Structural Injustice and the Decolonization of Global Health

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Abstract

This thesis examines how the discipline of global health has understood colonialism and explores why it has led to inadequate understandings of what decolonization entails in global health. The current discourse on decolonizing global health relies on a conceptualization of colonialism that is too narrow. This thesis argues for an account of colonialism as a structural injustice, using Iris Marion Young's framework. There are two consequences that adopting the structural account of colonialism could have for the decolonization movement in global health. Understanding colonialism as structural injustice would mean challenging the conceptualization of colonialism that is presented in the discourse, yet allow for a more critical examination of current, past, and perhaps even future, structures in global health. By analysing colonial injustice from a structural perspective, the movement to decolonize global health could strengthen its argument that current injustices can be related to past injustices, and that the social structures that enabled colonial injustice might still be present in current norms, attitudes, and arbitrary privileges in global health. This thesis analyses the colonial structures that have shaped American global health education specifically and uses Young's account of responsibility for structural injustice to guide recommendations for decolonizing global health education.

Résumé

Cette thèse explore comment le domaine de la santé mondiale interprète le colonialisme pour mieux analyser les incompréhensions concernant le rôle de la décolonisation dans la santé mondiale. Le discours actuel sur la décolonisation de la santé mondiale se fonde sur une définition du colonialisme qui est limitée. Cette thèse met en avant un rôle plus important du colonialisme, mettant en lumière l'injustice structurelle, fondée sur les arguments d'Iris Marion Young. Il y a deux conséquences que l'adoption de la structure même du colonialisme pourrait avoir sur le mouvement de décolonisation en ce qui concerne la santé mondiale. Le colonialisme interpreté comme une injustice structurelle mettrait en cause la perception du colonialisme contemporain, cependant ceci permettrait une analyse critique des structures actuelles, passées, et peut-être même futures dans la santé mondiale. En analysant l'injustice coloniale d'une perspective structurelle, le mouvement pour décoloniser la santé mondiale pourrait renforcer son argument que les injustices actuelles sont liées aux injustices précédentes et que les structures sociales qui permettaient l'injustice coloniale sont peut-être toujours présentes dans les normes, attitudes et privilèges actuels de la santé mondiale. Pour comforter ce point de vue, cette thèse explore l'Éducation Américaine concernant la santé mondiale. En premier, en analysant les structures coloniales qui l'ont créée et, en deuxième, en utilisant l'idée de Young concernant la responsabilité de l'injustice structurelle avec le but d'éclairer les propositions sur la décolonisation dans ce domaine.

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After almost five years of study at McGill University I am excited yet sad to leave this institution. I was a curious and perhaps directionless undergrad who took classes in departments such as geography, sociology, public health, history, despite being a political theorist. I eventually found myself in a global health research program where I loved bringing a political theorist's perspective to the table. I have tried in my work to bridge disciplinary boundaries and this thesis is the result of that. I am beyond grateful to McGill for providing the fertile ground for students and professors to work together across departments, and for all the wonderful people I have met here.

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Introduction

The field of global health has for the last few years been experiencing a fierce debate concerning the relationship between global health and colonialism. There have been several attempts to define global health as both an academic discipline and a real-world practice. It is a diverse and broad umbrella that includes a range of biomedical and social science topics. Generally speaking global health is concerned with improving health without concern for national borders (Koplan et al. 1994). Many scholars have recently called for the field to be decolonized, yet there is little to no consensus on what this entails and where to focus the efforts. This trend has several possible sources. Global health aid organizations, non-governmental organizations, international public health organization, private philanthropies, etc. are mostly concentrated in specific countries, such as the UK and the US. The seminal *The Global Health 50/50 Report 2020: Power, Privilege and Priorities* showed that 84% of global health institutions are headquartered in North America and Europe (30). A focus of the report was also on gender imbalances, as the report found the "70-80-90 'glass border'", which refers to how, "more than 70% of leaders in our sample are men, 80% are nationals of high-income countries and 90% were educated in high-income countries" (10). Another explanation is that the discipline was galvanized by the murder of George Floyd and the Black Lives Matter movement. The decolonization movement was initiated by global health students in the US, such as student groups in Harvard and Duke, before the murder (Hirsch 189). Another possible trigger for discourse is the emergence of the COVID-19 pandemic, which some argue has revealed and worsened already existing power structures, health inequities, and 'colonial attitudes' in global health (Büyüm et al. 2). Decolonization in global health is thus a reaction to power asymmetries within the field, health inequities, and a rejection of the concentration of knowledge and expertise in North America and Europe.

The reason that the movement is using the language of decolonization is because many scholars in the field argue that the issues and inequalities of global health, both within and outside the discipline, are caused by colonialism. Jessica Lynne Pearson, Randall Packard, and other historians have written extensively on the ways in which global health and colonialism have been historically intertwined. Pearson lays bare how French colonial ambitions led to uneven public health development in Africa (*The Colonial Politics of Global Health*), while Packard details how the birth of global health as we know it today was born from the womb of American colonialism (*A History of Global Health*). Global health's beginning as colonial medicine, some argue, has resulted in the replication of colonial-like relationships where money, resources, and humans, are exploited (Chaudhuri et al 1.). There are also scholars who argue that unequal global health outcomes are shaped by socio-economic contexts that themselves are the result of exploitative and extractive colonial relationships (Demir 1). By drawing on the relationship between colonialism and global health the proponents of the movement to decolonize global health are seeking to re-politicize and re-historize the field (Büyüm et al. 1).

This thesis argues for a structural account of colonialism as an injustice and develops how this would change and improve the call for decolonization in global health. Understanding colonialism as structural injustice would mean challenging the conceptualization of colonialism that is presented in the discourse and allow for a more critical examination of current, past, and perhaps even future, structures in global health. This will be explored using American global health education as an example of how to analyse the structures in global health. Moreover, the same example will allow us to explore what the responsibility for ameliorating and ending structural injustice should resemble.

The first chapter of the thesis will analyze and discuss the ways in which colonialism is currently being conceptualized in the discourse. The chapter reveals four trends in how colonialism is conceptualized, and how each of these characteristics presents problems for decolonizing global health. The current conceptualization ignores injustices done by non-governmental actors, settler colonialism, the temporal continuity of some colonialisms, and reinforce already existing harmful dichotomies in global health. By using Iris Marion Young's and Catherine Lu's account of structural injustice, the first chapter will argue that a different conception of colonialism is needed and how this framework can be conducive to decolonizing global health. The second chapter of the thesis will illustrate how a structural lens can be utilized by global health practitioners and academics to analyse and identify colonial structures impacting the current global health landscape. This is done by analysing the impact that the Rockefeller Foundation's early international health work has had on American global health education. In particular, the formation and genealogy of the 'American method' will be traced as a specific social structure that has both enabled and benefitted from colonialism. This structure has continued today and shapes current American global health education by encouraging harmful and exploitative 'voluntourism'. The third and final chapter will argue that understanding colonialism as structural injustice will also assist in the decolonizing process. Young account of responsibility for structural injustice will help guide a discussion on who should engage in decolonization and how it should be carried out. This chapter will use American global health education again to illustrate which agents are responsible and suggest ways that they might work against or stop the colonial structures still present. By analysing colonial injustice from a structural perspective, the movement to decolonize global health could strengthen its argument that current injustices can be related to past injustices, and that the social structures that enabled

colonial injustice might still be present in current norms, attitudes, and arbitrary privileges in global health.

Chapter 1: Conceptions of Colonialism and Structural Injustice

"Nevertheless, as of 2020, it is difficult to identify any compelling conceptions of global justice or global health justice or to identify any significant philosophical contributions to the practical improvement of global health and inequalities"

Sridhar Venkatapuram "Global Health without Justice or Ethics"

This chapter will unpack how colonialism is understood in the discourse on decolonizing global health, then discuss the issues with the conceptualization, and lastly offer an alternative framework. While there is much debate in the literature over how exactly decolonization should look and what it should entail, there has been little attention paid to what colonialism is, and how it has shaped global health (Abimbola and Pai 1627). This chapter will therefore first seek to understand what is meant by "colonialism" in the discourse. In doing so, this chapter seeks to highlight four characteristics constitutive to the conceptualization of 'colonialism' in the global health literature. The first characteristic is the temporal relocation of colonialism to the 'past' and to 'history'. The second constitutive feature of colonialism is that it is characterized as being enacted by governments, empires, or other formal political formations. The third characterization is that colonialism only took place in lower-middle income countries (LMICs). Lastly, the fourth constitutive characteristic is that colonialism took place strictly between high-income countries (HICs) and LMICs. The chapter will then explore how this conceptualization is in tension with the goals of the movement to decolonize. The conceptualization obscures forms of colonialism, reinforces existing harmful dichotomies in global health, and ignores important structures that have facilitated colonialism. Lastly, the chapter will introduce the structural injustice framework and its application to colonial injustices as a competing and favourable conceptualization of colonialism.

