffman, 2014, p. 298).

Shiffman rightly notes that many commissions and special issues organised by *The Lancet* have drawn large amounts of attention to a given health issue, leading to policy change in the global south. For example, despite a longstanding interest at the WHO mental health conditions remained ignored and under resourced in many high- and low-income country settings. The 2001 World Health Report on mental health (WHO, 2001) noted that average contributions of national spending at rates between 0% and 2% of health budgets in the majority world. Following the publication of *Lancet* special issues in 2007, 2011 and 2018 mental health was moved out of the shadows and into the limelight. Increased policy attention placed mental health on platforms where it was previously overlooked, including the World Bank agendas (Organization and Group, 2016), and saw many countries committing to new action plans (see Chapter 3 for a full discussion on these points).

Arguably, there is something to be gained from the international attention given to an issue when it falls under the remit of then *Lancet's* attention. The simple notion of scale enables issues that are seen as under recognised or poorly resourced in terms of health to take centre stage. For some global health scholars, publication emerges as an opportunity to push evidence where there has previously been none, which is a positive space.

Yet, the power held by many high-impact journals, of which *The Lancet* is one of the most highly regarded, raises important questions for Shiffman, and for scholars interested in power in global health in general. With each special issue, agendas, and attention from high-impact funders shift. With each new concern placed on the global health stage, what has happened with the one that preceded it? As attention shifts from HIV/AIDS to Global Mental Health, to neglected tropical diseases, and beyond, does it suggest that we have 'done all we can' in each area?

Prior to seeking answers to such questions, it is important to understand *how* academic journals like *The Lancet* gain their power and authority. The ability for

certain groups to establish a concept or idea as truth in a particular time and place can be linked the work of Pierre Bourdieu and his concept of symbolic power. Bourdieu was long interested in the workings of social groups and classes, and the ability for certain groups to hold power over others – consciously or not.

In his work on symbolic capital and symbolic power, Bourdieu acknowledged that society is organised around objective classes (Bourdieu, 1974). They are defined as groups in society divided in clearly visible ways such as sex, age, position and type of production – that serve to reify particular logics and positions in society. At the outset of the women's movement, great amounts of symbolic power were held by grassroots groups of women. In the years that followed, the power of grassroots women's organisations ebbed and was taken over by women in more formalised positions who held different positions within society: policy makers and academics. The power held by this objective class[1] is different to that held by everyday women who comprised Domestic Violence movements of the 70s and 80s globally. Their technocratic positions in society and systems enable them access to forms of power that are productive in different ways: establishing discourses and versions of truth that have the ability to shape action in particular ways (Jenkins, Narayanaswamy and Sweetman, 2019). For example, in Lehrner and Allens (2009) analysis of the history of the violence against women movement in the UK, they lament the unexpected consequences of state intervention within the women's movement. As state investment increased, they highlighted how the involvement of state apparatuses also shaped a de-politicisation of the movement. Ultimately, with the inclusion of an issue as a state agenda comes the mechanics of the state; an interest in targets, outcomes and clear 'wins' from the implementation of policy. Nancy Fraser (2013) suggests that when problems and needs (such as violence against women) are successfully politicised and become the object of attention for formal political intervention, this process can also establish 'runaway needs'. These new requirements emerge as points of action and problems resulting from the political re-interpretation of the problem, and how best to respond. Ironically, those who drive the initial movement – such as activists, upon drawing the issue into focus and attention of the welfare state, they simultaneously lose somepower in shaping the nature of response.

Ultimately, subjective classes operating in state structures also have discursive forms of power at their disposal. In his works on power and knowledge, Foucault (1988) emphasises the productive force of power vis a vis a discourse's ability to create validated and accepted types of knowledge and related actions. Policy is anchored directly to academic discourse through platforms of 'evidence base policy' and as such, the two domains work in tandem to reinforce and validate certain types of responses to problems. In applying Foucauldian notions of power in policy, Carol Bacchi (2010) highlights three effects of discourse exemplifying its productive power. These are as follows: *discursive effects*, which create a limit to how we can talk or think about a particular issue; *subjectification effects*, where particular subject positions and functions are enabled or disabled; and finally, *lived effects*,

which are the material impact of a particular discourse or positionality on the bodies and lives of those it seeks to shape. These effects would also allow us to explore the implications and silences wrapped up within global health agenda setting, and the outcomes created by a global health anchored discourse to violence against women and girls. The following section explores this in more depth through an exploration of selected debates around the violence against women and girls agenda and its location within the sphere of global health.

From proposals to reality: A (brief) critical analysis of Violence Against Women as a global health issue

What do women themselves gain when their governments and volunteer sectors problematise violence against women (VAW) as a health problem? The most obvious and valid answer is the increased availability of appropriate health services for women who are victims of violence. If 30% of women have experienced physical or sexual violence at the hand of their partner, the health consequences of these experiences cannot be understated. Such statistics establishes a well-understood and important platform for noting the global implications of violence against women and creates pathways for women to access support in places where previously these have not existed. However, there is increasing attention to the fact that the causal chain for violence and *violences* for women in low- and middle-income settings are incredibly complex and involve deeply ingrained systems of relations between men and women (Bott, Morrison and Ellsberg, 2005). Furthermore, women and family relationships to structural and state domains should also be viewed as sites for violence too; recent work by Mannell and colleagues (2021) highlights the clear relationship between colonial histories and violence, and current rates of violence against women in girls in high prevalence settings . In western democracies, such as the United States, the prison industrial complex has also been identified as a system that perpetuates violence in the lives of Black and Latinx women (Sokoloff, 2007). How does an encounter with global health discourses response to these realities that women face? What is sacrificed in this process?

Carol Bacchi (1999, 2009) provides a valuable approach to exploring such 'sacrifices' within policy analysis. The *What's the Problem Represented to Be* (WPR) approach[2] is a form of policy analysis that works backwards from proposals for change and action to identify the conceptualisation of the problem that produced it. She argues that policy agendas are often based on particular sets of assumptions that, when left unacknowledged, create a disconnect between proposed and actual outcomes. In this way, she suggests that policies give shape to *problems*, through the definitions of actors and actions, rather than actually addressing them. The WPR policy approach is rooted within an acknowledgement of the complexity of policy and the process of making policy a reality, to explore how policy

TABLE 2.1 The WPR approach (adapted from Bacchi, 2009)

What is the problem represented to be in a specific policy?
What assumptions are imbedded in this representation?
How has this representation come about?
What is left out? What are the silences?
What are the effects produced by this representation of the problem?
How has this representation of the problem been produced, defended and promoted? How could it be questioned?

strategies can often miss the mark. To her, polices govern and engage with individuals based on how the problem is defined, rather than the actual problems that people on the ground seek to manage in their everyday lives. To map how this occurs, Bacchi recommends an analysis that seeks answers to six questions. Together, they highlight not only what a problem is represented to be (its discourse) but also the factors that inform this representation, and outcomes at multiple levels (Table 2.1).

While her approach is designed for policy documents in this chapter, I use *The Lancet* series as a critical set of documents for two reasons. First, in global health, policy action is consistently called to be 'evidence based' (Kelly *et al.*, 2007). In engaging with discourse produced by leading academic outlets, before it reaches policy, gives us an opportunity to engage closer to the space where discursive knowledge, and its various assumptions are often produced. Second, there is an overdue need to put global health knowledge production processes under scrutiny, given the power they hold – which speaks directly to Shiffman's (2014) concerns.

Each question contributes to actioning Shiffman's (2014) interests in exploring the nature of the power utilised by journals like *The Lancet* to set global health policy agendas, and the ramifications of externally driven agenda setting on those who are at the heart of targeted action. Reworking Bacchi's questions to unpack *The Lancet*'s endorsement of violence against women as a specific global health issue, a series of important questions arise:

1. How does the influence of *The Lancet* impact the representation of a violence against women agenda in the global south? (Or, what is the problem presented to be because of the *Lancet's* engagement?)
2. What assumptions are implied by this representation?
3. What are the implications of this representation of the problem of violence against women and girls? Particularly for the women themselves, the *lived* effects?

In the following section, I explore each question in turn, highlighting the ways in which agenda setting power within the disciplinary domain frames and produces responses that emerge as disconnected from the local realities of communities and individuals.

How does the influence of academic discourse produced by journals like **The Lancet** *impact the representation of a violence against women agenda in the global south? (What is the problem presented to be because of the Lancet's engagement?)*

As noted by Bacchi (2009), the process of identifying representations can be complicated, as they are rarely straightforward, and often contain multiple dimensions that highlight a range of views about an issue. This is certainly the case within *The Lancet*'s VAW special issue.[3] Over the course of five publications and two commentaries, a mix of perspectives presents VAW as a complex social and relational phenomenon involving individuals, systems and wider social structures. Only one explicitly referrsto a health system's response, despite *The Lancet*'s own position as a health journal.

For example, the first article in the special issue, which focuses on existing evidence, highlights a picture of success that is linked to tackling not wider systemic problems of inequalities between sexes, but rather the advancement of women-focused programmes that work to reduce the risk of further victimisation and violence (Ellsberg et al., 2015), as this is where the most 'robust' evidence currently exists. Many of these studies, which are conducted in high-income country settings, highlight secondary prevention (targeting women who have been direct victims of violence or perpetrators) as the most valuable form of intervention. Evidence on primary prevention – which engages with the wider complex relationships between women, men and society as put forward in the papers of Michau *et al.* (2015) and Jewkes, Flood and Lang (2015) – is linked to a weaker evidence base. Interventions linked to these approaches are described as 'group-based training and workshops' and include working with groups regardless of their exposure to or history of violence. Many of these studies are ranked as providing 'insufficient', conflicting or 'ineffective' evidence, with only a handful of studies (i.e., community mobilisation, empowerment training and economic supplements, such as cash transfers) highlighted as promising.

Embodied within these arguments are the classic debates around what 'counts' as strong valid evidence in public health. This is the purview of many high-ranking health journals. Across the global health landscape, the prioritisation of quantitative, epidemiological or 'value-free' methods uphold hierarchies of evidence that place the search for scientific validity, ahead of embodied and experiential knowledge, rooted in complex realities of personhood. For example, in their work arguing against the use of randomised control trials (RCTs) exclusively to inform public health policy evidence, Lie and Miller (2011) explore a similarly socially complex health issue: Male circumcision as a form of HIV prevention. The authors aptly highlight that within the evidence informing debates and public health policy decisions around male circumcision, RCTs and observational studies are not held to the same standards, despite each approach carrying its own set of limitations. Specifically, observational studies were marked by Cochrane reviews as unable to

determine causation vs. correlation within the relationship between circumcision and HIV infection – given their inability to control for wider contextual factors in a similar manner to RCTs. However, the authors point out that for interventions where the 'active' ingredient is incredibly complex, many wider behavioural and social factors interact with the medical procedure to influence the outcome of an intervention – and as such can't be controlled.

Such findings highlight the inability of RCTs to provide meaningful avenues for exploring or understanding complex behaviour change and health decision-making. Reliance on them despite such limitations leads to a needless devaluing of evidence from non-controlled studies which provide more valuable insights into such complexity. This is particularly important given arguments which highlight the importance of context and resources in the achievement of successful research outcomes in the global south (McMichael, Waters and Volmink, 2005). In the space of literature reviews that dominate evidence-based practice, studies which do engage with this complexity, such as qualitative evaluations and observational studies, are often deemed as acceptable forms of evidence.

Another RCT study on community mobilisation (Abramsky *et al.*, 2014) also struggled to report significant findings. In this study, otherwise positive outcomes that showed decreased incidents of violence in study villages in descriptive data were weakened by their inability to show statistically significant changes over time as a result of low variability between the study sites – i.e., over time, individuals move between and across communities. These mixed reports put into question what the added value of RCTs serve in relation to complex behavioural interventions. As suggested by Tarquinio *et al.* (2015), RCTs may not be adequately set up to deal with the realities of research in the real world – particularly complex interventions that seek to promote behaviour change. In demanding a reliance on pre-determined outcome measures, and self-reported outcomes, less attention is paid to understanding the realities of complex interventions. Furthermore, the positive gains established by innovative approaches that seek to engage with complexities, are shadowed by labels of 'inconclusive' and 'mixed' evidence. These labels limit the ability of certain studies to be taken seriously in a world increasingly reliant on successful RCTs to drive evidence-based decisions.

In another paper in the series, García-Moreno *et al.* (2015) position health care responses as critical secondary- and tertiary-level responses to violence against women. Here there is an expected focus on the individual – despite arguments across other articles in the series which highlight the importance of normative and power related issues (Jewkes, Flood and Lang, 2015). Authors suggest a strong role for health sector workers in supporting women affected by violence, through a process of identification and change, which is felt to result in increased self-efficacy of women to support them to leave violent relationships. However, the suggested model of supporting 'readiness for action' emerges as a theoretical framework that struggles to account for any of the wider systemic challenges that face women who seek to leave violent relationships. This is a critical absence, given that many of the

conditions linked to women's decisions to leave may be beyond the reach of any one health professional or service sector. For example, in Uganda, studies have highlighted the ways in which victims of violence are entrenched in relationships due to complex social norms. For some women in our Uganda study for example, marriage provides positive senses of identity when they have little recourse to other forms of power or recognition in society (Burgess and Campbell, 2015), reducing their desire to leave unions. In the UK, some women facing violence in relationships are limited by wider legislation such as immigration rules that make complicated to leave a violent spouse if their leave to remain is linked to marriage. Furthermore, migrant women may lack recourse to public funds that would support efforts to leave their abusers (Burman and Chantler, 2005). These dynamics feed into many of the challenges faced by universal screening programmes for violence against women in heath settings, which the series itself confirms as having limited evidence to their effectiveness.

Within the series call to arms, five recommended actions are presented that illuminate the tensions in the representation of violence that is presented in the series. The first and second are linked to systemic and structural changes to political will. Specifically, development of legislation is supported by public leadership that condemns violence against women and girls and develops national coordinating mechanisms that can work across sectors to monitor and implement plans effectively. They speak to the more social dynamics of the problem, which formed the focus of two papers in the issue including gendered social relations (Jewkes, Flood and Lang, 2015) and power inequalities between men and women (Michau *et al.*, 2015).

The third and fourth recommendations relate to interventions. First, those that prevent violence are explicitly identified – with suggestions to work with communities at changing social norms and working with individuals to address specific risk factors. Then, attention to strengthening the health sector is suggested, to be achieved through scaling up training and education for how health sectors should be responding to reports of violence against women and supporting access to partnerships and resources. The final recommendation revolves around research, and increasing the evidence base to support prevention and response programming.

Overall, the series tries to maintain complexity within its representation of violence against women. However, as maintained by Bacchi, a representation of an issue will always be mixed, *and it is within modes of action and response that directionality of a problem representation can be implied*. The unifying thread that links the set of papers together is an underlying agreement on what counts as valid evidence to determine action about violence against women. They argue that robust epidemiological evidence and RCTs are needed for us to move ahead. Four of the primary papers hinge their arguments on literature reviews that overwhelmingly prioritise the findings from controlled trials and investigations to confirm the success of an intervention. The series did not produce a single qualitative article which presented women's own voices within arguments and planning for action. This is

largely because the journals such as *The Lancet* and other medical journals continue to question the value of qualitative methods, their rigor in directing action and their validity more widely (Braun and Clarke, 2019).

It is widely argued that the result of practices which prioritise positivist approaches to science is the stripping of complexity in the reporting of findings, and ultimately from the evidence base which drives action. In a recent series of the journal *BMC Medicine*, Greenhalgh and Papoutsis (2018) noted that the complexity sought in health services research has not borne itself out in practice, noting that despite high citations of their work calling for these changes' actions have not followed. They argue that complex systems – much like those alluded to throughout *The Lancet* special series on violence against women – are not suited to randomised trials because they are turbulent and the opposite of the traditional positivist science desire for certainty, predictability and linear causality.

However, setting out a call for action in a journal like *The Lancet* required a privileging of certain types of perspectives and knowledge over others. It is a journal critiqued for its pursual of the biomedical at all costs (García-Moreno *et al.*, 2015). This is traded off in exchange for being able to leverage its symbolic power to drive policy action. Following the publication of this series, the landscape on funding to tackle violence against women changed. The UK's commitments to violence against women and girls (VAWG) have increased since the publication of this series, launching the *what works programme*, to fund violence against women research at the cost of £25 million pounds in a four year programme that same year (Crawford *et al.*, 2020). In 2017, it was extended for seven years to scale up programming with more than 65 million in funding. Of course, this funding was used in part, to fund large-scale RCTs – the same gold standard valued by medical journals. Interestingly, an evaluation of the programme in 2017 cited the series as a valuable piece of evidence to drive scale up, despite reflecting on the limitations of reliance on RCTs as a way of measuring impact for such programming (Fulu, Kerr-Wilson and Lang, 2017).

Who is left out? Assumptions and the silencing of structural and symbolic violence against women in a global health response

In the previous section, I have tried to highlight that despite the complexity of the representations shared in the special issue, by virtue of its connection with a leading medical journal, the framing becomes reduced to a simplified one. The emphasis on action stemming from this, was an interest in the production of positivist evidence which narrows the possible imaginary for solutions. To start to make sense of the consequences framing of violence against women as a global health issue, key assumptions that are implicit within a framing of this nature must now be understood. First, are the assumptions around definitions of violence. Second, are assumptions around definitions of gender (i.e., women and girls vs. LGBTQI+). As I argue in subsequent pages, both assumptions result in a blind spot for intersectionalities, the

multiplicities of violence and sexual and gender orientations outside hetero-normative biological categories of male and female.

In the call to action for the series Garcia-Moreno *et al.* (2015) lay out categories of violence that should be of concern globally. Each presents vectors of violence that have direct physical and psychological consequences for women and girls. Phenomena such as intimate partner violence and sexual violence, trafficking, female genital mutilation, honour killings; early and forced marriage; and sexual abuse of children are all identified as global challenges (García-Moreno and Temmerman, 2015). Each of these categories of violence is supported by epidemiological evidence which highlights their global reach and their impacts on women's health and well-being (WHO, 2013a). For example, 30% of women in relationships globally have experienced intimate partner violence, which is linked to physical and emotional consequences.

However, each of the aforementioned categories of violence could arguably be viewed as dimensions of one form of violence, defined by Zizek (2008) and Garth Stevens (1995) as subjective violence. Subjective violence is a visible form of violence that is clearly performed by an agent, often leading to the outcomes that can be engaged with as a project of intervention. Treating physical injury resulting from intimate partner violence (Fanslow and Robinson, 2011), supporting and emotional and mental health outcomes that stem from early experiences of violence (Moffitt and Klaus-Grawe 2012 Think Tank, 2013) or redressing the impacts of neglect (Manion, 2011) are projects that are actionable within a framework of response that is well-aligned to global health projects. However, these could also be thought of as downstream problems that result from intersecting challenges linked to the exercise of other forms of power and violence. And if this is the case, then we begin to see the misgivings of shifting the debates to ones that focus narrowly on health-related outcomes of violence in and of themselves.

Alternatively, Zizek argues that there is a need to attend to the contexts that shape 'outbursts' (Zizek, 2008, p. 1) of action, placing visible forms of subjective violence within a trajectory of causation that is far more complex, located further upstream from the violent events that are counted as part of epidemiological evidence and data. He suggests that behind every violent act exists a backdrop of contexts that leads to the expression of aggression between one group of actors and another. This backdrop is what Zizek (2008) defines as objective violence – the hidden mechanisms that maintain the foundations that drive subjective violence in everyday life. Importantly, he suggests that by focusing on subjective violence, overly simplistic responses to violence emerge that position violence as if a 'zero' baseline where there are no acts of violence within society could be achieved. This illusory state of being becomes an obsession of state intervention, whose role revolves around returning society to its violence free baseline. However, emphasis on tackling the subjective violence pathway draws attention away from other forms of violence that work behind the scenes. Zizek identifies two forms of objective violence that maintain the visible forms of subjective violence in everyday life.

Symbolic violence, which is defined as the type of violence that is embodied in language, ways of relating and normative structures within a society (Bourdieu, 1998, 2001). Second is systemic violence (similar in scope to structural violence) linked to systems within society such as political and economic systems that in many ways govern and set out possibilities of action for individuals in society.

Critical voices within the VAW movement provide clear examples of the relevance of Zizek's argument, and the need to look upstream in our engagement with the problem. Feminist theorist and activist Janice Haaken (2010) has linked the ineffectiveness of the VAW movement in the United States to an obsession with a binary approach to men and women in the movement. She argues that viewing men solely as perpetrators and women as powerless victims, obscures issues upstream that lead men to batter such as experiences of abandonment, violence in childhood (Murrell, Christoff and Henning, 2007), sense of powerlessness and hopelessness (Krakowski and Nolan, 2017). The outcome is the individualisation of social pathologies – ignoring the intersections of structural factors such as race, economic exploitation of poor men within economic systems that lay the wider foundations for violence against women in many settings. This is crystallised for Haaken by the types of responses to violence against women that achieve 'gold standard' status. For example, the Duluth model which posits that men are individually and solely responsible for violence and tries to support them through the delivery of anger management and behavioural interventions for men to prevent future bouts of violence.

Crucially, authors in the special issue seek to maintain some focus on the importance of certain types of symbolic violence that feeds into subjective forms of violence against women. Papers by Michau et al. (2015) and Jewkes et al. (2015) articulate the contexts of gender relations and gender inequalities, such as social norms that determine patterns of behaviour between men and women and help to entrench inequalities between women and men in society. For example, the inability for women to have control over sexual and reproductive choices in their lives is presented as a form of violence with direct consequences for health, such as increased rates of HIV, unwanted pregnancies and unsafe abortions. However, acknowledgements of these normative forms of violence remain locked at the interpersonal level. In doing so, there is little consideration for how structures beyond the community play into the maintenance of norms that drive women's exposure to subjective forms of violence.

Furthermore, the ability for state structures themselves to become vectors of violence – through their connections to other domains of power also receives little attention. For example, state-enacted violence against citizens has been found to affect women predominantly in many countries in the world (Montesanti and Thurston, 2015). Political dynamics also have direct consequences for women's ability to have control over their sexual and reproductive choices. For example, the issue of women's rights and access to abortion in South American countries. Though not explicitly identified as a form of violence against women and girls by

the authors of the issue, the necessity of development of 'pro-women policy' is acknowledged as an important aspect ending violence against women and girls alongside issues such as strengthening of the health sector (García-Moreno *et al.*, 2015, p. 1687). Work towards achieving important structural changes, such as government lobbying and establishment of political will to stop violence against women, is explicitly mentioned. In countries such as Brazil and Colombia however, rights to abortions are restricted, with many women and girls being forced to have unsafe procedures that are rightly identified as placing women's health at risk. However, wider institutions influence how far political will can go to improve the outcomes of women's inequalities in society. As argued by Wilson (2014), there is a direct relationship between the role of religious institutions, machismo culture and the improvement of women's rights in Latin America. As such, states themselves become direct vectors of violence against women though the maintenance of laws that ultimately maintain women's lack of ability to have ownership over their own lives and bodies.

By positioning the solution as one that revolves around the notion of health, the kind of work required to engage with these wider contexts of other 'violence(s)' upstream can be sidelined. It is here that the limitations of a global health agenda in responding to violence against women begins to emerge. In part it creates an almost too convenient process through which government systems and the upstream forms of violence they enact on women can be glossed over. Instead, government activity around the downstream outcomes of this violence is prioritised. The emphasis becomes the health system itself with satisfaction when these aims are achieved.

Examples from high-income countries where similar health systems approaches are more well established highlight the impacts of this approach. The depoliticisation of issues of violence against women and a lack of attention to intersectional realities that influence the outcomes of systems responses for women of varied social positions. In interviews with women working in the VAW field in the United States, Lehrner and Allen (2009) highlight the gradual depoliticisation of the violence against women movement in the United States over the past 40 years. Participants articulated the need to treat VAW as you would any other social problem: something politically neutral and an individual problem that requires professional support services, such as counselling, housing support or health care. Lehrner and Allen (2009) suggest that this conceptualisation shifts attention to efforts that only describe the social impacts of violence – its impacts on society, and widespread prevalence. This is in contrast to a social *analysis* of the problem, where the causes of VAW beyond the individuals (i.e., social structures such as race, gender and income inequalities) are in focus. This difference in perspectives ultimately shapes a differentiation in lines of response, where engaging with individuals affected by violence take precedence over the social challenges that drive violence in the first place. The authors note a professionalisation of the problem, which is enabled by a wider neoliberal logic that has been argued to promote individual responsibility for problems linked to wider social realities. The result is women are

supported in accessing individualised responses to the effects of their violent victimisation: support workers, individual advocates to support understanding of legal systems. At best, women may engage in peer-peer support that are identified as social. But, in reality, these socio-relational approaches do not necessarily link back to the wider structural dimensions of social life – power dynamics, structural inequalities and resource inequalities. These are the same structures widely recognised as placing women at risk for certain types of violence and as articulated in earlier sections of this chapter, are vectors of violence themselves.

Attention to intersectionalities of the violence in women's lives centres a second assumption within the use of a global health agenda to tackling violence against women. Definitions of gender and sex currently utilised within that do not make mention of non-heteronormative sexual identities. Specifically the struggles facing transgender women and men who are also more likely to be victims of violence (Mitchell and Howarth, 2009) remain a silence. Recent work by Samudzi and Mannell (2015) highlights that South African transgender sex workers highlighted that they were in constant fear of their wellbeing. Recent research from Puerto Rico notes that one fourth of transgender people interviewed were discriminated against when they tried to make use of health services (Rodríguez-Madera *et al.*, 2017).

However, the primary arguments within *The Lancet* article are silent on the issues facing these groups. Transgender violence does not appear as a global priority health issue, despite wide acknowledgement of the dangers transgender people face. In the same Puerto Rican study, almost three quarters of participants knew a transgender person who had been killed (Rodríguez-Madera *et al.*, 2017). During the COVID-19 pandemic, various laws and policies were associated to increasing violence against transgender communities through the maintenance of gender binaries (Perez-Brume & Silva-Santisisteban, 2020). In not engaging with these more complex identities, policy-driven responses create systems responses that do not prepare them to engage with the needs of complex groups. The result is that historically marginalised groups are further marginalised within systems that will be set up without acknowledgement of their specific needs. In an era of increasing violences and erasures of these communities, academic spaces should be more willing to enage with the full complexities of people's lives.

What are the implications of this representation of the problem of violence against women and girls? What are the **lived** *effects for women themselves?*

The final question to be addressed within this analysis links to this notion of silencing faced by transgender women in the violence against women discourse; namely - that the exclusion of groups from particular problem representations (or discourses) produces significant consequences in the lives of others. This is an important space to understand the workings of power in women's lives. Thus far,

we have seen that the framing established by an externally driven and designed agenda has the ability to do two things. First, it enables assumptions about what counts as violence, and who count as 'women', and second it directs attention away from efforts to improve overall health systems action through recommending vertical programme-specific interventions around violence within already weakened health systems. However, in exploring the 'lived effects' (or material impacts) of a global health framing of the violence against women problem, it is best to explore the lived effects of this discourse in a context where this type of framing has already been implemented – the UK.

Since the 1990s, the UK domestic violence policy has incorporated a multi-agency collaboration at various levels of government in order to tackle violence, which have included health professionals locally and the National Health Service (NHS) nationally. The role of the health sector as part of this process has been linked to its location at the coalface of the consequences of violence. Women and girls who are abused are most likely to encounter a health provider during the course of their abuse than any other sector. Its priorities have thus revolved around the importance of early identification and intervention, appropriate training for health professionals to carry out screening. Specifically, in Matczak, Hatzidimiytiadou, and Lindsay's (2011) review of UK domestic violence policy, the Department of Health was identified as having four priorities: first, raising awareness of violence as a public health issue; second, training and developing the health sector to improve quality of care for victims of domestic violence; third, improving the quality-of-service provision; and, finally, developing information and research frameworks. These recommendations bear a close resemblance to the priorities raised by *The Lancet* special issue. However, global evidence has highlighted mixed outcomes in terms of the contributions that the health sectors can contribute to supporting responses to violences that women face. For example, studies from the United States highlight that racialised barriers to accessing screening, with women from Black and Hispanic and other marginalised communities face greater challenges in accessing services and care (Lipsky *et al.*, 2006; Ragavan *et al.*, 2018; Robinson, Ravi and Voth Schrag, 2020). In the UK, a recent evaluation of the widely celebrated independent domestic violence counselling intervention highlighted that fewer women from Black and Asian backgrounds, and people from LGBT groups sought support from hospital or community-based supports (Halliwell *et al.*, 2019). Other studies have asserted that despite a positive policy environment in the UK, women from Black backgrounds are consistently unable to make use of services, as complex social and political contexts continually shape their exposures to and attempts to leave violent relationships (Anitha, 2010).

Given global health's primary interest in low- and middle-income settings, it is also worth exploring explicitly what this representation produces. In Kenya, Githui *et al.* (2018) noted that the efficacy of IPV screening for pregnant women in hospitals was directly impacted by the lack of positional power held by nurses within the institutional hierarchy despite being the primary resource for

implementing this policy on the ground. In Brazil, an assessment of health care provider barriers to screening for IPV published in 2021 found that the largest barriers were linked to the structure of the system itself (Evans *et al.*, 2021). Providers noted that institution wide reforms would be needed in order to successfully implement screening programmes for women affected by IPV, and authors suggested that health care providers themselves needed to participate in those system designs in order for them to be relevant. In Egypt, a study by Aziz and El-Gazzar (2019) found that in a national hospital, one third of doctors and nurses across a range of departments were reluctant to screen for IPV because wider social norms and wider referral systems made it unlikely that women would ever get the support they needed. What such studies suggest is that a global health or health systems framing meets a similar fate as it has in the UK.

