THE FOREIGN GAZE

Essays on Global Health

Seye Abimbola

IRD Éditions

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collection
[santé globale]

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Cover photo : © London Stereoscopic Company/Hulton Archive/Getty Images. South African singers Albert Jonas and John Xiniwe, of the African Choir, in a staged photographic portrait session (London, 1891).

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To S.O., for example.

INTRODUCTION

"Something changed when Africans began to take photographs of one another: you can see it in the way they look at the camera, in the poses, the attitude. The difference between the images taken by colonialists or white adventurers and those made for the sitter's personal use is especially striking in photographs of women. In the former, women are being looked at against their will, captive to a controlling gaze. In the latter, they look at themselves as in a mirror, an activity that always involves seriousness, levity, and an element of wonder."

Teju Cole (2016)

There is growing disquiet in the field currently known as global health – about its knowledge practices, its academic arm. This book is about one of the reasons for that disquiet, a reason that is easy to ignore and difficult to name: which is that the field's knowledge practices are constructed for a powerful audience. An audience that is typically foreign – in the physical and social sense of the word "foreign". What that audience wants often shapes how those who address it behave, and what they can – or choose to – see or say. Imagine the scene of a photoshoot. The photographer is behind the camera. The person being photographed strikes a pose, calibrated to the photographer's gaze. The photographer cues, shoots from different angles. The photos reflect the poses struck in response to the gaze. They reflect the relative power of the person striking the pose, and the person whose gaze is shot through the camera. The photoshoot is co-produced, staged perhaps, on a platform.

Now imagine a third party observing the scene of a photoshoot. In each essay in this book, I describe, as an observer, scenes of an academic global health photoshoot. Each essay attempts to say something about gaze in global health – and, by extension, pose or standpoint – and about the "foreign" in relation to the "local". Each essay is a photoshoot of a photoshoot, some of which include the platform on which the photoshoot is staged. I observe and take notes from varying standpoints. I shift around to see and shoot from different angles. Each essay presents reflections on my experience of academic global health, refracted through the explanatory lens of the foreign gaze. But what I have tried to explain here can be done differently, through other lenses – and has been and will be by others. This is my lens: your audience has power (the gaze), and where or how you stand in relation to it (the pose) shapes what you can – or choose to – see or say. Shot in this way, some features of global health are easier to see than if shot differently. Each essay presents pictures. This collection presents several photoshoots.

Any book on global health must first get one thing out of the way: what global health means, or should mean. In the first essay, "In the world, but not of it", I use personal and world history to show how I make sense of "global health" as action "at a distance". To define the foreign gaze, one must establish the markers of distance: when or why an actor may be deemed foreign or local to a place or an issue. The second essay, "The foreign gaze", attempts to do this. It maps how the foreign gaze often neuters the global health literature. The foreign gaze has an appetite for simplicity. It makes people "at a distance" think and act as if complex social systems and realities were simple. The third essay, "Evidence as cliché", reflects on the harmful effect of oversimplification, especially as it relates to learning in health systems. In the fourth essay, "Thinking in two triangles", I use stylised scenarios from my personal and others' experience to show how one might discipline one's thinking about the governance of a health system when positioned or acting "at a distance".

The fifth essay, "The uses of knowledge", maps the users of knowledge within any unit of social organisation. It maps one set of proximate knowledge actors and another set of actors that are "at a distance". It also makes the case for using the principle of subsidiarity to guide relations between proximate and distant knowledge actors – or between local and foreign actors. It is one thing for the foreign gaze to shape the action of foreign actors acting "at a distance". It is another to consider what it means for foreign actors or even local actors to disregard the local gaze. Using personal and world history, the sixth essay, "The dignity of the spectator", explores what it means to not hold in high regard the proximate audience, the local gaze; to violate their dignity as knowers. The seventh essay, "To be wronged as a knower", uses a constructed narrative from personal history to examine the complexities of speaking up or talking back to an audience that represents the foreign gaze, an audience that may have violated one's dignity as a knower.

Each of the essays collected in this book contends with the power of the foreign gaze. But the essays have something else in common: the conception of each began with an image, a picture. "In the world, but not of it" began with the image of distance, even in the context of some form of intimacy. "The foreign gaze" arose from the idea of a photoshoot: understanding a person's pose as a performance for a certain gaze. "Evidence as cliché" was imagined as a chat in which a speaker deploys a thought-stopping cliché, and the wise listener, rightly, rolls their eyes. "Thinking in two triangles" began with the image of a triangle, with two nodes interacting within a context created by the third node. "The uses of knowledge" began rather as an image of four circles; two big circles proximate to action, and two small circles distant from action – the big ones are much more important, but the small ones get all the attention. "The dignity of the spectator" emerged from an image of the parable of the six blind people and the elephant. "To be wronged as a knower" originated from the image – in fact, a series of images – of giving a talk to a suspicious, defensive, potentially dismissive audience.