Understanding what is meant by 'colonialism' in global health discourse necessitates piecing together a definition from its use in the literature. Few of the surveyed articles discussing

decolonization of global health engage with clear frameworks and theories. The way colonialism is talked about, how it is bracketed, and the scope of its injustice is collected and analyzed. This allows for the construction of a working definition of colonialism within the discourse. In a sense, this is a reverse form of conceptual analysis as described by Johan Olsthoon in Adrian Blau's *Methods in Analytical Political Theory.* While this chapter engages in, "systematic study of concepts" by studying the concept of colonialism, the goal is not to create a definition of colonialism (154). Rather than "elucidating complex concepts by breaking them up into their simpler and more comprehensible constituent parts", this chapter seeks to elucidate the concept of 'colonialism' as it is used in the discourse on decolonizing global health by identifying the constituent parts of the concept. The first step of this process was to collect a sample of articles that are part of the discourse. These articles were found using the search terms "decolonizing", "decolonising", "decoloni*", and "global health" in the title, in online journal databases World Cat, PlosOne, and Web of Science. The range of dates was between 2019 and 2022. A sample of twenty-one articles was found[1]. Each of these articles were then analysed in order to understand which characteristics were presented as constitutive of 'colonialism', whether explicitly or implicitly. The goal of this was not to form an exhaustive list and analysis of every view expressed by every author and article that has participated in the discourse. The aim of this section is to identify and analyse conceptual trends in the discourse. This chapter seeks to identify patterns in the conceptualization of colonialism in the discourse. The account of colonialism extrapolated from the decolonizing global health discourse can be defined as having four specific characteristics: being an event that happened in the past; being perpetrated by

[1] Blogposts, magazine articles, and other such mediums, were also used by global health academics and practitioners to discusses the decolonization of global health. This thesis chooses to only use academic articles in order to have a more concise scope of analysis.

states, empires, and other explicit political formations; only taking place in the LMIC; only taking place between HIC and LMIC.

I.1: Colonialism denotes wrongs that took place in the past.

Perhaps the most common trend in the global health literature is the relegation of colonialism to the past and to treat it as an event that is leaving lasting 'legacies' and 'remnants' in global health. Some authors provide a clear cut definition of colonization, as being specific to global health, such as Garba et al.: "Colonization in global health refers to the enduring legacy of colonial structures and power differentials that drive discrimination and allow for disproportionate benefits to individuals at HIC institutions at the expense of their [LMIC] partners" (Garba et al. 2). Colonialism here is defined only as a 'legacy' – there is not present colonialism. Conceptualization of global health as being plagued by, "the historical effects of colonialism" and that issues of power asymmetries, bigotry, and epistemic exclusion are leftovers of this "legacy of colonialism" are present in various articles (Naidu 4–5). Another example comes from Eichbaum et al., as they seek to "examine the legacies of colonialism and their lingering impact on the practice of global health" (329). Others describe the unequal Covid-19 responses and health outcomes for Indigenous nations in the US, as stemming from, "the historical injustices that put them at greater risk in the first place" (Büyüm et al. 2). This reveals a pattern in describing the temporal characteristics of 'colonization' within global health literature. It is a historical event that has come and gone, leaving behind 'legacies' that need to be addressed by a form of 'decolonization'.

Temporally bracketing colonialism as being only in the past suggests that colonial injustice only occurred in the past and has ended. By fixing colonialism as a concept to the past, the scope of the injustices acknowledged and in need of rectification are also limited. If

colonialism is a ‘past’ or ‘historic’ injustice, then there needs to be an explanation for how the past injustices are connected to current injustices that need to ‘fixed’ through decolonization. The issue is not that colonial rules and occupations have happened in the past and might currently have ended. Even if there are only historical effects and legacies leftover from a past colonial situation, why would decolonization be the solution to this problem. Continually referring to the justice-oriented movement as being decolonization and referring to colonialism as being the cause of current injustice necessitates more conceptual flexibility concerning the temporal characteristic of colonialism. In other words, one cannot simultaneously claim that colonialism writ large is over and yet still a problem. Stating that a current injustice is the ‘legacy’ of past injustice (colonialism) might even suggest that the current field of global health is colonial only because of its historical origin, and nothing else. This is especially pertinent if the normative political project of a movement is to stop present-day injustices that are informed and shaped by colonialism. If colonialism is over, then it is not clear what decolonization is targeting.

I.2: Colonialism is perpetrated by states, empires, or other explicit political formations

The second characterization of colonialism is that it was perpetrated by states, empires, or other explicit political formations. Colonialism is associated with government policies and state power and as a result considerable amount of the discourse on decolonization contends with inter-state and government-related actions and policies. Some articles have warned how the ‘political decolonization’ that resulted in independent nation states should be viewed as a ‘warning’ for how decolonizing global health can fail, as it resulted in, “a relationship of dependence” between HIC and LMIC (Mogaka et al. 1359). The nation-state and its relations with other nation-states becomes the locus of interrogation and of ‘colonial legacy’. Some, perhaps due to the focus on the state, also frame decolonization in terms of development. In

advocating for decolonization of global health, one article argues that, “in recognizing that principle [decolonization], the research and practice of global health have to go hand in hand with the socioeconomic development of all nations” (Kwete et al. 4). Furthermore, other articles claim that the goal of decolonization is non-interventionism. While ignoring current colonialisms, one article posits that, “if global health institutions are serious about their commitment to working against the legacies of colonialism and fighting racism, then they will need to give up some or all of their power. That means … a limitation to our power to intervene in [LMICS] (Hirsch 190). Others make this connection even more explicitly, as they describe how, “colonizers were pushed out of their colonized territories and bilateral aid agencies were born around the same time, many, from former agencies that managed colonial assets for their regime”(Kwete et al. 1). The framing of history is thus that it was only after colonial ‘regimes’ were ‘pushed out’ that non-governmental institutions had anything to do with colonialism.

If states are the main perpetrators of colonialism, then it is not clear why the actions or attitudes of non-governmental actors, such as global health institutions, is connected to colonialism. The global health landscape has been, and is still, populated by many non-governmental organizations, such as private philanthropic organizations, alongside countless individuals who are not government officials. The current account does not provide a reason why actors such as these would also be connected to a past colonial political rule. Discussions of reparations between individual countries, or focus on inter-state colonial injustice, is not in itself a problem. Colonial governments and other political regimes were culpable. There are, however, organizations and individuals who were not part of the state that also perpetrated colonial injustice. While it is also ahistorical to suggest that non-governmental organizations were not involved in colonialism(s) prior to the ‘political decolonizations’ that are referred to by sampled

papers, it also does not bode well for the normative political goal of decolonizing the field of global health, given the scope to which NGO's and philanthropies are currently involved (Youde 50). Simply stating that present day issues that are present both in the public and private sector, is the 'legacy' of such a narrow conceptualization of colonialism as only practices by governments on an inter-state basis is not enough.

I.3: Colonialism was an injustice that took place in LMIC.

The third characteristic of colonialism is that it is located geographically in LMICs. While this is absolutely true, that colonialism was present geographically in countries that fall into the LMIC category, the issue is that colonialism is presented as only being present there. Some scholars argue that, "for those of us in the Global South who continue to endure the suffocating legacy of colonialism in global health…We simply cannot wait for the reimagining and rebuilding of the global health field as has been called for by some of our counterparts in the Global North" (Oti and Ncayiyana 1). Oti and Ncayiyana are rightfully concerned with decolonizing from the location from which they find themselves – the 'global south' – but they fail to consider that they might have 'counterparts' that are like themselves experiencing colonialism even if they are in the 'global north'. Other scholars have made a point to try and de-essentialize the experiences of colonialism by arguing that "colonial mindsets" are found in LMICs as well (Khan et al. 1). This nonetheless fails to consider that colonialism itself is not confined to the LMICs. Some scholars discuss global health as replacing colonial authorities, ignoring colonies where colonizers were in fact not pushed out, and where global health and international aid agencies have their headquarters (Daffé et al. 558). This characterization goes hand in hand with the dichotomization of 'HIC' and 'LMIC' as one author refers to HICs as, "countries that built their centers of academic excellence through wealth built from the

exploitation of their former colonies" (Binagwaho 3). Other authors explain how American global health is an example of how 'even in post- and non-colonial settings, international health experts continued to perpetuate colonial ideas that became "naturalized as global health science,"' (Daffé et al. 558). Other authors recommend that, "global health curricula and predeparture training modules in HICs could include fundamentals of colonial theory and the sociohistorical impacts of colonialism in LMICs" (Eichbaum et al. 331).

Assuming that colonialism was a wrong done only to LMICs excludes settler colonialism as well as the inequitable access to health in HICs that are rooted in racial hierarchies. Settler colonialism writ large is ignored by global health and is not present in the discourse on decolonizing global health. Scott Lauria Morgensen has succinctly critiqued global health for only taking notice of, "colonization's continuation within the structural inequalities of a putatively decolonized world", while rarely acknowledging that, "settler colonialism is not even nominally decolonized within contemporary settler states" (Morgensen 189). This is doubly concerning. For one, Indigenous health is included under the mandate of global health in settler states such as Canada and the US, despite being under a 'domestic' purview. Racial minorities and immigrants are also placed in this category of 'domestic' populations that global health can be practiced on (Hanrieder 307).

Secondly, a normative political project concerning decolonization that ignores colonialism that is present in some of the most populous and over-represented countries in the global health field means ignoring colonial injustices, both past and present. There is no need to argue that engaging in over-seas colonialism has 'brought back' colonialism to the US, the colonialism has always been there, and arguably has informed over-seas colonialism[2].