What the discourse produces in the lives of women themselves is ultimately a medicalisation of the structural realities at work in women's experiences of violence. Used widely by sociologists, medicalisation refers to the process where non-medical problems become understood and treated as medical problems. Popularised by the work of Peter Conrad in the 1970s, the term often carries negative connotations, with authors criticising the implications of behaviours being defined as medical problems or illness, and thus creating a mandate for it to be dealt with or treated by medical professionals and systems. Theorists such as Illich (1976) and Zola (1983) lament the medicalisation of everyday life and its impacts on particular groups in society, as it is often forms of social deviance that fall under the remit of this process. For example, homosexuality, mental illness, child abuse, and infertility are all examples of non-normative social positions that have, or are, affected by medicalised gaze. Conrad's (1979) early work highlighted three types of social control enabled through the medicalisation of deviance. First is *medical ideology*, which imposes a medical model because of its social and ideological benefits. Second is *medical collaboration*, where doctors assist in control through taking on the role of information providers, gatekeepers and institutional agents and technicians in a process of monitoring and evaluating action. Third is *medical technology*, which supports wider forms control through technological means, including medical screening, drugs or surgical procedures.

A medicalised approach to violence against women invokes both ideological and collaboration as processes of control. It is likely that the alliance with a medical journal and the production of the special issue was imagined as producing a social and ideological benefit for women and girls. However,earlier arguments have also shown this also produced ideological limitations, as the framing required by academic biomedical sciences involves the prioritising of hierarchies of evidence that strips away complexity. These discourses also push practice towards medical collaboration – within health systems that across the world struggle to enable the very screening processes that are imagined to help provide pathways for women to leave violent circumstances. The illusion is created that when these pathways exist, empowerment will follow. But, as noted by Mary, women's empowerment is no

simple task, and if that is what is truly needed to end violence against women and girls – we will struggle to do so in our current systems and structures. We will certainly need changes in multiple domains.

Conclusion: Women need a (series of) revolutions

In Uganda, the MAD bill was about legislative and policy spheres of action. When women like Mary described the reasons why this wouldn't work for them – the response from mainstream feminist circles was one that attempted to label them as backward, as not comprehending the oppression that they faced. Such sentiments are false. Women like Mary have no illusions about the challenges they face because of misogyny. However, they do not see violence at the hands of partners as separated from the other violences in their lives – and think of their emancipation in more complicated ways. In her calls for wider attention to various forms of powers at work in the lives of African American women, Collins (2000) demanded that we consider the intersecting impacts of many types of power, working in tandem. This is clearly the case within the context of the violence against women agenda. However, from the minute the idea is placed within the remit of a global health academic lens, it is distilled and operationalised to promote disciplinary and management concerns and processes. The result is the development of systems around the globe that, through the medicalisation of women's concerns relating to violence, may provide incomplete, or theoretical pathways to help.

There is, of course, a route to reducing the likelihood of this outcome, first referenced to in the case study that started this chapter. In Uganda, the MAD bill was stopped for more than five years, as a result of meaningful community consultation practices. These were not just consultations with practitioners, or professionals, but everyday citizens with whom the law would have direct, everyday consequences. By involving community and citizens, a law that was potentially problematic to everyday women was put on hold – for five years. But in many cases, laws don't go through consultations that reach deep into rural and poor areas of society to engage with and in discussion and debate on the future of a policy. In this case, it did, and the decision sided with women most likely to be affected.

It is possible that research on addressing the health consequences of violence against women that are rooted in community engagement will create opportunities to engage deeply with women about the issues that matter to them. Our work in Uganda illuminated the need for multiple, concentric movements for women's emancipation (Burgess & Campbell, 2015). In community psychology, the acknowledgement of the role of participants to serve as active participants rather than passive participants provides a platform to begin this work. As argued by Nelson and Prilleltensky (2010), the result of treating participants as active agents is the acknowledgement of their ability to dictate the nature of involvement of external actors on their own terms.

It is likely that their terms will draw attention to the very complexity that high-ranking medical journals setting priorities for action often eschew. For example, recent work by Mannell *et al.* (2021) on violence against women in Afghanistan showed that women articulated a relationship between conflict, domestic violence, criminal violence (the drug trade) and structural violence linked to conflict-driven poverty. The intersections of these violence(s) demand a type of intervention that cannot be served through viewing women as passive recipients of interventions. It cannot be served through establishing health system referrals, or through a focus on shifting culture or relational dynamics in the household alone. It would require all the above, and more. Is there a version of global health that would allow us to respond to this need?

Notes

1 I acknowledge that as a cis-gendered woman, writing an academic piece of work, I also occupy a space within this objective class. However, I hope that using the power associated with my objective class and position within the wider social order to shed light on complexities of issues facing women and people of the global south, this relative power can be used for change.
2 What's the Problem Represented to be (WPR) approach is rooted within the acknowledgement of the complexity of policy, power and reality. The approach is grounded in responding to six questions, though for the purposes of this chapter we focus on three of these questions.
3 This will be referred to as 'series' for the remainder of this chapter.

3

EVERYDAY INTERVENTIONS

Psychiatric power revisited in global mental health

We are no longer in that little house where we lived that was abandoned – we are in a more dignified house living with our children – that is recovery.

– M, Colombia, 2017

Mental health, once labelled by a South African psychiatrist I met in 2010 as 'Cinderella's Ugly stepsister of health issues', is now a topic on everyone's lips. Mainstream media outlets make continued reference to the impacts of mental health conditions on individuals in both high- and low-income countries on an almost daily basis. Globally, estimates suggest that one in five individuals will experience a mental health condition in their lifetime (Steel *et al.*, 2014). Four of every five individuals are argued to suffer with a mental disorder living in low- and middle-income country (LMIC) settings (Funk *et al.*, 2012; Rathod *et al.*, 2017). Many argue that the attention experienced by the topic of mental health conditions is linked to the global awareness that was created by the *Movement for Global Mental Health*, whose research and advocacy around mental health inequalities has drawn the attention of royal families, governments and international bodies like the World Bank. Much like actors described in the previous chapter, this collective of scholars and lived experience activists, launched their efforts with a *Lancet* special issue, published in 2007. The power and momentum generated from that has reverberated globally.

The resulting 'call to action' from this series established a framework for international engagement in the area of mental health which drove action for the next decade, and into the present day. Collective efforts to reduce the treatment gap (the gap between those in need of treatment, and availability of services) have

DOI: 10.4324/9781315623788-3
This chapter has been made available under a CC-BY-NC-ND 4.0 license.

dominanted practice, mediated primarily through 'scaling-up' the availability of evidence-based treatments in LMIC settings (Group, 2007). Funding streams were established by leading global health agencies including the US National Institutes of Health (NIH), the British Department for International Development (DFID) and Grand Challenges Canada. Masters training programs were established , such as the MSc in Global Mental Health jointly offered by the London School of Hygiene and Tropical Medicine and Kings College London. WHO guidelines were directly influenced by this collective of actors, with the MH GAP guidelines published in 2010. But do these sorts of efforts translate into the desired change: a reduction in poor mental health outcomes globally?

In continuing the themes of the previous chapter, generating a response to this question may best be served by focusing on the stories of the actors that the movement claims to support. In October 2010, during my PhD fieldwork, after driving down a long red dirt road, the sand settles, revealing a middle-aged woman sitting to the right of her home. Thembe tell us that she has been waiting for us all morning, as we settle into chat. The afternoon will be our second conversation, and an opportunity to explore how her symptoms of common mental disorders (anxiety, depression and post-traumatic stress disorder [PTSD]) fit into a broader picture of her life in rural KwaZulu Natal. At that time, my work revolved around an ethnographic study of rural mental health services exploring how the voices of women fit into a picture where the increasing power of the movement was evident in national and local policies (Burgess, 2013).

About a year before our conversation, Thembe participated in a larger epidemiological study, designed to identify the level of common mental disorders in the wider health district. The study, which included screening for depression, anxiety and PTSD indicated that Thembe had mid-range scores in all three of these conditions, at levels that were just below clinical threshold. When we spoke, part of our discussion was a reflection on this previous survey, asking her to discuss times when she felt those types of symptoms were present in her life.

Unsurprisingly, much of her story referred back her partner. Though never married because they lacked the finances to pay for a traditional wedding, Thembe and her partner were together for 15 years. They had three children and moved to their small town[1] at the height of a personal crisis. When Thembe discovered her HIV-positive status, she attempted suicide for the first time. Her husband asked that she keep it quiet, and he moved her and their children to his childhood homestead. But more than anything, she spoke of the crushing anxiety at not being able to provide for her family. Her constant worries were about having enough money to feed and clothe her children, and enough food to eat so she can take her HIV medication. These are the things that keep her up at night, that map clearly onto her symptoms of depressed mood, disrupted sleep, beliefs of worthlessness guilt hopelessness.

But our conversation that day also showed her capacity for survival. Her main source of social support is her church, though she is hesitant to call the people she meets her friends, as friends also equate to gossip for her. She supports her children

off the income from one child support grant and whatever she earn from washing clothes and linens for neighbouring cottages. She draws strength from her children, which for her remains the most important source of stamina and drive to keep going. She perseveres – and this is her story too. Survival in the face of adversity.

Life for women like Thembe is a picture of survival in the face of desperate conditions. At the time, HIV prevalence rates in the province were the highest in the country at 37% and remained largely unchanged with reports identifying the province as having the highest rates of new infections in the country[2] in 2016. The town is organised predominantly around Zulu culture, which shapes systems of beliefs and family relationships. Homesteads are vast and often separated by distances of kilometres or more. Employment opportunities are few and far between, with the 2006 census identifying 90% of females and 89% of males as inactive or unemployed in the wider district. This means that most individuals rely on incomes from social welfare grants, whose value at the time of the study rarely exceeded 1,130 rand/month (for older persons and individuals with a disability). Most families like Thembe relied on child support grants, at that time valued at 260 rand/month/child (Burgess, 2013).

Responding to mental health needs of women like Thembe in South Africa then, and now is aligned to WHOMH Gap guidelines (2010). At the time of research, policy recommendations focused on the integration of mental health services into primary care, to support on community-based services. Within this policy framework, women were offered access to three types of services, in line with the national implementation: pharmacological interventions, access to psycho-social interventions and improvement in quality of life through promoting vocational and life skills training where appropriate. On the surface, this treatment plan holds some relevance to the experiences of women in its attempt – to provide vocational and life skills. In reality, the delivery of such services was limited and often times non-existent. Women's entrenched struggles with poverty, unemployment and gender disadvantage found no recourse within the policy structures put forward by global mental health policy (See Burgess 2013).

During my trip, I met many women like Thembe, each facing their own melange of structural violence in their everyday lives. The resultant emotional distress, sometimes led to mental illness was inescapably social. When women like Thembe entered the primary mental health care system at times of crisis, the cycle that was activated in most instances lead to the administration of psychiatric medications. Not because this is the best option, but often because this is the most readily available option. Recent work by China Mills on the reality of implementation of these guidelines elsewhere, confirms this is a widespread practice that remains hard to shift in some settings (Mills and Lacroix, 2019).

In the presence of certain practitioners, some women would receive referrals to additional interventions that recognised the health-related impacts of structural violence enacted by unequal positioning in society, endemic poverty and lack of

opportunities. At times, women were given referrals to the social work department, who could provide support in accessing grants. Others were referred to the local NGO or support groups to provide access to social networks and support systems (Burgess, 2013, 2014). But even in such instances, political will to support the ongoing availability of these options was scant. Funding for support groups were often cancelled, NGO resources were limited and social work referrals often resulted in short-term solutions – including temporary food parcels or small financial grants (Burgess, 2015, 2016). In much of the global south, it is unlikely that women like Thembe will ever access meaningful financial resources that will make her daily situation more stable and alleviate the main source of her depression. For example, the picture in South Africa today, remains as difficult - if not more so, for many women in that region and nationally. Data from the 2016 community survey indicated in the same district, 90% of income was reported as linked to grants and subsidies (Statistics South Africa, 2016). The 2019 general household survey identified that nationally, Black African headed households had the highest levels of subjective poverty, with over 50 % percent noting that they did not have the monthly income needed to meet their family needs (Statistics South Africa, 2021). If this is the case, how valid are interventions that primarily focus downstream on the alleviation of symptoms of distress?

A call to action? The movement for global mental health and voices of dissent

The rapid expansion of knowledge production and policy action following the launch of the movement in 2007, led to the declaration that the field had 'come of age' only three years after its inception. By 2010, Marin Prince and Vikram Patel, the later who is known as Movement's leading academic and public figure head[3] argued the field was poised to achieve meaningful gains in addressing global mental health challenges. The WHO, World Bank, and other multi-lateral organisations began to take interest in mental health conditions and their impacts on wider society. Much of this concern was linked to the economic implications of days lost to disability as a result of mental health conditions (Organization *et al.*, 2016) and consequences of these losses for development in LMIC settings through poor educational outcomes and high unemployment (WHO, 2010). Globally, funding for mental health has risen by nearly 5% each year since 2001, and in 2016, accounted for 20% of development assistance for health targeting non-communicable diseases (IHME, 2017). By the time of publication of this book, mental health was a global priority, with large funding agencies such as the Wellcome Trust, naming it as a priority condition for investment, and one of the worlds largest challenges.

In the face of figures stating annual spending on mental health in low income country settings stands at 0.25 USD per person (WHO, 2013b), actions by the movement were consistently presented as a moral necessity, to justify the pace at which they moved. As noted by movement advocate, psychiatrist Arthur Kleinman

in 2009: '*The fundamental truth of global mental health is moral: individuals with mental illness exist under the worst of moral conditions*' (Kleinman, 2009, p. 603).

Yet, from the earliest days of its inception, the movement has faced critique. Scholars have taken aim at the three premises behind knowledge production within the movement's existence. First the universality of mental conditions; second the validity of the evidence-base supporting the new 'best practice' interventions in LMIC countries. Finally, the validity of the existence of a 'treatment gap' at all. For example, critical psychiatrist Derek Summerfield, the Movement's most ardent critic, has likened their efforts to an exercise of neo-colonialism, where western definitions and ideals of sickness are presumed universal. The exporting of definitions and interventions to other parts of the world in the form of 'packages of care', contribute to the erasure of other ways of being, personhood, and care (Summerfield, 2012, 2013).

In 2012, a collection of critical psychiatrists (Bracken *et al.*, 2012) argued that the movement for global mental health was ill-placed to make recommendations on the usefulness of psychiatry in the global south given weaknesses within the existing evidence base in the global north. Recent studies confirm such concerns, with a recent umbrella review published in 2022 by Joanna Moncrieff (Moncrieff *et al.*, 2022) argued that the well-known hypothesis that depression is linked to serotonin imbalances had been entirely overstated, with little to no evidence proving this relationship. Their findings illuminate the limitations behind long-held beliefs that maintained the application of psycho-pharmaceuticals in the treatment of depression worldwide.

Critical psychiatrist David Ingleby similarly argued that both the intervention and epidemiological evidence base underpinning the Movement was 'highly speculative, and bordering on what psychiatrists themselves call 'magical thinking' (Ingleby, 2014, p. 222). Specifically, he suggests that epidemiological data establishing the degree of burden facing the global south was inflated by discussions of aggregate figures. In instances, where was no data available, he claimed figures were based on theoretical estimates. Such arguments given wide acknowledgments in the limitations to the quality data contributed by low-income countries to large epidemiological studies. For example Byass et al. (2013) highlight that the global burden of disease estimates are limited by the fact that huge portions of the global south have less than 5% of their deaths recorded by vital registration. Furthermore, for countries with higher rates of recording, only recorded 50% of their causes of death.

Many authors in the field of transcultural psychiatry have noted the limitations to a universal diagnostic approach. For example, work in Burundi highlighted the inability for PTSD and depression categories to map across local idioms of distress (Familiar *et al.*, 2013). Instead, four separate conditions were identified that actually were a mix of the two. Fernando (2014) and others (Bemme and Nicole, 2012) have argued that in order to address distress and trauma in the contexts that

establish it, one must be aware of the dangers posed by the decontextualised and individualised labels that reduce complex life experiences to diagnostic categories.

Across the body of her work, China Mills (2014, 2015) questions the value of linking mental ill-health to experiences of poverty in the global south. She argues that in linking poverty to the development of mental disorders, responses to everyday systemic structural realities fall under the responsibility of medical systems, rather than public authorities. The result is that little emphasis is placed on actually addressing the poverty that blights the lives and existence of individuals. Worse still for this medicalisation of social failures emerges as a route to labelling poor distressed individuals as 'mentally ill' and the othering of those who, through their sick bodies ultimately pose a 'challenge to the liberal capitalist economy' (Mills, 2015, p. 217).

The work of critical scholars in the global mental health space reminds us that the movement entered a space where the 'best routes' to improving mental health needs were consistiently debated. In total, critical mental health scholarship illuminates the longstanding conflicting views of the best role for psychiatry in the betterment of people's lives, which dates back to the earliest days of the practice. If global health is a field interested in 'interventions into the lives of others', then the Movement for Global Mental Health is a doubling down of two forms of power in the lives of others. The arm of a collective of actors from high income settings, whose positional and discursive power (i.e. – the disciplinary and hegemonic domains) enable them to determine the structure for response in the lives of women like Thembe. Second, are the ways in which these efforts extend the arm and coloniality of psychiatric power.

The remainder of this chapter explores how 'everyday interventions' for common mental disorders – namely depression, anxiety and PTSD, travel from upstream 'expert' notions of health and wellbeing, downstream to users of services. Through a process of medicalisation and psychiatrisation, types of power produced in the disciplinary domain, everyday struggles are transformed into psychological and individual problems that originates within the body or brain, rather than the world beyond it (Ingleby, 1981; Foucault, 1994a; Summerfield, 2013). Then, using reflections on my work in Colombia, I suggest that upstream externally defined guidelines and interventions to tackle conflict-related depression Colombia fall short of what people need. It concludes with reflections on challenges created by a movement that begins with deficits, instead of the agency of others.

The power of the psy-disciplines at work in the disciplinary and interpersonal domains: Subjectification, (in)action and agency in the face of structural violence

In his series of lectures on psychiatric power, Foucault asserts one must focus not on 'power' itself but the processes that are involved in the exercise or workings of power. By this, he suggests that we attend to the various ways that disciplinary

apparatuses and systems of organisation are used to achieve particular outcomes, most often the control of individuals.

For Foucault, the psy-disciplines provide a clear example of how systems of power can establish and frame notions of the individual, in ways that impact and shape their everyday actions. It is important to note here the difference between the workings of power enacted over individuals, and those that seek to regulate systems, as we have discussed in previous chapters. The movement for global mental health has the ability to operate at two domains of power simultaneously. For example, China Mills' seminal work on global mental health (Mills, 2014), which links the field to a legacy of colonial discourses, allows it to operate as a form of governmentality that appropriates, directs and dominates various spheres of activity. Here, we are interested in the ways in which various apparatuses are put in place to enable individuals to ultimately self-regulate, a process that is achieved initially through the establishment of a disease-related identity (Leventha *et al.*, 1997; Heffernan *et al.*, 2016), or what Foucault refers to as subjectification.

The power of subjectification is linked to the notion of medicalisation, which we first introduced in Chapter 2. We will explore this in more detail here. In tracing the establishment of 'social medicine',[4] Foucault (1994b) suggested that over time, societies became increasingly interested in the improvement of the lives, control and management of individuals. For example, in 18th-century France, the growth of cities coincided with the expansion of mechanisms designed to control and manage the circulation of disease, namely the plague. Towards the latter half of the 19th century, Foucault acknowledges that the role Poor Laws provided platforms for medical support. Beyond this, he posits that they also established a mechanism for controlling of the health of the labour force, and surveillance to protect the wealthy classes from public dangers. For Foucault, social medicine (or medicine to manage the masses) is an antecedent for a process of medicalisation. It is the first occurrence when it is clear how wider dimensions of individual lives fall under the medical gaze and under systems of regulation.

Medicalisation is enabled through the ability for power of actors and systems to create and categorise individuals in society. As such, medicalisation can emerge as a form of governmentality of the body, where there is ever increasing systems of organisation, management and control of the human body. According to Conrad and Schneider (1980), medicalisation occurs at various levels. Conceptually, when problems are defined using medical vocabulary; institutionally, when medical approaches are adapted by organisations to treat a problem; and at the level of doctor–patient interactions. Gabe (2013) maps these levels across three dimensions of analysis of actors who engage in the process of medicalisation – macro, meso and micro. Macro-level actors are envisioned as governments, national organisations and medical researchers and discourses. Meso-level actors include local organisations and micro-level actors are practitioners.

For the purposes of this chapter, we are concerned medicalisation at work within global level, beyond national governments. This is enabled by the increasing

transnational nature of ideas and discourses, and practices of 'global health governance' enacted through transnational partnerships and agreements between United Nations or WHO. This 'global' space is driven by a constellation of actors from high-income countries, whose influence and authority are achieved through their relationships to the power wielded by evidence and discourse. As we discussed in previous chapters, this gives them the ability to establish agendas and garner political will for desired forms of action at country level. The movement for global mental health represents one such group of global actors, who through the creation of evidence gain access to a productive force of power that supports the expansion of psychiatric interventions.

Though this process of medicalisation is not unique to the movement for global mental health movement, it produces particular challenges and outcomes when it is marshalled in low resource settings. The implementation and delivery of gold standard interventions becomes the process by which global medicalisation becomes a *local* problem. National-, district- and community-level health systems operate as structural domains of power, which implement mental health services in particular ways. The outcome is a trickle down of medicalisation to the meso and micro spheres of everyday life. Understanding the impacts of a medicalisation of everyday life and suffering into psychiatric concerns is enabled through Foucault's notion of subjectification: the process through which individuals and 'groups' are created within society. In his writings on the subject and power, Foucault defines subjectification as a

> *... form of power that applies itself to immediate everyday life, categories the individual, marks him by his own individuality, attaches to him his own identity, imposes a law of truth on him that he must recognise and other have to recognise in him.*
>
> (Foucault, 2002, p. 331)

As psychiatric power organises life, the process of subject creation establishes a 'new' individual, who is organised and positioned in line with a particular diagnostic category. Now, this in itself is not automatically problematic. As Broom and Woodward (1996) argue, some positive clinical and symbolic benefits for medicalisation exist, particularly in contexts where health conditions provide the opportunity for creating a coherent narrative to a set of disruptive experiences, or appropriate opportunities for surviving life with the new 'syndrome'. This is often presented within notions of bio-citizenship, a positive manifestation of the subjectification linked to diagnostic categories, and as displayed by a large body of evidence, new forms of citizenship and identity linked to biological advances create opportunities for previously excluded groups to find recognition and gain access to resources and support they may have not otherwise had access too, in the cases of HIV/AIDS activism globally as seen in Uganda (Russell *et al.*, 2015), South Africa (Mills, 2017; Robins, 2006) and Brazil (Parker, 2011).

However, , the ability to make use of this opportunity to leverage positive new opportunities for action is not always evenly distributed. For those in the majority world, new subject identities may not always be helpful, and the social benefits of identities aren't equally available to all who share the label. Rebecca Marshland (2012) has argued extensively about the limits to HIV citizenship in some parts of Africa, where high levels of stigma alongside systemic poverty means that a diagnosis and access to ARVs are insufficient to enable a full sense of wellbeing. With regards to mental health in global contexts a similar outcome from access to global mental health interventions could be argued. Perhaps a less acknowledged impact of subjectification linked to a mental health diagnosis in the majority world is that as one particular truth is imposed, the validity of other social truths impacting on an individual's life is erased. Evidence from some global mental health scholars support such a claim. In Clara Han's (2015) ethnographic work on poverty and emotional wellbeing in Chile, she speaks of the importance of understanding the limits of care amid economic and societal precariousness. Her participants named their ongoing experience of poverty, insecurity and struggle neo-liberal depression, which linked their experiences to wider social failures within society. In South Africa, the mental health-related practitioners I encountered created their own diagnostic label of psychosocial depression, to come to grips with the same outcomes among women they saw in practice (Burgess, 2015). These two examples show an unwillingness to accept the subjectification created by a mental health diagnosis that imposes a version of truth that also erases the validity of other truths impacting on patients and community members' lives. Left unchecked, mental health diagnostic practices can also emerge as a form of epistemic violence - where knowers are denied the ability to know, and have their views of the world taken seriously. Given the wider colonial contexts that the movement operates in, Espinosa Minoso's definition of epistemic racism as a process which *"invalidates the purlarity of knowledgs and condems the knowledge developed outside the centers of world power"* (Espinosa Miñoso, 2022 p 475) is perhaps the most relevant form of epistemic violence to consider for the movement.

One way to make sense of what this subjectification process produces is to reflect on the notion of structural violence as a form of productive power, and its relationship to the cycle of medicalisation and subjectification within global health. Structural violence is defined by Johan Galtung (1969) as a form of violence where social structures or institutions harm individuals by preventing them from meeting their basic needs. He argues that we can see violence at work most clearly, when it causes a break between possible and the actual outcomes; that we are unable to achieve wellbeing because violence(s) prevent us from doing so. Paul Farmer's (2004) earlier work has expanded on the role of structural violence in global health spaces, arguing for attention to pathologies of power. This relates to the reality that much of the illness experienced by the poor of the world is directly attributed to inequalities in power within and between states transnationally. While Farmer rightly argues that global health efforts should intersect with ideas of justice and

redressing inequalities of income, access and rights (Farmer, 2003), the efforts of global health movements in many areas have not managed to. Instead, they find themselves becoming unwilling vectors for the same injustices that drive their work in the first place; their proposed solutions produce outcomes that push people further away from achievements of wellbeing.

Within global mental health, psychiatric power enables processes of medicalisation and subjectification to work through mental health technologies and interventions, reducing agency of communities, and obscuring the importance of upstream challenges to good mental health. Thus, the movement itself, becomes a new vector of structural violence. For example, within the WHO mental health GAP intervention guide (2017), treatment packages and interventions to tackle the most prevalent mental disorders in community and primary care settings are presented. Treatment packages for depression, PTSD and alcohol-related disorders are informed by evidence founded in the assumed universality of biological markers of mental illness, seen by many as incomplete (Canino and Alegría, 2008; Ingleby, 2014). However, the power of the movement, underpinned by the power of psychiatric discourses and universality of psychiatry, pushes forward action in these arenas, to the exclusion of other narratives. As a result, interventions linked to biomedical or bio-psychosocial frameworks such as pharmaceutical intervention and individualised psychological therapies are promoted worldwide, with very limited attention to the geopolitical realities that surround these ill-bodies.

Take, for example, the recent wave of interest in scaling up e-mental health services globally. In the wake of the COVID-19 pandemic, there has been a drive to increase access to e-mental health services. For example, in New Zealand, 600 million NZD have been earmarked for investment in data and digital infrastructure for the health system (Mathias, 2022). These interventions have been linked to expanding care, but they also pose challenges to implement in the majority world and resource poor contexts. Evidence has shown that technology can work to increase health disparities, rather than reduce them, because of an underappreciation of the structural disparities in access to data or relevant technologies among the most vulnerable groups (Skorburg and Yam, 2022). As stated elsewhere, socio-political and economic drivers of poor mental health cannot be addressed through these pathways (Burgess, 2020).

In high-income settings, individualising nature of psychological therapies has long been argued to be dangerous in contexts where social and political realities are at the heart of experiences of distress (Harper and Speed, 2012; Ormel *et al.*, 2019). This is even more the case for individuals living in contexts where the wider structural realities that frame global health problems are deeply entrenched in the social organisation of society, driven by state mechanisms, or linked to wider transnational political economic trends. Responding to distress within these realities and the structural violence they produce ultimately require spaces for agency to support long-term engagement with projects of social change (Campbell, 2014). Instead, the work is focused on ensuring the pragmatics of care and delivery, and

less on changing the local realities where interventions themselves are delivered. These new interventions becomes a source of productive power, a vector of a new form of structural violence.

Across the Atlantic, another group of women facing similarly complex vectors of structural violence working to manage its mental health consequences, provide an opportunity to reflect on the extension of psychiatric power through mainstream interventions, remain insufficient. In 2016, the Colombian government signed a peace treaty between the largest group of resistance fighters, FARC to end a nearly 60-year-long civil war, that resulted in 220,000 deaths, and internal displacement of more than 7 million individuals (CNMH, 2018). Like most post-conflict settings, part of its restructuring programme has focused the mental health needs of its citizens. At the top of this list is the need to attend to PTSD – which is often linked to repeated exposure to violent situations and war. What is also up for grabs during this time of reconstruction is a chance to rectify an unequal redistribution of social, economic and political opportunity. These three needs are at the heart of the causes of the civil war – and were the driving force behind much of the work of the largest rebel group, the FARC (Burgess & Fonseca, 2019). The government's efforts to provide redress in the post-conflict era is cognisant of this need, prioritising the collection of social and collective memory, alongside attention to the social welfare and health-related needs of its citizens. A national mental health survey completed in 2015 identified that while 66% of adults reported as needing mental health services and supports, less than 40% of this group were able to address this need (Ministerio de Salud y Proteccion Social, 2015).