These essays all began as an attempt to explain an idea to students, colleagues or friends, or with an invitation to give a talk or write an article. "The foreign gaze", "Thinking in two triangles" and "The uses of knowledge" first appeared as editorials in *BMJ Global Health*; and "Evidence as cliché" first appeared in the *CODESRIA* (Council for the Development of Social Science Research in Africa) *Bulletin*. These four essays are republished here under slightly different titles, and with the chance to return to them, somewhat different text. An earlier version of "To be wronged as a knower" was delivered as my keynote address, invited by Chisomo Kalinga, at the 2021 "Finding Joy in Healthcare in Africa" symposium organised by Medical and Health Humanities Africa. A version of "In the world, but not of it" was delivered as my inaugural lecture as the 2020–2022 Prince Claus Chair in Equity and Development at Utrecht University in the Netherlands. An earlier version of "The dignity of the spectator" was delivered as the 2022 annual lecture of the Warwick Interdisciplinary Research Centre for International

Development (WICID) at Warwick University in Britain, which was hosted by Oyinlola Oyebode. The conclusion was first delivered as a public lecture in my role as the 2023–2024 Radulovacki Visiting Scholar in Global Health at Northwestern University in the United States.

I am grateful to the many people who have asked me to speak or write an article, or listened to me voice ideas as they developed, read or critiqued my work, or suggested additional references – in social settings, in classrooms and seminar rooms, on X (formerly known as Twitter), by email, or on Zoom – in particular, Onikepe Owolabi, Joni Lariat, Alice Bayingana, Jumoke Adebayo, Kenneth Yakubu, Nimi Hoffman, Dorothy Drabarek, Pip Crooks, Aliki Christou, Emilie Koum Besson, Sarah Bernays, Supriya Subramani, Himani Bhakuni, Thirusha Naidu, Vikash Keshri, Veena Sriram, Jaime Miranda, Madhukar Pai, Stephanie Topp, Valéry Ridde, Christopher Wright, Rochelle Burgess, Neha Faruqui, my spouse Oine Omakwu (who kindly tolerates my appetite for solitude), and our daughters Erin Joy and Kori Ene (who make writing more fun by agreeing to read my words out loud). The work presented in this book was done at the University of Sydney, Australia (on the lands of Indigenous peoples whose sovereignty over the place currently known as Australia was never ceded), supported by fellowship grants from Australia's National Health and Medical Research Council and the Australian Research Council. I owe much to the combined wisdom of James Baldwin (1924-1987) and Toni Morrison (1931-2019), and my mother, Sola Abimbola (1954-2009). Their work and how they made sense of the world greatly inspired the essays in this book. Their example allowed me to think more clearly about what it means to define what one does in relation to the foreign gaze – and what it means to stubbornly resist that pull. Their example allowed me to ask with all seriousness: What does it mean for a society to see itself, organise itself, and make, use, share and value knowledge (including its own knowledge) based on terms defined from outside? What does it mean to take the measure of oneself, one's soul, one's destiny, on another's terms?

The current disquiet in global health has a rich antecedent. There is a long history of engagement with unfair knowledge practices by anthropologists and ethicists of global health and health systems (ADAMS, 2016; CLOSSER et al., 2022; PRATT et al., 2017; AELLAH et al., 2016). But this engagement has only recently taken the form of direct complaints about these practices and efforts to undo them (AELLAH et al., 2016; Richardson, 2020; Kalinga, 2019). Articulating these concerns as complaints is a recent phenomenon even in global health (Naidu, 2021; Lancet Global Health, 2021; Hanson-DeFusco et al., 2024). Even more recent is framing them as epistemic injustice – or, more accessibly, as unfair knowledge practices (Bhakuni & Abimbola, 2021; Fillol et al., 2022, 2023; Fillol, 2022; Koum Besson, 2022; Bhakuni, 2023; Pratt & De Vries, 2023; Abimbola, 2023a; Abimbola et al., 2024; Burgess, 2024). Yet there is an established tradition of critical epidemiology in Latin America (Breilh, 2021) which, since the 1970s, has developed a critique of downstream analyses of health inequity, and promoted approaches to quantitative and qualitative analyses aimed at undoing unfair epistemic (and political) status quo. But as most of the literature is in Spanish or Portuguese, its spread elsewhere has, unfortunately, been limited. Literature in English on unfair knowledge practices has grown recently, much of it by scholars and practitioners from Africa, Asia and Latin America, including those in the diaspora (Abimbola et al., 2021; Sharma & Sam-Agudu, 2023; Lancet Global Health, 2023; Montenegro et al., 2020); but to date this is much less advanced than Latin American critical epidemiology. Work questioning academic global health in other languages is beginning to take off, but slowly. Scholars and activists writing in French, for example, have begun to engage in it more deeply and to ask others in their orbit to take unfair knowledge practices in global health more seriously (Ridde et al., 2023). Change will require a critical mass of people working in French, as in other languages and in other places. The essays in this book were written and are collected here to help build that critical mass.