[2] Jodi Byrd has argued this in *The Transit of Empire: Indigenous Critiques of Colonialism*

Institutional and academic power is heavily concentrated in several settler colonial states, such as the US. Morgensen makes this tension explicit, as he argues that, "settler colonialism may appear to be contained within settler states, its actions are inherently transnational: settler states and societies define and lead the economics and laws that articulate a globalized world with ongoing, naturalized colonization" (Morgensen 189). Proponents of decolonizing global health need to take settler colonialism seriously, otherwise they risk, "ignoring the settler colonial context where one resides and how that inhabitation is implicated in settler colonialism, in order to establish "global" solidarities that presumably suffer fewer complicities and complications" (Tuck and Yang 30). By only placing colonialism geographically in LMICs, and ignoring colonialism within HICs, the movement to decolonize global health is ignoring a common and prevalent form of colonialism.

I.4: Colonial interactions took place strictly between HICs and LMICs.

The fourth and final trend in conceptualization colonialism is that it took place between the dichotomized HIC and LMIC. Common terminology in the global health literature is the use of the terms HIC and LMIC to denote broadly 'colonizers' and 'colonized'. The point here is not that the colonialism described did not take place or is not important to global health. Rather, the point is that the conceptualization is very narrow considering that global health is, broadly speaking, concerned with health globally. There are types of colonialism, such as settler colonialism, that do not fit into this dichotomy. Another result of this dichotomy, perhaps paradoxically, is that decolonization itself is not confined to the governments themselves. Rather, the dichotomy of the HIC/LMIC becomes the focus, no matter where in society there is interaction between the two. One article is explicit about this, as it discusses how "colonial legacies" creates uncomfortable tensions in, "partnerships between institutions in the former

colonizing countries (mostly HICs) and the formerly colonized countries (often low- and middle-income countries [LMICs])" (Eichbaum et al. 329). This is made explicit again, as others argue that eliminating white supremacy should be the goal, not decolonization, state that it is, "the primary cause of colonization and of the divide between HICs and LMICs" (Binagwaho et al. 6). The dichotomy of the (former) colonizers and (formerly) colonized, expressed itself generally through the terms HIC and LMIC remains ubiquitous throughout the discourse on decolonizing global health.

Even when discussing how individuals or institutions act in colonial ways within the field of global health, scholars participating in this discourse still seem to be attached to viewing this relationship as happening between independent nation-states. One article articulates the issue within global health as being the distribution of "disproportionate benefits to individuals at HIC institutions at the expense of their low- and middle-income country (LMIC) partners" (Garba et al. 2). In global health practice, one author argues, "wholesome improvement of the health-care system of LMICs is often minimal or non-existent, highlighting the priorities of HICs" (Mogaka et al. 1359). The two examples shown here are not incorrect, there is a power asymmetry in both the academic and practical dimensions of global health. Others are more explicit in their framing of academic issues, as they argue that "These ethical issues commonly arise as a result of power and resource imbalances between HICs and LMICs, which largely stem from a history of colonialism" (Harper and Pratt 2). The interplay of institutions, academic norms, language, and other such structures are thus flattened into a relationship between to states.

Casting colonialism as an act that only happens within a strict dichotomy reinforces the already problematic tendency in global health to broadly categorize countries as either being part of the 'Global North' or the 'Global South'. Aside from the previous critique that this framing

also ignores settler colonialism in so-called HICs, this framing flattens colonialisms in so-called LMICs. Scholars in global health have already argued that this terminology used uncritically, shrinks the histories and unique characteristics of countries. The act of sorting them into one of two groups is "unnuanced, reductionist, and othering" (Hommes et al. 897). While one might defend the use of these terms and this framing as a shorthand for very real political and economic imbalances globally, it is ultimately imprecise and concealing of the specific colonialism experience both between so-called LMICs and within so-called LMICs. If one is advocating for a project of decolonization, then surely there needs to be more space for recognizing that colonialism can have, and is taking on, distinct and different forms.

This characteristic also casts colonial injustice as an act that happens strictly between nations through state interaction. As other scholars have pointed out, this distinction can harm decolonization projects. An over-emphasis on inter-country relations in decolonization can be harmful, as "diverse cultures (or cultural subgroups) can coexist in geographic regions affected by educational global health partnerships, and host-country stakeholders may have differing perspectives, values and cultures" (Kulesa and Brantuo 2). Focusing entirely on inter-country relations there both risk flattening the unique structures, histories, and needs of communities within countries and what those communities might need and want in terms of decolonization. This therefore risks obscuring both past and present colonial structures. If the goal of the movement to decolonize global health is to politicize and critically examine past and present structures, relationships, and power dynamics, then this conceptualization of colonialism is inadequate for diagnosing contemporary inequities that global health practitioners seek to address.

Several of the surveyed articles counter the dominant trend as they engage explicitly with theories of colonialism to make a normative argument concerning either the future or past of global health. Ali and Rose utilize Frantz Fanon's ethnopsychiatry to analyze the interactions between global health practitioners and patients during the 2014 West African Ebola outbreak (Ali and Rose 5). Affun-Adegbulu and Adegbulu draw from Walter Mignolo's work on the colonial matrix of power (CMP) to argue for a "pluriversal" global health field that utilizes decolonial questioning (2). They state that, "In our opinion, there can be no one-size-fits-all approach, as this would again mean (re)producing the universalism that is inherent to coloniality" (2–3). This article in particular stands out as it both engages significantly with decolonial theory and rejecting universal and global theories of colonialism and for that matter, decolonization itself. These articles illustrate that while there are identifiable trends in how colonialism is defined and perceived in the discourse, it is not entirely uniform in its approach to colonialism, coloniality, and decolonization. My thesis contributes to decolonial approaches that aim to challenge the hegemonic/dominant discourse on colonialism in global health.

Part II: Understanding colonialism as structural injustice

Iris Marion Young's account of structural injustice and Catherine Lu's account of colonialism as structural injustice provide a better theoretical approach to understanding both colonialism and decolonization, than the one currently present in the global health discourse. Understanding colonialism as structural injustice would mean challenging the conceptualization of colonialism that is presented in the discourse, but also enable a more critical examination of current, past, and perhaps even future, structures in global health. By analysing colonial injustice from a structural perspective, the movement to decolonize global health could strengthen its argument that current injustices can be related to past injustices, and that the social structures that

enabled colonial injustice might still be present in current norms, attitudes, and arbitrary privileges in global health.

Structural injustice is distinct from explicit government laws that seek to oppress and from individuals explicitly seeking to do harm. Broadly defined, structural injustice happens when, "social processes put large groups of persons under systematic threat of domination or deprivation of the means to develop and exercise their capacities, at the same time that these processes enable others to dominate or to have a wide range of opportunities for developing and exercising capacities available to them" (Young 52). The structures that enable injustice have certain key characteristics. For one, they are often part of the baseline of expected behaviour from individuals. Social structures that cause injustice are the result of, "Action in conformity with or in reliance on institutional rules… not part of the intentional consciousness of the actors, but is, rather, routine or habitual" (62). Structural injustice is not an aberration of expected action. Social structures are often upheld by non-state agents seeking to fulfill their own teleology.

Social structures are conceptualized as a network of relationships, both between people and between humans and objects, that constrains individuals in those relations through schemas and resources. Schemas in this context refer to collective beliefs, concepts, expectations, and are according to Sally Haslanger mutually constitutive with resources in creating social structures. In a social structure, "there are public schemas for interpreting, conceptualizing and responding to resources, and such resources are utilized and modified in order to fit the schemas" (126). This structure, in turn, limits and enables individual actions through schemas and resources as they, "structure the possibility space for agency" (127). These enabling and constraining, social, relational, structures also have the aspect of, "commonly involving the unintended consequences

of the combination of the actions of many people" (Young 54). The individuals that find themselves to be experiencing structural injustice might be upholding and enabling the very same structures themselves. Acknowledging this is not meant to victim-blame, but rather to point out that experiencing structural injustice is about being in a structural position that makes one vulnerable to injustice. As Young articulates succinctly, "Being vulnerable to [structural injustice] names a common position in which individual persons with diverse attributes, life histories, and goals find themselves" (56).

Social structures are not necessarily limited by national borders nor specific temporal political contexts. Young uses sweatshops as an example of social structures that reach across borders and cause injustice. The global sweatshop industry reaches across borders as it involves disparate actors, such as large retailers, factory owners, governments, consumers, and lastly, the workers who work in the sweatshops themselves. Young points to the fact that, "there is a complex chain of production and distribution involving dozens or thousands of contractually distinct entities that bring the clothes manufactured in multiple places to the stores in which people buy them" (129). This also means that structural injustice can be sustained and enabled by individuals and other actors outside national borders.

The social structures that cause injustice can also have a temporal continuity beyond explicit laws or political rules that might have caused, enabled, or exacerbated the structures. In discussing the relationship between current structures and past injustices, Young draws on the argument that slavery is the historical cause of the structural injustice that Black people in the United States currently face. While our obligation to end structural injustice is forward-looking, it is still important that one be, "concerned with historic injustice in order to understand present injustice as structural" (185). Therefore, the structures that cause the injustice can have a

continuity that connects past injustice with current injustice, on a global scale. A structural injustice approach to colonialism differs from other theoretical frameworks that seek to explain the relationship between past and present injustice by focusing specifically on the continuity of structures. Consider Jeff Spinner-Halev's enduring and historic injustice. He argues that some groups suffer from enduring injustice, where the historic injustice endures because the present is also unjust, and the future would also be unjust, unless something changed. A condition that needs to be met for an injustice to be an enduring injustice, is that the political community to which the injustice has happened, needs to have a collective narrative of the injustice (63). Judging whether an injustice is enduring based on a collective narrative, as opposed to more material measurements such as economic status, does not seem like a very strong condition. As Spinner-Halev writes, collective narratives can be misused and misrepresented (62). In comparison, the focus of structural injustice is not on whether a specific event, memory, or even government 'endures'. The focus is rather on whether there is a temporal continuity of structures, social or otherwise, that have enabled past and present injustices.