Access to mental health services across the country has been historically uneven (Chaskel *et al.*, 2015; Tamayo-Agudelo and Bell, 2019). As such, the government has rolled out a programme to focus on the implementation of the global mental health movement-driven MH Gap programme; 1,800 professionals were trained in the administration of supports for PTSD and other trauma-related emotional conditions. The emphasis within WHO guidelines is interpersonal needs, focusing on providing individuals guidance on how to resume normal social activities (such as attending school and community activities) and support with stress management techniques – such as breathing exercises and muscle relaxation protocols (WHO and UNHCR, 2013). Where possible, recommendations suggest the access to psychological interventions also mentioned in the MH Gap guidelines: CBT, problem-solving and brief individual and group psychotherapy. Such supports have been adapted and delivered locally, often by international organisations such as MSF. But it is worth exploring how relevant these treatment packages are to the everyday experiences of those affected by trauma seeking to establish the foundations for recovery.

As part of a participatory action research project being conducted in San Maria,[5] colleagues and I ran workshops to illuminate understandings of some of the concepts underpinning most mental health interventions, emotional distress, wellbeing, mental health and recovery. Over the course of two days, we met with 28 women

who were officially registered as victims of the armed conflict and had been internally displaced as a result of violence in their home communities. Many women reported stories of separation and division from their families, and feelings of desperation and isolation despite having lived in their new community for as many as 20 years. In all of our women's accounts, their understandings of emotional distress and its corollary of mental health revolved around the establishment of strong relationships within society. Central to this was the ability to reconstitute family and positive senses of identity. Women's narratives of what caused emotional distress were similar to their South African counterparts discussed earlier, highlighting the importance of maintaining survival for their families and children. The inability to get a job in their new surroundings was a source of demoralisation, and a primary hindrance to building a new life in their new communities. As noted by one woman:

> *I've spread all my CVs looking for a job – but there is no job. I have worked with children in family houses – my husband has had three heart attacks – and I haven't been able to find a way to help him to do my own business and for me that is emotional distress. You start thinking that maybe you are worthless, and you don't have the chance to work – A.*

Imagined opportunities are met with harsh realities for many internally displaced individuals in Colombia – but particularly in San Maria, where the community is well known for its high levels of industry and employment opportunities. Many individuals who manage to find jobs work in opportunities that do not satisfy their everyday needs – leading to struggles in accessing food, quality housing, the ability to fund education of their children. Resolution of these challenges are unsurprisingly the heart of what defines recovery and well-being, defined in our research as being possible in the presence of societal and relational support. In these discussions, individual psychological wellbeing – the ability to manage their emotions and to forget difficult memories from the conflict – is just one of many factors that are linked to the achievement of recovery. For the most part, women identified the importance of achieving social improvements – like a better house, education and stable income – as markers of 'recovery' linked to mental health – as stated by M, at the outset of this chapter.

It appears that services on offer for individuals seeking to recover from the mental health consequences of their entrenched exposure to conflict and violence within Colombia's civil war do not engage with the social realities citizens name as the cornerstones of their distress. Addressing the societal drivers of distress is a multi-sector response – but within a wider context of mismanagement of resources (Tamayo-Agudelo and Bell, 2019), the process of access to economic reparations for victims of the conflict has been slow. Many people in our project reported a lack of attention to these crucial structural realities as linked to their distress. It is likely that as mental health services become increasingly available as part of post-conflict reconstruction, societal needs will once again find

themselves side-lined, in favour of increased attention to manageable treatment options that focus on addressing internal emotional worlds. Women may gain access to resources that promote strategies to deal with the psychological manifestations of anxiety when they arise. But they also remain unable to pay for their children's needs, access education or guarantee meaningful futures for their children. The everyday reminders of what a life marked by conflict has done to their worlds will remain unchanged.

In Colombia, as in South Africa, we see that psychiatric power implemented to alleviate suffering produces new pathways that may entrench other kinds of suffering. This is the result of the ability for pharmaceutical and psychological interventions to produce their own form of violence, which crtical theorists like Alberto Toscano (2019) have described as a violence of abstraction within modertn capitalist societies. In continuing with Galtung's (1969) original definition of violence as something that limits the ability for people to reach their potential, others have expanded this in thinking about how violence can be embodied within structural systems and global interventions (see Bornstein, 2005 and 2012). Seen as extensions of globalisation and capitalist systems, projects, interventions do not automatically result in what is promised: an improved lifestyle, a full alleviation of symptoms that enables full participation in society. Instead, these interventions help to, as Harper and Speed (2012) suggest, shift the blame of social and structural realities from the system to an individual, and remove the ability for local knowledges which suggest otherwise to be centred or valued within projects of change People's participation in treatment regimens that focus almost exclusively on internal psychological worlds and states of being shift action and attention away from the social and structural drivers of distress and inward towards the self. The work becomes about changing thought patterns, acceptance of the condition and patience with self in the management of treatment. In Colombia, this means drawing attention away from political realities where corruption and inequality help dictate the social realities for internally displaced persons. In South Africa, this means promoting a complacency with inadequate health systems, gendered oppression and uneven development. In both cases, psychiatric power becomes a productive force for the continuation of structural violence in the lives of women and others. And in this moment, these efforts are directly linked to a global power base of the MGMH to dictate the nature of interventions that encounter everyday people. In providing a woman with an anti-depressant, we do not change her access to financial resources, or exposure to various forms of violence at the heart of that experience. We instead, quite possibly, dull her ability to identify and name the issues in the world around her as problematic.

Conclusion

Emotional distress exists around the world in varied forms, and this distress, whatever name it may take, is real and demanding of support. The importance of enabling access to support and care for those who struggle with common or severe

forms of mental distress should not be discarded in the face of critique. Some efforts have been made in recent years, to better take on board lived experience perspectives. But these still adhere to upholding a uniform vision of what good care looks like. The nature of support and care should be detrmined on the terms of those who require it, not those who deliver it. This chapter attempted to illuminate the unintended consequences of a movement for global mental health dictating the shape of interventions for the majority world. The processes implied by its primary modes of intervention create cycles for structural violence to work unaddressed in people's lives – as the psychological responses to social strife are forced into non-social, psychiatric pathways.

The case studies and relections on power presented in this chapter provide an example of how the will to improve can result in the promotion of interventions that may make things worse by ultimately keeping the world the same. They also illuminate the importanace of critques of the movement . However, this critique must also be translated into shifting modes of response that take seriously the needs and demands of everyday citizens linked to their mental health. Where these demands are for formal services, they should be made available. But the content of those services must also engage with the fullness of people's demands. Without it, the movement for global mental health will do little more than reify the historical mistakes of psychiatry as it has been marshalled globally for hundereds of years (Watters, 2010; Mills, 2014).

Community-oriented platforms may once more provide opportunities for work in these areas. I have argued elsewhere that current modes of engagement in global mental health don't adequately reflect the complex realities of everyday individuals, who are the objects of a global health project (Burgess, 2016). Thus far, where attempts to engage with complexities are present in the global mental health movement, the application of 'community-based' approaches utilised community members as passive facilitators of a largely externally defined paradigm. They are volunteers, or low-paid actors working within platforms and frameworks developed by those outside these realities. Communities provide legitimacy for externally imposed programmes through displays of acceptance, and enable a sustainable work force for services in the face of huge human resource limitations (Campbell and Burgess, 2012; Elias, Singh and Burgess, 2021). However, they very rarely dictate the nature, shape, content or structure of interventions.

This is despite a clear interest in community involvement and a commitment that seeks to rebrand the disability rights movement rallying cry of *nothing for us, without us*. Yet still, there is less acknowledgement in practice of what the 'us' seem to want. In recent work, we articulated that the movement's de facto rallying cry of addressing the treatment gap has pulled efforts away from a more pertinent understanding – that people often don't use mental health services even when they are available (Roberts *et al.*, 2022). It seems that when you ask people what their interventions should look like, they have very clear visions of that, which look little like what is on offer. The interventions look a lot like social change. Our thoughts in this piece closely align with what Nelson and Prilleltensky (2010) identify as a

fundamental problematic assumption in much intervention and research work. That the emphasis and driver for action sits, with a deficit, or problem to fix, rather than a focus on strengths - or a belief that people have the ability to determine what is best for them. The huge resource gap in low- and middle-income countries demanded a rapid action to fill that gap, but also led to assumptions that sidestepped the complex reality of people's situations, and their agency to determine what is needed to make mental health better and acheivable for all.

But a focus on the latter would enable two things in the global mental health world. First, it would drive an interest in exploring how people were already negotiating survival as the locus of action. In understanding survival a clearer picture emerges of what matters most to people in terms of their mental health. The task is to build responses that engage with this complexity and support existing efforts to survive through it. It remains to be seen if we can live up to the claim of 'nothing for us, without us' .

Notes

1 All names changed to protect the anonymity of participants.
2 http://www.news24.com/SouthAfrica/Local/Greytown-Gazette/kzn-highest-new-hiv-rate-20160621
3 Patel was named one of the world's 100 most influential people in 2015.
4 Foucault's notion of social medicine differs from the Latin American practice made popular in Chile in the 1970s. While the Chilean model demands attention to the political and structural factors that create illness, Foucault's use of the term originates in an analysis of the ways in which the discipline of medicine involved to be a mechanism to establish and maintain control in societies in the 19th century.
5 Name of municipality changed to protect the anonymity of participants.

4

RE-THINKING THE GLOBAL HEALTH EMERGENCY

Power at work in making and shaping global health crises

Sometimes it felt like we were being forced to sing a song no one had any interest in singing.
– Marc, Interview

In the middle of writing this book, the world was stopped by a global health crisis continually described as unprecedented. Coronavirus-19 or more widely known as COVID-19 was not, however, the first virus of this type to breach the zoonotic barrier[1]; however, the pace and rate at which it spread across much of the planet drove a much quicker move to declare it a public health emergency of international concern (PHEOIC) on 30 January 2020.

The last time a PHEOIC was declared was during the 2014 West African Ebola Crisis. Ebola, a hemmoragic fever caused by a filovirus, is named after the river Ebola which travels through the north of the Democratic Republic of Congo. Ebola has a high mortality rate, claiming the lives of around 50% of those who are exposed to it, though recent WHO statistics suggest that rates of death in various outbreaks range from 20% to 90%. There are five known subtypes, each named after the geographical location where it emerged: Zaire, Bundibugyo, Sudan, Reston and Taï Forest, though the largest outbreaks have been linked to Zaire and Sudan streams (WHO, 2017). Though its symptoms are similar to Malaria and the Flu in its initial onset, its progression is far more severe – with patients experiencing severe diarrhoea, dehydration and death within days of contracting the disease.

During the 2014–16 outbreak, the language of emergency was heavily leveraged to mobilise a global response to what was, at the time, the worst Ebola outbreak in history, resulting in more than 11,000 deaths (Chérif *et al.*, 2017). The language of emergency helped to raise more than 459 million dollars for the Ebola response

DOI: 10.4324/9781315623788-4
This chapter has been made available under a CC-BY-NC-ND 4.0 license.

(WHO, 2016). But by 2017, Ebola emerged again, in Democratic Republic of Congo (DRC), an outbreak that has continued till 2020. Though the DRC outbreak was the second largest in history, the language emergency was not leveraged to the same extent – despite arguments that the DRC, a country plagued by civil war, has been in a state of crisis since 1997. In 2022, Ebola appeared again, this time in Uganda and eastern Africa, a region where international engagement is longstanding. Who and what has the power to determine what counts as emergency? What bodies and places are deserving of our intervention? What does the power at work in 'emergency' contexts produce? To explore these questions in more depth, this chapter turns to the 2014–2016 Ebola outbreak in West Africa, and the story of Marc, an advisor working for Medicens Sans Fronteirs.

Life after Ebola? Undertanding the 'original' emergency

Marc*,[2] arrived in Sierra Leone in 2018, in the wake of the Ebola pandemic. 'It was a hard time to join the ranks – everything was in transition' he told me in an interview, in early 2020. During the height of the outbreak Sierra Leone was a site where multiple Medicines Sans Frontieres (MSF) branches were situated; Spain, Netherlands and Belgium, each with varying inputs and responsibilities. However, by the time Marc had arrived, Spain and Netherlands had begun to pull out, leaving the Belgian section behind. To their credit, the desire to remain was, as Marc put it, a reflection of the 'tensions' within modern humanitarian practice in health. During our conversation, he noted the mood at the 2017 UK general meetings reflected similar interests.

> *There were a lot of internal discussions as to what the, MSF presence in Sierra Leone would look like in the post Ebola periods … I recall going to one of the MSF UK annual general meetings.. in which there was a very clear commitment was made to continue to work in Sierra Leone … a certain sort of moral obligation that had developed because of [Ebola] to the Ministry of health, and people felt very strongly that we should maintain some long term commitment.*

What this equated to for MSF (Belgium) in Sierra Leone was a renewed focus on health systems investment, linked directly to his role to expanding and deepening investment . Of course, this is a step in the right direction. A major reason why the outbreak was thought to have spread so rapidly was the weakness of health systems in these west African countries, legacies of conflict and state failure. In an analysis of Ebola as a complex emergency, Piot, Muyembe and Edmunds (2014) identify a perfect storm of conditions driving the rapid spread of the virus in 2014: decades of civil war leading to a low level of trust in authorities despite their efforts to reconstruct the country; dysfunctional health services and health worker scarcity (particularly in Liberia and Sierra Leone). On the cultural side, they noted strong

traditional beliefs in disease causation and denial of the virus' existence; high-risk traditional funeral practices that amplified transmission, including recent healing where the bodies of patients with Ebola are touched. Finally, in the global domain, a slow and inadequate national and international response and high population mobility across borders.

However, nowhere on this list appears any mention of the systemically imposed underdevelopment of these three countries, mediated through structural domains of power driving globalisation processes. The International Monetary Fund has provided support to Guinea, Liberia and Sierra Leone, for 21, 7 and 19 years, respectively, and at the time of the outbreak, all three countries remained under IMF programmes. Such lending comes with strings attached – so-called 'conditionalities' – that require recipient governments to adopt policies widely criticised for prioritising short-term economic objectives over investment in health and education. As many have pointed to, these structural adjustment policies have not equated to improved economic performance in many spaces, but have created the crumbling of health and social welfare systems (Hickel, 2016).

Kentikelenis et al. (2015) reviewed the impact of a series of IMF-advocated policies from the 90s on establishing health systems fragility in the region, concluding it contributed heavily to the rapid spread of the illness. For example, they note that the prioritisation of debt repayments at the expense of public spending resulted in missing targets for social spending (on key areas such as health) in 2013 prior to the first outbreaks of Ebola. These strategies also impacted on health workforce spending – where in Sierra Leone, for example, IMF-mandated policies explicitly sought the reduction of public sector employment. Between 1995 and 1996, the IMF demanded retrenchment of 28% of government employees. The limits placed on wages continued well into the 2000s, and in 2004, they noted that the country was spending less on wages than the average in Sub-Saharan Africa.

Figures like this make the temporary infrastructures associated with humanitarian health interventions all the more heart breaking – the graveyards of ambulances that countries don't have the money to maintain after an organisation has left; the empty lots of land where temporary health sites once stood. These become the remnants of international investment once an emergency has been 'solved', once cases recede and life begins to return to normal. Its as though there is a collective amnesia, a forgetting, that the 'normal' returned to in many places where emergency resides, is nothing but. It is not normal for a country of 7 million people, to have fewer than 200 doctors (0.04 per 1000) (McPake, Dayal & Herbst, 2019). With each intervention, there is a hoping for more - but what transpires is rarely that. In Laurie Garrett's account of the 1995 Ebola outbreak in Zaire(now DRC), a similar process of hoping for more is cristalised in the following quote:

> *When the international response came we were happy. We knew WHO came here to save our lives … In that time the entire world community came here to Kikwit, and [it] became the centre of the world. The population believed that because of the terrible disease a health*

> *infrastructure would be developed … but everything has returned to square one, where people are suffering to find medicine and medical support. Everything is forgoten. Could it happen again? For sure! There are no changes – Lusilu Manikasa, Nurse, Zaire (DRC).*
> (Garrett, 2014, p. 104)

In my conversations with Marc, he recalled coming across an 'ambulance graveyard' in his first few days in country - more than 20 years on. . In light of these histories, Marc's accounts of the new phase of work entered into by MSF, their interest in health systems strengthening and improvement, are welcome, and long overdue. In the region prior to this, very few organisations worked in models that focused on strategies of long-term engagement and development, and those who did, represented the few success stories from the crisis. In fact the success stories of Ebola revolve around the practices that do the opposite to traditional humanitarain practices. For example, Partners in Health (PIH) was also based in Serria Leone during the crisis. Evidence suggests that their strategies, rooted in a biosocial approach to health that attends to the social, political, ecological and economic drivers of poor health, were able to manage the emergency while holding an eye to the future. Cancedda and colleagues' (2016) account of PIH work in four highly affected districts signified a commitment to health systems development during and after the crisis. First, they opted to reinforce ongoing government efforts, working to support capacity and resource gaps beyond human resources and medical supplies. By strengthening policies and procedures for health service delivery, and redevelopment of existing government facilities instead of building new temporary structures, they reflected a concerted effort to reject the paternalisim that drives much securitised and humanitarian approaches taking place at the same time.

And yet, despite the emergence of a new discourse guiding the practices of MSF in Sierra Leone in the years post Ebola, remnants of this old practice remained. As we neared the end of our interview, Marc mentioned that part of the local efforts he saw there involved the construction of a new hospital. I was delighted, excited and hopeful. The project had been planned during the height of the Ebola period, a response to shortages in addition to community outreach initiatives. In response to my question about where it was being built, he paused a smile in his voice '*a project built from scratch, on an empty plot of land about 10 km away from Kenema city where there is, of course, already a functional government hospital*'. This decision, in a context where 92% of doctors and 72% of nurses reside in urban areas, but only 18% of the poulation does (McPake, Dayal & Herbst, 2019), beggars belief.

As Marc and I continued our discussions, the challenges behind the planned centre for excellence around issues linked to longer wave investment in the local health system development emerged. An emphasis on pediatric care and reducing maternal mortality within this new site is exciting. Sierra Leone has a maternal mortality ratio of 1 in 75 pregnancies resulting in maternal death (The World Bank, 2015), which is one of the highest in the world. . But the historical backdrop to this tale seems inescapable. A specialised center, in many ways overlooks other health

challenges that faces citizens of Sierra Leone. The recent World Health Organisation country cooperation strategy identified that only 13% of the population had access to adequate sanitation facilities (WHO, 2017), which have knock on consequences for a range of infectious disease burdens. Furthermore, the remnants of the temporality driving humanitarian engagement were also painfully evident: even in attempts to engage in structural advancement, a hospital is built in temporal ways. Marc described the use of technologies that on one hand, minimise transmissions of infections via easy to clean surfaces, but on the other, only have a lifespan of only 10–15 years. The temporality within emergencies remains a position that seems hard to shift.

Many have struggled to make sense of what exactly went wrong in managing the 2014–2016 outbreak. Before the west African outbreak, MacNeil and Rollin (2012) suggest that Ebola should belong to the category of conditions called 'neglected tropical diseases' given it's comparatively rare presence in the global health arena, and it's disproportionate impact on the poorest countries and most under resourced health systems. However, post-2014, there is little possibility it could hold such a label. A Lancet editorial published at the height of the 2014–2016 outbreak Professor Peter Piot argued that Ebola was no longer simply a disease outbreak, but now a *humanitarian emergency of a global scale*. Piot argued that this was the world's first *'global health humanitarian crisis'* . Unlike previous Public Health Emergencies of International Concern, governed by the International Health Regulations (IHR) such as Swine Flu (2009), and the Zika virus (2016), the realities of the location of the pandemic, the region's geopolitical histories and contemporary realities created a 'perfect storm', where public health concerns intersected with humanitarian discourses of emergency, aid appeals and securitisation (Piot, 2014; Nunes, 2017).

At the peak of the two-year response, academic and media outlets attempted to grapple with the 'how' of this particular outbreak, in the wake of what many called a failure of global systems of monitoring and response. For example, critical global health scholar Laurie Garret has argued that the response was badly mishandled by the WHO, most clearly in its delayed declaration of a PHEOIC, which didn't occur until 8 August 2014, many months after the first cases were identified. In a world that is, at most times, in most places, experiencing some sort of emergency, why didn't we act sooner, and why weren't we, as a global community better prepared?

A collage of reasons have been offered, most of which, like Garrett, focus on the mechanisms of global health governance, which resides firmly in what Collins (2012) defines as *disciplinary spheres* of power. Global health governance is a complex space of actors, institutions and processes that, when working effectively have the ability to promote the achievement of good health. The rules, regulations and practices established by these actors work within, and across national and regional boundaries, though some factors and determinants also also understood to operate transnationally (Dodgson, Lee and Drager, 2002; Kickbusch and Szabo, 2014). For example, Clare Wenham (2016) argued that a general lack of

preparedness and coordination at the global levels of the WHO contributed to challenges in the response, shaped by limitations of country level reporting from countries at the epicentre. However, Joao Nunes of MSF (2017) positions failures more widely in the hegemonic and structural domains of power; reflecting on how norms around securitisation processes within the global health space limited local-level action.

Unfortunately, fewer explorations into the 'how', 'why' and 'what next' of the Ebola response focused explicitly on power relations beyond the domain of governance. Linked to this is the underestimation of the importance of understanding power at work when organising action under the idea of the 'emergency' in the first place. Ideas and ideals (or discourse) exists within the domain of hegemonic power, which intersect with and are maintained by structural types of power anchored to legacies of colonial rule and oppression. As the world continue to grapple with 'emergencies' in various forms, it is worth considering what is gained and lost in use of a discourse of this nature in the global health space.

The rest of the chapter proceeds as follows. First, we explore an account of the history of the ideal of emergency in humanitarianism and global health, tracing the power dynamics that anchor it to global health and humanitarian and practice. Then, it reflects on how this language of emergency manifests in framings and shaping of further ideas, actions and practices. It suggests that Stephen Lukes third form of power, defined as, '*the ability to decide what can be decided*', is more than just politics, and that decision-making power in this context is inseparable from the normative power of the idea of emergency itself. This in turn is supported by constellations of other power forms, such as paternalism. What this produces by way of validation or invalidation of local knowledge and governance systems is critical to global health and worthy of our attention.

The power of an idea: The global health/humanitarian emergency

The idea of the 'emergency' holds great power. In fact, how many everyday people make sense of the purpose and content of humanitarian and global health work is linked to this imaginary. It is a concept that calls people to action, building on a social and moral code which demands that a particular event, and its consequences , must be responded to. In his 2004 work 'A world of emergencies', Craig Calhoun argued that 'emergency' is a way of grasping problematic events. It allows us to imagine them in a way that focuses attention to features such as their unpredictability, abnormality and importantly, their brevity, which means they can and should be managed. When one mentions international emergencies, many international organisations responsible for this management easily spring to mind; MSF, World Health Organisation (WHO), Oxfam. But in making sense of where and how these associations emerge, we need to examine one of the key premises at the heart of global health and humanitarian responses under the umbrealla of emergency: the right to interfere. According to Allen and Styan (2000), *the right* to

interfere became synonymous with humanitarian and NGO practices through a complex process, where interventionism in the name of humanitarianism became more explicit. Specifically, they link it with the establishment of the most well-known international humanitarian agency, MSF.

In reflecting on Bernard Kouchener's work during the early years of the establishment of MSF, Allen and Styan (2000) clearly illustrate the power of a development industry that marshals the idea of emergency defined by Calhoun (2004). The transition between pre- and post-cold war politics signalled a transition in thinking about aid and responsibility and moral obligations. Pre-cold war politics was a period of development that focused on larger systems change; the overhaul of politics, systems and structures to align them with principles of communism or capitalism. In this era, large-scale development, projects and visions looked very different to the post-cold war environments that dominat the first few decades of global health and humanitarian practice. Now, the preference is short-term projects that prove 'success', through focus on discrete outcomes and individual impact. Within global health, this transition is embodied in the difference between the hope, and reality of Primary Health Care. At the 1974 World Health Organisation Alma-Ata meeting a dream to create *Health for All* through community and country level action and social change targeting social and political drivers of poor health never materialised. (Rifkin, 2018). Instead, the establishment of vertical health interventions targeting specific health conditions, such as immunisation programmes and breastfeeding emerged, based on the arguments and interests in advancing western donor progress (such as vaccine development) rather than local 'action' (Burgess, 2022).

These core national interests among donor countries coincided with a global shift towards the 'necessity' of interference in humanitarian spheres. Doctor Bernard Kouchner was working for the International Red Cross at the time of the Nigerian civil war, established MSF in response to the failures of neutrality by organisations during that period. Alongside colleagues he spoke publicly about atrocities happening in the country and formed MSF as a testament to the importance of acting in response to the needs of people, rather than governments. By 1988, the right to interfere was written into UN constitution with the passing resolution 43/131, which, affirms the sovereignty of states on the one hand, but allows organisations and actors in other countries the ability to act in ways that promote the survival of victims, to preserve life and dignity (Allen and Styan, 2000, p. 831).

Though arguably pushed forward in part by one man's politics and political positioning, the idea of foreign government intervention to save lives has shaped an entire field of practice. As time passed, development organisations working in low resource settings globally contributed to the advancement of the pillars of short-term and rapid interventionism (HPN, 2015). In Vanessa Pupavac (2006) neccessary account of humanitarian emergencies and practices, she views short-term intervention projects as *anti-development*. The humanitarian emphasis on survival in the short term over a longer-term vision also contributes to a process of supporting the

neo-liberal policies that embed countries in poverty, and promote development of wealth in former colonial countries . For example, instead of widespread poverty alleviation programmes orchestrated by state level intervention (such as debt relief), sustainable development projects and associated humanitarian endeavours calls for people to 'end poverty for themselves' through micro-finance schemes and small-scale enterprises. Parts of this critique have been taken to heart by many humanitarian agencies; MSF being one such actor. In his chapter reflecting on the Ebola Response, Nunes (2017) describes a 'misrecognition' of Ebola as a humanitarian crisis, in direct contrast to Piot's (2014) assessments. Nunes argued that this contributed to the deployment of technocratic responses. This is a challenge for both global health, and humanitariansim, which has been hard to shake, as it is emebdded within the very ideas that establish the field in the first place.

Who knows best? Quick fixes, paternalism and the global health emergency

The right to interfere embodies a form of power that is marshalled through interpersonal and structural domains: paternalistic power or authority. Buchanan (2008) defines paternalism as the removal of the decision-making power of individuals along three pathways. First, by preventing them from doing what they desire; second, by interfering in how they arrive at their decisions, or substituting one's judgement for theirs, in the name of improving their welfare. Debates on paternalism are no stranger to the public health landscape. For example, Bartlett (2018) explores these dynamics within the space of non-communicable disease prevention, reflecting on the ability of policy actors to actively manipulate and frame ideas often away from public interest. Childress and colleagues (2002) suggest that the management of illness or social threat which poses a high probability of harm warrants paternalistic control. Thus it comes to occupy a central space of global health governance, particularly within the contexts of global health security interests, as seen within the COVID-19 debates. Unsurprisingly many global health governance spaces struggle with this tension of care and control, particularly in an era where power inequalities between nations, states and legislative bodies are continually being debated. The interests of public security continually misalign with public interest (Barreto, 2017). Still, within the global health space, the emergency discourse is sustained by the fact that action is driven by resource rich actors. If they view a context as 'emergency' then they have the access to structural and economic power that ensures their view, determines action. Ultimatley, they that their decide what is to be decided.

To overcome this, humanitarian scholars like Dorothea Hilhorst highlight the importance of viewing humanitarian spaces as dialogical, with a range of relationships between key actors (donors, agencies, recipient countries and community members) negotiating across varied aspirations meaning and assumptions about target communities (Artur and Hilhorst, 2012; Hilhorst, 2018). While this has resulted in governance spaces that argue for national-level led action on the crisis

itself, an interest in 'state led' responses have rarely translated into action that addressed the wider needs of that state, or local communities. For example, prior to the Ebola outbreak in west Africa, policy and governance spaces have acknowledged the devastating impact of structural adjustment policies on health-related infrastructure (Heymann *et al.*, 2015). However, global, or health specific investment in that region had not been directed towards redressing these challenges in the lead up to or following the crisis. For example, according to the 2020 Financing world health report data (IHME, 2020), DHA allocated to Sierra Leone in 2010 was 74 million. By 2015, one year after the outbreak began, this increased to 581 million. Much of this was targeted directly at Ebola activities. In 2022, Sierra Leone recieved addtional $20.8 million as part of IMF facilities to support economic programems that could make progress towards sistainable and improved macroeconoimc growth. The reccomended 'growth enhancing reforms' are focused specifically on 'monetary tightening' (IMF, 2022). These terms are in direct conflict to the stated needs for health care stability and reform called for by the WHO, which call for increased investment in the health workforce in the next few decades (Boniol, Kunjumen, Nair, et al., 2022).

Paternalism and it's impact on the failures seen during the West African crisis embodies the tendency for humanitarian and global health disciplines, and the wider structures that sustain them, to doubt the capacity of communities to lead responses to their own crises. Paul Richard's (2016) work on the outbreak details successes achieved by rural communities in Sierra Leone who, in the weeks and months prior to the arrival of external intervention, rapidly adapted and deployed their own practices to protect themselves and loved ones, linked to traditional ethics of care. Richards refers to the subsequent erasure of local practice by western actors and systems in the name of care, as the growth of ignorance (p. 8) a social process, initially described by Mark Hobart as the purposeful cultivation of ignorance as a form of protectionism by certain actors.