This moment in academic global health – and perhaps also in its parent fields of public health and international development (or is it their sibling, cousin or rebellious foster child?) – places the focus of change on those who do it, not only on a vaguely defined set of actors external to the field. Unfair knowledge practices in global health are as much about the role of we academics and the institutions (the rules, norms, expectations, conventions) we tolerate, accept, build and uphold, as they are about the role of other actors and institutions. This long overdue shift in focus puts the onus for transformative change on all of us involved in academic global health and its adjacent domains of research and practice. We cannot fulfil our commitment to health equity globally – to "global health" the mission, not the field (Krugman, 2024) – without a careful self-examination and without being clear about what ails us.

Which is that we tolerate, accept, build and uphold institutions that default to inflicting epistemic injustice on marginalised others – choices and tendencies which are powered by colonialism and other sources and forms of inequity everywhere. We have to be clear about what needs to change and why. We are, many of us, so immersed in the field, so educated and socialised into its flaws, so beholden to its antecedents, that we allow ourselves too little room to resist, or to imagine alternatives.

These essays offer ways to think and act against the potential for unfair knowledge practices – the epistemic injustice – inherent in academic global health. The aim is not to be prescriptive, but to show why many of our accepted knowledge practices are unfair, and to suggest how we might entrench more just knowledge practices. How we might transform academic global health. The Yorùbá caution against being overwise: *Bí ọgbọń bá fo àràbà, t’óbá fo ìrókò, ẹ̀yìnkùlé agọ̀ náà níí já sí*. (“When wisdom jumps over the tall àràbà tree [~75 m] or jumps over the tall ìrókò tree [~50 m], it lands in the backyard of folly.”) I take this as a caution against epistemic hubris; one that our field must heed. The current disquiet in academic global health is long overdue, and I hope it persists long enough and goes deep enough to transform the field. So I will risk being overwise this once, and predict the coming of a field that will have the nickname: “the field formerly known as global health”.

CHAPTER 1

IN THE WORLD, BUT NOT OF IT

"They are not of the world, just as I am not of the world… As you sent me into the world, so I have sent them into the world."

John 17:16, 18 (*King James Bible*, 2017 [1769])

Long after my Christian childhood, few lines in the Bible have stayed with me as much as the one about being in the world, but not of it. It is an invitation to do something near impossible. Like swimming without being touched by water; your entire body covered by a fine, transparent, waterproof fabric. In it, but not touched by it. Or what the African-American feminist scholar Patricia Hill Collins called the "outsider within" (Collins, 1986). This is how I have often seen my place in global health. In one telling of its history, what we describe as the field of global health today began as an enabler of the European colonisation of much of the rest of the world – as colonial medicine, missionary medicine, military medicine, or tropical medicine (Tilley, 2016; Keller, 2006; Anderson, 2021; Bruchhausen, 2020; Packard, 2016; Seth, 2018). In that telling, the field of global health was created by people who did not recognise my full humanity as a colonial "subject", and did not have my best interests at heart. Even if I found myself *in* that field, I could not allow myself to be *of* it.

The missionary strand in the origin story of global health involved European colonisers seeking to redeem and reclaim for their God the hell-bound souls of natives (Bruchhausen, 2020; Packard, 2016; Seth, 2018; Hardiman, 2006; Cattermole, 2021). Many of the

Christian missionaries were health and care workers, out in the tropics to aid the colonial mission: the Bible in one hand, medicine in the other. Fully convinced their belief system was superior, they cast traditional health, knowledge, governance and belief systems as evil and proceeded with zeal to destroy and erase them. What they did was supremacist savagery disguised as civilising mission. It helped to excuse what else was going on – the invasion, the pillage, the theft, the dispossession, the horrors, the racism, the disrespect, the torture, the terror, the killings. Amidst all that evil, missionaries were busy saving lives and souls, often looking away from what else was going on. If they could show the inherent depravity of the natives, then the colonial mission was justified. In their support of the colonial mission, the missionaries were in the world, and of the world. They were agents of power.

There is a saying that "All's fair in love and war" (Smedley, 1850). It speaks to the notion that anything goes when one's goals are pure – or, in fact, when you have managed to convince yourself and others, against the weight of the evidence right before your eyes and their eyes, that your goals are pure. That you can wreak havoc all you want in pursuit of something worthy – true love, winning a war, being kind, being generous, even preserving or imposing "civilisation". No matter how appealing that sentiment may be, or how useful it is as an excuse for evil or for bad behaviour, we know that it is not true. All is not fair in love and war. In many ways, colonialism was and continues to be very much a combination of love and war; but the love is a special kind of love. I call it colonial love. If all is fair in love and war, especially in war, it is the job of colonial love to make it seem fair. Many colonisers managed to believe that colonisation was fair. Even more so, like many of their successors who do global health today, many missionaries believed that what they did was love. But theirs was the kind of love that made war palatable. Instead of justice, colonial love served to justify the evil of colonialism.