Analyzing colonial injustice from a structural standpoint means examining the social structures that enabled or contributed to the injustice. Catherine Lu makes the point that colonial rule, "at times reinforced or exacerbated other existing structural injustices among the colonized" (2017, 130). The structures that enabled and upheld colonial injustice are not necessarily fixed to colonial political power, however. As Lu writes, "While political regimes may change, and new constitutions herald new political and social structures, structural injustices may continue to pervade norms, values, and beliefs and shape social practices and habits, fortified by long-standing and obdurate material conditions" (165). As social structures themselves can have a continuity that is delinked from political rule it gives both structural injustice and the

consequences of that structural injustice a possibility of being continuous. Lu presents this idea succinctly, as she writes, “If structural injustices implicated in the production of past colonial injustices have not been eliminated, then there is a significant sense in which colonialism is not yet over, even if particular unjust acts have ended or particular forms of wrongful practices have been changed” (264). Thus, past colonial injustice might have a temporal continuity through social structures.

Structural injustice is also compatible with accounts of settler colonialism, as the former gives an account of specific structures that engender, support, and benefit from settler colonialism. Patrick Wolfe argued famously in “Settler Colonialism And The Elimination Of The Native” that settler colonialism is, “a structure, not an event” (388). What is meant by this is that settler colonialism never ended, that it instead created and is sustaining settler colonial societies such as the US, Canada, New Zealand, and Australia. Lorenzo Veracini has built on Wolfe’s seminal work by explaining how settler colonialism structures function and are distinct from other colonial structures. In likening settler colonialism to bacteria, Veracini describes how settler societies seek to, “exercise a type of biopolitical control and prevent the reproduction of exogenous alterities within the body politic” (24). This is part of the goal of assimilation, namely, “The aim to reproduce racially or culturally ‘homogeneous’ [populations] was historically an explicit policy objective in all of the settler polities” (24). Yann Allard-Tremblay and Elaine Coburn have also argued that settler colonial structures can be found in contemporary political theory. Namely, that there are current ideologies that support the continued structures of settler colonialism, where, “the elimination of the native is performed at the level of ideas, as well as in practice” (8). As Allard-Tremblay and Coburn reveals, this argument persists in the work of contemporary political theorist Tom Flanagan and is used to affirm the validity of settler

colonial structures as being justified (9). Glen Coulthard's seminal *Red Skin, White Masks*, also uncovers how settler colonial structures in Canada seek to disenfranchise and separate Indigenous communities from the land for the sake of resource extraction. In particular, a function of the settler colonial structures in Canada is to acquire and exploit the land, and seeks to undermine and suppress Indigenous self-determination in order to do so (78). Settler colonialism thus structures injustice in a distinct way, as the structures of settler colonial societies have specific contents and effects on Indigenous communities.

A structural injustice approach is fitting to global health as proponents of decolonizing global health continually make references to challenging, changing, or eliminating 'structures' writ large. The structural injustice approach allows for the possibility that the social structures that enabled and benefitted from colonial injustice can survive even if explicit colonial rule has ended. This is highly relevant to arguments that make references to existing "colonial structures" in global health (Chaudhuri et al. 3). Understanding colonialism as structural injustice includes non-state actors as possible enablers of injustice. Colonial structures can be upheld and enabled by agents outside governments, including individuals simply going about their day or private organizations. While government aid agencies have significant power in this field, much of both the issues and supposed decolonizing solutions have little to do with official governments, states, or even inter-state reparation. Besson makes explicit reference to structural violence, specifically racism, as engendered and caused by social structures in her article on white supremacy and the decolonization of global health (2329). Understanding colonialism as structural injustice does not presume a specific geographic location of colonialism. This allows for critiques of global health colonial structures that do not ignore settler colonialism (Morgensen 189). The structural injustice approach challenges the dichotomization of the globe into two strict categories because

it focuses on structures that rarely contain themselves to national borders. Structural injustice involves structures beyond government laws and policies, and therefore necessitates analysis beyond state-interaction. This is highly relevant to the movement to decolonize global health, as decolonization is imagined as involving more cultural sensitivity training (Eichbaum et al. 335), a more representative demographic in global health funding panels (Khan et al. 2), and a general desire to see the end of "colonial structures" (Abimbola and Pai 1627). Structures, social or otherwise, are both part of the problem and the solution in decolonizing global health. Applying a structural injustice framework therefore seems both appropriate and needed. The next chapter will illustrate how understanding colonialism as structural injustice would aid understanding and identifying harmful structures in global health by analysing the issue of global health educational experiences.

Chapter 2: Structural Analysis of Global Health Education

"As Manifest Destiny declared its intent to slide from one shining city upon a hill to the next as it progressed westward towards Hawai'i and the Philippines, those intervening lands initially deemed external and terrifying were continually remade and remapped as internal in an attempt to obliterate any other possible spatial, historical, or sovereign memory"

Jodi Byrd, *Transit of Empire*

This chapter seeks to illustrate how utilizing the structural injustice framework, and specifically understanding colonialism as structural injustice, aids with the challenging of unequal and possibly harmful structures in the global health field. The historical starting point will be the Rockefeller Foundation's work in American colonies. The organization had significant influence not just on how global health as a field developed, but also specifically on how American global health practitioners interacted with patients. This chapter will not only argue that the relationship between doctor and patient is itself a social structure, that this social structure can be both replicated and carried on through education, but that this has happened with American approaches to practicing global health. In doing so, the chapter will also unsettle the conceptualization of colonialism as presented in the first chapter, as these social structures illustrate that colonialism also operates outside explicit political rule, outside the HIC/LMIC dichotomy, and outside definitive temporal brackets.

Part I: The Rockefeller Foundation and American global health

The Rockefeller Foundation is one of the most influential organizations in global health, and American approaches to global health specifically. While the US government did increase their budgetary spending for global health in the early 2000's with The U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the American involvement with global health is older than that. Rockefeller Foundation's work predates, and in many ways influenced the World Health Organization's (WHO) work in what we now consider global health. The foundation's work started during what was known as colonial health, then international health, and now what

is called global health. The Rockefeller Foundation was founded by American oil-tycoon John Rockefeller in 1909, with a starting fund of over 1.5 billion dollars in 2022 equivalencies, and soon began to turn that financial power towards global public health (Farley 3). The WHO's predecessor, the League of Nations' Health Section, was active during the inter-war period but had a much more modest budget and influence. The Rockefeller Foundation was in this period, "the main provider of funds for the development of international activities in the sphere of public health…and an important sponsor for fundamental biological and biomedical research" (Löwy and Zylberman 366). Moreover, it has been foundational for American global health academia, as some of the most influential global health schools were founded and financially supported by the foundation.

The Foundation's work in health started with the International Health Commission (IHC), created in 1913[3]. The board was assembled in what has been referred to as the "glow of the imperial public health array", developed and enforced during the US's colonial projects in the Caribbean and the Philippines (Palmer 59). One of the first recruits was Major William Gorgas, who had risen to public health fame after his yellow fever-eradiation campaigns in occupied Cuba and during the construction of the Panama Canal. In both instances, Gorgas was recruited by the American colonial authorities to combat yellow fever for the sake of 'development', as he, "shared a belief with many of his countryman that the development of the tropics depended on the success of white settlement… He felt that the greatest significance…was that it demonstrated that white men could live in the tropics" (Packard 23). The construction of the Panama Canal and the resulting eradication campaign entailed intervention and control by the US military and the local colonial authorities. The campaign, running from 1889 to 1901, "required meticulous

[3] The IHC was renamed the International Health Board from 1916 to 1927, and from 1927 to its dissolution in 1951, the International Health Division.

reporting and surveillance. It also required the cooperation of local residents, which was not readily obtained, as they objected to the intrusive measures introduced by Gorgas" (Packard 20). Gorgas was successful and ultimately facilitated the completion of the Canal. The newly formed IHC saw Gorgas' treatment of yellow fever a highly desirable model of public health and recruited him to their organization (Packard 28). Gorgas was not the only American physician whose colonial work would inspire and influence the IHC's approach to global public health.

American physicians took the lessons learnt from Havana and Panama and refined them during the colonial project of the US in the Philippines. Warwick Anderson argues that during the start of the 20th century, "military medical officers developed a novel, and at first distinctively American, understanding of the tropics and the bodies inhabiting the region" (Anderson 2). Renowned physician Victor G. Heiser lead colonial health authorities in the Philippines from 1905 to 1915 and shared Gorgas' attitude towards the medical capabilities of the colonized population (Packard 30). Unlike Gorgas, however, Heiser was not tasked with specific disease eradication but rather massive public health campaigns that in the end sought to discipline and sanitize the Filipino body. With, "almost complete military power", Heiser invaded and controlled the public and private lives of the Filipino population as he, "enforced vaccination, household hygiene, and improvements in housing, water supplies, nutrition, and— above all— sewage disposal" (30). The model of public health and sanitation that Heiser wanted to see implemented was, of course, American. During Heiser's mandate, he sought to enforce American approaches to sanitation, such as the use of latrines, seeing them, "producing unfaithful copies of the American originals" (Anderson 181). When he returned to the Philippines in 1925 after leaving his post in 1915, he was thrilled to discover the sizable number of latrines built, a sanitary practice he considered American (181). Heiser, like Gorgas, was

recruited by the IHC in 1915. The Rockefeller Foundation's IHB recruitment of both Gorgas and Heiser heavily influenced the board's future work and influence on American global health.