This resonates with Stanley Cohen's writing on Denial (2013), who argues that the inability of the human conscious to absorb the full reality of our environments means that denial emerges as a logical mechanism for survival – we continue to operate within the current state of affairs. Within Ebola, Richard suggests that this manifested as the outright denial of the ability of communities to do home care of any kind during the outbreak. However, over time, the international response eventually, with focused lobbying, acknowledged and incorporated their innovations. For example, with respect to burial practices and home care, Richards focused on the story of the response to Ebola in Jawei Chiefdom; located in the epicentre of the epidemic in Sierra Leone. The first confirmed case of Ebola in the country was in May 2014 – but Chief Kallon were warned about Ebola by the local government much earlier, in March that year. After falling ill with Ebola himself, he marshalled a local task force of 55 young men from across his chiefdom, paid for their training in virology and use of personal protective equipment. Crucially, he revived an old traditional burial practice, which meant young people managed burials of elders – meaning only young men trained in safe handling and burial procedures handled bodies in their most infectious stages

(Richards, 2016). Despite the successes seen by these practices in the early stages of the outbreak, the arrival of international intervention threatened to bring them to an end:

> *The approach adopted in Jiawei chiefdom later became the model for local Ebola response throughout Sierra Leone … byelaws were introduced nationally from August 2014 … security services and other government agencies began to support these local initiatives … Task forces were initially successful at finding cases, reducing inter-village movement, and enforcing bye-laws. The Jawei force undertook 'safe burial' from the outset, having been trained and equipped. Task forces were threatened with marginalization after the militarization of the Ebola response accompanying the international surge from November 2014. but paramount chiefs successfully petitioned State house not to exclude chiefdom task forces from the ramped up response.*
>
> (Richards, p. 131)

It is not hard to see that denial of local capacity is somewhat inseperable from the logic of emergencies and humanitarian practice. Recent analysis by Dorothea Hilhorst (Hilhorst, 2018) explores the tensions between Dunantists and Resilience based paradigms of humanitarian action. She highlights that, within the latter, which occupies the current focus of humanitarian praxis, have shifted their commitment to engagement with community, replacing language such as 'recipient' with terms like clients and survivors. But even within such framing, the outcome created remains limited by a short-term logic. On the one hand, Dunantist humanitarianism is limited by an inability to truly view communities on the ground as partners:

> *Although aid in this tradition is motivated by the desire to relieve suffering and is based on the ethics of a shared humanity, in practice, it is really delivered on the basis of mistrust of the society in which it operates, and the local providers of aid and the aid recipients must be kept under close surveillance.*
>
> (Hilhorst, p. 5)

On the other hand, while resilience humanitarianism appears to be better suited to the social realities of continued and cyclical crisis (p. 9), it also places the burden of long-term survival on the shoulders of those who are made more vulnerable through crisis, which individualises and celebrates resilience:

> *In a world in which an estimated one billion people – migrants and resident poor – are part of this precariat, refugees may become a hardly distinguishable lot of urban poor, and is equally left to fend for themselves. There is a real risk that the politics of resilience towards refugees turns instead to a politics of abandonment.*
>
> (Hilhorst, p. 6)

Hilhorst's vision for a way beyond these dichotomies calls for new ways of working; that resonates more with longer term investment and engagement in

spaces before during and after crisis. The West African Ebola crisis has pushed the need for this transition further, with more classic Duantist organisations such as MSF picking up this mantle of shifting away from the complexities and limitations of their work. In 2017, MSFs published an edited volume on the challenges faced by the organisation during the West African outbreak. A large focus of the book was an analysis of the impact of a securitisation discourse on their practices, resonating with critiques raised by Harman and Wenham (2018). However, the politics of fear and the process of securitisation are linked with the push towards short-term logic and engagements. As Joao Nunes (2017) notes, 'The politics of fear has lead to a short-termist agenda focused on crisis management and disease containment' (p. 19). However, such a claim is rooted in an underappreciation of the ways in which the entire logic of interventionism in Humanitarianism and global health more broadly has a propensity for such interventions. It is no surprise, that the afterlife of humanitarian discourse, is harder to shift than we imagine. This is clearly embodied in Marc's story – and an ongoing dissatisfaction with processes that erase critical local knowledge and learning that could meaningfully contribute to preparing for future emergencies, or better yet, preventing them from becoming emergencies in the first place.

Another, and potentially more entrenched implication of the paternalism embodied within emergency discourse, is the way in which it shapes relationships between states and citizens in resource rich countries, and their perceptions of need, action and responsibility to the majority world. The dynamics and relationships between states and their own citizens also shape aid practices, and contribute to the 'politics of fear' described by Nunes (2017). Broadly, we know that aid is linked to domestic political ideologies, and as well as the presence or absence of public, or political will (Wood and Hoy, 2018). However, it would be unwise to underestimate how power also works in subtle and overt ways to shape or limit the political interest in certain stories, and how this determines which ones capture the notion of 'emergency' in the first place.

Stanley Cohen's 2004 once more provides a valuable platform to interrogate this nuanced marshalling of paternalistic power within the humanitarian arena. In making sense of how the denial of certain atrocities is possible for those who view the suffering of distant others (the external audiences), he introduces the concept of the bystander state. This concept allows us to understand the role of governments in enabling citizens to turn a 'blind eye'; or 'unsee', what they already have partial knowledge of. This could include the ability for states to deny their understanding of the pre-existing realities within west-African countries affected by the 2014–2016 outbreak, and how new practices interact with these contexts. Drawing on examples of previous global health challenges, including HIV, Cohen highlights how state actors need everyday citizens to be aware, but simultaneously blinded to complicated truths. In the case of Ebola, this amounts to the need to limit citizens from understanding the direct and indirect contributions of rich nations to the current states of underdevelopment

within the epicentre nations – namely previously mentioned IMF policies and their downstream consequences. But feel the urgency of the current emergency to contribute to new action they determine as neccesarry.

A mechanism viewed as enabling and benefiting from this partial 'seeing' which happens in global health and humanitarianism spaces are public appeals. Such initiatives draw on the notion of a collective responsibility and ownership of response in response to crises. A significant portion of Cohen's analysis focuses on this phenomenon. He postulates, that these approaches are crucial to state mechanisms which attempt to create the illusion of action in response to crisis. A rapid google search of the phrase '*Ebola public appeals*' generated more than 42,000,000 items, reflecting the various phases of what Stanley Cohen (2011) defines as the appeal dynamic: public announcement, media response and reporting. The Ebola crisis signified for many disaster organisations a significant shift in mechanisms for engagement, perhaps for the first time, wading into the global health sphere as the core definition of emergency. For example, the Disasters Emergency Committee (DEC) who co-ordinates joint public appeals bringing together the 14 leading aid agencies working in response to disasters, identified Ebola as their first 'health-related emergency' and through a combination of public appeals and matched funding, raised £12 million dollars in six days, raising £6 million in the first 24 hours (Corfe, 2014). The impact of these funds is rarely explored – often because to do so illuminates the limitations of the current system, where evidence indicate that these types of bilateral funding arrangements follow donor priorities, rather than national/community ones (Fuchs and Öhler, 2021). But one clear result is its ability to establish a system of accountability to everyday citizens, who are unsurprisingly satisfied with 'quick fixes' and a focus specifically on the disease at hand. It is easier to justify spending funds on Ebola treatment centres, than the building of new permanent infrastructure that could work across a series of health challenges facing western African countries when you have never been educated about the ways in which these same countries were prevented from building permanent structures for the past 50 years.

Conclusion: Where to for the next emergency?

My conversations with Marc are a lamentation from a global health and humanitarian practitioner on the front lines haunted by the acknowledgement that much of his work involves the repeated use of tools that are not always fit for purpose. In a highly cited publication in the *New England Journal of Medicine*, he predicted the current state of affairs as the world grapples with its next emergency, COVID-19.

> *As the Ebola epidemic fades from the world's attention, we risk missing the opportunity to learn from it. Even if the system we have today had worked perfectly for Ebola, it would fail to contain a more infectious disease. It's instructive to compare our preparations for epidemics with our preparations for another sort of global threat – war.*
>
> (Gates, 2015, p. 1381)

We were not ready. Not even close. Yet at the time, he drew heavily on the discourse of emergency and crisis around Ebola to call for the establishment of new systems of governance, funding and management, and largely around technological advances. None of the things he advocated for were likely to provide Marc, or communities at the epicentre of the outbreak, with much solace during COVID. In fact, many of the successes achived during this outbreak, were established by National actions, with local paretners taking the lead, and International partners having more auxillary roles. For example, an International red Cross report on successes during the pandemic, noted that mobilsing with local chifdoms enabled critical local action around screening, health communication of risk, and work to challenge qeustiosn and rumors in early days of the pandemic (IFRC, N.D).

This, is a huge contrast with the action linked to the arrival of international support in November 2014 in the epicentres, which meant the unravelling of many local structures.. The assumption of a *Tabula Rasa* was enabled by paternalistic power operating across multiple decision-making processes. The wider allure of the emergency idea in the general population will continue to support additional resources being funnelled into this system. One wonders what might have happened if communities who had adapted successful practices locally became the starting point for action and investment. The impact that COVID had in high-income countries meant that foregin attention was focused internally, leaving space for more independence of local actors in low resource countries. The disbelief in lower numbers of impact in these countries is also shaped by this same deinal linked to paternalism: where it is not possible that 'they' could survive without our intervention. One could hope that we have turned a new leaf in humanitarian praxis, as this new pandemic has made clear the possibilities that emerge when community ownership and expertise is the starting point, rather than the afterthought in a response strategy.

The main barrier to humanitarian global health spaces seems to be assumptions made about the goals and the roles of humanitarian interventions. Their short-term nature means that the emphasis is often rooted in what Nelson and Prilleltensky (2010) argue as the error of viewing actors primary role in interventiosn as linked to compliance with the intervention –rather than viewing communities as routes to leading a response to crisis. As seen in Richards' (2016) work, what local communities and States are expected to do is to adhere to the frameworks and strategies established and verified by external actors. And as Hillhorst (2018) reminds us, this is a problem across the entirety of the humanitarian and global health landscape. The long-term consequences of assumptions fuelled by paternalistic power at work across multiple domains are perhaps most painfully seen in the country at the heart of the case study in our next chapter: Haiti.

Notes

1 The wetlab/ zoontoic barrier is one of multiple proposed theories for the origins of Coronavirus-19.

2 Name and details changed to protect anonymity.

5

OLD BECOMES NEW

Haiti, Cholera and the matrix of domination in global health

In Haiti the communities I work with always say 'participation just means we end up carrying the rocks'.

– Greg Beckett, Interview, 2020

I've never been to Haiti. But there is something about the way it has been described, particularly in the writings and conversations I have had with Gregg Beckett and Johnathan Katz, which makes me feel as if I have. Stories portraying a two-world phenomena: one for locals and another for expats, which are familiar in many ways. In international development, these polarities were always described, as the Tarmac Bias that impacts our ability to understand the realities of peoples' lives (Chambers, 2006). Colliding and blurring with memories from my time living in South Africa; childhood visits to family in Jamaica, where both sides of my family originate; research visits to Colombia, the Kingdom of Eswatini and Kenya. They are all united by and trigger a collage of familiar images, smells, tastes and sounds; busy streets, fried plaintain; bass filled music pouring through alleys and doorways; heat thick with promise of rain; oppressive reminders of failed sewage systems; black smoke from burning waste. Then, following journeys down roads that are more potholes than road, wind and weave their way through mountains, defying logic and laws of gravity – you arrive in spaces of opulence that defies other logics of understanding. My rage at inequity began in early years; wondering why guests at a hotel could have running water, but my grandmother could not. Thinking and feeling this while sat at the same hotel.

These jarring contradictions are what I have read in the pages of those who write about Haiti. These similarities which connect to a shared lineage of the everyday consequences of colonialism provided me with some comfort in a choice to delve

DOI: 10.4324/9781315623788-5
This chapter has been made available under a CC-BY-NC-ND 4.0 license.

into an analysis of a place I had not yet seen with my own eyes. These similarities reminded me I had seen some of it already; that I had been born of it; and returned to it in my work as a global health scholar and activist. That Haiti, much like Jamaica, like Colombia, South Africa – as soon as you step off the well-paved road; you wade into the places that time forgets. And unless, like me, you had family which demanded those crossings, the rest of us will never see it – until a crisis demands we pay closer attention. Hurricanes, conflicts, earthquakes, outbreaks they all remind us that for a world shaped by modernity, there are places that remain left behind. Despite the efforts of a billion-dollar industry that has worked tirelessly for over 50 years to change this, we are still far from the achievement of equity.

While COVID-19 unfolded across the world, Haiti was quietly celebrating the end of another infectious disease outbreak. On 23 January that year, the Pan American Health Organisation (PAHO) and WHO declared that the country was officially free of Cholera. The outbreak lasted for nearly a decade, affected more than 820,000 people, and killed close to 10,000 (Lee *et al.*, 2020). But news about Cholera in Haiti wasn't always quiet. Its emergence captured the world's attention when all eyes were already on the small island nation, following the 7.0 magnitude earthquake on 12 January 2010, which claimed 222,570 lives and injured over 300,000. By 21 October that same year, reports of a Cholera outbreak had emerged, first declared by Partners in Health and MSF (Katz, 2016). The outbreak began, not in the internal displacement camps set up in Port au prince to house people who lost everything in the earthquake. Instead, it was around 35 kilometres away, in the town of Mirebalais, where damaged roads meant that a journey from the capital took over three hours in a 4 × 4 vehicle (Ivers and Walton, 2012). The small town, which is home to mostly subsistence farmers with very high unemployment, was mostly unknown to much of the outside world before this. However, its location downstream from a UN peacekeeping mission would launch it into the spotlight. The arrival of new batch of Nepalese peace keepers, combined with faulty latrines, would lead to the contamination of the Artibonite River, the most important river in the country (Katz, 2016). Their arrival, was also the arrival of Cholera in Haiti.

And then, a literal storm hit, with the arrival of hurricane season in an already battered country. Beyond the destruction of infrastructure, severe flooding contributed to the countrywide transmission of Cholera. 48 hours following landfall of Hurricane Thomas, MSF reported seeing nearly 200 new cases in the slums and internal displacement settlement camps in Port au Prince (Walton and Ivers, 2011). By the end of 2010, over 4,000 people had died (Connor *et al.*, 2011).

On the surface, the story of Haiti in the last 10 years is one that depicts some of the bleakest realities of the global health landscape. A nation responding to a multiplicity of challenges; poverty, climate crisis, globalisation, infectious disease, natural disasters, political and social upheaval. It took 10 years to end Cholera in Haiti – though there are some who feel that it may never be gone forever. At the writing of this book, new cases were identified in the summer of 2022 (WHO, 2022). This is

because Cholera risk is linked to the very same challenges that cause poor health in the first place. Haiti is often defined as 'exceptional' – a case study in 'failed states' – but it is far from it. More realistically, Haiti is deeply emblematic of the impossibility of endeavours to promote good health that occur in the absence of structural, political and social change. Haiti, like many under resourced countries in the world can be brought to its knees by each wave of change. Elections. Hurricanes. A pandemic. . As such, I argue that a critical question to ask is *what makes good health seem so impossible in places like Haiti? And why do we keep getting things wrong in our attempts to change that?*

This chapter will suggest answers to this question, through an analysis of how power shapes, and has shaped, possibilities for change Haiti, using the Cholera outbreak as an orienting event. I argue that the Cholera response in Haiti could have gone better – quicker, if we had *started* with an interrogation of power and its complexities, and what it produces. However, for us to come to grips with this complexity, I will start with a story; one about Haiti and Cholera that is rarely told; buried in the bottom of UN archives and reporting structures. A story that I know about only by chance, or as an uncle of mine loved to say 'because I know a guy'.

The United Nation's secret success: Cholera Response Track 2

I have known Ramsey, a Humanitarian Advisor for a very long time. In fact, I have known him for the entirety of my life that I define as adulthood. He is my honorary little brother; we shared a flat during our masters at the LSE. Despite being in different departments, we studied the same topics, read the same readings, fell in love with Armatya Sen's capability approach and planned to save the world. Between the two of us, Ramsey got the closest. He has worked in places and on topics that rarely make headlines, for example helping young gay men cross borders to avoid execution in places where homosexuality remains criminalised. But Haiti is where he stayed. He's been there, in some capacity, since the earthquake in 2010, and unlike those who left when the fanfare of it all had passed, he is still there. During one of in person visits in 2019, when he came to meet my son, amidst discussions of maternal depression (mine) and falling in love (him) we drifted to work. This time, his eyes lit up. With a smile he said

> *"Shelly, we're doing something that's working. We're giving people the power – and it's working".*
> *"Of course it is!"* I say, in the way that annoying big sisters often do.
> *"So what's the problem?*" I ask, incredulously.
> *"Well"* he pauses, *"basically, no one wants to pay for it".*

The 'it', which he was referring to, is the lesser-known strand of the UN's flagship programme to end Cholera in Haiti. In Summer 2016, within a long-awaited response from the UN in relation to its role in the cause of the outbreak, then UN

Secretary General Ban Ki Moon announced a *New Approach to Cholera in Haiti* (United Nations, 2017). With UN resolution 71/161, the UN accepted that they had a moral responsibility to respond to the crisis despite vehemently denying a role in this in the initial weeks and months of the outbreak (Katz 2016). This momentous declaration, like the countless declarations on other topics that preceded it, called on all member states to contribute to eradication of Cholera from Haiti. The response was organised into two broad strategies. The first *Track 1* (a and b) focused on the elimination of Cholera through vaccination, chlorination, treatment and primary prevention measures, through implementation of WASH[1] programmes – well-worn staples of global health interventions.

Track 2 was the piece that felt different. Its aim was to address the fractured livelihoods of victims, families and communities in the places hardest hit by the Cholera outbreak with a particular emphasis on Mirebalais, which was closest to the UN Base. The scheme was rooted in principles of community engagement, providing opportunities and funding for community led – activity; an attempt to provide reparations and material assistance to manage the impact of the crisis. This type of acknowledgement was critical at the time; multiple legal cases were brought against the UN to pay compensation to individual families that were occupying global media (Garcin, 2015). Local mobilisation and protests had been ongoing since the start of the outbreak. Many blamed the UN and reflected a well-founded rage at the most current disappointment at the hands of the international development community in the country, a long history which includes the sexual abuse scandal of Sri-Lankan UN peace keepers previously stationed in Haiti (Dodds, 2017).

In the years that have followed that initial conversation with Ramsey, the process and the impact of Track 2 has been clearly documented – but not in the places you would expect to find it. Despite global media covering the successes of the Track 1 vaccination programmes in the country (Sharp *et al.*, 2020), stories of track 2 are buried within reports on the UN's Multi-Partner Trust funding mechanism website.[2]

Bit by bit, UN representatives and their partners worked with local organisations to implement a community led mechanism; identifying drivers of poor health and mapping the impact of Cholera in their communities and making plans for how to change it. They held community conversations, supported priority setting activities, they implemented and funded projects designed and developed by communities. Within this process, 18 communities were selected to participate, with the aim that each space would be given $150,000 to finance their projects of change.

When we next spoke, it was online, while the world was coming to grips with its current pandemic. I had so many questions.

'*Why aren't they shouting about this from the mountain tops?*' I asked. '*Why is it buried in the depths of the multi fund partnership reporting mechanisms that no one reads, unless forced? After all the horror of what happened in Haiti with the cholera epidemic, why don't people know about this*?' In writing this chapter, I interviewed many Haitian experts.

Ancito Etienne, Haitian Activist, Public health scholar and Trustee for Partners in Health; Greg Beckett, anthropologist and scholar who has worked in Haiti for more than a decade; Johnathan Katz, the journalist who broke the story of Cholera in Haiti. All of them knew about Cholera in Haiti. None of them had even heard about Track 2.

Ramsey was quick to remind me that all was not as exciting as it seemed. For example, of the $400 million requested by Ban Ki Moon at the launch of this initiative (Zarocostas, 2017), by 2021 only $16 million had been received in contributions towards these efforts. As Ramsey noted:

> *The UN doesn't have a central bank – it can't do anything without member states telling us to do it. General Assembly voted to allow support – but then tied our hands by saying it would have to come from volunteer contributions. The result? I spent years asking member states, rattling my little cup and say 'please sir, I want some more'? and the majority of them say – no. No one wants to touch cholera with a ten-foot pole … because it's a big black eye on the UN.*

In reality this black eye have more aptly be described as a gaping wound. Surely a public relations nightmare for our times, particularly in the initial weeks and months after the outbreak was reported and linked to the UN by Katz (2016). This is because the history of the UN in Haiti was already problematic. As noted by Beckett (Beckett, 2019) and others (Lemay-Hébert, 2014), the UN has had a presence in Haiti for some reason or another, for more than 30 years. Beyond the well-known scandals of sexual-abuse, it has been also charged with the use of excessive force (Wills and McLaughlin, 2020). Much research has highlighted an understandable fatigue among citizens over constant interventionism (Lemay-Hébert, 2014; Beckett, 2019). During our interview, Ramsey recalled proceedings of a meeting held between a local mayor and the UN team that puts this exhaustion into focus:

> And so we go to meet this community, meet with the mayor to ask his opinion of the project [Track 2] so far, and he says something that no one in the room, will ever forget. He says:
> *What has the UN ever done? All I see them being associated with, is death. You come in, you drive by, you do what you think we want you to do, and then leave again.*

The conversation didn't end there. Later, when they discussed the pilot of community-led action interventions, they compared past and present. Ramsey continued:

> So at the end of the pilot, I asked the mayor four questions. Do you think that this process was legitimate? Do you think this was actually done right? Do you think that you can accept this as an apology? And can your community accept

this as an apology? – and his response, showed me, that maybe we were on track. He said – *'for the very first time, the United Nations has come, and not told us what we need, but asked us what we need, and then worked with us to do it - we can accept this as a first step in a new relationship.*

This is the stuff of dreams. For decades critical health and development scholarship has called for deeper respect of local knowledge and agency. In 1967, Walter Rodney published an in-depth analysis of the impact of the advancement of European capitalism at the expense of the global south, with an emphasis on African nations. His work highlights how far back these relationships of extraction go, emphasising that what started with colonialism was replaced by capitalism and an aid infrastructure. He suggests that to sustain these new systems health and education sectors in former colonies needed to reinforce ideas of inferiority. Within these new sectors, indigenous practice, knowledge and contributions to survival were portrayed as irrelevant in the face of weakened contexts. The outcome was hoped to be widespread desires to replace local systems with European systems of practice and thought (Rodney, 1972).

Writing in the 21st century, Jason Hickel (2016) affirms the power of Rodney's seminal work, highlighting how modern aid structures become the handmaidens of capitalist infrastructure that ultimately maintains the status quo in many of the poorest parts of the world. Describing his work in Swaziland early in his career he notes:

Why were AIDS patients dying? Over time I learned it had to do with the fact that pharmaceutical companies refused to allow Swaziland to import generic versions of patented live-saving medicines … . And why was the government unable to provide basic social services? Because it was buried under a pile of foreign debt and had been forced by western banks to cut social spending in order to prioritise repayment.

(Hickel, 2016, p.13)

This is what makes the aims and successes of Track 2 so vital. This was not a case of simply putting Band-Aids on gaping wounds. 2019 year-end reports described the progress of work in five of the 18 communities who were selected through community consultation to be directly supported on this track. The projects in the Mirebalais and Grand Boucan included construction of a new market to replace one destroyed by the 2010 earthquake, construction of two water systems and a new road, and repairs of gutters and canals along a main road in Centre-Ville.

But deeper analysis into the wider roll out of this programme illuminates the persistence of the debates that Rodney (1972) draws our attention to in global health. In reports, explaining delays to implementation, next to a '*political instability around government corruption*', is an item described as '*project selection concerns*'. This item details the encounter of two sides: the community site (Centre-Ville), and the UNDP. The former, as part of their prioritisation and planning for their project,

identified the community priority of a solid waste management system. The answer to this request was a disappointing no.

I asked Ramsey how and why this happened. He described a complex process of push and pull between the UN, local government and structural realities of the country. The costs for a solid waste management system which civil engineers suggest would be somewhere around $5 million, depending on size of the community [3] plus maintenance, far outstretched funding the programme had available (a total of $7 million overall pledged to that track). But in a way, I didn't need to ask this question. This is the part of the story that is as old as the global health field itself. Somehow, despite a total of $13.5 billion raised to 'build back better' after the 2010 earthquake (Gov Track, 2014), there simply wasn't a way to build the one thing that would guarantee that Cholera wouldn't return. History repeats itself.

Randall Packard (2016, p. 9) notes six broad trends that have worked against the development of effective interventions to address health and its social determinants in the field. Three of these are particularly important to Haiti's experience, which I paraphrase here:

1 *Health interventions and plans for engagement are typically developed outside the countries where the health problem exists, and often involve very limited engagement with local communities and perspectives in planning or design.*
2 *Little attention has been given to supporting the development of basic health services.*
3 *Planning of health interventions typically occurs within the paradigm of crisis – where the simple, rapid response is privileged over longer-term interventions that develop new systems/infrastructure.*

In previous chapters of this book, each of these challenges are explored . In the case of Haiti and Cholera, all *three* challenges appear to be at work simultaneously. Such complexity requires a framework that turns into this reality, rather than away from it. As such, the remainder of this chapter proceeds by exploring how power works within each of the four domains of matrix of domination, to shape Cholera in Haiti. It draws on the work of scholars across a range of disciplines and discusses multiple forms of power seeking to overcome a false separation where we discuss single types types of power that hinder poor health outcomes.

The (im)possibility of health in Haiti? The matrix of domination in the context of Cholera

Power in the structural domain: Health without structures?

When I spoke to Ancito, we started with what the Cholera outbreak meant to him. The loss of a patriarch, a leader in his family and community – his grandfather. '*When the earthquake hit, I was away at school – and returned home to go and see if my family was alright. During the cholera outbreak, I went back to visit a few times, to see my uncle, who fell ill, and my Grandfather - who eventually died.*

What I saw, was not dignified care'. The irony of this of course is that where his uncle was being treated was a place that is known for being one of the few sites in the country where you can access good quality care. In describing what he encountered at the gates of *Nous petites Frere et soeurs* hospital supported by international organisations, he paints the picture of a warzone, despite it typically being one of the few sites for accessing quality care. People being treated in tents outside; holes cut through the bottom of mattresses so that the tell-tale sign of cholera, the consistent and unrelenting diarrhoea, could be more easily handled without having to move patients. "*In the 30 minutes I was there, two people died. 'They've been dying all morning' my uncle said. I thought this would be the last 30 minutes I would spend with my uncle, and I feared I would be right*".

The truth is Haiti didn't have the capacity to withstand this crisis, and continues to live through more than its share. By the time the earthquake and Cholera hit Haiti, it had already been battered by previous natural disasters, with increasing frequency in the last three decades. For example, the Atlantic hurricane season in 2020 was rated as the most active hurricane season on record with 30 storms. Hurricane Laura, one of three to hit Haiti that season caused $19 billion in damage and 47 deaths (Pasch 2020).

Environmental crises are not the only challenge Haiti faces. According to World Bank data, Haiti is the poorest country in the western hemisphere, and ranks 163rd 169th out of 191 countries in the Human Development Index (World Bank, 2022). Poverty and levels of inequality are particularly high. Recent poverty estimates suggest that more than 30% live at the extreme poverty line. ($2.15/day). Many scholars have linked the challenges in responding to Cholera in Haiti to the lack of basic health infrastructure. For example, Cerda and Lee's (2013) discussion of Cholera in the Americas highlights that the infection is opportunistic, and only takes root within economically vulnerable spaces. Poor water, waste management and sanitation infrastructure challenges were cited as longstanding challenges facing Haiti and contributing to Cholera by countless scholars (Dowell, Tappero and Frieden, 2011; Farmer *et al.*, 2011; Francois, 2020). Walton and Ivers (2011) noted that given Haiti's rank as having the worst water security in the western hemisphere (p. 4), an epidemic of this type would likely be devastating.

But how did Haiti get here? It is imperative to understand this through re-membering that structural systems were organised to prevent Haiti's development from the nations inception. Following the formal establishment of Haiti as a free state, it was immediately, and purposefully locked out of political and trade agreements with many of its neighbours, countries whose economies depended on the continuation of slavery in its current forms. The United States (in particular its southern states), France, England and the Netherlands managed to put set aside their own disagreements to establish a collaborative plan that limited trade with Haiti. As such, its rich resource and status as the largest exporter of key goods such as coffee, rum and sugar, mattered little if no one would trade with them. According to

Edmonds (2013), the plan was to bring Haiti to its knees by cutting off its access to achieving independent financial gain:

> *After numerous attempts to recolonise the newly established republic through military Force … the international powers put aside their colonial rivalries in a determined effort to destroy the revolution in its infancy by bleeding it to death financially … in 1825 Haiti agreed to take out a loanfrom a designated French bank, and pay compensation to the French plantation owners for their 'loss of property', including freed slave and loss of land … The amount of debt totalled 150,000,000 francs. Today that amount would equal US 21 billion dollars.*
>
> (Edmonds, 2013, p. 440)

In earlier chapters, I argued that structural violence is another way of viewing the manifestion of power at work in people's lives. As power within the structural domain creates and cements poverty in what eventually becomes intractable. This cycle in Haiti is highlighted in recent work by Keston Perry (2020) whose analysis of human development and interactions between poverty, production and environment for the Caribbean region highlights how various structural forms of power interact to determine progress. Focusing on the Caribbean Human Development Report, he argues that there is an underappreciation of structural contributions to poverty within the region's development solutions.