The Pentecostal church in which I was raised, the Apostolic Faith Church, arrived in Nigeria in 1944. It came by way of the United States, through a long and branching line of British colonial misadventures and related missionary activities (Robeck, 2017; Anderson, 2005, 2006; Magbadelo, 2004). I was seven when my mother, Sola Abimbola – whom we nicknamed S.O. (her initials) – started to attend the church. What soon stood out for her and the rest of the family about the church was its commitment to the doctrine of divine healing, and its strong opposition to watching television. Unlike earlier colonial Christian missionaries, the church was determined not to be of the world. The church eschewed other worldly things too: wearing jewellery or makeup, using alcohol, tobacco, recreational drugs or therapeutic drugs, dating, body piercing, men sporting facial hair or styling their hair, women dressing in trousers or clothes that were skintight, cut with low necklines, above the elbow, or above the knee – even in the tropical West African climate. It was a grave sin of faithlessness to seek medical services. It was a sin to watch television, which was known among ardent church devotees as "the devil's box". But in our family, we did both wantonly, without a sense of transgression, fully aware that doing so meant we were of the world. Whenever fellow church members visited our home, some averted their eyes from the television; others joined in watching, with noticeable unease. But there was no hiding our mother's work – she was a nurse-midwife at one of the two major hospitals in town.

Looking back, I wonder if these doctrinal prescriptions were somewhat convenient. That perhaps deprivations are easier to bear if the justification (to not use medical services, television and other "worldly" goods and services) is faith rather than poverty. In the 1990s, Owo, where we lived, was a typical peri-urban town in southwestern Nigeria. Televisions were expensive, and most people could not (and still cannot) afford the cost of health care. Like us, the relatively higher-income families in the church in Owo and elsewhere (there are about 600 branches across Nigeria) often had a television at home. As an astute student of power, and given her social status, my mother quickly gained influence in the church. Her influence also grew because she was a nurse-midwife. The few people in the church with similar social status to ours, people with relative wealth, position and power would consult her in secret when they or members of their family were ill. This was perhaps my earliest lesson in power. I was often there when the consultation started, or served as a go-between to relay messages and medicine. It was in the days before mobile phones were commonplace, and home phones were an extremely rare luxury in peri-urban Nigeria.

Before my mother – I will refer to her hereafter as S.O. – joined the church, the branch in Owo, like other Apostolic Faith Church branches across Nigeria, had a team of untrained midwives who attended births. Women died during pregnancy or childbirth at a high rate, and so did babies soon after birth. There was no chance S.O. could change church doctrine so that women could seek medical services at any of the health centres or hospitals in town. Even if she did, there was little chance it would make a difference – other barriers, including cost, limited women's access to health services. So she organised the women in the Owo branch of the church, some of whom already attended deliveries. To ensure her efforts would be accepted, she began with the wives of church elders. She trained the women to care for pregnant women and assist in deliveries more skillfully, ensure sterile procedures, conduct home visits, advise and support mothers during and after delivery, recognise danger signs, and when to consult her, especially in any indication of a potential emergency. She bought medical tools and equipment for use by church midwives. The only thing she had to leave out was the use of medicine. Every week, somewhere within the church premises, the midwives' group would have training and refresher classes, followed by a prayer meeting, or they would have a group antenatal care session with pregnant women. She later helped to create and support similar women's groups in Apostolic Faith Church branches across southwestern Nigeria, where she sometimes made consultation visits or accepted invitations to assist difficult deliveries several hours' drive from Owo.

Sometimes S.O. would disappear in the middle of the night, returning home in the morning to tell us that a church sister had a baby. Often, she would later mention that such home births involved the use of medicine she had provided freely. Initially done in secret, other midwives in the group soon got to know about such instances of violation of church doctrine, tacitly approved, and maintained a code of silence. This happened in a women-only space. In the broader church, it was still only the elite who would seek consultation and get treated using medicines. When others fell sick, if S.O. was consulted, she would often offer medicine or suggest they go to the hospital or health centre. Usually the patients or their families refused, which often meant that the person would die from the illness. It was never clear to me the extent to which faith, poverty or both was the reason for refusal. Church members died from inguinal hernia, tuberculosis, diabetes, HIV, stroke; children in particular died from malaria and pneumonia. Diarrhoea, once a frequent cause of death, became less so as S.O. trained mothers of young children in the church to use oral rehydration solution. This was accepted. It was neither expensive nor really a medicine, just salt and sugar in water.

On Sundays, church began at 9:00 am, with 250 to 300 people in attendance, most of them church members. Bible study was led by a Sunday school teacher, followed by a sermon delivered by a church minister. S.O. was not allowed to become a Sunday school teacher, a step on the path to becoming a church minister, because she worked in the medical profession. But she was allowed to join the church choir. I sang in the choir as well. On Sunday evenings at 6:00 pm, we had an evangelistic revival meeting. We would invite as many non-members of the church as we could, even people on the nearby streets. During the Sunday evening service, the choir would sing songs of salvation and redemption and what the Lord can do for you, if you would only believe. After the singing, a minister would invite church members to give testimonies on what the Lord had done for them and could do for you. Church members would tell stories of miracles and answered prayers. Those who had chosen the medical route, consulting S.O. or accepting the help she offered, would give their testimony as though they had not, false evidence on which many other church members would hang their faith. The hypocrisy was never lost on me and my siblings.

