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Commentary

The Ghost *Is* the Machine: How Can We Visibilize the Unseen Norms and Power of Global Health?

Comment on "Navigating Between Stealth Advocacy and Unconscious Dogmatism: The Challenge of Researching the Norms, Politics and Power of Global Health"

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Abstract

In his recent commentary, Gorik Ooms argues that "denying that researchers, like all humans, have personal opinions … drives researchers' personal opinion underground, turning global health science into unconscious dogmatism or stealth advocacy, avoiding the crucial debate about the politics and underlying normative premises of global health." These 'unconscious' dimensions of global health are as Ooms and others suggest, rooted in its unacknowledged normative, political and power aspects. But why would these aspects be either unconscious or unacknowledged? In this commentary, I argue that the 'unconscious' and 'unacknowledged' nature of the norms, politics and power that drive global health is a direct byproduct of the processes through which power operates, and a primary mechanism by which power sustains and reinforces itself. To identify what is unconscious and unacknowledged requires more than broadening the disciplinary base of global health research to those social sciences with deep traditions of thought in the domains of power, politics and norms, albeit that doing so is a fundamental first step. I argue that it also requires individual and institutional commitments to adopt reflexive, humble and above all else, equitable practices within global health research.

Keywords: Global Health, Norms, Power, Interdisciplinarity, Reflexivity, Equity

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Introduction

In his recent commentary to this journal, Gorik Ooms argues that if the "academic arm of global health is to survive," it is vital to "address the role of norms, politics, and power in global health head on."[1] Building on recent related discussions in this journal, Ooms argues that "denying that researchers, like all humans, have personal opinions… drives researchers' personal opinion underground, turning global health science into unconscious dogmatism or stealth advocacy, avoiding the crucial debate about the politics and underlying normative premises of global health." These 'unconscious' dimensions of global health are as Ooms and others suggest, rooted in its unacknowledged normative, political and power aspects. But why would these aspects be either unconscious or unacknowledged? One possibility, as the authors to this debate suggest, results from the disciplinary blinkering of the biomedical predominance within global health, which focuses on "the immediate biological, and sometimes behavioral, causes of illness and death"[2] rather than on identifying and analyzing the role of power, politics and norms. While this is certainly true, in this commentary, I argue that the blinkering of global health scholarship is rooted in broader and deeper social processes than a lack of interdisciplinarity alone. I explore a corollary possibility: that the 'unconscious' and 'unacknowledged' nature of the norms, politics and power that drive global health is a direct byproduct of the processes through which power operates, and a primary mechanism by which power sustains and reinforces itself. To identify what is unconscious and unacknowledged requires more than broadening the disciplinary base of global health research to those social sciences with deep traditions of thought in the domains of power, politics and norms, albeit that doing so is a fundamental first step. I argue that it also requires individual and institutional commitments to adopt reflexive, humble and above all else, equitable practices within global health research.

Reconsidering the Interplay Between Power and Norms

This assertion depends on an understanding of power beyond what Jeremy Shiffman calls traditional *compulsory* power — the direct control one actor has over another — to also encompass structural and productive power. Shiffman argues that *structural* power is "how we define ourselves in relationship to one another, in ways that enhance the capacities of some and limit those of others," while *productive* power is "how we create meaning, particularly through the use of categories that lead us to think about the world in some ways but not others."[3] Structural and productive power — the power to define and produce differential capacities and privilege — commonsensically produce structural differentials (like those associated with gender and race), which are in turn sustained by social norms (like those that systematically devalue women and people of colour). These latter examples in particular are illustrative of how structural power and its correlative norms can remain invisible to even the most well-intentioned practitioners: How else can we understand the prevalence of inequitable practices within

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global health research itself? For example, it is unlikely that the organizers convening conferences devoted to global health equity consider themselves sexist or racist at the same time that they populate their plenary sessions predominantly with white men.[4] This kind of blinkered practice gives some insight into how rhetorical commitments to explicit norms can be undermined by deeper socialized practices (and their sustaining unconscious norms) in ways that reproduce and sustain systemic inequities at a range of levels.

The global dominance of neoliberal economic logics provides another case in point, forming a "deep normative core" in global health governance that profoundly influences the range of policy preferences and solutions deemed useful for solving problems and which effectively limit "what is sayable, doable, and even thinkable in global health governance."[5] One visible outcome is a prioritization within global health governance, policy and research of technical and financial approaches to global health, which frame the imperative of global health intervention as a question of investment with 'impressive returns.'[6] Certainly this approach contrasts with the traditional neoliberal view of health and social spending as an unproductive obstacle to free markets, animated most notoriously in the social spending restrictions of the structural adjustment programs of the 1980's and 1990's as well as in prevalent austerity policies adopted after the financial crises of the past decade. Yet the frame of 'global health as investment' does not necessarily disrupt this logic to the extent that public/private partnership funding schemes like the Global Fund Against HIV/AIDS, Tuberculosis and Malaria (GFATM) and the Global Vaccine Alliance (GAVI) both substitute for increased state spending on health and advance trade interests by creating markets where none existed before. The impact within the academy has been a deprioritization of research approaches deemed unfavorable to economic logics, in favor of ostensibly 'apolitical' approaches to global health in the technical, biomedical or commercial domains,[7] approaches which tend to be reinforced by health research funders[1].[8]