For example, as global systems push Caribbean economies like Haiti towards 'modernisation' and away from agrarian economies, there is limited attention to implementing scaffolding that would enable this moderinsation to succeed. Processes accompanying modernisation have overlooked the absence of structural environments to protect these economies from the volatility of the markets linked to the core aspects of production. This includes physical commodities (such as oil and gas), tourism, and finance, which are consistently open to global market forces (Perry, 2020).

Perry (2020) also notes that such approaches lead to definitions of poverty that overlook economic structures and political institutions that are also required sustain long term change. The result is a global 'development' infrastructure satisfied with small 'partial' gains in poverty reduction where a handful of individuals experience transient, as opposed to endemic poverty, moving in and out of precariousness with the waves of market forces.

The result in Haiti is that endemic and chronic poverty is never addressed because the historical and structural events that established it in the first place are never acknowledged. One such event is the previously described reparations paid to France by the Haitian Government following its independence in the 18th century. Paul Farmer's (2003, 2004) work traces the histories and consequences of this structural action on Haitian development. In 1915 alone, 80% of government funds were diverted to debt repayments to the French. As recently as the 2000s, political sanctions and economic embargoes were placed on Haiti by the United

States, Canada and EU during the rule of its first elected democratic leader, Jean Bertrand Astride. The populist priest sought to put in place structural changes to protect the Haitian economy (such as increasing tariffs, and funding public works and development). However, the embargo locked Astride's hands and blocked his attempts at structural development building new social services or paying staff (Herard, 2016). Financial crimes committed by former Haitian presidencies supported by external powers, such as the United States backed Duvalier regimes, should also be considered critical to understanding poverty. For example, when former President Jean-Claude Duvalier fled Haiti in 1986, reports suggested that he took approximately $120 million from the Haitian Treasury (Maurisse, 2020) with him.

When contemporary responses to health improvement in Haiti overlook opportunities to correct the structural damage created by externally and internally orchestrated crimes against the Haitian people, the international aid infrastructure becomes another structural system which maintains and organises oppression – despite its best intentions. Without meaningful infrastructure and stable National industry, there can be no hope for stability or health in the long term. For example, the 2018 Centre for Disaster Philanthropy report on funding strategies in the sector suggests that financing for short term crisis response and relief consistently accounts for 47% of disaster related funding (CPD, 2018). Country-level donations since 2011 are largely given to organisations based outside of Haiti. Only 64 (of 214) organisations who receive funding to work in Haiti *are actually based within Haiti*, meaning less than half of these organisations can work on long term infrastructure projects, and half of this half do not feed directly into the Haitian economy (Foundation Maps, 2021). One well-known alternative to this is the Partners in Health organisation, established in Haiti by Paul Farmer and Opheila Dahl over 30 years ago. It employs over 6000 staff, mostly Haitian, and trains practitioners who remain in Haiti working to support its citizens. However, this is the exception, rather than the norm.

How can any state hope to address structural challenges driving poor health, in the absence of structural systems of development, or functioning state sectors? The absence of systems operating to achieve structural aims, is continually linked to externally defined objectives defined by external states and actors. For example, the resurgence of Cholera in autumn 2022, linked to gang-related violence and blockades which emerged following the murder of former president Jovenel Moïse. As international actors respond to these crises, they do so once more, without engagement in structural development that could mitigate future challenges. And in the absence of supportive state infrastructure working in parallel on such issues, little will change. Is there any hope to make those changes? Unfortunately, those decisions are often negotiated elsewhere, as explored in the next section of this chapter.

The disciplinary domain: Who is deciding what can be decided?

In Haiti, the clearest manifestation of power within disciplinary domain is rooted within the international aid and development infrastructure, its systems of management and operations, which contribute in part to maintaining the status quo. In 2009, just before the earthquake hit, close to 80% of Haiti's public services were delivered by the humanitarian and NGO apparatus (Edmonds, 2013). When I spoke to Johnathan Katz, the journalist responsible for breaking the story of UN responsibility for Cholera, he also summarised the world's obsession with saving Haiti in the simplest of terms: '*it always seems like Haiti is a place where people go to earn their stripes*'. People, in this case, being the global health and development industry. Many of the world's most well-known development and humanitarian organisations have worked in Haiti for many years. MSF, Save the Children, Care International and other organisations work alongside multilateral organisations such as the World Bank, WHO, as well as public private partnerships such as Digicel Foundation.[4] There are also countless smaller organisations that you may have never heard of. A revolving door of agencies and actors who arrive with one crisis and leave before it is finished. As Greg Beckett noted in his work describing his time in Bel-Air one of the hardest hit parts of Port-au-Prince after the earthquake:

> *About a month before my visit, a European NGO had come to the area to build several public showers and latrines, but they left only a half-finished structure. When it was clear they were not coming back, camp residents took apart the structure to use the wood to secure their new, temporary homes.*
>
> (Beckett, 2017, p. 226)

Interventionism by the United States and United Nations Peace Building missions have shaped life in Haiti throughout the 20th century. This clear form of governance through paternalism and patronage is linked directly to the ideas we discussed in Chapter 4[5] – and has made it almost impossible for the deep and large-scale development gains needed in Haiti to be achieved.

For example, in their recent accounts of peacekeeping missions installed in Haiti throughout the 1990s, Lemay-Hebert outlines a problem of too much governance emphasising peacekeeping to the exclusion of other areas of meaningful development. Technocratic approaches to state building established by successive rounds of security reform and peace keeping missions such as: UNMIH, UNSMIH, UNTMIH, MIPONUH and MICAH,[6] largely ignored the structural challenges facing Haiti. The primary goals included the achievement of security-related benchmarks such as number of police officers trained, or numbers of arrests made. Three of these missions were focused specifically on training the national police service; and has been noted by Michel Trouillot (1995) as a complex process resulting in

many who participated in violent insurrections by formerly ousted governments being folded into new police infrastructure (Trouillot, 1995; Muggah and Diniz, 2013).

While this emphasis on legal and militarised forms of disciplinary power persisted, action on the remaining indicators of development and wellbeing were left to the NGO industry, presented by many as somewhat incompatible with long term development. In 2011 when Cholera had claimed an additional 220,500 lives, a coalition of 40 Haitian organisations had decided they had enough. They called for the dissolution of the Haitian Reconstruction Committee which had organised collectives of NGOs working in response to these dual crises stating that:

> *The Haitian society continues to be locked into the same traps of exclusion, dependency and ignorance of our strengths, our resources, our identity … the structures of domination and dependence have been reproduced and reinforced by the constellation of agencies, including MINUSTAH, IHRC and large International NGOS.*
>
> (cited in Edmonds, p. 440)

These sentiments were felt countrywide culminating in the landmark legal battle between Haitian citizens and the UN. Led by the Institute for Justice and Democracy in Haiti (INJH), a coalition of 5,000 citizens and activists made numerous attempts to seek reparative justice for the impact of the Cholera epidemic. Their desires included demands for the installation of a national water and sanitation system in the country to control and prevent future epidemics, alongside individual compensation for victims.[7] In 2013, after the initial claims were denied, the IJDH filed a class action suit against the UN, on behalf of people injured or killed by Cholera.

In many instances, international law is often a proxy to maintain and secure access to human rights in more restrictive states. However, in this case, it was not possible to leverage this normative power to effect change, as the UN mobilised and utilised other legislative domains to maintain their innocence. For example, in Mara Pillinger et al.' (2016) scathing account of the UN and its response to the legal charges facing them at the time, she notes that the UN approached this issue as an incidental consequence of their peace keeping mission. By relating events to the formal public-political authority of the organisation, they denied individual actors grounds for public recourse (p. 5); marshalling the platform which provides the UN with immunity.[8] Normative power is described by Shiffman as a form of power held by actors that provides the ability to determine what is 'right', and what ethical principles should be followed to drive action (Shiffman, 2015). The UN perhaps more than any other multilateral institution, has the ability to mobilise this power . And in this context, they created a narrative that ultimately distances themselves from blame- leveraging their positionality as a moral actor within the global health space.

Pillinger (2016) notes that the UN provided a necessary but insufficient factor to accept blame for damages, noting that introduction of the cholera outbreak could not have happened without the existence of water and sanitation deficiencies that turned an environmental contamination into a widespread outbreak. Their negotiation within the disciplinary domain contributes to denial of action in a critical structural arena that would ultimately turn life around for people in Haiti: the construction of a waste and water management system across the country. While they attempt to address their moral responsibility through Track 2 and small projects of change in communities, the boundaries of the response were determined prior to community engagement. In reality, the structure of what is possible for communities was decided long before they were given the opportunity to imagine it.

Hegemonic domain: The enduring power of an idea and what it means for health in Haiti

Running contrary to the dominant stories told about Haiti is a remarkable history, which reads like a fairy tale to scholars in the Black Diaspora. Speak to the right people, and they will tell you of a people who fought for their right to self-determination, engaging in a war that ended slavery and established the first country led by free Black people. Haiti was the first nation to successfully bring to an end colonial rule; well before both the French and American Revolutions (Trouillot, 1995).

Yet over two centuries, the public narrative of Haiti has been distilled to be one of failure, instead of triumph, of dependence, instead of independence. Professor Greg Beckett, in his book *There Is No More Haiti* (Beckett, 2019), explores the modern idea of Haiti as perpetually in crisis, not from the vantage point of external actors and agencies, but through the language and perception of everyday Haitians who survive crisis. '*One real problem facing Haiti'* Greg tells me over Skype, while sat in front of a wall of unintentionally intimidating books in a comforting Canadian accent which reminds me of home, *'The idea of Haiti belongs as an exception. This perpetuates the idea that Haiti is a place that will always be in crisis – and that without an [global] imagination of Haiti beyond that, there is no real goal or target to work for change'*.

With such a statement, Greg invokes work of Haitian Scholar, Michel-Rolph Trouillot, a historian whose work should be better known in the global health field, particularly for those who seek to study the workings of power. According to Trouillot, our ability to understand the world and those within it, is anchored to the histories we are told, but beyond that, the ability for *certain* histories to be told in the first place. In his book *Silencing the Past*, Trouillot challenges the reader to re-imagine Haiti as a product of the complicated histories that contain it. His widely acclaimed work demands that we acknowledge that the truths, wisdoms and historical facts existing within our cannon of knowledge, are mediated by and through

power. Critically, this power has the ability to determine not just how history is produced, but what historical accounts emerge and are sustained; what voices are heard or erased within historical accounts. Thus, history and historical fact is as much about what is written, as what is not, and these silences have the ability to shape how we come to see ourselves and our relationships to a place, space or environment. As he notes his introduction:

> *Silences enter the process of historical production at four crucial moments; the moment of act creation (making of sources) the moment of fact assembly (the making of archives the moment of fact retrieval (making of narratives) and the moment of retrospective significance (the making of history).*
>
> (p. 26)

In this case, Haiti's history as a revolutionary power and leader in the late 18th century, through the *production* of history, becomes a narrative that is unthinkable. While we lack the space to give a full account of the Haitian revolution within this chapter, even the simplest summaries will paint a picture that is deeply contrary to the one conjured by current development and global health epidmiology and discourse.

In the 18th century, Haiti, then known by its colonial name, Saint-Domingue, was widely known as the jewel in the French colonial crown. It was the largest exporter of coffee and sugar in the world and the most profitable colony in the Western world (Trouillot, 1995). This was enabled by its parallel record in the number of slaves it held – housing more enslaved Africans than most colonies in the region, including the United States (Britannica, 2020). In August 1791, mistreatment and harsh labour enabled by French law which allowed the abuse of slaves led to a widespread revolt, with resisters from individual plantations collaborating under the under the banner of Toussaint L'Ouverture. After his death, Jean-Jacques Dessalines assumed leadership of the revolution, and defeated the attempts of the French to restore slavery in the region. Independence was declared in 1804, and they renamed the country Haiti (Ayiti), in homage to the indigenous peoples murdered by successive waves of Spanish and French colonial powers.

Gurminder Bhambra (2016) notes the ability for history to all but eradicate our ability to understand how the Haitian revolution exists as an origin story for modern-day notions of equity. Their declaration of independence and subsequent constitution was rooted in an understanding of citizenship that not only ended slavery but also unlinked citizenship from race or ethnicity. It identified all Haitians as equal, including white migrant Polish workers who were brought to Haiti against their will by Napoleon's armies, who later defected. Bhambra (2016) positions the revolution as the most radical of the time, and as a result, the most dangerous. When Haiti called for an end to slavery everywhere, other revolutions unfolding elsewhere in the United States and France had no such interests, and extended freedom only to white European descendants. In France, it maintained inequalities linked to race.

Trouillot's wider historical analysis of the revolution (1995, p. 82) also points to the normative and cognitive frames circulating in wider society at the time of Haitian independence that underpinned these actions. Slavery was presented as a common and undeniable fact of life. His work traces a process in which the rebellions of Black people, which existed both in Haiti and elsewhere long before the revolution, are understood and accounted for within paradigms of maladjustment, illness or madness. This becomes an example of the fact that it was impossible for the world to understand the resistance as something to be revered, acknowledged or celebrated within the wider context of the world.

One cannot imagine, what one cannot visualise. Among European populations it could be argued that there were no cognitive framings or foundations (See Kulinski, Luskin and Bolland 1991 for a discussion on cognitive frames) to enable the possibility of seeing Black people as capable of driving successful social change. In social psychology, knowledge is argued as embedded within the social fabric of everyday life. According to Sandra Jovchelovitch (2007), its production, though anchored to power within the social field, comes to represent what is seeable and knowable in a particular landscape, as well as the possibilities for action. This is particularly valuable in linking knowledge about the world, to the realm of action and possibility in global health, and elsewhere. For example, evidence of this relationship emerges in the generation of biological knowledge systems that link specific types of disorder to the presence of Black agency at the time, in the United States. In the Southern United States, the labelling of runaway slaves with a form of mental illness called Drapetomania was widely applied to account for adverse behaviours (Fernando, 2010). Recent work by Jarman (2011) also highlights the wide use of the diagnostic category of 'hebetude of mind', and among plantation owners, 'rascality'. With the latter, Jarman's quotation of the scholars who established the term are nearly intractable evidence of Trouillout's claims:

> *According to unalterable physical laws, Negroes as a general rule, can only have their intellectual faculties in a sufficient degree to receive moral culture, and to profit from religious and other instruction when they are under the compulsory authority of the white man.*

The Neoliberal logic that underpins much of interventionism is predicated on this imaginary of the 'suffering' faced by Black and Brown bodies. This imaginary idea that formerly colonised countries are unable to decide for themselves the course of action is as ever present as always and contributes to the deluge of interventionism that Haiti has faced. Paul Farmer (1994) identifies this as the branding of Haiti as the 'nightmare republic' (p. 226), portraying an idea of Haiti as the only sovereign state led by Blacks, as incapable of self-rule. The colonial project across the rest of the west, depended on the failure of Haiti. So, the symbolic and normative ideal that pervaded at this time helped to give

credence to this and bore the same tonality as the narratives used to justify management of slavery noted above. As Farmer noted, writing at the time served to strip the Haitian narrative of humanity, emphasising:

> British Envoy Sir Spenser St. John set the tone in his memoir of Hayti or the Black republic: '*I know what the Black man is, and I have no hesitation in declare that he is incapable of the art of government'* … He delighted his audience with tales of voodoo and cannibalism.
>
> (Farmer, 1994, p. 228)

These ideas of Haiti as the exotic, the dangerous, the ungovernable, aren't totally gone. In 1983, CDC's guidelines about AIDS named Haitian people as carriers, alongside homosexual men, haemophiliacs and intravenous drug users. While the evidence for risks faced by the latter three was present at the time, there was nothing to specifically suggest that Haitians were more vulnerable than others. As a result of this policy, many Haitians who fled violence in the 80s and 90s in search of asylum in the United States experienced horrific treatment and vilification at the hands of the government (Farmer, 1994), including violations of human rights at refugee camps.

Today, the afterlife of these ideas persist, though perhaps in muted tones. In my discussions with Johnathan Katz, I inquired about a particular quote in his book. It was a statement by a former UN official, who at the time was fairly high ranking within the country. When reading it I couldn't comprehend that something would be so blatantly stated in public to a journalist, for context, an excerpt from this section in Chapter 11, *A Gut Feeling*:

> *It was immediately apparent that the soldiers had literally covered up the most incriminating evidence, most notably the smell … He stood by helplessly as they admitted to having undertaken repairs on the eve of our visit, including replaces the broken PVC pipe from the back of the base … One pipe was held together with what looked like electrical tape. In the river below, where the canal let out, a soupy brown mixture bubbled along the bank. "It – it does not mean it is from the base" he said. 'The people here, they swim in the river' … He pointed to the swimming man 'They – you know how they are'.*
>
> (Katz, 2013)

I shared my incredulity with Johnathan.

> *He said it! I have such a vivid memory of him saying this. But it was so matter of fact. Ironically, I couldn't find the exact quote, so I made sure to get it fact checked with him directly before I published it. And when my researcher called to make sure that was what he said – he doubled down. He stood by it*

These colonial hangovers that still shape cognitive framing play a clear role in the narrow and limiting discourses we hear about Haiti. It has become an internal

narrative too – one where symbolic power held by financial elites have also contributed to the hollowing of the state, and challenges faced by the people in the country.[9] The most notorious of these stories are embodied by the Duvalier Regimes, their collusion with, and maintenance of US interests, and intervention. During their nearly 30-year rule, they provided platforms to enable foreign investment, with low taxes, banning trade unions. The regime presided over mass migration of the professional and political classes, and the murder of an estimated 60,000 suspected progressives and communistis. After their removal, successive interim governments maintained the support of international actors, through the implementation of structural adjustment policies, which further liberalised and opened the economy to foreign extraction.

When Jean-Bertrand Aristide was elected to the Haitian presidency in 1987, he did so through leveraging a narrative rooted in a different imaginary of Haiti. One rooted in the early history and promises of its constitution, to use this imaginary as leverage, and enact a different vision of Haiti. According to Dimmy (2016), Astride was the only ruler who viewed everyday citizens as agents and called for them to act as such, instead of subjects, in the process of creating a new Haiti. As noted by Edmonds (2012), his view of the true capacity of the Haitian people was most powerfully symbolised through the historic claim for France to return the value of reparations paid for their independence – in current value – $21 billion. However, his struggles in actualising this knowledge system reminds us that when understanding this domain, we must never forget the wider structural and disciplinary forces of power at work.

Interpersonal domain: Resistance, rejection and hope for a different future

The interpersonal domain of power calls us to continue this acknowledgement of how the other domains shape the ability for others to act. It also drives us towards an understanding how hegemonic and structural systems also feed into the views that people hold of themselves. The latter has been argued as key in supporting the widespread mobilisation of citizens for change, by critical scholars in the social and health sciences ranging from Paulo Freire (1970) to Catherine Campbell (2014). In the case of Cholera in Haiti, we can see this clearly. On the one hand, mass mobilisations in the streets at the start of the epidemic displayed the capacity of local actors to understand the sources of their oppression . Long before the UN accepted its 'moral responsibility', everyday citizens were aware, and mobilised, to ensure the world knew about the UNs role in the outbreak. As noted by Beckett's work, there is a longstanding fatigue and rejection of international intervention in the country by local citizens, illuminated aptly by a quote from his recent book:

> *We pulled to the side of the road. Flore smoked a few cigarettes and just looked at the camp. Eventually she stood up and said "I can't believe they're fucking here again!" she*

had lived in the United States … she had no problem with Americans, but she could not stand to see their military occupying her country again. "All of this … all of it has to go! Just leave us the fuck alone".

(Beckett, p. 222)

A belief in the capacity for local power to drive change is the cornerstone of track 2. When we started this chapter, accounts suggested success in response to the crisis was possible; when given the chance, local people mobilised to build more meaningful and long term responses to the cholera outbreak, on their own terms. All they needed was the structural infrastructure to do so. And arguably, this type of response would not have happened, without the work of activism and the launch of the class action suit against the UN in 2013. We can't know for sure of course, but the clear ways in which this response diverges from efforts of the past suggests that without local resistance, track 2 may not have existed.

The value of resistance to global health interventions cannot be overstated. In his work on hidden resistance, James Scott (1990) advances arguments that draw attention to the danger of hegemonic ideas about people's awareness of their own to cloud our ability to recognise subtle power at work. It is often the case that in our efforts to promote change we ultimately silence the everyday sites of action and resistance at work in the microcosms of people's lives. Guillaume *et al.* (2019) emphasise this in their own accounts of people's lived experience, noting how people manage in the absence of functional state apparatuses:

There are people who dug pits themselves and use it to defecate … sometimes, people use the state as an excuse; but really you must help yourselves. By the time to cover the entire country of Haiti ***– what kind of state would be able to****?*

(p. 6, emphasis added)

However, the second half of the quote also illuminates how individuals can start to accept state failures as given and unchangeable. One of the clearest ways these psychologies manifest is in the form of acceptance of the status quo, or the acceptance of individualised narratives of risk and responsibility in the global health landscape. Further participant quotes from Yodeline Guillaume (2019) illuminate what this may look like in the case of Cholera narratives:

Cleanliness is good, because even though there were a lot of people in my compound, only one person had the diseases, because people always took their responsibility, always cleaned their hands and bodies.

The danger of the individual risk and responsibility narrative is that it erases all of the structural, disciplinary and hegemonic systems of power that establish the risk in the first place. What you are left with, is the above – which amounts to the

impossibility of imagining a state that is able to provide for its citizens. The truth is, all over the world, states, particularly those that benefited from colonial and neo-liberal economic systems, are able to provide safe and healthy water and sanitation systems for their citizens. Countries whose development trajectories were not interrupted by countless foreign actors, are able to provide for their citizens. This is not to say that in the absence of colonial intervention perfection lies - as inequality is a function of more than structural oppressions. But the problem is that we will never know for sure. This is perhaps the biggest discomfort within the global health field – that when we look at a problem in the way we have done in this chapter – we can see the intractability in all its confusion. But we can also see a way out; structural infrastructure investments – for a start – and these ways out are always visible to everyday people themselves.

Conclusion: There is always a way

When exploring the issue of Cholera in Haiti, an application of the full matrix of domination illuminates critical insights. First, it shows us the value of working with local communities – as happened in track 2 – to develop solutions. However, in order to act meaningfully on those solutions, particular perspectives must be taken to create an enabling environment for change. The international community must understand the power of hegemonic ideals, and how they work in ways that limit their ability to value and respect local knowledge . In Haiti, this manifests within the disciplinary domain rooted to notions of emergency action, funded and fuelled by short-term external organisations and systems that overlook the importance of structural development. Finally, the international commuinty must acknowledge the ways that structural violence, rooted to the payment of repatriations to France – has resulted in the development of a system that will be perpetually locked in cycles of crisis without repair.

When combined, all these factors and forces limit our ability to engage in the activities that would actually reduce the cycles of crisis in Haiti. Without that shift, we will remain locked in a cycle we cannot escape; and yet we must.

Of course, there are groups within Haiti who are working with this vision of self-determination. In every country, there always are. There are community-led organisations, like the Economic Stimulus Projects for Work and Action (ESPWA),[10] grounded in *community-led* action, whose aim is to build the long-term capacity of community actors, and other Haitian organisations. By focusing on transformation projects, defined and actioned by communities, they tackle the core socio-economic power inequalities that place health at risk. In my communications with their director, who I invited to teach on a previous course, they argued that their work was not directly health related. I tried to change their mind – because health in Haiti was only possible through action and efforts like those driven by ESPWA.

What organisations like EPSWA reminds us, is that when given the opportunity for self-determination, communities have the capacity to write and build their own

visions of change. In saying this, I don't suggest that all responsibility for change should be devolved to the ground in its entirety. As suggested by Camara Jones' (2000) in her work on racism and health, powerful actors always have a responsibility to turn their attention to the historical insults that create the inequalities that people live through across generations, and answer for them.

This chapter illuminates the inability to dismiss historical insults in the face of a contemporary crises. Global health is by definition a discipline that seeks to respond to insults, sometimes without naming them. In the cases when it does name them, the responses still bear little resemblance to the type of repair that is needed. The consequences of this cycle we find ourselves in are dire, and will continue to be where organisations like ESPWA are the exception, rather than the rule; where efforts like Track 2 are hidden from sight, instead of celebrated, and funded – as best practice.

The final chapter of this book begins to explore a possible pathway through which global health can change its stripes, to embody the views and actions like ESPWA and move beyond the discomforts of its past, and present. A pathway that begins where the UN tried to in Track 2, with putting multiple forms of power back in the hands of communities.

Notes

1 Water, sanitation and hygiene.
2 See http://mptf.undp.org/factsheet/fund/CLH00, last accessed October 2021.
3 Estimated costs for a solid waste management system for a similar sized population, range between 3 and 5 million CAD, Burgess-Small, BASc, Personal correspondence.
4 This is the charity arm of Digicel Corporation, which is the largest Caribbean-owned mobile company that operates across the region.
5 See discussions on paternalism in public health and humanitarian praxis more widely (p. 78).
6 Acronyms are as follows: United Nations Mission In Haiti (UNMIH), United Nations Support Mission In Haiti (UNSMIH), United Nations Transition Mission In Haiti (UNTMIH), United Nations Civillian Police Mission In Haiti (MIPONUH) and International Civillian Support Mission In Haiti (MICAH).
7 These particular claims were the foundations for track 2, when the UN accepted moral responsibility for the pandemic.
8 In summary, the rules state that the UN and its delegates *are immune from every form of legal process, except insofar as in any particular case it has expressly waived its immunity*, which is granted in the territory of each of its members. See Pillinger (2016, p. 6) for full details.
9 Haiti's struggles cannot be left entirely the determination of external forces. For example, Trouillot 1994 piece is a scathing account of how the existence of class structures within Haiti follow the remnants of the colonial systems initially following emancipation, and even today. For example, the military powers who worked so hard to free its people immediately adorned themselves with labels such as 'general for life' (Matthewson, 1995). Under the first presidents of Haiti, the plantation economy was attempted to be restored, establishing a ruling urban elite and rural peasants who opted for share farming on small crops of land claimed from abandoned plantations. Taxation systems taxed the poor mercilessly. For example, taxes from markets where peasants sold their agricultural outputs provided upwards of 90% of government revenues in 1842, and by 1891, import

and export duties accounted for over 98% of state revenue (Trouillot, 1994). What worse, import taxes were high on food and necessities including flour, oil and candles, rather than tax luxury items consumed by elites. For Trouillot, this symbolised an active choice of Haitian elites to maintain their lifestyle over contribute to the aims of the revolution being achieved for the masses.

10 See https://www.espwa-haiti.org/ for more details on the work of this organisation.

CONCLUSION

A future better than our past in global health

The first real global health book I read was Catherine Campbell's book called *Letting Them Die: Why HIV Prevention Programmes Fail.* In its pages, she recounts the complexity behind the failure of a 'gold standard' intervention at the height of the HIV pandemic: peer-led health promotion programmes. The pillars of these programmes – health education, STI testing, free condom distributions – remain highly valued standards across the global health landscape (Thompson *et al.*, 2022). However, the programme in South Africa at the heart of the book was far from successful. Challenges revolved around power at work in ways similar to what has been described across the pages of this book. For example, a lack of appreciation of historical contexts that embed power inequalities and silence the voices of particular groups of actors (as shown in Chapters 2 and 5). Intervention approaches that medicalise (Chapter 3) or minimise (Chapter 4) the social and political contexts that maintain health challenges in the first place. In fact, many peer education programmes of many shapes, sizes and stripes continue to struggle to succeed for these reasons. For example, challenges facing peer support interventions in LMIC contexts relate to the structural barriers that limit their wider access to economic stability – and many peer programmes rely on volunteerism (Mpango *et al.*, 2020).

In reading that book many years ago, I found solace in knowing I was not alone in my rage. Much of that rage remains; and provided the foundations for this book some 14 years later. For in those 14 years very little has changed. And yet, they are not quite the same, as the global health field is in the midst of a long overdue reckoning. COVID-19 has spurred a series of high-profile pieces in leading health journals, like *The Lancet, BMJ, Nature* and others. Suddenly they became spaces of critique in a way made me feel – that 'the jig', as they call it, was up. But nothing of what they were saying, felt overly new to me. I had read much of this before; in the pages of *Letting Them Die,* it was all laid bare. If we wanted to end HIV, we would

need to reduce the social inequalities that undermine good health and the life chances of those most vulnerable. We would also require political will to do things differently, a willingness to learn from mistakes. As Campbell notes in her concluding chapter writing at a time when HIV was approaching the peak of its grip on southern African nations, particularly South Africa:

> *In the HIV field, there is currently a great deal of concern being expressed by countries to the North at the thought of all the suffering the epidemic has caused. This has been accompanied by efforts to raise large amounts of money for the fight against HIV-AIDs. However here again, the problem is often conceptualised as a biomedical and behavioural one, rather than a social one … it is located 'out there in Africa' rather than being framed within the context of the wider global processes that impact on health and health care in Africa, in which the international community is deeply implicated … the same mistakes are made again and again.*
>
> (Campbell, 2003, p. 193)

In response to the continuation of the COVID pandemic, a new generation of critical global health scholars is now singing an almost identical tune in calls for an end to vaccine hoarding by rich nations:

> *Policy-makers in rich nations are aware of these issues. But the solutions they have proposed so far do nothing to address the underlying structural problems. They offer charitable donations and partial, temporary fixes that are designed to deflect the substantive demands for reform that global South countries are fighting for, including challenges to unethical intellectual property (IP) regimes. This approach will not work, because it is not designed to 'work'. If we want to end vaccine apartheid, we need to target the root causes of global health inequities. We need reparative justice.*
>
> (Harman *et al.*, 2021)

So the question remains, why are we still asking for the same things? At the start of this work, I suggested that this is becaue our theorising of power in the has often been incomplete. Recent work by Topp *et al.* (2021) affirms this and attempted to provide us with platforms to integrate power into health systems research. But for the most part, grappling with power has been siloed; Across the breadth of our field, we can name power – identify where it works. What we do less well is recognising the power at work in the everyday lives of citizens to resist the work of power and its many forms in their lives. In this book, we have seen the impacts of this misrecognition. The level of communities feels absent from many frameworks.