Steven Palmer traces the creation of this method by the Rockefellers as they employ it against hookworm epidemics in the Caribbean British colonies. Building on Anderson's exploration of US colonial medicine as tracing a, "specifical American, and specifically colonial, mode of tropical medicine", Palmer seeks to trace the contemporary and civic evolution of this mode (9). The Rockefeller Foundation's work took them from one colonial project to another. It deployed both Gorgas and Heiser, as well as several of their trainees to Latin America, the Philippines, and very importantly, to the British Caribbean colonies, in its global hookworm eradication campaign. It was here that the American method was named, to draw distinction between the type of public health that the British colonial officers and the American Rockefeller officers were engaging in (Palmer 75). Packard argues that following Gorgas and Heiser, "reveals the influence that ideas and practices developed in America's colonial possessions had on the IHC's early hookworm campaigns" (33). It was during hookworm campaigns in Caribbean that the 'American method' of public health was enforced. Calling it the 'intensive method' instead to discharge it politically, the method required, "systematic surveillance, census registry, physical examination, and drug treatment of all bodies within its boundaries" (Palmer 115–16). Influence by Gorgas and Heiser's approach to public health, the American method was employed in various hookworm campaigns, to various degrees of success. What remains however, was that the American method's, "totalizing grid did become an established part of the repertoire of international public health…" (214). Unlike earlier colonial campaigns, the Rockefeller Foundation did not rely as heavily on colonial authority during its global hookworm campaigns.

The American method was introduced not through force, but rather through training, cooperation with national governments, and sought instead to be, "egalitarian and inclusionary" (Palmer 215). The non-compulsory yet dilutive nature of the hookworm campaign illustrates perfectly how the American method spread as a social structure, rather than as an authoritative policy. Palmer makes this explicit:

> "The international Health Commission's hookworm array was an exemplary institution of modern U.S. imperial power – a power that operates not through intervention, imposition, and direct control, but through implantation of regimes that are subsequently assumed locally and adapted to local conditions in sovereign fashion without ceasing to be part of a dispersed web of connections, conditions, financing, epistemology, and influence operating, ultimately, in the interests of empire" (216)

Despite the work of the Rockefeller Foundation's IHB in the 1930s and 1940s relied less on coercive powers and the dilution of the American method into various public health traditions, it ultimately proved to be deeply influential in American approaches to global health. Comparing it to fast food, Palmer notes that the American method touched upon millions and millions of lives under the auspices of the Rockefeller Foundation (217).

American global health was saturated with the American method because of the Rockefeller Foundation's educational work. Starting in 1918, the Foundation endowed and founded one of the world's most renowned Global Health-affiliated universities, the John Hopkins School of Public Health. Soon a network of Rockefeller Foundation-supported public health schools started forming, mostly in North America and Europe. The goal was to, "transplant American scientific models of public health, with all their imperfections, to these and other countries…trained at the three most important schools: Johns Hopkins in Baltimore, Toronto, or London" (Farley 239). This process would happen initially by staffing the leadership

and managerial positions with Americans but would eventually transfer to 'local' hands. This illustrated, according to Lowy and Zylberman, "the Foundation's preoccupation with the diffusion of the 'right' science of public health, but also its ambition to instruct local experts, and to hand responsibility for this to national authorities as rapidly as possible" (372). For example, the position of leader at the Sao Paolo School of Hygiene, "was then transferred to a Brazilian doctor who had been educated at Johns Hopkins and was an enthusiastic supporter of American methods" (372). American doctors were also being trained in the American method abroad, as the Rockefeller Foundation consciously used the hookworm campaigns in the Caribbean to train them in the American method (210-211). Much of the organization's focus in the early 20th century thus went to training both Americans and selected 'locals' in the American method to spread a certain kind of public health.

The 'American Method' and colonial public health was not limited to overseas colonialism and enabled American 'domestic' settler colonial projects. The methods and attitudes described as being part of the 'American Method' were not only practiced towards the US' colonial projects in the Philippines, but also towards the settler colonial project in Hawai'i. This is perhaps most clearly evident during WWII where the US military imposed martial law on the territory and used the American method in running vaccinations, blood drives, and other public health interventions. Juliet Nebolon has argued that public health, intertwined with militarism, supported settler colonialism during the second World War. The compulsory vaccine drive instated in 1941 is an example of this, as it resulted in the "reduction of individuals to a serial number, photograph, and fingerprint", and punishments for those who refused (29). The diseases from which persons were inoculated were often themselves a result of settler colonialism as well. The US military used scientific rationality both to justify its presence and to

obscure the diseases white settlers had introduced in Hawai'i. These logics, "rationalized the increasing US military presence, its continued acquisition of land, and its technologies of population regulation and surveillance. Yet settlers themselves had introduced many of the diseases… from which Hawai'i needed this 'protection'" (Nebolon 30).

It was not just that Hawaiians could become 'Americanized' as a form of mimicry, they were placed, "alongside immigrants as an 'assimilable' racial minority" (Nebolon 29). Palmer might have argued that the American method was "egalitarian and inclusionary" in treating each body within the disease vector the same, but when this structure is utilized and enabled under settler colonialism, this form of egalitarianism becomes part of the logics of assimilation that seeks to eradicate Indigenous peoples. Jean Kim's work on nursing education in Hawai'i in the first half of the twentieth century illustrates the extent to which nursing academies led by white nurses sought to Americanize the "local girls" (148). Specifically, the nursing colleges would circulate among American readers images of "…student nurses wearing their nursing uniforms and, elsewhere, their 'native garb' to illustrate the normative power of the profession juxtaposed against the polyglot background of Hawai'i's population" (156). These pictures symbolized the successful "Americanization" of local girls and therefore supported and justified continual settler colonialism in Hawai'i. The American method worked therefore in tandem with settler colonial logics of assimilation and eradication. Both by incorporating Indigenous Hawai'ians into a larger category of racialized 'other' but also in terms of 'Americanizing' the racial 'other' in public health through public health training. The goal of Americanization in public health therefore enabled settler colonialism by seeking to justify American occupation while also seeking to eliminate Indigenous Hawaiians through assimilation.

The 'American Method' thus is an example of social structure that was developed during colonialism, yet also informed and enabled both 'overseas' and 'domestic' colonial projects. This highlights the foundations and genealogy of a specific social structure that has had a significant impact on American global health. The American method was simultaneously developed during and in support of various American colonial projects, and was disseminated and spread through education, ultimately becoming part of global health rationale. The American method structures how individuals interact and shapes avenues of possible action in public health and carried an American chauvinism with it. As it was spread initially with the intention of 'Americanizing' local populations both by training health workers in these methods but also by centering American global health educational norms by creating a network of global health practitioners through the Rockefeller Foundation's involvement in education. The next section will argue that the American method as a social structure is still present in the current American global health educational system, and as a result is contributing to coloniality in the field.

Part II: Structural continuity: voluntourism and exploitative educational experiences

A key aspect of global health in the American academic setting is the opportunity for students to travel abroad to 'experience' global health. There has been an increasing interest in providing or enabling the travel and practice of medicine for students specifically[4]. While not uncommon before the 1980's, the percentage of students who seek 'international experiences' either before or during medical school has increased significantly in the last years (Hanson et al, 175). Despite the popularity of these trips and initiatives, there is little knowledge on how many students exactly are participating each year, and whether they received specific training, before, or during the trip itself (174). This demand also reaches beyond academia, as an increasing

[4] There exist a variety of terminology for these trips, such as calling them Short Term Global Health Experiences, International Medical Experiences, and medical voluntourism.

number of students and young adults seek the opportunity to 'do' global health via private for-profit companies (Sullivan 311). American students simultaneously receive and pour a considerable amount of money into practicing medicine abroad (Adams et al 2). This trend has also meant that there is an increasing focus on the effects of these trips, both on the 'local' population, but also on the American students themselves. Serious ethical, structural, and normative questions have risen out the literature on these global health experiences in the last 15 years (Bauer 1). In detailing the ways in which American global health academia engages with African universities to create institutional partnerships in order to enable these experiences, Crane warns that the dynamic could replicate a colonial relationship as, "global health becomes an increasingly hot field, there is a risk these well-intentioned efforts are creating a 21st-century scramble for Africa by US universities" (1388). This concern has been echoed by others, as worries over the ways in which American universities and Non-Government Organizations (NGOs) are in their quest to form global health partnerships, are "carving up" slices of the continent in ways that, "recalls colonial-era scrambles for power in the continent" (Brown 345). Other scholars describe the norms, power dynamics, and attitudes of visiting students and health workers as neocolonial (Sullivan 311; Bauer 2; Adams et al. 3). This section will argue that the social structures that shape the behaviour of American global health student are themselves are also putting both patients and health workers in structurally vulnerable position.