Moving Towards Visibility

How then can we make visible the invisible norms, power and politics of global health? A first step is to expand our understanding of the mechanisms of structural power, in particular the "deeply rooted forms of political socialization" whereby we accept the dictates of power even if it is not in our interests.[9] This is what Stephen Lukes calls power as "thought-control," in other words, "the power to shape, influence or determine others' beliefs and desires, thereby securing their compliance."[9] This view suggests that one of the ways in which power sustains unfair social norms is to make the rules themselves invisible, including by keeping potential issues out of politics, whether through "social forces and institutional practices or through individual's decisions."[9] Similar ideas are articulated in literature on privilege, itself the predominant product of the exercise of power: Peggy MacIntosh argues that we deny privilege and turn it into a taboo subject as a functional way to maintain it.[10] Indeed, as David McCoy points out in his cogent critique of the Lancet Commission on Global Governance for Health, researchers may shy away from directly confronting power in order to avoid being labelled as "an unrealistic or quixotic 'radical.'"[11] Yet MacIntosh argues that if we are to redesign the social systems that sustain inequities like those associated with race and gender, we must first acknowledge their colossal unseen dimensions.[10]

A second step, as Ooms and others have suggested, is to view interdisciplinarity as a key strategy for advancing the process of visibilizing these invisible parts of the global health enterprise. As Ooms argues, the insights of "the humanities and social sciences, like international law, ethics, philosophy, and political science are probably better equipped to study, analyze and discuss normative premises than biomedical sciences."[1] To these domains can be added insights from social epidemiology, international relations, sociology and anthropology, amongst other disciplines well-versed in investigating the systemic dimensions of inequity. These disciplines have deep traditions of scholarship on norms, power and politics, that it is simply inefficient to ignore when it comes to addressing these areas within our research and practice. From social epidemiology comes Nancy Krieger's conception of an 'ecosocial' view of heath inequities as constructed by interactions between biological predispositions and the social 'scaffolding' that different social groups daily reinforce or seek to alter, and which defines the potential and constraints of human life.[12] Krieger argues that these interactions "exist at every level, subcellular to societal, repeating indefinitely, like a fractal object."[12] From feminist political economy, comes Isabelle Bakker and Steven Gill's suggestion that our systems constitute our identities and preferences, turn us into their consumers and producers, and in these ways, continually reproduce themselves.[13] These disciplinary perspectives shed light on some of the lenses and processes through which global health researchers can begin to make these systems visible, and once seen, interrupt their cycles of reproduction, including within our own conduct.

If we are to recognize that we are inextricably part of the power relationships that Kelley Lee suggests global health is shot through with,[14] then reflexivity must constitute a third key practice. Rushton argues that rather than attempting "to take cover behind some bogus claim to 'objectivity' or 'neutrality'" we should be "reflexive about our own positionality vis-à-vis the issues we study – including the solidity of our own claims to expertise and moral authority."[15] Rather than viewing reflexivity as an exercise in 'navel-gazing' or self-indulgence, we could view it as the imperative of "reflecting on how one is inserted in grids of power relations and how that influences methods, interpretations and knowledge production."[16] Reflexivity requires considering "how one relates to research participants and what can/cannot be done vis-à-vis the research within the context of institutional, social, and political realities. As such, it is integral to conducting ethical research."[16] For global health researchers in well-resourced institutions in well-resourced countries, this practice might incorporate considerations of how geographical location influences their choice of projects, their interactions and collaborations with co-investigators in low- and middle-income countries, and their treatment of research subjects.

Fourth, actors and institutions should consider making an overarching commitment to equitable practice *within* global health. If we are serious about the imperative of achieving global health equity, then uncovering where we stand in relation to the systemic production of inequity (and how these systems impact global health practice), are surely essential first steps towards the remediation at the heart of the ambition of global health project. To repurpose Eleanor Roosevelt's famous

statement about rights – if equity does not have meaning in these small places close to home, where we live, work, learn, it will have little meaning anywhere.[17] To be clear, it would be hard to conceive of an academic enterprise not immune from the need to ensure equitable practice. Yet the imperative to 'practice what we preach' is surely greater for a project so explicitly rooted in achieving health equity. It is heartening in this regard to see academic enterprises in Canada committing to equity in global health outcomes as well as practice[2].[18,19] The challenge for institutions and researchers will be to move from principle to practice in coherent, meaningful and thoughtful ways. At a minimum, such practices should encompass: more equitable gender and racial representation at conference panels and in academic hiring and promotion; considerations of the nature and extent of student funding (especially for low- and middle-incomes country students); and considered integration of equitable practices into research collaborations with low- and middle-income investigators—from authorship of study results to methods of disbursing funds.

Conclusion

These are starting points for continuing discussions and processes that institutions and researchers alike should initiate to determine the scope and content of additional institutional and individual practices necessary to translate global health equity as principle into practice. In the absence of similar approaches that permit us to identify and consciously choose our normative premises, and consciously and directly confront inequitable power dynamics in ourselves and our global health institutions, we should resign ourselves to accepting that norms, politics and power are not simply ghosts in the global health machine,[20] but its essential drivers.

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Endnote

[1] For example, while the Canadian Institutes of Health Research, Ottawa, ON, Canada (Canada's federal national health research funding body) funds the domains of biomedical, clinical, health systems services and social, cultural, environmental and population health research, in 2013/14, almost 80% of funding was directed towards biomedical and clinical research, with only 12% going to social, cultural, environmental, and population health research.

[2] In two examples close to home: equity and humility are explicit values driving the vision and mission of the Dalla Lana School of Public Health's emerging Institute for Global Health Equity and Innovation, as well as the Canadian Coalition for Global Health Research's Principles for Global Health Research.

Ethical issues

Not applicable.

Competing interests

The author declares that she has no competing interests.

Author's contribution

LF is the single author of the manuscript.

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