Each case study presented in previous chapters are examples of what happens when the voices of communities and everyday actors are absent from spaces driving global health action. In Chapter 2, the academy – embodied by publication processes such as commissions – operates in ways that have important, but parallel unintended consequences on the lives of the people for whom the work is conduced. In Chapter 4, the downstream consequences of humanitarian and

emergency discourses bring investment that despite good intentions can leave communities less prepared for subsequent waves of crisis and emergency over time. In Chapter 5, Haiti emerges as a case where you cannot understand difficulties, without thinking about how power has worked across time and various domains to create a space that only supported citizen action can navigate. These case also draw us closer to the lives of everyday citizens, illuminating opportunities for innovation, acknowledging that there is power in the minutia of everyday worlds.

In the introduction, I suggested that we could best understand power at work through models that drive complexity in our analyses, and proximity to everyday citizen experience. This is a necessity created by the fact that the people who global health seeks to support are also actively negotiating these matrices of domination. Chapters also gave examples of how our disciplinary orientations can at times perpetuate systems of domination. Elsewhere, I have argued that this is the biggest problem global health faces – the need to acknowledge that it is a disciplinary landscape that must work in the wake of the worst realities produced by power distribution globally (Burgess, 2022). This wake is structural: global economic and financial systems which perpetually disadvantage the poor. The wake is hegemonic: systems of belief that maintain beliefs in the inadequacies of local knowledge systems. The wake is interpersonal: individual acts of violence driven upstream by structural violences. In that work, as here, I suggest that solutions can only be found through meaningful engagement and the application of frameworks that centre those who live through this wake. Their knowledge, truths, and action.

In the past, I have found some of these solutions in community psychology. As stated in the introduction, community psychology is a discipline rooted in a deep and longstanding respect for the capabilities of everyday citizens, service users and local actors. Respect for the people in whose lives we intervene. The people who have been denied the chance to speak. If community psychology potentially drives us to understand how to work through, and re-distribute power, then perhaps it is also a space to imagine better ways to respond to Bumi, and the millions of women like her, who consistently ask: *if I speak, will you hear me?*

If community psychology has any hope for responding to the voiced needs of everyday actors – it should coalesce with the global actors who have called for the redistribution of power across time and space. In the following section, I draw on scholarship from decolonial writers and thinkers, largely from the African continent to see what hope this disciplinary frame provides for guiding scholars and actors within the global health space towards new horizons.

The matrix of domination undone? Community psychology as panacea for responding to global health challenges

What is perhaps most important to take away from the matrix of domination is the space it gives to position actors who are often excluded and labelled as oppressed, as

knowing actors within their own lives (Collins, 2009). Too often in global health, we overlook this resistance and power present in people's lives because we lack the frameworks that would enable us to see it; because power in many forms works to obscure it. This is where the scholarship of liberation theorists have so much to teach us, in not only recognising this erasure, but finding a way forward. Liberation activists from the African continent, such as Thomas Sankara (2007), have put this in clear and uncertain terms; a clarity which many argue lead to his demise. In speaking to the United Nations in 1984, he spoke of the dangers of interventionism, and the ways even well intentioned engagement contributes to the silencing and limitations of local power:

> *It must be proclaimed that there can be no salvation for our people unless we decisively turn our backs on all the models that al the charlatans … have tried to sell us for the past twenty years … . There can be no salvation … . no development without breaking that … Far be it from me to ridicule the patient efforts of those honest intellectuals who, because they have eyes to see, are discovering the terrible consequences of the devastation imposed by the so called specialist in Third World Development. The fear haunting me is that the fruit of so much effort may be commandeered by Prosepros of all kinds to make a magic wand, designed to return us to a world of slavery redone in the fashion of the day.*
>
> (Sankara, 2007, pp. 63–64)

To avoid this, he asserted the necessity of resistance among African peoples, and a shared southern political project that was no longer in the shadows, but in the foreground of social and public life.

> *We [Burkina Faso] want to place ourselves within this world, without leading any credence to that gigantic fraud of history … we want to assert our awareness of belonging to a tricontinential whole and … acknowledge … . That there is a special relationship of solidarity uniting the three continents of Asia, Latin America and Africa in a single struggle against the same political traffickers, the same economic exploiters … . We swear, we proclaim, that from now on nothing in Burkina Faso will be done without the participation of the Burkinabe. Nothing that we have not first decided and worked out ourselves. There will be no further assaults on our sense of decency and our dignity.*
>
> (Sankara, p. 63, 69)

Paulo Freire notes the impact of this blind spot to our projects of change in relation to others within the western world in his work *Daring to Dream: Toward a Pedagogy of the Unfinished* (Freire, Macedo and Freire, 2008). Here, he notes that when actors are driven by an interest in promoting change, they may fail to notice the changes that are already in progress. This simple oversight carries implications that are far reaching – in global health, they colour our most devastating and often repeated mistakes, many of which fail to be recognised as mistakes to begin with. Most recently, we see this in the case of the COVID-19 pandemic and the fight for

vaccine equity; calls for waivers on patents which would allow autonomy for the hardest hit countries in the global south, fall on deaf ears; in the exact same way, they did for the first decade of the fight for equitable access to ARV medications. In the everyday practices of global health, we also see this most plainly in the erasures of everyday knowledge described in previous chapters. As Bhakuni and Abimbola (2021) remind us, global health as an academic sphere/space is littered with practices that work as forms of epistemic violence in the lives of global health researchers, practitioners and citizens in the global south. Specifically, interpretive injustice that limits the ability for certain voices to be heard, valued and shape knowledge production processes in meaningful ways.

This is not simply a problem of the academy – as it operates a pipline through which evidence, interventions move from the pages of journals to the real world. This pipleine also becomes a mechanism though which we fail to notice what is already at work. As highlighted throughout this book, when knowledge is produced ways that exclude everyday voices, the programmatic response are also reflective of intepretive injustice. When a programme for cholera ignores poverty; or a gender and health programme underestimates the social value of an anti-feminist practice of bride price to a woman's ability to leverage respect and power in her daily life; this is unjust. In truth, those with the greatest credibility deficit (where lower value is attributed to a speaker's word, through processes that silence, undervalue and distort their contributions and perspectives) are everyday people in marginalised settings. How is it possible to escape these narratives within a modern global health when, at its core, it is still rooted in a relationship that assumes a cognitive superiority over people at the receiving end of aid and health programmes, and the countries where they delivered?

Freire points us in a direction to overcome this, through his *pedagogy of desire*, where practitioners and actors work to create spaces that enable the illumination of the contexts that lead us to accept particular realities as given, and turn towards supporting actors in a process of reconstructing wishes and desires by questioning the fatalistic perceptions of their current circumstances. Or perhaps more simply put, a pedagogy where individuals and societies come to recognise how they already utislie power at work in their own lives and how they can participate in the creation of new realities, and achievements of their dreams.

Community psychology, is highly influenced by Freriean principes. As such, the methods of the discipline provide an opportunity to create exactly these spaces of desire, and importantly, the production of new possibilities. In their introductory book to community psychology, Nelson and Prilleltensky (2010) highlight that central to the operation of the field is a commitment and passion to emancipatory work, with a core tenant as working in solidarity with disadvantaged people, in order to accompany them along their own quests for liberation and wellbeing. Community psychology, then, is formally defined as a sub-discipline of psychology that:

> *… is concerned with understanding people in the context of their communities, the prevention of problems in living, the celebration of human diversity, and the pursuit of social justice through social action.*
>
> (p. 23)

Community psychology shares an allegiance with critical psychology, sociology and activist versions of anthropology. But beyond that, it is interested in processes of health that connect it to the idea of community and diversity of environment, action and thought.

Community psychology feels like a fair place to start as within global health there is a long-standing fascination with the idea of community. The term is littered around countless policies, practices and programmes. It underpins notions of primary care in Alma Ata; it is positioned as a locus of action in achieving sustainable development goals; it is the gold standard for ensuring acceptance of programmes across various locations. If you enter the term community into the search engine of the WHO, it produces over 800 references to reports produced in the past *two years alone*.

But its longevity also makes it a strange place to pin our hopes; surely if this were the way to go, we would have seen changes already? The absence of change, is in reality, due to its position as a term that is among the most misused the field, one which lacks an agreed definition or form. Typically commuity is referred to as an entity that unites individuals across cultures, identities or physical location. Elsewhere I have argued that the contested nature of the term has allowed it to be used as a platform for quite varied forms of action within global health, typically united by an interest in health promotion or intervention (Elias, Singh and Burgess, 2021). For example, community-owned interventions, community-based interventions, community engagement or community participation in intervention design all invoke the idea of a unified collective of individuals participating in health improving action and activities.

This is part solution, but also part illusion. As Cornwall and Eade (2010) suggest in their work on discourse in international development, community is a term that has become so benign that it garners wide range appeal, because it elicits a warm response; generating an automatic approval linked to a 'feel good' factor (p. 5). It is synonymous with the ideal of 'local'. And it is in this parallel that the word begins to lose its power. In the same way, community like the 'local' is thought to mean everything, and nothing; it covers a multitude of sins, where community and stakeholder engagement occurs at each stage of a global health project, without the local vision of action or change ever being fully centralised into practice.

However, this does not mean that the community is a space to be ignored, but rather, that we must move our approach in the direction of the ways that more critical scholarship engages with this notion. Though often positioned as a static and geographical location in global health, critical, indigenous, and Black scholarship on community reminds us of its transformative nature. In his writings on Black

consciousness and liberation, Steve Biko was consistently drawn to the power of community. It was an opportunity to establish a foundation and backbone for the struggle to recognise Back humanity. It was also a mechanism to overcome the fragmentation that enabled varied groups of Black South Africans – Zulu, Xhhosa, Venda, Indians – to see each other as enemies, rather than as having a shared cause and experience of oppression (Biko, 1978). In his final work written before his murder, *Where Do We Go from Here?: Chaos or Community* (King, 2010), Martin Luther King Jr makes the same plea; for African Americans to realise their shared struggle not only with poor white people in the United States, but poor people all over the world; who share a commonality in the roots of their oppression, in the systems designed to break them and their spirit.

Black feminist scholarship from across the globe – and here I aim to include Latin American, and Indigenous feminists in a category of political Blackness – too recognise this power of community and the communal in ensuring health and survival. Audre Lorde's most famous quotes on community reminds us that '*without community – there is no liberation … but community must not mean a shedding of our difference, nor the pathetic pretence that these differences do not exist*'. What each of these approaches to community share is a passion for productivity – that community is an active site of transformation; of change; of hope. One that accepts difference, and works, not to diminish it, but to work with difference to produce new ways of being, thinking, living; to create the shared imaginary of an existence that is beyond what any one person currently experiences.

The importance of community processes to health cannot be understated; when we look at mechanisms for wellbeing, for example, all the makings of community are there. Countless scholars have shown that improved mental health, cardiovascular health, diabetes, HIV adherence, cancer outcomes are associated with markers of community, including social alliances, recognition, social actualisation, various forms of social capital. It is undeniable that man is social; that our health depends on it. What we struggle in the global health space, is the ability to recognise and elevate community as a site for transformation of the structural, hegemonic, and political dynamics of social life that sustain poor health.

As liberation and Black scholarship suggests – community provides a pathway to change, that shifts power from those who have it, to those who don't. This in some senses demands a redistribution of resources (work in the structural domain), but it is also, crucially, the elevation and crystallization of the need to recognise quiet work in the interpersonal and hegemonic domains; where ideas and everyday practice begin to shift in ways that do the slow work of community mobilisation (Campbell, 2014). If we advanced Global health as a praxis - which in my view, would be defined as a the method and work to reflect and act in the world with the aim to transform it (in line with Frerie (1972) definition of praxis): then community would always be the starting point, and the holding of complexity in our response, the goal.

This is where community psychology as a disciplinary platform may step in. Its praxis in its entirety, is rooted at transferring power, action and credibility to the

voices that are most often denied it. It appears in theory and practice to take seriously the works of Thomas Sankara and others – to ensure and avoid the capacity for a well-meaning actor to leave things worse than they found it; to disrupt and interrupt a natural course of growth and change that local communities engage in every day. It takes this stance within the space of research and everyday practice.

Table 6.1 presents my vision for a praxis of transformative global health. Using the initial categories of assumptions identified by Nelson and Prilleltensky (2010), it presents some basic assumptions of our field, the traditional dominant approach and the possibilities enabled by an alternative transformative approach to global health. This approach may help to move us in new directions that put an end to cumulative practices of 'letting them die',despite our best efforts, which feels to permeate much of this field to this day.

TABLE 6.1 TOWARDS A TRANSFORMATIVE GLOBAL HEALTH PARADIGM

Locations of assumptions and key practices	*Traditional global health approaches*	*A transformative global health*
Defining the 'problem'	Dominance of individualist philosophies (can result in victim blaming, separation of groups with shared adversities)	**Problems reframed in terms of socio-political context and diversity**
Focus of intervention or research	Dominance of deficits and problems – health challenges; resource deficits and gaps	**Competence and strengths as the orientation to support programming: there is no such thing as a tabula rasa**
Goals of intervention or research	Reduction of behaviours deemed 'maladaptive': reducing risky behaviours, promoting healthy behaviour	**Promotion of competence and wellness; illuminating structural barriers to healthy actions; establishing platforms for social action and new possibilities**
Role of 'client' or participant	Compliance with treatment regimens; compliance with interventions	**Active participant who exercises choice and self-direction; dictates the involvement of external actors on their own terms**
Types of research	Applied research based on binary assumptions research embedded within paradigms that contribute to interpretive marginalisation and silencing	**Participatory research & methods that highlight influence of context and complexity, and resist silencing, and co-produce outcomes along a trajectory of short and long term action for social change**

Nelson and Prilleltensky note that Transformative paradigms are rooted in alternative assumptions in three key areas: ontology, epistemology and methodology. In terms of its ontology (or perspective on what counts as reality), transformative approaches acknowledge that the real world is organised around institutional and social structures shaped by social, cultural, political and gendered relations advantaging some groups and disadvantaging others. Transformative approaches view epistemiology (knowledge) as co-created and formed by interactions between the researcher and researched; where all actors are aware of their positions in society; that starts with those who have been positioned as less powerful; and centres their experience as a central truth to be held and validated. In terms of methodology, it opts for dialogical and dialectic processes within research – findings are a work in progress, social action and participatory methods are used in effort to ensure accountability and transfer of power to oppressed groups.

These are contrasted to the assumptions and key practices listed in the left of the table, which present current pillars of the global health industrial complex. Each of these assumptions are imbued with various forms of power we have explored in earlier chapters. For example, d*efining the problem*, as noted in Chapter 2 on violence against women discourses, and Chapter 3, on global mental health interventions, was linked in part to agenda setting and discursive forms of power. When this process is situated externally to sites of local action, it leads to a series of actions and recommendations remain external to the needs of local actors and downstream recipients of support. This is the power of disciplinary perspectives, such as the epidemiological gaze, to contribute to silencing of particular types of knowing and acting among communities, which has recently been engaged with at length in the work of Eugene Richardson's (2020) *Epidemic Illusions*. The impact of a limited *role of the client* is also illuminated in Chapters 4 and 5. In times of crisis, when local actors are given limited productive spaces in response or determining their own fate; good action can be hindered; replaced by well meaning, but incomplete responses.

A transformative global health, underpinned by community psychology principles, shifts these assumptions towards a space of transformation, and begins to imagine a praxis that is person centred from start to finish. What is suggested in this table, is the need for us to develop language and praxis that moves beyond the identification of power at work in people's lives, towards mechanisms that change its distribution, through recognition of spaces where it works and operates. In a recent *BMJ* global health comment on the challenge of the white saviour complex in global health, Agarwal *et al.* (2020) highlight the importance of exploring how power works across the levels of a traditional ecological model (global, structural, interpersonal and individual), which shares an interest in complexity with the matrix of domination.

Though the work is pitched to one particular cadre of global health practitioner – clinicians, they identify specific actions that align to the role of professional as a scholar activist, akin to what we see in community psychology. Viewing their role as providing resources and opportunities for meaningful collaboration. In their argument, Agarwal and colleagues' suggestions for action at

global and structural levels acknowledge that downstream action is enabled and hindered by the presence of policy, but specifically, policy that identifies and creates room for diversity, rather than assumes capabilities based on historical positions. Here, we see the importance of shifting global health perspectives around goals, from 'finding solutions' to 'promoting the ability for others to make their own solutions'. It is the embodiment of taking power seriously from the top of the pyramid (academics, practitioners) to the bottom (communities and citizens).

So how might we go into putting this into practical action in the global health field? In this instance, it is important to remember two things: (1) that we live in an imperfect world, rife with human error; (2) that the course of change and justice is long. With regards to (1), I am referring to the fact that global health at scale is still largely driven by the interests of the few, the motives of economic power and the whims of philanthropists; who make errors that trickle down to the lives of others. This human error doesn't need to automatically trickle down throughout the rest of the global health infrastructure; new ways of working, new guidelines for action, can ensure that even within the limitations of short-term funding and shifting agendas; downstream actors have it within their remit to ensure that community power and strengths are centred.

For example, recently scholars have called for increased humility and accountability among global health researchers and actors as they engage in their work (Abimbola *et al.*, 2021). But humility is not an automatic process for everyone. Instead, we need to perhaps consider the value in operationalising such a practice. This would require the development of guidelines that demand a particular kind of introspection among actors with the most proximity to power within global health partnerships. In Box 6.1, I suggest six questions that researchers and practitioners across disciplinary orientations can use to guide their encounters within the global health space. They are adapted with permission from Professor Sunny Singh's work on storytelling, which she uses to guide stories that are respectful, honest and ethical. These questions explore motivations, and implications of work across power dynamics. The use of these questions in our field is is purposeful, as storytelling is at the heart of what we ask citizens to do within our research and intervention design practices.

Box 6.1. Humility and ethical praxis in transformative global health: six questions for ensuring more equal partnerships

1 Why do you want to do this project? What is your motivation?
2 What is your personal, emotional, psychological and ethical investment in writing it?
3 Can someone else do this project better? Is it your project to run? Who should do it and what would happen if you supported someone else to do it?

4 What does YOUR place in the project do? Does it replicate prior violence, oppression/injustice? Does it provide new understanding or insight?
5 What is your power imbalance as a practitioner/researcher in relation to the issue/context/setting?
6 Should you be doing this at all? What will it leave behind if you do it?

In accepting that the course of justice is long; I call on actors to remember that the changes we desire in this field do not happen overnight. It would be irresponsible to claim it as such; a slap in the face to those who have fought for justice and paid with their lives for hundreds of years. This book is littered with the words of people who have lived and died with a vision for changing the world. But this should not be an understanding that instils us with fear. Instead, it is one that calls us to hold close the truth that each of us exists at varied stages of access to various forms of power to implement change – and we need to understand where we are at any current moment to best understand, and acknowledge how we work to contribute to the arc of change we so desperately desire in this field.

Finally, all of the above, must come with a caveat. Community orientations to practice, which call for and sit within social justice paradigms, require complex work. Difficult. At times, painful. In the years, I have worked in the global health, I have been struck by the impossibility of many avoiding burn out in the face of what feels like insurmountable challenges. Working in global health is a huge Catch 22. People often go into it to change the world – and find that those aspirations fall hard and heavy on the reality of institutions, systems and the implicit power, politics and oppressions therein. I found the hardest part of teaching in this subject the past 10 years has been trying to prepare students for that. There is an emotional labour to responding to the same challenges over and over again throughout one's career.

To deal better with burnout, I think we need to normalise working across multiple levels of action. This takes to heart the arguments of Scott (1990) who argues that resistance and drives for change will always look different, depending on the capacity of the individual engaged in that practice and the space in the public sphere for that change to be heard. This is not to suggest that active visible mobilisation is to be overlooked, but to acknowledge that all of these forms of action are necessary in a quest for changing the multiple systems which help to maintain and sustain health-related inequality globally. I believe we can achieve this, as practitioners and scholars, by starting with, and centralising the question: 'what does our work leave behind?'

But beyond this, it requires an acknowledgement of the fact that change requires multiple actors, working at multiple levels, in different ways, towards a shared goal. Social movement scholarship increasingly recognises this, for example, calling to mind differences between loud and quiet activism (Gumbonzvanda, Gumbonzvanda and Burgess, 2021) or the importance of thinking about ecosystems for social change. For

example, Deepa Iyer (2018) articulates a social change ecosystem that includes 10 roles ranging from disrupters and story tellers to front line workers. Each of these actors play seperate but critical roles in path for change. Where might we be, if such roles were mapped out within a Transformative global health landscape?

In Table 6.2, I suggest a stagged approach to working towards transformation in global health, recently published in *BMJ Global Public Health* (Burgess, 2022). It seeks to keeps an eye towards the ideal world, while keeping a foot in the pragmatic everyday realities of those in engaged in this work. In this way, it reminds us of the ways in which those who are perhaps more vulnerable in the current infrastructure may engage in more quite forms of transformation and activism as part of a shared goal for change.

These suggestions are guidelines for how to achieve the aims of Mertens (2001), whose work on Transformative paradigms suggests that research, regardless of methodologies used, should begin with a desire to change the circumstances of those who are implicated in the work. Transformative paradigms thus take an epistemological position that the purpose of knowledge production is always starting from a place of inequality, and works to counter that through practical steps

TABLE 6.2 Achieving transformative global health in practice: three levels of value-driven work tocentre typically excluded and marginalised actors (Adapted from Burgess, 2022)

The dream – co-owned research with communities	*Where possible – co-design sharing responsibility of decision-making*	*At a minimum: inclusive methods and acknowledgement of contributions*
• Co-produced questions and research strategy (priorities and goals are set with the community) • Long timelines that allow communities to experience change • Transfer of power and resources is the outcome – building foundations for future independent work (if needed) • Impact occurs during the research process	• Co-design and shared practices of research/ project implementation • Open and flexible research questions • Action to ensure transferability and impact after the study	• Participatory methods used where research questions are pre-determined • Compensation and partnership systems that reflect understandings of local need • Reflection and action on transferability of outcomes
Likely actors in our current landscape: senior/protected academics at top of current power structures with flexibility to push boundaries	*Likely actors in our current landscape: mid-career academics locked within difficult systems, but some control over design*	*Likely actors in our current landscape: early career or precarious researchers with limited control over design*

to shift power; to move from relationships that are extractive, to ones that are about transference of power and resources. Crucially, this paradigm is not owned by particular methods. In fact, Mertens argues that mixed methods are an ideal route to promoting research with transformative aims, as it allows a diversification of data, stories and perspectives. The key is the extent to which certain actors namely those typically excluded from research and design are included in and have ownership over methodological decisions. In this way, we don't just reframe understandings of worldviews, but push this reformulation to how we choose to explore those world views. As they note in their work:

> *[R]eframing of methodological decisions leads to an inclination to use mixed methods with a conscious awareness of the benefits of involving community members in the data collection decisions with a depth of understanding of the cultural issues involved, the building of trust to obtain valid data, the modifications that may be necessary to collect valid data from various groups, and the need to tie the data collected to social action.*
>
> (Mertens, 2007, p. 220)

Within a transformative global health, the goal remains, as always, the problematising of the unseen, the acknowledging the capacities and power existing within groups that are studies; to move our inquiry and engagement with communities as recipients, to equal collaborators at a standard. And overtime, collectives of independent actors who work with external actors on their own terms. Had this been the orientation of actors in each of the case studies reflected on in this book; the story would have been different. We will never know for sure. Crucially, in working in this way, were Bumi to tell me that she had told researchers that she needed electricity – they would have worked to find it for her, and by the time I arrived, she would have explained how others were now working to make that a reality. It may have been slow, but it could have instilled a new form of trust between scholars, communities and a shared vision for change.

The book that brought me to global health ended with a phrase '*In the old South Africa, they killed people. Now they are letting them die*' (Campbell, 2003). The actions of actors, governments, people, in the years that have followed, feel at times, so close to this. It is my hope that we have learned enough to finally change that. It is my hope that the future of global health can become worthy of its aims – that we can look into the discomfort, and come out the other side, having built a vision of that new world so many dreamed of. That we, as the inheritors of the world's revolutions, find our way to staring power in the face and remembering our own. Remembering that we have the capacity to finish what they have started, as imperfect as it has been.

Until then, a luta continua.

REFERENCES

Abimbola, S. (2019) 'The foreign gaze: authorship in academic global health', *BMJ Global Health*, 4, e002068

Abimbola, S. *et al.* (2021) 'Addressing power asymmetries in global health: imperatives in the wake of the COVID-19 pandemic', *PLoS Medicine*, 18(4), e1003604.

Abrahams, N. *et al.* (2014) 'Worldwide prevalence of non-partner sexual violence: a systematic review', *The Lancet*, 383(9929), pp. 1648–1654. 10.1016/S0140-6736(13)62243-6

Abramsky, T. *et al.* (2014) 'Findings from the SASA! Study: a cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda', *BMC Medicine*, 12(1), p. 122. 10.1186/s12916-014-0122-5

Adams, C. M. (2006) 'The consequences of witnessing family violence on children and implications for family counselors', *The Family Journal*, 14(4), pp. 334–341.

Agarwal, A. *et al.* (2020) *The White Savior Industrial Complex in Global Health. BMJ Global Health Blog.*

Allen, T. and Styan, D. (2000) 'A right to interfere? Bernard Kouchner and the new humanitarianism', *Journal of International Development*, 12(6), pp. 825–842. 10.1002/1099-1328(200008)12:6<825::AID-JID711>3.0.CO;2-I

Anitha, S. (2010) 'No recourse, no support: state policy and practice towards South Asian women facing domestic violence in the UK', *British Journal of Social Work*, 40(2), pp. 462–479.

Artur, L. and Hilhorst, D. (2012) 'Everyday realities of climate change adaptation in Mozambique', *Global Environmental Change-human and Policy Dimensions*, 22, pp. 529–536. 10.1016/j.gloenvcha.2011.11.013

Aziz, M. M. and El-Gazzar, A. F. (2019) 'Health care providers' perceptions and practices of screening for domestic violence in Upper Egypt', *Sexual & Reproductive Healthcare*, 20, pp. 93–99.

Bacchi, C. (1999) *Women, Policy and Politics: The Construction of Policy Problems*. 1st edn. SAGE Publications.

Bacchi, C. (2009) *Analysing Policy: What's the Problem Represented To Be?* Pearson Australia.

Bacchi, C. (2010) 'Foucault, policy and rule: challenging the problem-solving paradigm', *FREIA – Feminist Research Center in Aalborg*, pp. 1–25. Available at: http://freia.ihis.aau.dk/Publikationer+og+skriftserie/Skriftserie0907-2179

Banks, N. and Brockington, D. (2020) 'Growth and change in Britain's development NGO sector (2009–2015)', *Development in Practice*, 30(6), pp. 706–721.

Barber, C. (2004) *Stitched Up: How Rich-country Protectionism in Textiles and Clothing Trade Prevents Poverty Alleviation*. Oxfam: Oxfam International.

Barnett, M. and Duvall, R. (2005) 'Power in international politics', *International Organization*, 59(1), pp. 39–75. 10.1017/S0020818305050010

Barreto, M. L. (2017) 'Health inequalities: a global perspective', *Science & Collective Health*, 22(7), pp. 2097–2108. 10.1590/1413-81232017227.02742017

Bartlett, O. (2018) 'Power, policy ideas and paternalism in non-communicable disease prevention', *European Law Journal*, 24(6), pp. 474–489. 10.1111/eulj.12216

Beckett, G. (2019) *There Is No More Haiti: Between Life and Death in Port-au-Prince*. University of California Press.

Bemme, D. and Nicole, D. (2012) 'Global mental health and its discontents', *Somatosphere*, pp. 1–11. Available at: http://somatosphere.net/2012/07/global-mental-health-and-its-discontents.html

Benatar, S. (2016) 'Politics, power, poverty and global health: systems and frames', *International Journal of Health Policy and Management*, 5(10), 599–604.

Bhakuni, H. and Abimbola, S. (2021) 'Epistemic injustice in academic global health', *The Lancet Global Health*, 9(10). e1465–70.

Bhambra, G. K. (2016) 'Undoing the epistemic disavowal of the Haitian revolution: a contribution to global social thought', *Journal of Intercultural Studies*, 37(1), pp. 1–16. 10.1080/07256868.2015.1122578

Biehl, J. G. and Petryna, A. (2013) *When People Come First: Critical Studies in Global Health*. Edited by J. Biehl and A. Petryna. Princeton University Press.

Biko, S. (1978) 'Black consciousness and the quest for a true humanity', *Ufahamu: A Journal of African Studies*, 8(3).