Observing S.O. and eavesdropping on informal consultations that were often conducted in our living room gave me my first lessons on the social dimensions of health and ill health; on how poverty kills, not alone, but along with other forces. It was also my first lesson in governance – that rules are made for the public and are bent and evaded by the powerful as needed. And that they are often easier to change or evade by stealth, in practice, when no one is looking. In the late 2000s and the early 2010s, when I began to interact with people who do global health just as the "social determinants of health" rhetoric was beginning to gain traction (Marmot et al., 2012), I did not know what to make of the field. What my mother did (S.O. died in 2009) for much of her life was not in fact deemed "global health" because of who did it. It made little sense to me that global health often defined itself by who does it (white people or foreigners) rather than by what is done. If S.O. had been an Irish nun working in a rural or peri-urban town in Nigeria, it would have been global health. Had she been a nurse on a neo-colonialist medical mission from Europe or North America, her work would have been global health. That seemed wrong, conceptually, as a way to define a field of practice or research.

Like its antecedents, the field of global health is often defined in a way that reserves it for foreigners, for outsiders. As if being an outsider is necessary for the work. Perhaps it is. I always saw S.O. as an outsider in the Apostolic Faith Church. She was in the church but not of it, just as the church is in the world but not of it. Like everyone who defines what they do as global health, S.O. too was working across a gulf – at a distance. The same is true for people who work in public health even within their own country or community. Their inevitably elite status defined by class, income, expertise by specialisation, or other markers of power and privilege means they too work across a gulf – at a distance. We are in a position to do this work locally or elsewhere because we are somewhat elite, or we inevitably become elite as we learn to do it. It is a distance that reflects inequity in society. It is a distance that is inevitably part of public health and global health work, and yet which both fields should, as a guiding star, continually seek to eliminate. This sense of what public health or global health means applies to our health equity or global health work everywhere, including work that takes place in countries and communities in Europe and its settler colonies.

But during Europe's colonial misadventure, "global health" was not created to close the gulf of inequity, but to aid and excuse the dispossession that created, widened or entrenched inequity (Acemoglu et al., 2001, 2002; Van de Walle, 2009; Chakrabarti, 2014). Even if some of those involved were unaware of what was implicit in what they were doing, they were inevitably agents of colonial power (Kim, 2021). Some, blissfully unaware; and others, wilfully unaware. Many others knew exactly what they were doing – they were aiding colonial conquest (Bruchhausen, 2020). Their work does not pass for global health as I would define it. Even today, at its most aspirational, global health is still framed as something done by people from the "West" or high-income countries or on their terms, as if they/we have it all figured out; as if people who are marginalised there/here – women, Indigenous peoples, migrants, sexually, ethnically and racially minoritised people – do not require local efforts as well as global solidarity to address inequities. It is a supremacist framing of global health that allows high-income countries to mystify the political origins of inequity at home and abroad.

If high-income countries' global health efforts focus on political decisions at home, they/we will have to own up to their/our role in creating, widening or entrenching the inequities they/we seek to address abroad in the name of "global health". The dominant framing of global health as something that happens elsewhere, away from high-income countries, is also one that makes it possible to pretend that political problems are technical problems. That equity could be achieved through simple, one-off, downstream technical solutions introduced from outside. As a field designed to obscure or mystify the political origins of failures, global health (like public health, international development and development economics), has a clear bias for technical solutions. Yet at its roots, inequity is not, at any scale, a technical problem. It is a political problem, upstream. No matter what she did, S.O. could not save the lives of many of her friends and fellow church members who died avoidable deaths.

Tropical medicine sought to keep white people on colonial missions healthy. It focused on infectious diseases, sought to explain them and developed drugs and vaccines against them. The focus was technical, but within the colonial political system that it served. The academic disciplines responsible for finding solutions to diseases – pathology, pharmacology, surgery, medicine, microbiology, parasitology – pre-date efforts to achieve equity and would exist without those efforts. The quest to prevent, treat or eliminate disease, even widespread disease, cannot be what defines global health. Sometimes these overlap, but not necessarily, and very often, they do not. Like tropical medicine, the fields adjacent, overlapping and overarching in relation to global health – public health, international development, development economics – default too readily to technical explanations or solutions, and to things that elites in high-income countries or elsewhere care about. They are often, without knowing it, instruments of power, looking after the "natives" (or the marginalised) only when not doing so threatens the security, position or wealth of the colonialists (or the powerful). Global health must therefore be in the world, but not of it. Rather than reenact and reflect the world back to itself in the varied forms of entrenched systems of injustice, global health must offer the world a better version of itself.