The dynamic between American students and 'local' doctors and patients often takes an exploitative, dismissive, and exotifying turn, and is in a sense a social structure that carries with it certain assumptions about the 'who', 'where', and 'how' of global health. The social structure that shapes interactions between visiting American students and their host colleagues and patient contains certain norms, ideals, and attitudes about what global health consists of. One of these

norms is that the travelling American global health student will have a certain level of access to patient bodies. Johanna Taylor Crane's work on the American global health response to the HIV/AIDS crisis in Africa reveals to the extent the expectation that students held concerning their access to HIV/AIDS patients. She found that students, "were drawn to work in Africa both by a desire to ameliorate bodily suffering and by the unparalleled learning opportunities afforded by ready access to thousands of HIV patients" (147). This desire, while still coupled with a humanitarian wish to end suffering, nonetheless exemplifies the dual view of patients as patients and patients as resources. While this is considered part of any kind of medical research, in the context of global health or not, Crane wants to, "emphasize the ways in which global health, as envisioned in the American academy, encourages the mobility of particular bodies while requiring others to remain geographically rooted in place…ailing patients in Africa are positioned as offering certain kinds of valuable knowledge opportunities to highly mobile North American students and researchers" (148). Health workers in the countries that host these American students are often themselves non-mobile bodies, as worries of the global trend of brain drain from the 'Global South' to the 'Global North' results in countries limiting the mobility of their health workers (Wendland 112). The relationship that the American students have to their patients becomes one where viewing them as a desirable resource is normalized as part of the experience of global health itself. Seeing public health in other countries as a training ground for American doctors to practice medicine, and in particular the American method, was a key characteristic of many Rockefeller Foundation missions in the 1930's (Palmer 210).

American global health students see doing global health 'somewhere else' as the most authentic way to 'do' global health. Some scholars have attempted to define global health as being "public health *somewhere else"* to acknowledge and encourage critical examination of the

baseline issues that come with practicing public health not "not at home" (King and Koski 1). Simply defining global health as such might not strike at the heart of the ways in which the dynamics between the 'here' and 'somewhere else' is imagined by American students and practiced through social structures. Tied with the idea that there are certain bodies that 'do' global health – the mobile American students versus the immobile and resource-aligned patient – is also the conception of where those bodies find themselves. Not neatly distinguishable, global health experiences for American students are "contingent upon the availability of certain kinds of bodies located in certain kinds of places. Southern patients and their ailments are envisioned as biological embodiments of settings alternately described as 'resource- poor,' 'resource- scarce,' and 'resource constrained,' and working with them represents the chance to 'do' global health" (Crane 158). Betsey Brada argues that the imagined location of global health as 'somewhere else' is far more specific than not being in the US. From her ethnographic fieldwork in Botswana, she observed how American global health students perceived the 'location' of global health. She writes that, "educators, students, and administrators must work to make vastly different times and places, diseases and people—a 6-week stint in a tuberculosis laboratory in South Africa, for example, and a summer working on HIV/AIDS prevention in Thailand—commensurable under the sign of 'global health'" (303). American global health students are not going overseas to learn from Thai or Botswanan doctors – rather they are seeking to practice American medicine and American global health.

Perhaps one of the most concerning and potentially harmful aspects of the schemas that American students engage in when participating in global health experiences are the assumptions concerning how to properly 'do' global health. A common imagination expressed by American global health students is that when they get to participate in these experiences that they will

‘make a difference’ in the geographic space they occupy. Brada’s interviews with global health students reveals the attitude that, “[a global health student’s] presence in Botswana should, ideally, contribute to the project of ‘‘building capacity’’ or ‘‘elevating the standard of care’’ in the long-term through the accumulation of short-term individual actions that added up to more than a sum of their parts” (305). This attitude was also present in American students who engaged with patients as well as colleagues from the host countries, as they, “saw themselves as entitled to particular experiences by virtue of their self-perceptions as future professionals and as citizens of a higher-ranking (predominantly white) country” (Sullivan 317). This can also result in conflicts with colleagues and patients. For example, accusing their colleagues of not caring about their patients when they also have to live through crisis situations (Wagner 46). The assumed superiority and desire to ‘do good’ results in American medical students providing care or giving treatments that they would be unqualified for (Hanson et al. 172). The social structures that form between American students and the ‘local’ health workers and patients they work with often is qualified by a certain assumed ability to ‘do’ global health in certain ways, following certain American global health icons, to enact ‘real change’. This attitude is less surprising or out-of-place when considering the prevalence of the American method in the founding of prominent global health institutions. The birth of global health was partially the result of Americans seeking to practice medicine and global health the American way. Combined with other structural factors, however, this social structure can make certain individuals, often patients, vulnerable to domination, exploitation, and injustice.

A common concern is that the stream of volunteers is disrupting ‘local’ medical systems as well as normalizing uneven, underfunded, or otherwise structurally limited medical services. Students, or even fully educated health workers, risk disrupting already existing medical services

by creating "duplicate or parallel health systems" which fracture "…services with people rather waiting for the next arrival of free health care from overseas than consulting local personnel" (Bauer 4). A clear example of this comes from post-earthquake Haiti, where a steady and constant stream of health workers challenged the already pressed healthcare system. Laura Wagner's ethnographic work in Haiti illustrates the extent to which both Haitian doctors and hospitals were pressed financially and socially by the influx of volunteers (47). The conclusion was clear: "if Haiti remains a country where medical professionals cannot make a living, where they are made to compete with foreigners who provide free care and challenge their expertise and commitment, it will be impossible for Haiti to train and keep qualified Haitian doctors" (55). There is also the worry that the disruption is also seen as morally valid because it is filling gaps in the existing medical system. Sullivan argues that "The popularisation of international clinical volunteering relies on long histories of under- and unevenly resourced health systems in LICs, which make the journeys of foreigners abroad to assist in health facilities appear justifiable, even laudable" (310). Others argue that these short-term experiences at best, "can only be a short-term fix which may benefit individual patients but does not improve long-term access to quality health care" (Bauer 4). Having a continual stream of American global health students providing short-term and inadequate healthcare, that they might even not be qualified to practice in the US, arguably worsens already fractured health care systems, and thus puts individuals in a structurally vulnerable position.

This chapter has served as an illustration of how one would use a structural injustice framework to analyse colonial injustice and their possible continuity. There is no doubt that current American global health educational programs are contributing to injustice that are structural in nature, both domestically and internationally. There is also evidence to suggest that

the social structures that are taken for granted in American global health are colonial – not because they imitate past behaviour or because any kind of inherited colonial 'legacy'– but because the structures themselves have persisted and continued since their colonial inception. Understanding colonialism as a structural injustice and being able to analyse current global health structures from such a lens, has revealed continuities in American global health education. Colonial injustices are perpetrated by non-government agents, across dichotomies such as HIC/LMIC, through social or other structures that persist. The structural injustices that American global health students contribute to today are not that far removed from the colonial injustice that global health was borne from.

Chapter 3: Responsibility, Guilt, and the Future of Global Health

"If I share responsibility with many others for every social injustice that results from structural processes to which I contribute by my actions, then this makes me responsible in relation to a great deal. That is a paralyzing thought. How can I begin to take action to discharge my responsibility in the face of such massive and diverse problems?"

Iris Marion Young, *Responsibility for Justice*

Identifying and analysing structural injustices and harmful social structures means also working towards undoing them. The movement to decolonize global health and the surrounding discourse struggle with how exactly to decolonize, and specifically, who should be the ones to decolonize. The purpose of this chapter is not to present a plan to decolonize all of global health, everywhere. Rather, this chapter will explore how these discussions should consider Young's parameters of reasoning about responsibility to guide those in the field of global health to engage in a collective political movement that seeks to address structural injustices in global health. Young's conception of responsibility for structural injustice and the Social Connection Modal will be introduced and discussed. This chapter will argue that the framework can be useful for decolonizing global health, using the example of American global health education again. While universities in HIC can 'lean out' of leadership roles in decolonization, they ultimately have significant responsibility when it concerns harmful structures in global health education. Lastly, this chapter will also argue that global health students themselves have both agency and responsibility in the decolonization movement.

Part I: Responsibility and the Social Connection Model

In order to answer the question, "how shall agents, both individual and organizational, think about our responsibility in relation to structural injustice?" (94), Young presents the Social Connection Model (SCM) of responsibility. This model of responsibility is defined through comparison with what Young refers to as the liability model of responsibility, which is based on the logics of criminal and tort law (98). Young wants to demonstrate that the liability model,

while appropriate in some situations, is not appropriate for addressing structural injustice (100). Five key differences between the liability model and the SCM are then drawn to elucidate the salience that the SCM has for structural injustice. As Young seeks to create a theory of responsibility that can elucidate political action and organization, she also highlights that she sees responsibility not as a question of assigning "guilt or fault" but rather means, "agents' carrying out activities in a morally appropriate way and seeing to it that certain outcomes obtain" (104). This distinction is key to keep in mind for the SCM and her discussion on the role of guilt and blame.