Bott, S., Morrison, A. and Ellsberg, M. (2005) 'Preventing and responding to gender-based violence in middle and low-income countries: a global review and analysis'. World Bank Policy Research Working Paper. 10.1596/1813-9450-3618

Bornstein, E. *The Spirit of Development: Protestant NGOs, Morality, and Economics in Zimbabwe*. Stanford, California:Stanford University Press.

Bornstein, E. (2012). *Disquieting Gifts: Humanitarianism in New Delhi*.Stanford, California: Stanford University Press.

Bourdieu, P. (1974) 'The school as a conservative force: scholastic and cultural inequalities', *Contemporary Research in the Sociology of Education*. Edited by J. Eggleston. Methuen, pp. 32–46.

Bourdieu, P. (1989) 'Social scape and symbolic power', *Sociological Theory*, 7(1), pp. 14–25. Available at: http://www2.southeastern.edu/Academics/Faculty/jbell/symbolicpower.pdf

Bourdieu, P. (1998) *Practical Reason: On the Theory of Action*. Stanford, CA: Stanford University Press.

Bourdieu, P. (2001) *Masculine Domination. Trans. Richard Nice*. Stanford, CA: Stanford University Press (Argumentos (Anagrama)).

Boniol, M., Kunjumen, T., Nair, T. S. et al., (2022). The global health workforce stock and distribution in 2020 and 2030: a threat to equity and 'universal' health coverage? *BMJ Global Health*, 7, e00931610.1136/bmjgh-2022-009316

Bracken, P. *et al.* (2012) 'Psychiatry beyond the current paradigm', *British Journal of Psychiatry*, pp. 430–434. 10.1192/bjp.bp.112.109447

Braun, V. and Clarke, V. (2019) 'Novel insights into patients' life-worlds: the value of qualitative research', *The Lancet Psychiatry*, 6(9), pp. 720–721. 10.1016/S2215-0366(19)30296-2

Britannica, T. E. of E. (2020) 'Haitian revolution', *Encyclopedia Britannica*. Available at: https://www.britannica.com/topic/Haitian-Revolution

Broom, D. H. and Woodward, R. V. (1996) 'Medicalisation reconsidered: toward a collaborative approach to care', *Sociology of Health and Illness*, 18(3), pp. 357–378. 10.1111/1467-9566.ep10934730

Buchanan, D. R. (2008) 'Autonomy, paternalism, and justice: ethical priorities in public health', *American Journal of Public Health*, 98(1), pp. 15–21. 10.2105/AJPH.2007.110361

Burgess, R. and Campbell, C. (2015) 'Creating social policy to support women's agency in coercive settings: a case study from Uganda', *Global Public Health*, 11(1–2), pp. 48–64. 10.1080/17441692.2015.1005654

Burgess, R. A. (2013) , ... Supporting 'community' in an era of global mental health: a case study of an HIV-affected South African community. PhD thesis, London School of Economics and Political Science. London UK

Burgess, R. A. (2014) '"It depends on them" – exploring order and disjuncture in responding to the local needs of AIDS affected communities in the Kingdom of Swaziland', *The Journal of Development Studies*, 50(4), pp. 467–480. 10.1080/00220388.2013.858123

Burgess, R. A. (2015) 'Supporting mental health in South African HIV-affected communities: primary health care professionals' understandings and responses', *Health Policy and Planning*, 30(7), pp. 917–927. 10.1093/heapol/czu092

Burgess, R. A. (2016) 'Policy, power, stigma and silence: exploring the complexities of a primary mental health care model in a rural South African setting', *Transcultural Psychiatry*, 53(6), pp. 719–742. 10.1177/1363461516679056

Burgess, R. A., and Fonseca, L. (2019). Re-thinking recovery in post-conflict settings: Supporting the mental well-being of communities in Colombia. *Global Public Health*, 15, 200–21910.1080/17441692.2019.1663547

Burgess, R. A. (2020) *COVID-19 Mental-health Responses Neglect Social Realities*, *Nature*. Available at: https://www.nature.com/articles/d41586-020-01313-9 (Accessed: 30 November 2022).

Burgess, R. A. (2022) 'Working in the wake: transformative global health in an imperfect world', *BMJ Global Health*, 7:e010520.

Burman, E. and Chantler, K. (2005) 'Domestic violence and minoritisation: Legal and policy barriers facing minoritized women leaving violent relationships', *International Journal of Law and Psychiatry*, 28(1), pp. 59–74. 10.1016/j.ijlp.2004.12.004

Buse, K. and Bertram, K. (2021) *G7 leaders made few concrete, strong, or deep health-related commitments at Carbis Bay*, *The BMJ Opinion*.

Byass, P. *et al.* (2013) 'Reflections on the Global Burden of Disease 2010 Estimates', *PLoS Medicine*, 10(7). 10.1371/journal.pmed.1001477

Calhoun, C. (2004) 'A World of Emergencies: Fear, Intervention, and the Limits of Cosmopolitan Order*', *Canadian Review of Sociology/Revue canadienne de sociologie*, 41(4), pp. 373–395. 10.1111/j.1755-618X.2004.tb00783.x

Campbell, C. (2003) *Letting Them Die: Why HIV/AIDS Prevention Programmes Fail - African Issues*. Edited by Currey, J.. Oxford: Indiana University Press.

Campbell, C. (2014) 'Community mobilisation in the 21st century: Updating our theory of social change?', *Journal of Health Psychology*, 19(1), pp. 46–59. 10.1177/1359105313500262

Campbell, C. and Burgess, R. (2012) 'The role of communities in advancing the goals of the Movement for Global Mental Health', *Transcultural Psychiatry*, 49(4), pp. 379–395. 10.1177/1363461512454643

Campbell, C. and Jovchelovitch, S. (2000) 'Health, community and development: towards a social psychology of participation', *Journal of community and applied social psychology*, 10(4), pp. 255–270.

Cancedda, C. *et al.* (2016) 'Strengthening Health Systems While Responding to a Health Crisis: Lessons Learned by a Nongovernmental Organization During the Ebola Virus Disease Epidemic in Sierra Leone', *The Journal of Infectious Diseases*, 214 (suppl_3), pp. S153–S163. 10.1093/infdis/jiw345

Canino, G. and Alegría, M. (2008) 'Psychiatric diagnosis – is it universal or relative to culture?', *Journal of Child Psychology and Psychiatry*, 49(3), pp. 237–250. 10.1111/j.1469-7610.2007.01854.x

Cerda, R. and Lee, P. T. (2013) 'Modern cholera in the Americas: An opportunistic societal infection', *American Journal of Public Health*, 103(11), pp. 1934–1937. 10.2105/AJPH.2013.301567

Centro Nacional de Memoria Histórica (CNMH). (2018). Sujetos victimizados y daños causados.Balance de la contribución del CNMH al esclarecimiento histórico.Bogotá: CentroNacional de Memoria Histórica.

Chambers, R. (2006) *Poverty Unperceived: Traps, Biases and Agenda*. Brighton.

Chaskel, R. *et al.* (2015) 'Mental health in Colombia', *BJPsych. International*, 12(4), pp. 95–97. 10.1192/S2056474000000660

Childress, J. F. *et al.* (2002) 'Public Health Ethics: Mapping the Terrain', *The Journal of Law, Medicine & Ethics*, 30(2), pp. 170–178. 10.1111/j.1748-720X.2002.tb00384.x

Chérif, M. S. *et al.* (2017) 'Ebola virus disease in children during the 2014–2015 epidemic in Guinea: A nationwide cohort study', *Eur J Pediatr*, 176, pp. 791–796.

Cohen, S. (2011). *Folk devils and moral panics: The creation of the Mods and Rockers*. Routledge.

Cohen, S. (2013/2001). *Sates of Denial: Knowing About Atrocities and Suffering*. Polity Press: Cambridge.

Collins, P. H. (1989) 'The Social Construction of Black Feminist Thought', *Signs*, 14(4), pp. 745–773.

Collins, P. H. (2000) 'Gender, Black Feminism, and Black Political Economy', *The ANNALS of the American Academy of Political and Social Science*, 568(1), pp. 41–53.

Collins, P. H. (2002) *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. New York: Routledge.

Collins, P. H. *et al.* (2021) 'Intersectionality as Critical Social Theory', *Contemp Polit Theory*.

Connor, K. A. O. *et al.* (2011) 'Risk Factors Early', *Emerging Infectious Diseases*, 17(11), pp. 2010–2012. Available at: www.cdc.gov/eid

Conrad, P. (1979) 'Types of medical social control', *Sociology of Health & Illness*, 1(1), pp. 1–11. 10.1111/1467-9566.ep11006751

Conrad, P. and Schneider, J. W. (1980) 'Looking at levels of medicalization: A comment on strong's critique of the thesis of medical imperialism', *Social Science and Medicine. Part A Medical Psychology and Medical*, 14(1), pp. 75–79. 10.1016/S0271-7123(80)90804-4

Corfe, E. (2014) '£12m raised in six days for DEC Ebola Crisis Appeal', *Civil Society News*.

Cornwall, A. (2002) *Making Spaces, Changing Places: Situating Participation in Development*. East Sussex: IDS.

Cornwall, A. and Eade, D. (2010) *Deconstructing Development Discourse: Buzzwords and Fuzzwords*. Practical Action Publishing.

Crawford, S. *et al.* (2020) *Final Performance Evaluation of DFID's What Works to Prevent Violence Against Women and Girls Programme*. Surrey.

CPD. (2018) *Measuring the State of Disaster Philanthropy 2018: Data to Drive Decisions*.

Dahl, R. (1957) 'The Concept of Power', *Behavioral Science*, pp. 201–125.

Devries, K. M. *et al.* (2013) 'The Global Prevalence of Intimate Partner Violence Against Women', *Science*, 340(6140), pp. 1527–1528. 10.1126/science.1240937

Dodgson, D., Lee, K. and Drager, N. (2002) *Global health governance: a conceptual review*. World Heal. World Health Organization. Available at: https://apps.who.int/iris/handle/10665/68934

Dodds. (2017) 'UN Peacekeepers in Haiti Implicated in Child Sex Ring', *The Independent*. Available at: https://www.independent.co.uk/news/world/americas/un-haiti-peace-keepers-child-sex-ring-sri-lankanunderage-girls-boys-teenage-a7681966.html (Accessed: 16 July 2021).

Dowell, S. F., Tappero, J. W. and Frieden, T. R. (2011) 'Public health in Haiti - Challenges and progress', *New England Journal of Medicine*, 364(4), pp. 300–301. 10.1056/NEJMp1100118

Du Bois, W. E. B. (1996) *The Souls of Black Folk*. Penguin Classics.

Edmonds, K. (2013) 'Beyond Good Intentions: The Structural Limitations of NGOs in Haiti', *Critical Sociology*, 39(3), pp. 439–452. 10.1177/0896920512437053

Elias, L., Singh, A. and Burgess, R. A. (2021) 'In search of "community": a critical review of community mental health services for women in African settings', *Health Policy and Planning*, 36(2), pp. 205–217. 10.1093/heapol/czaa140

Ellsberg, M. *et al.* (2015) 'Prevention of violence against women and girls: what does the evidence say?', *The Lancet*, 385(9977), pp. 1555–1566. 10.1016/S0140-6736(14)61703-7

Escobar, A. (1995) *Encountering Development: The Making and Unmaking of The Third World*. Princeton: Princeton University Press.

Evans, D. P. *et al.* (2021) 'Intimate Partner Violence: Barriers to Action and Opportunities for Intervention Among Health Care Providers in São Paulo, Brazil', *Journal of Interpersonal Violence*, 36(21–22), pp. 9941–9955. 10.1177/0886260519881004

Familiar, I. *et al.* (2013) 'Community perceptions of psychological distress in a post-conflict setting: A qualitative study in Burundi', *Global Public Health*, 8(8), pp. 943–957.

Fanon F (2001) *The wretched of the earth (C. Farrington Trans.)*. Penguin Classics.

Fanslow, J. L. and Robinson, E. M. (2011) 'Physical injuries resulting from intimate partner violence and disclosure to healthcare providers: results from a New Zealand population-based study', *Injury Prevention*, 17, pp. 37–42.

Farmer, P. (2003) *Pathologies of power: health, human rights, and the new war on the poor*. Berkeley: University of California Press.

Farmer, P. (2004) 'An anthropology of structural violence', *Current Anthropology*, 45(3), pp. 305–325. 10.1086/382250

Farmer, P. *et al.* (2011) 'Meeting Cholera's challenge to Haiti and the world: A joint statement on cholera prevention and care', *PLoS Neglected Tropical Diseases*, 5(5). 10.1371/journal.pntd.0001145

Farmer, P. *et al.* (2013) *Reimagining Global Health: An Introduction*. 1st edition. Berkeley: University of California Press.

Fernando, S. (2010) *Mental health, race and culture*. Third. Bloomsbury Publishing.

Fernando, S. (2014) *Mental health worldwide: Culture, globalization and development*. Palgrave Macmillan.

for Health Metrics, I. and Evaluation. (2017) *Financing Global Health 2017: Funding Universal Health Coverange and the Unfinished HIV/AIDS Agenda*. Available at: www.healthdata.org

for Women in the Horn of Africa, S. I. (2014) 'Anti-Pornography Act – Human Rights Activists and Civil Society Organisations Challenge the Legality of the Act in Constitutional Court – Uganda', *SIHA Network*. Available at: https://sihanet.org/anti-pornography-act-human-rights-activists-and-civil-society-organisations-challenge-the-legality-of-the-act-in-constitutional-court-uganda/

Foucault, M. (1973) *The birth of the clinic: an archaeology of medical perception*. London: Tavistock Publications.

Foucault, M. (1980) *Power/Knowledge: Selected Interviews and Other Writings 1972–1977*. Edited by C. Gordon. New York: Pantheon.

Foucault, M. (1988) 'The Concern for Truth', *Michel Foucault: Politics, Philosophy, Culture. Interviews and Other Writings, 1977–1984*. Edited by L. D. Kritzman. Routledge.

Foucault, M. (1994a) *Power: Essential Work of Foucault 1954-1984*. Penguin.

Foucault, M. (1994b) 'The Birth of Social Medicine', *Power: The Essential Works of Michael Foucault*. Edited by J. D. Faubion. New Press.

Foucault, M. (2002) 'The Subject and Power', in *Power: The Essential Works of Foucault 1954 – 1984*. London: Penguin Books, pp. 326 – 348.

Foundation Maps. (2021) *Measuring the State of Disaster Philanthropy*. Available at: https://maps.foundationcenter.org/#/map/?subjects=all&popgroups=all&years=all&location=3723988&excludeLocation=0&geoScale=ADM0&layer=geo_area&boundingBox=-139.219,-31.354,135,66.513&gmOrgs=all&recipOrgs=all&tags=all&keywords=&pathwaysOrg=&pathwaysType=&ac (Accessed: 16 July 2021).

Francois, J. (2020) 'Comment Cholera remains a public health threat in Haiti', *The Lancet Global Health*, 8(8), p. e984. 10.1016/S2214-109X(20)30299-0

Fraser, N. (2013) *Fortunes of Feminism: From State-Managed Capitalism to Neoliberal Crisis*. 1st edn. Verso.

Freire, P. and Ramos, M. B. (1970) *Pedagogy of the oppressed*. New York: Seabury Press.

Freire, P. (1972). Pedagogy of the Oppressed.Penguin.

Freire, P., Macedo, D. and Freire, A. M. A. (2008) *Daring to Dream Toward a Pedagogy of the Unfinished*. Routledge.

Fuchs, A. and Öhler, H. (2021) 'Does private aid follow the flag? An empirical analysis of humanitarian assistance', *The World Economy*, 44(3). 10.1111/twec.13021

Fulu, E., Kerr-Wilson, A. and Lang, J. (2014) *What works to prevent violence against women and girls? Evidence Review of interventions to prevent violence against women and girls*. Pretoria, South Africa: United Kingdom Government.

Funk, M. *et al.* (2012) 'Mental health, poverty and development', *Journal of Public Mental Health*, 11(4), pp. 166–185. 10.1108/17465721211289356

Gabe, J. (2013) 'Medicalization', *Key concepts in medical sociology*. 2nd edn. Edited by J. Gabe and M. L. SAGE, pp. 44–53.

Galtung, J. (1969) 'Violence, Peace and Peace Research', *Journal of Peace Research*, 6(3), pp. 167–191.

Gander, K. (2014) 'Uganda mini-skirt ban: Protests after women are assaulted and forced to undress in public', *Independent*.

Garcia-Basteiro, A. L. and Abimbola, S. (2021) 'The challenges of defining global health research', *BMJ Global Health*, 6(12). 10.1136/bmjgh-2021-008169

Garcin, M. (2015) 'The Haitian Cholera Victims' Complaints Against the United Nations', *Heidelberg Journal of International Law*, 75, pp. 671–705.

García-Moreno, C. and Temmerman, M. (2015) 'Commentary: Actions to end violence against women: A multi-sector approach', *Global Public Health*, 10(2), pp. 186–188. 10.1080/17441692.2014.986163

García-Moreno, C., Zimmerman, C., *et al.* (2015) 'Addressing violence against women: a call to action', *The Lancet*, 385(9978), pp. 1685–1695. 10.1016/S0140-6736(14)61830-4

García-Moreno, C., Hegarty, K., *et al.* (2015) 'The health-systems response to violence against women', *The Lancet*, 385(9977), pp. 1567–1579. 10.1016/S0140-6736(14)61837-7

Garrett, L. (2014) *Ebola: story of an outbreak*. Hachette Books.

Gaventa, J. (2006) 'Finding the spaces for change: a power analysis', *IDS Bulletin*, 37(6), pp. 23–33.

Genel, K. (2006) 'The question of biopower: Foucault and Agamben', *Rethinking Marxism*, 18(1), pp. 43–62. 10.1080/08935690500410635

Githui, S. N. *et al.* (2018) 'Barriers to screening pregnant women for domestic violence: a cross-sectional study', *Journal of Community & Public Health Nursing*, 4(1). 207

Gov Track. (2014) *Assessing Progress in Haiti Act of 2014*. Available at: https://www.govtrack.us/congress/bills/113/s1104/text (Accessed: 16 July 2021).

Greenhalgh, T. and Papoutsi, C. (2018) 'Studying complexity in health services research: desperately seeking an overdue paradigm shift', *BMC Medicine*, 16(96). 10.1186/s12916-018-1089-4

Group, G. M. H. (2007) 'Scale up services for mental disorders: A call for action', *The Lancet*, 370, pp. 1241–1252.

Guillaume, Y. *et al.* (2019) '"It was a ravage!": lived experiences of epidemic cholera in rural Haiti', *BMJ global health*, 4(6). 10.1136/bmjgh-2019-001834

Gumbonzvanda, N., Gumbonzvanda, F. and Burgess., R. (2021) 'Decolonising the 'safe space' as an African innovation: the Nhanga as quiet activism to improve women's health and wellbeing'. *Critical Public Health*, 31(2), pp. 169–181.

Haaken, J. (2010) *Hard knocks: Domestic violence and the psychology of storytelling*. Routledge.

Hall, S. (1994) 'Cultural Identity and Diaspora', in *Colonial Discourse and Post-Colonial Theory: A Reader*.

Halliwell, G. *et al.* (2019) 'Cry for health: a quantitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse', *BMC Health Services Research*, 19(718). 10.1186/s12913-019-4621-0

Han, C. (2015) 'Echoes of Death: Violence, Endurance, and Experience of Loss', *Living and Dying in the Contemporary World: A Compendium*. Edited by V. Das and C. Han. University of California Press, pp. 493–509.

Harman, S. *et al.* (2021) 'Global vaccine equity demands reparative justice — not charity', *BMJ Global Health*, 6: e006504

Harper, D. and Speed, E. (2012) 'Uncovering recovery: The resistible rise of recovery and resilience', *Studies in Social Justice*, 6(1), pp. 9–26. 10.1057/9781137304667

Hatch, A. R. (2016) *Blood sugar: racial pharmacology and food justice in Black America*. University of Minnesota Press.

Hatch, A. R. (2019) *Silent Cells: The Secret Drugging of Captive America*. Minneapolis: University of Minnesota Press.

Heffernan, E. *et al.* (2016) 'Understanding the psychosocial experiences of adults with mild-moderate hearing loss: An application of Leventhal's self-regulatory model', *International Journal of Audiology*, 55, pp. S3–S12. 10.3109/14992027.2015.1117663

Herard, D. (2016) 'The Politics of Democratization: Jean-Bertrand Aristide and the Lavalas Movement in Haiti', *FIU Electronic Theses and Dissertations*. Available at: https://digitalcommons.fiu.edu/etd/3037

Heymann, D. L. *et al.* (2015) 'Global health security: the wider lessons from the west African Ebola virus disease epidemic', *The Lancet*, 385(9980), pp. 1884–1901.

Hickel, J. (2016) 'The true extent of global poverty and hunger: questioning the good news narrative of the Millennium Development Goals', *Third World Quarterly*, 37(5), pp. 749–767. 10.1080/01436597.2015.1109439

Hilhorst, D. (2018) 'Classical humanitarianism and resilience humanitarianism: making sense of two brands of humanitarian action', *Journal of International Humanitarian Action*, 15(3). 10.1186/s41018-018-0043-6

Hirsch, L. (2019) 'In the wake: Interpreting care and global health through Black geographies. Area. 2019; 52: 314– 321', *Area*, 52(2), pp. 314–321.

Hook, D. (2007) *Foucault, Psychology and the Analytics of Power*. London: Palgrave Macmillan.

HPN. (2015) *Special feature: The Ebola crisis in West Africa*.

IHME. (2020) *Financing Global Health 2019: Tracking Health Spending in a Time of Crisis*. Seattle, WA.

IHME. (2021) *Financing Global Health 2020: The impact of COVID-19*. Seattle, WA.

International Foundation of Red Cross (IFRC). no date. From ebola to COVID-19: Coordination with local authorities for effective responseAccessed online: https://www.ifrc.org/sites/default/files/2022-03/Preparedness_COVID_SuccessStory_Sierra%20Leone_EN.pdfDate accessed: May 2023

International Monetary Fund (IMF). (2022). MF Executive Board Completes Fifth Review Under the Extended Credit Facility Arrangement and Concludes the 2022 Article IV Consultation for Sierra Leone. Press Release. June 27th 2022. Accessed online:https://www.imf.org/en/News/Articles/2022/06/28/pr22234sierraleone-imf-executive--board-completes-fifth-review-ecf-and-2022-article-iv-consultation

Illich, I. (1976) *Medical Nemesis: The Expropriation of Health*. Random House, Inc.

Ingleby, D. (1981) *Critical Psychiatry: The politics of mental health*. Harmondsworth: Penguin.

Ingleby, D. (2014a) 'How "evidence - based" is the Movement for Global Mental Health?', *Disability and the Global South*, 1(2), pp. 203–226.

Ingleby, D. (2014b) 'How "evidence-based" is the Movement for Global Mental Health?', *Disability and the Global South*, 1(2), pp. 203–226.

Ivers, L. C. and Walton, D. A. (2012) 'The "first" case of cholera in Haiti: Lessons for global health', *American Journal of Tropical Medicine and Hygiene*, 86(1), pp. 36–38. 10.4269/ajtmh.2012.11-0435

Iyer, D. (2018) *The Social Change Ecosystem Map, Building Movement Project*.

Jarman, M. (2011) 'Coming up from underground: Uneasy dialogues at the intersections of race, mental illness, and disability studies', in *Blackness and disability: Critical examinations and cultural interventions*. Michigan State University press, pp. 9–30.

Jenkins, K., Narayanaswamy, L. and Sweetman, C. (2019) 'Introduction: Feminist values in research', *Gender & Development*, 27(3), pp. 415–425. 10.1080/13552074.2019.1682311

Jewkes, R., Flood, M. and Lang, J. (2015) 'From work with men and boys to changes of social norms and reduction of inequities in gender relations: A conceptual shift in prevention of violence against women and girls', *The Lancet*, 385(9977), pp. 1580–1589. 10.1016/S0140-6736(14)61683-4

Jones, M. and Jones, R. (2004) 'Nation states, ideological power and globalisation: can geographers catch the boat?', *Geoforum*, 35(4), pp. 409–424. Available at: 10.1016/j.geoforum.2003.12.002

Jovchelovitch, S. (2007) *Knowledge in Context: Representations, Community and Culture*. Routledge.

Kalema, W. W. (1965) *Report of the Commission on Marriage, Divorce, and the Status of Women*. Government Printer.

Katz, J. M. (2016) *U.N. Admits Role in Cholera Epidemic in Haiti*, *The New York Times*. Available at: https://www.nytimes.com/2016/08/18/world/americas/united-nations-haiti-cholera.html (Accessed: 16 July 2021)

Kelly, M. P. *et al.* (2007) *The social determinants of health: Developing an evidence base for political action*.

Kentikelenis, A. *et al.* (2015) 'The International Monetary Fund and the Ebola outbreak', *The Lancet Global Health*, 3(2), pp. e69–e70. 10.1016/S2214-109X(14)70377-8

Keshri, V. and Bhaumik, S. (2022) 'The feudal structure of global health and its implications for decolonisation', *BMJ Global Health*, 7: e010603

Kickbusch, I. and Szabo, M. M. C. (2014) 'A new governance space for health', *Global Health Action*, 7(1), p. 23507. 10.3402/gha.v7.23507

King, M. L. (2010) *Where Do We Go from Here?: Chaos or Community?* Beacon Press.

Kleinman, A. (2009) 'Global mental health: a failure of humanity', *Lancet*, 374(9690), pp. 603–604. 10.1016/S0140-6736(09)61510-5

Kleinman, A. (2010) 'Four social theories for global health', *The Lancet*, 375(9725), pp. 1518–1519.

Koplan, J. *et al.* (2009) 'Towards a common definition of global health. Lancet', *Lancet*, 373(9679), pp. 1993–1995.

Krakowski, M. and Nolan, K. (2017) 'Depressive symptoms associated with aggression', *Psychiatric Times*, 34(2). Accessed online: https://www.psychiatrictimes.com/view/depressive-symptoms-associated-aggression

Krug, E. *et al.* (2002) *World report on violence and health*. Edited by W. H. Organization. WHO Press.

Kuklinski, J. H., Luskin, R. C. and Bolland, J. (1991) 'Where Is the Schema? Going Beyond the "S" Word in Political Psychology', *The American political science review*, 85(4), pp. 1341–1380.

Lee, E. C. *et al.* (2020) 'Achieving coordinated national immunity and cholera elimination in Haiti through vaccination: a modelling study', *The Lancet Global Health*, 8(8), pp. 1081–1089.

Lehrner, A. and Allen, N. E. (2009) 'Still a Movement After All These Years?: Current tensions in the domestic violence movement', *Violence Against Women*, 15(6), pp. 656–677. 10.1177/1077801209332185

Lemay-Hébert, N. (2014) 'Resistance in the Time of Cholera: The Limits of Stabilization through Securitization in Haiti', *International Peacekeeping*, 21(2), pp. 198–213. 10.1080/13533312.2014.910399

Leventha, H. *et al.* (1997) 'Illness representations: Theoretical foundations', *Perceptions of Mental Illness*. Edited by K. H. Petrie and A. Weinman. Amsterdam: Harwood Academic Publishers, pp. 19–46.

Lie, R. K. and Miller, F. G. (2011) 'What counts as reliable evidence for public health policy: the case of circumcision for preventing HIV infection', *BMC Medical Research Methodology*, 11(1), p. 34. 10.1186/1471-2288-11-34

Lipsky, S. *et al.* (2006) 'The Role of Intimate Partner Violence, Race, and Ethnicity in Help-Seeking Behaviors', *Ethnicity & Health*, 11(1), pp. 81–100.

Lukes, S. (2005) *Power: A radical view*. 2nd ed. New York: Palgrave Macmillan.

MacNeil, A. and Rollin, P. E. (2012) 'Ebola and Marburg Hemorrhagic Fevers: Neglected Tropical Diseases?', *PLoS Neglected Tropical Diseases*. Edited by T. Geisbert, 6(6), p. e1546. 10.1371/journal.pntd.0001546

Madhok, S. (2013) *Rethinking Agency: Developmentalism, Gender and Rights*. Routledge, Taylor & Francis Group.

Manion, K. (2011) 'Focusing on the child: Redressing neglect in child protection 48', *Social Work Now*, 48, pp. 27–32.

Mannell, J. *et al.* (2021) 'Decolonising violence against women research: a study design for co-developing violence prevention interventions with communities in low and middle income countries (LMICs)', *and middle income countries (LMICs)*, 21(1147). https://doi.org/10.1186/s12889-021-11172-2

Marsella, A. J. (1998) 'Toward a "global-community psychology": Meeting the needs of a changing world', *American Psychologist*, 53(12), pp. 1282–1291. 10.1037/0003-066X.53.12.1282

Matczak, A., Hatzidimiytiadou, E. and Lindsay, J. (2011) *Review of Domestic Violence Policies in England & Wales*. Kingston University and St George's University of London.

Mathias, K. (2022) *Pixels are not people: mental health apps are increasingly popular but human connection is still ke*, *The Conversation*. Available at: https://theconversation.com/pixels-are-not-people-mental-health-apps-are-increasingly-popular-but-human-connection-is-still-key-192247 (Accessed: 30 November 2022)

Matthewson, T. (1995) 'Jefferson and Haiti', *The Journal of Southern History*, 61(2), pp. 209–213.

Maurisse, M. (2020) *Haitian dictator money remains a tough nut to crack*, *Swissinfo*.