It is in fact distance – and the gaps in knowledge that come with it – which, for me, defines global health: the distance between the helper and the helped. What makes global health peculiar is that decisions are made at a distance, removed from the reality of their targets, or supposed beneficiaries. This is not always physical distance. It is also social distance, even when physically proximate, marked by power differentials across divides of class, income, status, gender, ability, race, caste, ethnicity. It cuts across geographies. It exists inside and between countries. It is present when people with the resources to address inequity do not have the knowledge (or the incentive) to do so or to do it well. In the "public health elsewhere" sense of global health, the distance is even much wider. With distance, feedback and accountability between actors takes longer or does not even happen at all.

In a field defined by distance, its knowledge infrastructure, its academic arm – how it makes, uses, shares and values knowledge of all kinds – must intentionally bridge that distance and deliberately facilitate exchanges, conversations and connections that limit the distance. The values that underpin whose knowledge is valued, prioritised and privileged must begin from a place that wholeheartedly admits the ignorance that comes with power and privilege. Those values must be based on the recognition that in global health, as in other spheres of life, the only thing "the helper" certainly has more of than "the helped" is power. The helped have far more knowledge on how to intervene in their lives, even if they do not always have access to knowledge that is available within the spaces where they live and move and have their being. We may be in their world, but we are often not of it. We who find ourselves in a position to be helpers, in a position to do global health, must be willing to acknowledge and embrace our ignorance, and take it as the starting point of our work. Work that must begin by seeking, using and sharing knowledge already held by the people we seek to help.

The helper is in the world of the helped, but not of it. As people who do academic global health, we often make, use and share knowledge about a world we are not of. In defaulting to the knowledge of the helper, the global health literature functions as an exercise in gaslighting. This faux benevolence can make the helped doubt their own thoughts, memories, experiences and sensemaking. What they know, but are told – or related to as if – they don't. In the context of colonial love, the helped are made to question the validity of how they make sense of the world, and are unable to function fully in their capacity as knowers – as holders, makers, users, sharers of knowledge. There is always the risk of gaslighting in relations between the helper and the helped, given the inherent power differential (Abramson, 2014; Spear, 2019; Sinha, 2020; Ruíz, 2020). Gaslighting is easier in the context of love, especially colonial love, as in the missionary medicine kind of colonial love. But for the African-American activist and philosopher Cornel West, colonial love is no love at all. He asks that we "never forget" – because it is easy to forget – "that justice is what love looks like in public, just like tenderness is what love looks like in private" (West, 2011a, 2011b). In both public and private, love requires that we respect people's dignity; that we hold them in high regard as knowers.

It was clear to me while in medical school that I was being trained to be in the world of the helped, but not to be of it; to remain foreign to the realities of most people who will need or seek my care (Naidu & Abimbola, 2022). We were trained – as other medical students in most low-income post-colonial settings around the world – in hospitals that only look after people who could afford to be there, or people who had to impoverish themselves by coming there, many of whom came so late it was already too late. The space was also culturally distant by colonial design, foreign to the daily realities of its supposed users. Delay meant death, or a worsened condition that led to greater spending and further impoverishment. This awareness became intense in my penultimate year in medical school, while on paediatrics rotation and seeing children with malaria whose mothers had delayed coming to the hospital. By the time they arrived, things were very bad; the child was anaemic, in respiratory distress. Nurses, doctors and medical students would blame the mother: Why did you come so late? It's your fault that your child may die! Send someone home for more money so we can care for your child. Sell your property. Dip into your savings. Do all you can to save your child!

I joined in saying such things. I did not see what was right in front of me. But a phone call with S.O. helped me see differently. It was the mid-2000s, and mobile phones had become commonplace in Nigeria. I went to medical school at Obafemi Awolowo University, where most of the clinical rotations took place at the teaching hospital in Ile-Ife. But we traveled to a neighbouring peri-urban town, Ilesha, for parts of some rotations, including paediatrics. As I often did as a medical student, I called S.O., this time from Ilesha, to share my clinical experience. By this point, I had seen and learned enough clinically to really benefit from her extensive experience, which she would also share with me during our phone calls. But I was often much more interested in her political activities; how she won over or fought her colleagues at the hospital and the church. She would update me on the latest events. In that conversation, I told her that I had cried as I watched a grieving mother who had lost her child. The child had died three days after being brought in with respiratory distress from anaemia, and with other symptoms consistent with severe malaria. As I told S.O. the story, I went on to blame the mother for coming to the hospital too late.

S.O. stopped me. She wondered if the mother was afraid to spend all the family's savings or sell property to look after the child as the siblings at home would then suffer whether or not the child survived. It was far from certain that the child would survive. It is almost impossible for me to imagine such a scenario, but I should not have needed to be told of such possible calculations. S.O.'s insight made me consider an additional dimension to how poverty kills – the heart-breaking calculation a mother may have to make whether to commit all available resources to saving a child versus being able to feed and send the child and their siblings to school when the illness is over or the child is dead. S.O. had made me see that it was Nigeria, and the world, and politics, and history that failed the child, and not the child's mother. It was a pattern I began to notice in other mothers who came late. I learned to ask the right questions, pick up on the right cues, and think about clinical events as political events. The lesson from S.O. was: we cannot truly help people without seeing the world through their eyes.