The first comparison between the two is about the isolating effect of the liability model. Criminal and tort law aims at finding individuals responsible by way of highlighting or distinguishing them from other individuals, who are not responsible, to demand compensation or to punish them. This is not necessarily appropriate in cases where the injustice is structural, and where typically, hundreds, if not thousands or millions, of individuals are implicated (106). Contrastingly, the SCM focuses on structures themselves. The second key difference between the two models lays in the role the background conditions of the injustice play in assigning responsibility. Structural injustice is the result of some of those baseline norms and social structures. Responsibility then should not be assigned based on deviancy, in relation to structural injustice, but rather in accordance with contribution (107). The third difference between the liability model and the SCM is about the temporalities of the injustice and the responding responsibility for that injustice. Young argues that the liability model is primarily backward-looking, while the SCM is primarily forward-looking (109). Being forwards-looking still necessitates looking to the past to understand how exactly the social processes constrain and enable individuals. In the fourth comparison, Young contrasts the SCM's shared responsibility as

being distinct from the liability model's corporatist account of responsibility. By participating in and enabling the social structures that cause injustice, individuals thus become responsible in a shared way, rather than as a collective or corporate entity (111). This ties in with the fifth, and final, point of comparison between the SCM and the liability model. Young argues that with structural injustice, collective action is the only way to stop the injustice. As social structures are enabled and kept in place by many individuals and can therefore only be challenged or undermined by many individuals acting together (112). Building a political movement that can discharge responsibility as described under the SCM is therefore key to stopping and preventing structural injustice.

In the specific context of colonial structural injustice, Lu offers the argument that responsibility is not tied to temporal nearness. Namely, that current actors are still responsible for structures that stem or originated from past injustices. The elimination of structures that enabled colonial injustices in the past is still the responsibility of current actors, as, "the moral and political responsibility to eliminate them constitutes the unfinished work of the political struggles for justice and reconciliation in international and transnational relations, especially as they relate to the legacies of empire, slavery, and colonialism" (264). Responsibility is therefore not tied to the origins of the structural injustice, and with the case of colonialism, but rather to end the structures themselves. For ongoing colonial injustices, such as settler colonialism, settler responsibility is just as present. Erich Steinman points out that since settler colonialism is ubiquitous is settler societies, such as the US, the possibility for resistance is therefore also everywhere. He argues that "[settlers] do not have to go looking for settler colonialism so that we can oppose it. We are in it, all the time, and we can act to undermine it where we are" (561).

Responsibility to undo and combat structural injustices therefore comes from participation in the structures.

Invoking responsibility does not mean invoking a personal feeling of guilt nor blame. Young remains wary of the rhetoric that might be invoked when building movements towards eliminating structural injustices. She argues that using blame language might inspire resentment and defensiveness, which is not pragmatic for building political movements that require massive collective action, as those emotions can have an individualizing effect, and focus people "more on themselves than on the social relations they should be trying to change" (114). The language of blame and guilt can also produce harm to a collective moment even if it does not inspire a defensive reaction or resentment as people admitting guilt or blameworthiness can be equally unproductive (118). She also finds the language of blame has a flattening effect on how structural injustice itself is perceived, as she argues that, "a blame language can be inappropriate and unproductive in the context of structural injustice because it tends to divide people between powerful wrongdoers and those who are innocent" which "overs-simplifies the causes of injustice" (116). Her theory of responsibility and the SCM was created with guiding political movements in mind.

Young's writing on responsibility for structural injustice has received various critiques. Andrea Sangiovanni has argued that Young has been "unsuccessful" in arguing that individuals can be responsible for structural injustice, yet not be considered "wrongdoers" (466). Robin Zheng has critiqued Young for failing to discuss exactly the kind of responsibility invoked by the SCM, and arguing that she is presenting a "desiderata for a theory of responsibility than a full-blown theory itself" (109). Corwin Aragon and Alison Jaggar have sought to build on Young's work by qualifying that responsibility for structural injustice stems partially from what they refer

to as "structural complicitly" (449). This is meant to support Young's SCM by clarifying why participation in harmful structures generates any kind of responsibility, as they argue that pointing out that many people contribute to structural injustice is not a sufficient normative reason (446). These authors, whether seeking to rescue or add to Young's theory of responsibility, have in common the critique that the present account is not sufficient. The strength of her theory, however, is that it is geared towards political action. The argument that avoiding blame-focused language to not inspire negative sentiments in a political movement is salient when viewed in a more practical context. Inspiring political action is also a key component of the theory itself as the only way to discharge any kind of responsibility for structural injustice requires collective action. Lu defends Young's conception, namely that the distinction between moral wrongdoing and political responsibility, is fueled in part by her argument that, "the conventional practices of holding agents accountable for their morally blameworthy acts…are not the appropriate practices for engendering responsibility for structural injustice" (2018, 47). Responsibility for structural injustice must therefore be considered in light of this practical bent.

Part 2: Structural decolonization and universities in HIC

Understanding colonialism as structural injustice can help guide decolonization in global health. The movement to decolonize global health and the surrounding discourse struggles with how exactly to decolonize, and specifically, who should be the ones to decolonize. Some scholars have critiqued the movement as coming from "academics based in HICs" as well as researchers in LMICs who have "built their careers within the current colonial global health structure" (Mogaka et al. 1359). There has also been those in the discourse who advocate for those of privilege to 'lean out' of global health leadership (Pai). There is simultaneously tension

over white saviourism among those who seek to contribute to the decolonization of global health (Herrick and Bell). Lastly, there is a genuine concern over the ways in which the academic discourse itself is centered in and filtered through academia in HICs (Oti and Ncayiyana). These concerns are all completely valid and need to be taken into account. As understanding colonialism as structural injustice enables collective political action by identifying the harmful structures that persists and need to be stopped, it also assigns responsibility for the structural injustice. Namely, agents, whether individual or not, that participate to these structures have a responsibility to work against them. One thing that might need to be discussed briefly is the role of positionality can play in combatting structural injustice. Young is clear that any work needs to be collective but discussing positionality can be a way of identifying harmful structures that one might be enabling and benefitting from.

Positionality can play a part of collective political work to combat structural injustice[5]. Sean Hiller and Suzanne Hindmarch have in their paper on decolonizing global health ontology situated themselves as part of the work. Hiller is queer, Mi'kmaw, and registered member of the Qalipu First Nation, while Hindmarch is a white settler who at the time of the writing of the article lives on unceded territory of the Wolastoqiyik and Mi'kmaw people (2). Their positionality matters especially for the work they're doing, namely seeking to decolonize global health through challenging current hegemonic global health ontologies. One example is the emphasis on the individual even when engaging in social determinants of health analysis (5). As part of this work, they reveal their positionality, because "Our perspectives, including our own ontological assumptions and understanding of some Indigenous ontologies, have emerged out of

[5] My own positionality is also relevant. I am currently enrolled in a university that is located on unceded territory of the Haudenosaunee confederation and the Anishinabeg nation (known as Montreal), in a Global North country. The work in this thesis is shaped by this position, especially as much of the discourse and sources used have come from the academic world and in particular global health researchers.

specific geographic and political locations, relations, and learning from elders and scholars whose teachings have shaped our own perspectives and intellectual approaches and whom we recognise with gratitude and thanks" (2-3). This position is also fully compatible with Young's account of both structural injustice and responsibility for stopping structural injustice. We are all positioned in complex webs of structures, social or otherwise. Acknowledging and incorporating in our work the position we find ourselves in in relation to these structures, such as whiteness or registered First Nation status, can be relevant for the work we do to undo harmful structures. Hiller and Hindmarch's work provides an excellent example of this, as they are identifying ontologies that in many ways fuel and sustain harmful structures in global health, yet also using their own experiences to decolonize and Indigenize global health ontologies (8). This work will ultimately have to be collective to change harmful structures but discussing positionality can be a good start to political movements that seek to stop structural injustice.

Global health programmes, partnerships, and research groups in the academic sphere are responsible for both encouraging and enabling potentially harmful international global health experiences. For one, there needs to be serious debate over whether 'international' global health experiences should count at all towards admissions into various medical or other global health related programmes. Students are encouraged to gain global health experience as part of their admissions to prestigious global health programmes and degrees (Bauer 6). This arguably increases the chances of students engaging in harmful international trips, as they might seek out voluntourism trips in the private-sector, where there is little oversight and even less accountability (Sullivan 313). Secondly, global health educational programmes need to limit or even eliminate short-term global health experiences. Global health programmes are often the ones organizing, funding, and facilitating the 'international' global health educational

experiences. They attract students to their programmes by advertising semesters abroad and other such opportunities (Hanrieder 299). As discussed in the previous chapter, these trips can contribute to destabilizing already vulnerable health systems, among other harms. As evidenced by the travel disruptions that limited these experiences during the first two years of the COVID-19 pandemic, there are ways to teach global health that does not involve short-term placements (Weine et al. 3). Universities could utilize the already existing and strong international connections between global health programmes through organizations, such as the Consortium of Universities for Global Health (CUGH), to create standards, policies, and agreements that limit both short-term experiences and the harm they can do.

Limiting, monitoring more closely, or dissuading global health students from going on international global health experiences does not mean engaging in 'domestic' global health work by treating both racial minorities and Indigenous communities as the 'third world at home' (Hanrieder 300). This is especially important in settler colonial states, such as Canada and the US. Decolonizing global health also means fighting settler colonialism, which cannot be done if global health practitioners and students keep uncritically othering and lumping together vulnerable communities. In settler colonial states there is a real need for non-Indigenous global health students to ally with and learn from Indigenous decolonization movements. Eve Tuck and K. Yang's seminal paper "Decolonization is not a metaphor" critiques heavily the tendency to sweep settler colonialism under other forms of oppression. They argue that, "…remaining silent on settler colonialism while talking about colonialisms, or tacking on a gesture towards Indigenous people without addressing Indigenous sovereignty or rights, or forwarding a thesis on decolonization without regard to unsettling/deoccupying land, are equivocations….they ambiguously avoid engaging with settler colonialism" (19). Any movement that seeks to

decolonize global health therefore also needs to take decolonizing settler colonialism into account – which means among other actions unsettling the current paradigm in global health that sees Indigenous communities in settler colonial countries as a possible 'resource' for experiencing global health domestically. Decolonizing global health research needs to be fully reciprocal and benefit communities that decide to participate in the research (Tuck, 2013, 369). Decolonizing global health should mean unsettling and fighting to change structures both locally and globally.