McCracken, K. and Phillips, D. R. (2017) *Global Health: An Introduction to Current and Future Trends*. London: Routledge.

McMichael, C., Waters, E. and Volmink, J. (2005) 'Evidence-based public health: what does it offer developing countries?', *Journal of Public Health*, 27(2), pp. 215–221. 10.1093/pubmed/fdi024

McPake, B., Dayal, P. and Herbst, C.H. (2019). Never again? Challenges in transforming the health workforce landscape in post-Ebola West Africa. *Human Resources for Health*, 17, 1–10. 10.1186/s12960-019-0351-y

Mendenhall, E. (2017) 'Syndemics: a new path for global health research', *The lancet (British edition)*, 389(10072), pp. 889–891. 10.1016/S0140-6736(17)30602-5

Mertens, D. (2001) 'Inclusivity and Transformation: Evaluation in 2010', *American Journal of Evaluation*, 22(3), pp. 367–374.

Michau, L. *et al.* (2015) 'Prevention of violence against women and girls: Lessons from practice', *The Lancet*, 385(9978), pp. 1672–1684. 10.1016/S0140-6736(14)61797-9

Mills, C. (2014) *Decolonizing global mental health: the psychiatrization of the majority world*. Routledge, Taylor & Francis Group.

Mills, C. (2015) ‘The psychiatrization of poverty: Rethinking the mental health-poverty nexus’, *Social and Personality Psychology Compass*, 9(5), pp. 213–222. 10.1111/spc3.12168

Mills, E. (2017) ‘Biopolitical precarity in the permeable body: the social lives of people, viruses and their medicines’, *Critical Public Health*, 27(3), pp. 350–361. 10.1080/09581596.2017.1282153

Mills, C., and Lacroix, K. (2019). Reflections on doing training for the World Health Organization’s mental health gap action program intervention guide (mhGAP-IG). *International Journal of Mental Health*, 48, 309–322. 10.1080/00207411.2019.1683681

Ministerio de Salud y Protección Social. (2015). ncuesta Nacional de Salud Mental. Bogotá: MINSALUD.

Mitchell, M. and Howarth, C. (2009) *Trans Research Review*. Equality and Human Rights Commission 2009.

Moffitt, T. E. and Klaus-Grawe 2012 Think Tank. (2013) ‘Childhood exposure to violence and lifelong health: clinical intervention science and stress-biology research join forces’, *Development and psychopathology*, 25(4 Pt 2), pp. 1619–1634.

Moncrieff, J. *et al.* (2022) ‘The serotonin theory of depression: a systematic umbrella review of the evidence’, *Molecular Psychiatry*. 10.1038/s41380-022-01661-0

Montesanti, S. R. and Thurston, W. E. (2015) ‘Mapping the role of structural and interpersonal violence in the lives of women: implications for public health interventions and policy’, *BMC Women’s Health*, 15(1), p. 100. 10.1186/s12905-015-0256-4

Moon, S. (2019) ‘Power in global governance: an expanded typology from global health’, *Globalization and Health*, 15(Supplement1). 10.1186/s12992-019-0515-5

Moyo, D. (2010) *Dead aid: why aid makes things worse and how there is another way for Africa*. London: Penguin.

Mpango, R. *et al.* (2020) ‘Challenges to peer support in low- and middle-income countries during COVID-19’, *Global Health*, 16(90). 10.1186/s12992-020-00622-y

Muggah, R. and Diniz, G. M. (2013) ‘Digitally Enhanced Violence Prevention in the Americas’, *Syability: International Journal of Security and Development*, 2(3). 10.5334/sta.cq

Murrell, A. R., Christoff, K. A. and Henning, K. R. (2007) ‘Characteristics of Domestic Violence Offenders: Associations with Childhood Exposure to Violence’, *Journal of Family Violence*, 22, pp. 523–532.

Nelson, A. (2011) *Body and soul: the Black Panther party and the fight against medical discrimination*. University of Minnesota Press.

Nelson, G. and Prilleltensky, I. (2010) *Community psychology: in pursuit of liberation and well-being*. 2nd edn. Edited by G. Nelson and I. Prilleltensky. Palgrave Macmillan.

Nunes, J. (2017) ‘Doctors against borders: Medécins Sans Frontières and global health security’, *The politics of fear: Medécins San Frontières and the West African Ebola Epidemic*. Edited by M. Hofman and S. Au. Oxford Academic, pp. 3–24.

Oram, S., Khalifeh, H. and Howard, L. M. (2017) ‘Violence against women and mental health’, *The Lancet Psychiatry*, 4(2), pp. 159–170. 10.1016/S2215-0366(16)30261-9

Organization, W. H. (2010) *mhGAP intervention guide - For mental, neurological and substance abuse disorders in non-specialized health settings:Version 1.0*, *Mental Health Gap Action Programme*. WHO Press. Available at: http://scholar.google.com/scholar?hl=en&btnG=Search&q=intitle:mhGAP+Intervention+Guide#1%5Cnhttp://scholar.google.com/scholar?hl=en&btnG=Search&q=intitle:mhGAP+intervention+guide#1

Organization, W. H. *et al.* (2016) ‘Out of the Shadows: Making Mental Health a Global Development Priority’, *Report of Proceedings of Event*. Available at: http://pubdocs.

worldbank.org/en/391171465393131073/0602-SummaryReport-GMH-event-June-3-2016.pdf

Organization, W. H. (2019) 'Ebola Virus disease: Democratic Republic of the Congo', *Disease outbreak news*, pp. 1–12. Available at: https://apps.who.int/iris/bitstream/handle/10665/324996/SITREP_EVD_DRC_20190528-eng.pdf?ua=1%0Ahttps://www.afro.who.int/health-topics/ebola-virus-disease

Organization, W. H. and for Refugees, U. N. H. C. (2013) *Assessment and Management of Conditions Specifically Related to Stress: mhGAP Intervention Guide Module (version 1.0).* WHO. Available at: www.who.int/mental_health/mhgap

Organization, W. H. and Group, W. B. (2016) 'Out of the Shadows: Making Mental Health a Global Development Priority'.

Ormel, J. *et al.* (2019) 'Prevention of depression will only succeed when it is structurally embedded and targets big determinants', *World Psychiatry*, 18(1), pp. 111–112. 10.1002/wps.20580

Packard, R. (2016) *A History of Global Health: Interventions Into the Lives of Other Peoples*. Johns Hopkins University Press.

Parker, R. (2011) 'Grassroots activism, civil society mobilization, and the politics of the global HIV/AIDS epidemic', *The Brown Journal of World Affairs*, 17(2), pp. 21–37.

Parliament of the Rebublic of Uganda. (2022) *Marriage Bill returns to Parliament.*

Pasch, R. J. *et al.* (2020) *Hurricane Laura.*

Patel, V. and Prince, M. (2010) *Global Mental Health: A New Global Health Fields Comes of Age.*

Perry, K. K. (2020) *Structuralism and Human Development: A Seamless Marriage? An Assessment of Poverty, Production and Environmental Challenges in CARICOM Countries*, *International Journal of Political Economy*. 10.1080/08911916.2020.1824735

Pillinger, M., Hurd, I. and Barnett, M. N. (2016) 'How to get away with cholera: The UN, Haiti, and international law', *Perspectives on Politics*, 14(1), pp. 70–86. 10.1017/S1537592715003230

Piot, P. (2014) 'Ebola's perfect storm', *Science*, 345(6202), p. 1221. 10.1126/science.1260695

Piot, P., Muyembe, J.-J. and Edmunds, W. J. (2014) 'Ebola in west Africa: from disease outbreak to humanitarian crisis', *The Lancet Infectious Diseases*, 14(11), pp. 1034–1035.

Pupavac, V. (2006) 'The politics of emergency and the demise of the developing state: problems for humanitarian advocacy', *Development in Practice*, 16(3–4), pp. 255–269. 10.1080/09614520600694794

Ragavan, M. I. *et al.* (2018) 'Exploring the Needs and Lived Experiences of Racial and Ethnic Minority Domestic Violence Survivors Through Community-Based Participatory Research: A Systematic Review', *Trauma, Violence, & Abuse*, 21(5), pp. 946–963.

Rathod, S. *et al.* (2017) 'Mental Health Service Provision in Low- and Middle-Income Countries', *Health Serv Insights*, 28(10). 10.1177/1178632917694350

Richards, P. (2016) *Ebola: how a people's science helped end an epidemic.* Zed Books.

Richardson, E. T. and Farmer, P. (2020) *Epidemic Illusions: On the Coloniality of Global Public Health*. Cambridge: MIT Press.

Rifkin, S. B. (2018) 'Health for All and Primary Health Care, 1978–2018: A Historical Perspective on Policies and Programs Over 40 Years', *Oxford Research Encyclopedia of Global Public Health*. Oxford University Press. 10.1093/acrefore/9780190632366.013.55

Roberts, D. (1999) 'Foreword: Race, Vagueness, and the Social Meaning of Order-Maintenance Policing', *The Journal of Criminal Law & Criminology*, 89(3), pp. 775–836. 10.2307/1144123

Roberts, T. *et al.* (2022) 'Reconceptualising the treatment gap for common mental disorders: A fork in the road for global mental health?', *British Journal of Psychiatry*.

Robins, S. (2006) 'From "Rights" to "Ritual": AIDS Activism in South Africa', *American Anthropologist*, 108(2), pp. 312–323. 10.1525/aa.2006.108.2.312

Robinson, S. R., Ravi, K. and Voth Schrag, R. J. (2020) 'A Systematic Review of Barriers to Formal Help Seeking for Adult Survivors of IPV in the United States, 2005–2019', *Trauma, Violence, & Abuse*.

Rodney, W. (1972) *How Europe underdeveloped Africa*. London, England: Bogle-L'Ouverture Publications. Available at: https://www.nhc.noaa.gov/data/tcr/AL132020_Laura.pdf

Rodríguez-Madera, S. L. *et al.* (2017) 'Experiences of Violence Among Transgender Women in Puerto Rico: An Underestimated Problem', *Journal of Homosexuality*, 64(2), pp. 209–217. 10.1080/00918369.2016.1174026

Russell, S. *et al.* (2015) 'The Framing and Fashioning of Therapeutic Citizenship Among People Living With HIV Taking Antiretroviral Therapy in Uganda', *Qualitative Health Research*, 26(11), pp. 1447–1458. 10.1177/1049732315597654

Salm, M. *et al.* (2021) 'Defining global health: findings from a systematic review and thematic analysis of the literature', *BMJ Global Health*, 6(6). 10.1136/bmjgh-2021-005292

Samudzi, Z. and Mannell, J. (2015) 'Cisgender male and transgender female sex workers in South Africa: gender variant identities and narratives of exclusion', *Culture, Health & Sexuality: An International Journal for Research*, 18(1), pp. 1–14. 10.1080/13691058.2015.1062558

Sangaramoorthy, T. and Benton, A. (2022) 'Intersectionality and syndemics: a commentary', *Social Science & Medicine*, 295. 10.1016/j.socscimed.2021.113783

Sankara, T. (2007) *We are the Heirs of the World's Revolutions: Speeches from the Burkina Faso Revolution 1983–1987*. Pathfinder Press.

Santos, B. de S. (2018) *The End of the Cognitive Empire: The Coming of Age of Epistemologies of the South*. Durham: Duke University Press.

Satyanarayana, V. A., Chandra, P. S. and Vaddiparti, K. (2015) 'Mental health consequences of violence against women and girls', *Current Opinion in Psychiatry*, 28(5), 350–356. 10.1097/YCO.0000000000000182

Scott, J. C. (1990) *Domination and the arts of resistance: Hidden transcripts*. Yale University Press.

Sharp, A. *et al.* (2020) 'High cholera vaccination coverage following emergency campaign in Haiti: results from a cluster survey in three rural Communes in the South Department, 2017', *PLoS Neglected Tropical Diseases*, 14(1). e0007967

Sharpe, C. (2016) *In the wake: on Blackness and being*. Duham, NC: Duke University Press.

Shiffman, J. (2014) 'Knowledge, moral claims and the exercise of power in global health', *International Journal of Health Policy and Management*, 3(6), pp. 297–299. 10.15171/ijhpm.2014.120

Shiffman, J. (2015) 'Global health as a field of power relations: a response to recent commentaries', *International Journal of Health Policy and Management*, 4(7), 497–499.

Singh, J. and Gupta, S. (2016) 'Agriculture and Its Discontents: Coalitional Politics at the WTO with Special Reference to India's Food Security Interests. International Negotiation', *International Negotiation*, 21(2), pp. 295–326. Available at: 10.1163/15718069-12341334

Skorburg, J. A. and Yam, J. (2022) 'Is There an App for That?: Ethical Issues in the Digital Mental Health Response to COVID-19', *AJOB Neuroscience*, 13(3), pp. 177–190. 10.1080/21507740.2021.1918284

Sokoloff, N. J. (2007) 'The Effect of the Prison-Industrial Complex on African American Women', in *Racializing Justice, Disenfranchising Lives. The Critical Black Studies Series*. New York: Palgrave Macmillan, pp. 73–90. 10.1057/9780230607347_8

Speizer, I. S. (2010) 'Intimate Partner Violence Attitudes and Experience Among Women and Men in Uganda', *Journal of Interpersonal Violence*, 25(7), pp. 1224–1241. 10.1177/0886260509340550

Statistics South Africa. (2021). Subjective poverty in South Africa; findings from General Household Survey.

Statistics South Africa. (2016). Community survey 2016 - Provinces at a glance. Available online [date last accessed 10 June, 2023]: http://cs2016.statssa.gov.za/wp-content/uploads/2016/06/CS-2016-Provinces-at-a-glance.pdf

Steel, Z. *et al.* (2014) 'The global prevalence of common mental disorders: A systematic review and meta-analysis 1980-2013', *International Journal of Epidemiology*, 43(2), pp. 476–493. 10.1093/ije/dyu038

Stevens, G. (1995) 'Understanding and Preventing Violence', *The Journal of Nervous and Mental Disease*.

Summerfield, D. (2012) 'Afterword: Against "global mental health"', *Transcultural Psychiatry*, 49(4), pp. 519–530. 10.1177/1363461512454701

Summerfield, D. (2013) '"Global mental health" is an oxymoron and medical imperialism', *BMJ*, 346. 10.1136/bmj.f3509

Svadzian, A. *et al.* (2020) 'Global health degrees: at what cost?', *BMJ Global Health*, 5(8). e003310.

Tamayo-Agudelo, W. and Bell, V. (2019) 'Armed conflict and mental health in Colombia', *BJPsych International*, 16(02), pp. 40–42. 10.1192/bji.2018.4

Tarquinio, C. *et al.* (2015) 'Evaluating complex interventions: Perspectives and issues for health behaviour change interventions', *Psychology & Health*, 30(1), pp. 35–51. 10.1080/08870446.2014.953530

The Republic of Uganda. (2010) *The Domestic Violence Act*. The Republic of Uganda.

The World Bank. (2015) *Maternal deaths fell 44% since 1990*. Geneva/New York.

Thompson, D. M. *et al.* (2022) 'Peer support for people with chronic conditions: A systematic review of reviews', *BMC Health Services ResearchRes*, 22(427). 10.1186/s12913-022-07816-7

Topp, S. *et al.* (2021) 'Power analysis in health policy and systems research: a guide to research conceptualisation', *BMJ Global Health*, 6(11). e007268.

Toscano, A. (2019). The Violence of Abstraction: From debt to race and back again. In: Public Seminar 9th May, 2019. Accessed online: https://publicseminar.org/essays/the-violence-of-abstraction/date last access: June 1st 2023.

Tripp, A. M. (2004) 'Women's Movements, Customary Law and Land Rights in Africa: The Case of Uganda', *African Studies Quarterly*, 7(4), pp. 1–19.

Trouillot, M. (1995) *Silencing the past: Power and the production of history*. Boston: Beacon Press. 10.1086/ahr/102.2.426

UNDP. (2017) *Out of Poverty and Back to Poverty Transitions using Synthetic Panel Data, United Nations Economic Comission for Europe*.

United Nations. (2017) *New approach to cholera in Haiti*.

Venkatapuram, S. (2011) *Health justice: an argument from the capabilities approach*. Cambridge: Polity Press.

Walton, D. A. and Ivers, L. C. (2011) 'Responding to cholera in post-earthquake Haiti', *New England Journal of Medicine*, 364(1), pp. 3–5. 10.1056/NEJMp1012997

Watters, E. (2010) ‘Crazy like us: The globalization of the American psyche’, *Free Press*.

Wenham, C. (2016) ‘Ebola respons-ibility: moving from shared to multiple responsibilities’, *Third World Quarterly*, 37(3), pp. 436–451. 10.1080/01436597.2015.1116366

Weyers, S. *et al.* (2008) ‘Low socio-economic position is associated with poor social networks and social support: results from the Heinz Nixdorf Recall Study’, *International Journal of Equity Health*, 7(13). 10.1186/1475-9276-7-13

World Bank. (2023). The World Bank in Haiti. Country Overview. Accessed online: https://www.worldbank.org/en/country/haiti/overview. last accessed: May 2023.

(WHO), W.H.O. (2016) ‘Ebola Response Funding’, *WHO: Emergencies preparedness, response*.

WHO. (2001) *The World Health Report 2001. Mental Health: New understanding - New hope*. WHO.

WHO. (2010) *Health Systems Financing: the path to universal coverage*. WHO.

WHO. (2013a) *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*. Edited by W. H. Organization, L. S. of Hygiene & Tropical Medicine, and S. A. M. R. Council. ress. Available at: https://www.worldbank.org/en/topic/socialdevelopment/brief/violence-against-women-and-girls

WHO. (2013b) *Research for universal health coverage*. WHO.

World Health Organisation (WHO) . (2020). Ebola Disease Factsheet. Accessed online June 2020. Available online: https://www.who.int/news-room/fact-sheets/detail/ebola-virus-disease?gclid=Cj0KCQjwy9-kBhCHARIsAHpBjHjKGVv4X_vR9fw7T_QCkf5P647vsh1m6jf-dy-BZ3x3AUwzZRyiL7caAtoVEALw_wcB

World health Organisaiton (WHO). (2017). WHO country cooperation strategy 2017-2021: Sierra Leone. Accessed online: https://www.who.int/publications/i/item/9789290233572 [last accessed, July 2022].

WHO. (2022) *Disease Outbreak News; Cholera - Haiti*.

Wills, S. and McLaughlin, C. (2020) ‘The Production and Use of the Film It Stays With You: Use of Force by UN Peacekeepers in Haiti to Challenge the Exclusion of Survivors’ Experiences from Peacekeeping Success Stories’, *Journal of Human Rights Practice*, 12(3), pp. 642–663.

Wilson, T. D. (2014) ‘Violence against Women in Latin America’, *Latin American Perspectives*, 41(1), pp. 3–18. 10.1177/0094582X13492143

Wood, T. and Hoy, C. (2022) *Helping Us or Helping Them?* What Makes Foreign Aid Popular with Donor Publics? *Economic Development and Cultural change*. *70*(2): 567-586.

Zarocostas, J. (2017) ‘Cholera outbreak in Haiti-from 2010 to today’, *Lancet (London, England)*, 389(10086), pp. 2274–2275. 10.1016/S0140-6736(17)31581-7

Zizek, S. (2008) *Violence: Six Sideways Reflections*. Profile Books Ltd.

Zola, I. K. (1983) *Socio-medical Inquiries: Recollections, Reflections, and Reconsiderations*. Temple University Press.

INDEX

Note: **Bold** page numbers refer to tables and *italic* page numbers refer to figures.

abortions 5, 6, 8, 37–38
agenda setting face of power 7–8, 11, 21
alcohol-related disorders 53
Alma-Ata 65
anti-depressant 56
anti-pornography bill 25
anxiety 45, 49, 56

Bacchi, Carol 27, 29, 30, 31, 32, 34
Beckett, Greg 72, 76, 82, 84, 88
Benatar, Solomon 6, 8
Bertrand, Jean 81, 88
Bhambra, Gurminder 85
Biehl, Joao 3
Biko, Steve 99
biopower 9
Black feminist 99
Black Feminist Thought 14
Black women 14, 17
BMJ Global Public Health 104
Bourdieu, Pierre 8, 18, 29, 37
British Department for International Development (DFID) 45

Campbell, Catherine 19, 88, 93–94
causation *vs.* correlation 33
CEDAW *see* Convention on the Elimination of All Forms of Discrimination against women
child abuse 41
Cholera 22, 73–76, 78, 79, 81–84, 88–90, 97
Cohen, Stanley 67, 69, 70
collective efforts 45
Collins, Patricia Hill 14, 16–18, 27, 42, 63
Colombia 21, 38, 49, 54–56, 72, 73
colonialism 4, 5, 14, 72, 77
'community-based' approach 3, 40, 46, 57, 98
community participation 98
community psychology 20, 42, 95–105
conditionalities 61
Conrad, Peter 41, 50
Convention on the Elimination of All Forms of Discrimination against women (CEDAW) 25
co-produce 100
Cornwall, Andrea 12, 98
COVID-19 2, 39, 53, 59, 66, 70, 73, 93, 96
cultural capital 8, 10

DAH *see* Development Assistance for Health
Dahl, Robert 7
de Sousa Santos, Boavenntura 4
decision-making powers 6–7, 64, 66
Democratic Republic of Congo (DRC) 60–62
denial of food 27
depression 1, 45, 47–49, 52, 53, 74
Development Assistance for Health (DAH) 2, 5

Disasters Emergency Committee (DEC) 70
disciplinary spheres 63
discursive effects 29
discursive power 49
distress 46–49, 53–57
doctor–patient interactions 50
Domestic Relations Bill 25
Du Bois, W. E. B. 18

Ebola 22, 59–64, 66–71; as a humanitarian crisis 66; life after 60
Ebola public appeals 70
economic power 5–7, 66, 90, 102
encountering development 4–5
epistemic violence 52, 97
epistemic injustice 53, 97
Escobar, Arturo 5
Etienne, Ancito 76
evidence based 31, 33, 45, 48

face(s) of power 7, 10
false consciousness 10
Fanon, Franz 14
Farmer, Paul 3, 52, 80, 81, 86, 87
financial commitments 2
financial resources 47, 56
Foucault, Michel 8–10, 17, 29, 49, 50, 51
frameworks of power 7, 15
Fraser, Nancy 29
free condom distributions 93
Freire, Paulo 88, 96, 97
Fried plantain 72
funding streams 45, 47

Galtung, Johan 52, 56
Gaventa, John: different spaces 12; power cube 11–12
gender inequality 28, 32, 34, 37
global gag rule 5, 8
global health crisis 22, 59
global health emergency; paternalism and 66–70; power of an idea 64–66
global mental health 21, 22, 28, 45–54, 57, 58, 101
global south, poverty in 49
'gold standard' intervention 37, 51, 93

Haaken, Janice 37
Haiti 73; Cholera in 73; disciplinary domain 82–88; interpersonal domain 88–90; United Nation's secret success 74–78
Hall, Stuart 9
Han, Clara 52
Hatch, Anthony 14
health: as capability 4; education 5, 93; engagement 3; equity 4; justice 3
hidden transcripts 11
high income *vs*. low income 8, 30, 44
Hilhorst, Dorothea 66, 68
HIV 1, 2, 28, 32, 33, 37, 45, 46, 51, 52, 69, 93, 94, 99
homosexuality 41, 74
Hook, Derek 9, 10
humanitarian and NGO practices 65, 82

IHME *see* Institute for Health Metrics
IMF *see* International Monetary Fund
Ingleby, David 48, 49, 53
injustice 53, 97, 103
Institute for Health Metrics (IHME) 28
Institute for Justice and Democracy in Haiti (INJH) 83
international health 5
International Health Regulations (IHR) 63
International Journal of Health Policy and Management (2015) 6
International Monetary Fund (IMF) 16, 61, 67, 70
intimate partner violence 36
invisible power 11
Iyer, Deepa 104

Katz, Johnathan 72, 73, 75, 76, 82, 87
Kleinman, Arthur 3, 47–48
knowledge production 3, 21, 31, 47, 48, 86, 97, 104
Kouchener, Bernard 65

The Lancet 28, 31, 32, 35, 39, 40, 93
lived effects 29–30, 39–42
LMIC *see* low- and middle-income country
Lorde, Audre 99
low- and middle-income country (LMIC) 44–45, 47, 48, 93
Lukes, Stephen 7, 17, 64

macro-level actors 50
MAD bill *see* Marriage and Divorce (MAD) bill
Madhok, Sumi 11, 27
magical thinking 48
male-dominated spaces 26
Maria, San 54, 55

Marriage and Divorce (MAD) bill 24–28, 42
Marshland, Rebecca 52
Marx, Karl 5
matrix of domination 14, *15*, 16–19, 22, 78–81, 95–105
medical collaboration 41
medical ideology 41
medical technology 41
medicalisation 41, 42, 49–53
Medicines Sans Frontieres (MSF) 54, 60, 62, 64, 65, 66, 69, 73, 82
mental disorders 44, 45, 49, 53
mental health 1, 14, 21, 28, 36, 44, 99
see also global mental health
mental illness 41, 46, 49, 53, 86
meso-level actors 50
micro-level actors 50
micro-social partnerships 19
Minoso, Espinosa 52
modernisation 80
modes of power 6, 7
Moncrieff, Joanna 48
monetary tightening 67
Moon, Suerie 12
Movement for global mental health 21, 44, 47–51, 57

National Health Service (NHS) 8, 40
national implementation 46
Nelson, Alondra 14
NHS *see* National Health Service
nightmare republic 86
Nyanzi, Stella 25

objective violence 36
ODA *see* Overseas Development Assistance
Overseas Development Assistance (ODA) 5

Pan American Health Organisation (PAHO) 73
participation 12, 24, 56, 72, 96
Partners in Health (PIH) 62
Patel, Vikram 47
paternalism 62, 64, 66–70, 71, 82
Petryna, Adriana 3
PGHF *see* power in global health framework
pharmaceutical intervention 53, 56
pharmacological interventions 46
philanthropic entities 5
physical violence 24, 30
the plague 50
poor health 14, 62, 65, 74, 75, 78, 81, 99
post-traumatic stress disorder (PTSD) 45, 48, 49, 53, 54
poverty 1, 5, 16, 17, 43, 46, 47, 49, 52, 66, 73, 79, 80, 81, 97
power: disciplinary domain 14, 17, 18, 21, 27–31, 49–56, 82–88, 90; discourse 9; domains of power 17, 22, 26, 37, 50, 51, 61, 64; dynamics 21, 39, 64, 102; framework 12–19, **13**; hegemonic domain of 14, 17–18, 22, 27, 84–88, 99; hidden 8, 11; ideological 6; interpersonal domain of 14, 18–19, 27, 49–56, 88–90; power in global health framework (PGHF) 26–27; psychiatric 21, 49, 51, 53, 54, 56; structural 6; structural domain of 14, 16–17, 27, 51, 61, 64, 66, 78–81, 99; symbolic 8, 18, 29, 35, 88
Prince, Marin 47
productive power 6, 10, 16, 22, 28–30, 52, 54
project selection concerns 77
pro-women policy 38
psychiatrisation 49
psychological interventions 54, 56
psycho-social interventions 46
psy-disciplines 49–56
PTSD *see* post-traumatic stress disorder
public health emergency of international concern (PHEOIC) 59, 63
Pupavac, Vanessa 65

radical rudeness 25
randomised control trials (RCTs) 32–35
rascality 86
RCTs *see* randomised control trials
reproductive health 5
resistance 7–12, 18, 19, 25, 54, 86, 88–90, 96, 103
resource inequalities 39
Richard, Paul 67
Richardson, Eugene 101
Rico, Puerto 39
Roberts, Dorothy 14
Rodney, Walter xvi, 77
runaway needs 29

Sankara, Thomas 100
Scott, James 10
sexual violence 24, 30, 36
Shiffman, Jeremey 6, 28
Sierra Leone 60–63, 67, 68

Singer, Merrill 14
Singh, Sunny 102
social: actors 4; justice 10, 12, 19, 21, 27, 103; medicine 50; welfare grants 46
South Africa 1, 4, 21, 39, 44, 46–47, 52, 56, 72, 93–94, 99, 105
Stevens, Garth 36
structural inequalities 39
structural violence 22, 37, 43, 46, 49–57, 80, 90, 95
subjectification 22, 29, 49–56
subjective violence 36
Summerfield, Derek 48
survival 1, 11, 19, 27, 45, 46, 55, 58, 65, 68, 77, 99
symbolic capital *see* symbolic power
symbolic violence 35–39

Tarmac Bias 72
third world *vs.* first world 8
transcultural psychiatry 48
transformative global health **100**, 101, **104**, 105
transgender violence 39
treatment gap 44, 48, 57
Trouillot, Michel-Rolph 21

Uganda 24–26, 34, 42, 51, 60
US National Institutes of Health (NIH) 45

VAW *see* violence against women
Venkatapuram, Sridhar 3–4
violence against women (VAW): abortion 37, 38; global health issue 30–42; productive power in the disciplinary domain 28–30; in Uganda, the MAD bill 24–28
visible power 11

west *vs.* non-west 9
What's the Problem Represented to Be (WPR) approach 30–31, **31**
WHO *see* World Health Organisation
WHO-MH Gap guidelines (2010) 46, 54
women's equality 25, 27
World Health Organisation (WHO) 2, 24, 28, 36, 45, 47, 51, 53, 54, 59, 60, 63, 64, 67, 73, 82
World Trade Organisation (WTO) 16
WTO *see* World Trade Organisation

Zizek, S. 36–37