In fact, the distance between me and that deceased child's mother exists at all scales: for clinicians, and for those who make, change, monitor, enforce or apply health policies, within local, national or international spaces. If we consider an academic discipline as a field in which people share the same assumptions about how the world works and engage in debates on how to build on those assumptions (Greenhalgh, 2014), then global health is not yet such a discipline. A discipline needs a set of shared assumptions. It is potentially transformative to build that discipline, what we currently call global health, on the premise that it is such distance that defines it, and that its mission should be to eliminate inequity in health and the circumstances that create ill health anywhere in the world.

Starting here – with a quest for equity that attends to the gap between the helper and the helped – can help us foster, facilitate or forge a common language that links efforts across spaces. This does not yet exist. What we have now is a colonial form of gaslighting – talking past the helped, as if they do not know what they already know, as if they do not possess agency. To undo the colonial influence on global health is to see the world through the eyes of the helped, and to acknowledge the distance that makes it difficult to do so. We must localise the global. What should define global health is the mission and the nature of the relations involved, not the scale or location of activities or the identity of the people who fund it or do it. This inversion makes it possible to do what we currently call global health within a small community even in a high-income country, working with any local marginalised group. It means locals everywhere, like S.O., can "own" global health. It means learning can flow more easily across places, across issues, and across time about how to eliminate health inequity within or between countries.

* * *

I began with the narrative of global health that charts its origin in tropical medicine as an effort to keep white people and, subsequently, the labour force alive in the colonial tropics. It is a narrative that sees global health as a field in which people from previously colonising countries establish and lead health programmes in previously colonised countries. In this narrative, the next, if aspirational, stage is one in which people in previously colonised countries establish and lead health programmes in their own countries (Abimbola, 2018). What I have always found unsettling about this narrative is the assumption that what is so quotidian – people establishing and leading health programmes in their own countries – could be deemed aspirational; as if it was not already true. It reflects the foreign pose, the colonial position from which that narrative is crafted. Everywhere – coloniser or colonised – people have always established and led programmes to improve their own health. What may be unique about global health is the goal of equity and the acknowledgement of distance.

There are two versions of global health, both of which I recognise. In the first, framed as an extension of colonial medicine, I see the parts of global health in which I currently work, but never want to be "of". This is global health as necessarily international, as "public health somewhere else" (King & Koski, 2020), which takes for granted what the distance between here and there means for how we engage. The second version of global health is "public health everywhere" (Turcotte-Tremblay et al., 2020; Fischer et al., 2020; Herzig van Wees & Holmer, 2020), all the way down to the distance between the helper and the helped. This is the version I have known from childhood. From this vantage point, it is a version of global health that I can be "of"; that compels me to see the full humanity and complexity of the helped across that distance. It is a version of global health that trains my eyes to see the unjust structures that underpin inequity and commits me to undoing them. This version of global health could be mine, even if I never left Owo. It could belong to everyone. To define global health only by health issues that cross national borders is to exclude the vast majority of people around the world working daily across all kinds of distances to close equity gaps.

As long as the world is run by colonial politics and forces intent on perpetuating inequity, global health will be in the world, but cannot afford to be of the world. As long as we live in that world – *this* world – there will always be people, groups, communities, districts, provinces, countries, regions, continents that need help. There will always be distance between the helper and the helped. But the helper must commit to reducing, and ultimately eliminating that distance, even as it infinitely regresses. As one distance is eliminated, another one surfaces; another line of inequity emerges that creates new helper-helped divisions. The previously helped become the helpers of someone or someplace else. And so, it repeats itself, over and over, until a time, as yet hard to imagine, when there will be no need for such help at all. But this infinite regression is neither expeditious nor inexorable. It requires vigilance. The current oppressors are very often the previously oppressed.

Long after global health as a field began to self-consciously define itself, it is now time to admit that we have likely looked in the wrong places for what is or should be at the core of global health. If we take the meaning of our field seriously – that it is about distance and equity; about being in the world, but not of it; about trying hard to change the world so that we can be free to be of it – and if we go where that meaning leads, we will do things differently. That road leads to a place where we can imagine the helped at different scales, the people alongside and on behalf of whom we work, as the people who should define what global health means for them and decide how it is studied, practised and reported. Who decide how knowledge is made, used and shared, and whose knowledge is valued, prioritised and privileged. But there is one more stop along that road, where we reexamine not just what global health means and how we do it, but also why we do it, what is in it for us, for "the helper". To transform global health is to see it, imagine it and build it from that place. Where "the helped" have the space to say to all would-be helpers what the Indigenous Australian elder and philosopher Lilla Watson and her fellow activists once said to would-be helpers: "If you have come here to help me you are wasting your time, but if you have come because your liberation is bound up with mine, then let us work together" (Watson, 1985).