An example of resisting colonial structures in the field of health is the Inuit Tapiriit Kanatami's (ITK) *National Inuit Strategy on Research*. The ITK is a national political organization that represents Inuit in Canada ("The National Voice for Inuit Communities in the Canadian Arctic"). Published in 2018, it serves to protect and enhance the priorities of Inuit in research done in the Inuit homeland, the Inuit Nunangat. The reason why this strategy document is necessary in the first place, is because, "colonial approaches to research endure in Canada that prevent Inuit from making decisions about research activity in [Inuit] homeland…" (4). This includes not sharing or being transparent about the use and access to data collected, a focus on research areas that are not respectful of what Inuit need and want, and lack of access to funding opportunities to do research (4). These issues are not arbitrary, as "Inuit in Canada are among the most studied Indigenous peoples on earth", despite rarely receiving the benefits of the research themselves (5). This leads to what is known as 'research fatigue', a frustration with continually being the object of research without ever benefitting from it (Brunger and Wall 1868). The ITK's research strategy seeks to combat this tendency with five priority areas: Advancing Inuit governance in research; enhancing the ethical conduct of research; aligning funding with Inuit research priorities; ensuring Inuit access, ownership, and control over data and information; and

building capacity in Inuit Nunangat research (33). This is an excellent example of how collective political action can combat structures that perpetuate colonialism and other forms of injustices. Another example is that of Ixil University in Guatemala. The Indigenous Ixil community, part of the Maya people, established the university in 2011 as a critique and alternative to the settler colonial education system[6] (Batz 110). Focusing on issues and methodologies that are relevant to the Ixil people and their struggle to decolonize, the Ixil university has invigorated and supported a resurgence among Ixil youth in reconnecting with ancestral knowledge and represents a radical way of organizing education (114). As mentioned in the ITK strategy document, there are currently no universities in the Inuit Nunangat, which limits both funding and research capabilities (4) The Ixil university might therefore serve as a future inspiration for decolonizing health education in settler colonial states, such as Canada and the U.S.

Part III: Student agency and responsibility

There has been much activity dedicated to trying and implement ethical principles for global health educational programs, yet none of these escape the dynamics that they seek to circumvent. In 2009, Andrew D. Pinto and Ross E.G. Upshur published their highly cited "Global Health Ethics for Students" in order to prepare global health students for their "international" experiences. The paper provides an ethical framework for international global health learning experiences that focus on humility, introspection, solidarity, and social justice in order to avoid, "causing harm to patients, research subjects, and communities" (2). This paper is only addressing ethical dilemmas that might arise if they travel to a different country to work. It never addresses the structures around the students nor the patients or colleagues that might shape or enable certain choices. Both the possible harm and the actions taken to prevent it center

[6] While not recognized by the Guatemalan government, the Ixil university is recognized by Ixil and other Mayan elders, as well as formed partnerships with international organizations and universities (Batz, 113)

around educating individuals to "do the right thing" despite acknowledging that issues in global health are influenced by "socioeconomic status and other upstream factors" (2). Some more recent approaches to 'training' students for their international global health experiences and developing frameworks for 'ethical' global health experiences have taken more holistic approaches. The Brocher Declaration, developed in part by the CUHG, includes principles that promote creating "programs based on the host country and community's priorities" and committing to, "long-term healthcare development and sustainability" (Prasad et al. 3). It was developed mostly because, as the paper states, "To date [may, 2022], there are no universal, authoritative, or widely-accepted best practice guidelines for [short-term global health experiences]" (2). These principles still maintain that short-term global health experiences can be sustainable, empowering, and beneficial to both "host country" and the visitors implied to be from a wealthier and more powerful country (Prasad et al. 4–5). There is no talk of mutual educational engagements, where students are exchanged, nor does it ever suggest that maybe there should not be any kind of short-term experiences at all.

University students do have an ability to change global structures. Universities Allied for Essential Medicines (UAEM) is an organization that brings together students and faculty in universities across the world that work towards making research, and especially pharmaceutical and health technology research, widely available (Chokshi). In addition to campaigning on social media and using strategies such as letter writing, chapters of UAEM have also been successful in changing university policies by putting together, "several teams of experts to develop licensing language and policy documents that universities can use to enhance their efficacy in improving global public health" (Wasan et al.). The University of British Columbia chapter of UAEM was able, in 2007, to work with the university to establish a set of research mandates that aimed at

facilitating the sharing of research. The principles had the goal of providing the "developing world with access to UBC technologies" (Wasan et al.). The UAEM chapter at McGill University has also enjoyed some success, as they have been able to work with the university to implement Global Access Licensing Principles (McGill university) in 2019. The Global Access Licensing Principles are in keeping with the Global Access Licensing Framework (GALF), which has the goal of preventing, "patenting practices and intellectual property policies from creating barriers to the life-saving results of publicly-funded research conducted in universities' laboratories" (McGill university). The decentralized network has now turned its attention to COVID-19 vaccines, and are campaigning to make tests, vaccines, and treatments for COVID-19 more accessible by advocating for the use of TRIPS waivers ("UAEM Responds To Covid-19"). This is a good example of student-led activism that seeks to change global structures that shape health outcomes across the world.

Global health students have great capacity to assist with decolonizing global health. It is valid to argue that global health students in the Global North should not be leading the movement to decolonize global health. That does not mean, however, that students in the Global North should not do anything at all about decolonization. One of the first steps is to recognize harmful structures, social or otherwise, that students and faculty might be enabling or upholding. Michael Harvey et al. have argued that the newly developed educational framework of "structural competency" be incorporated into global health education as it trains global health practitioners, "to recognise and respond to disease and its unequal distribution as the outcome of harmful social structures, such as policies, institutions, and systems" (342). The competencies needed are, among others, "(1) Describe the role of social structures in producing and maintaining health inequities globally, (2) Identify the ways that structural inequalities are

naturalised within the field of global health, (3) Discuss the impact of structures on the practice of global health…" (343). The same article also encourages and describes ways in which practitioners can "structurally intervene" once they have gained the competency to do so (351). The before-mentioned UAEM proves as an excellent example of structurally intervening. Global health students seeking to decolonize should therefore first consider the structures, global or otherwise; intentionally or unintentionally; social or otherwise, that they might be enabling or upholding in relation to various forms of colonialisms. This act is both necessary to identify the structures that need to be targeted and to assume the necessary responsibility, as argued by Young.

Global health students seeking to decolonize global health must also take responsibility and work to form political movements that can tackle harmful colonial structures. Responsibility here is not necessarily meant to be assigned to global health students just by the virtue of being global health students. Rather, it is assigned due to their participation in harmful social structures in global health, such as exploitative educational experiences. Discharging this responsibility means that global health students will need to participate in and build political movements that can address harmful and colonial structures. In the case of exploitative international global health experiences, it will be especially necessary for global health students to build collective movements to prevent more harm from being done. Drawing inspiration from the UAEM, this thesis suggest that university students build a decentralized network of student activist organizations that seek to limit, monitor, and change the ways in which students engage with global health experiences. This also means using Young's SCM of responsibility, which makes it clear that structural injustice can only be fought collectively and forming collective political movements. This is a daunting task, and perhaps most importantly, because it also requires

students to be willing to give up benefits and privileges that they might gain from engaging in exploitative and colonial global health experiences. Initially convincing students that they uphold harmful structures could be a hard task – a key characteristic of structural injustice is that the structures that sustain the injustice might be seen as conventional.

Conclusion

The thesis has argued that understanding colonialism as structural injustice can improve the call for decolonizing global health both analytically and politically. Understanding colonialism as structural injustice means challenging the conceptualization of colonialism that is presented in the discourse. Taking a structural perspective, however, enables a more critical examination of current, past, and perhaps even future, structures in global health. The social structures that shape American global health education can hopefully serve as a salient illustration of how one might use this framework to analyze past and current injustices. A structural injustice framework can also help guide future action to fight against these structures, as Young has developed a view of responsibility that is tailored for these types of injustices specifically. Using again the example of American global health education, this thesis has argued that both universities and students have agency and responsibility in ameliorating and ending structural injustice. It should be clear by now that global health is a field that has been shaped deeply by colonialism, in its various forms. The problem, however, is that global health is a massive, diffuse, and constantly mutating field. The focus of this thesis has been limited in scope, partially because there is no one way to decolonize the entirety of global health at once. Decolonizing global health will look differently depending on where one is, as the structures, even if they are colonial, will look different. This thesis has not been exhaustive, but rather has focused on illustrating how the structural injustice framework can be useful for decolonizing. There are scholars who seek to lay the groundwork by examining the relationship between colonialism and global health. Invaluable to global health, and to this thesis too, are the global health historians, sociologists, political scientists, and other such social scientists who have studied global health from various perspectives (Packard; Pearson; Morgensen). By combining

rich historical and sociological work with global justice theory and thought, one has the potential to both understand and perhaps even change the harmful structures one is a part of. Future work on this topic, both academic and political, would benefit immensely from using sources such as these to understand the structures that shape our actions, both locally and globally.

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