What this offers to a field such as global health is an invitation to a form of enlightened self-interest, but not the material kind. A self-interest which is about one's own liberation, emancipation. Why do you want to help me? Is it because you recognise a certain pain, or something missing in yourself, or something you are desperate to make right, something that affects you deeply, personally, even historically? What is it? Can you own up to it? It is like being in love. You both need each other in a deep way. Each of you knows that there is something the other person fulfils in you. It is a two-way need. The "helping" is reciprocal, not charity. It is mutual liberation; the opposite of colonial love. It is justice. Lila Watson and her colleagues' invitation offers global health a transformational way of knowing itself. It invites global health to define what it does in ways that go beyond distance and inequity. Each person, group, community, district, province, country, region, continent with power will have to confront their own brokenness, the pain, the weakness, the complicity they are most desperate to ignore. The sin of dispossession harms the coloniser and the colonised, the oppressor and the oppressed, the master and the enslaved, the rich and the poor. The two parties – we – must get to a place where we both acknowledge that we need each other to be made whole.

But to love you, I must respect you. I cannot love you only on my terms. In academic global health, it is colonial love when the knowledge of marginalised people is not taken seriously, when their learning needs and perspectives are not what define our research questions, when they are not the primary audience of the knowledge that we produce. It is colonial love when our work does not begin from a place of emancipation and liberation; when instead of undoing the systemic, structural injustices that create inequity, we are content with tinkering on the edges. It is colonial love when we play along with a system that extracts knowledge, disregards and destroys local and Indigenous knowledge; a system that harms even while tries or claims to help. We have to find ways of being in global health, while not being of it – for now. All is not fair in love and war. We cannot legislate or compel love. But we can work together to craft rules that govern what we do, how we do it, what kind of knowledge we make, whose needs or knowledge take precedence, and how knowledge is made, used and shared. We can craft rules that default to justice in how we relate with one another across distances marked by inequity. Rules that help make our own motives for doing global health clear to us. Rules that set our eyes on working primarily to remove unjust structures that create distances between us.

We are a long way from that version of global health. When we get there, we will no longer need to say "global" before we recognise and act as though health equity is inherently global. The word "global" would have done its job, and we would be well served to do away with it. Health (inequity) is always global, in the same way that climate (change) is global. We do not say "global" climate change. We understand, implicitly, that it is a global phenomenon. So is health. As with climate change, what matters are the unjust structural origins of health inequity, for everyone in the world, wherever they live. The origins of health inequity are so connected globally that to undo one is to significantly impact the others; to study one is to make a dent in understanding the others; to work on one provides lessons for the others. Connecting social systems and social realities across the globe can help us see one another more clearly. It could also help to build a much larger and more diverse coalition for change. That, above anything else, is what is "global" about health and what the term ought to mean. The sooner we see and build those connections, the sooner the label "global" will become redundant.

When colonial love persists, as it does in global health, the aggrieved cry for justice. This is well illustrated in the Ifá verses, which make up the literary corpus at the heart of the Yorùbá knowledge and belief system. In a set of precepts elicited from these verses and translated by the Nigerian writer and philosopher, Wole Soyinka, Ifá says: "Justice is the mortar that kneads the dwelling-place of man" (Soyinka, 1991). Ifá asks: "Can mere brick on brick withstand the bloodied cries of wrong from the aggrieved?" Ifá answers: "No more than dark withstands the flare of lightning or roofs of straw the path of thunderbolts. Sàngó [the Yorùbá deity of justice] restores." Ifá sees justice as restorative, as a path to healing. Ifá says there cannot be peace without justice; that our dwelling place, the house of global health, is weak without justice; justice in how we make, use, share and value knowledge; justice in how we relate to one another. We cannot work together without justice. We cannot live together without justice. We cannot love one another without justice. We cannot do global health without justice.

CHAPTER 2

THE FOREIGN GAZE

"I was really interested in Black readership. For me the parallel is Black music, which is as splendid and complicated and wonderful as it is because its audience was within; its primary audience. The fact that it has become universal, worldwide, anyone, everyone can play it, and it has evolved, was because it wasn't tampered with, and editorialised, within the community. So, I wanted the literature that I wrote to be that way. I could just go straight to where the soil was, where the fertility was in this landscape. And also, I wanted to feel free not to have the white gaze in this place that was so precious to me."

Toni Morrison (1998a)

"And I have spent my entire writing life trying to make sure that the white gaze was not the dominant one in any of my books. The people who helped me most arrive at that kind of language were African writers. Those writers who could assume the centrality of their race because they were African. And they didn't explain anything to white people. Things Fall Apart *[by Chinua Achebe] was more important to me than anything only because there was a language, there was a posture, there were the parameters. I could step in now, and I didn't have to be consumed by or concerned by the white gaze."*

Toni Morrison (1998b)

There is a problem of *gaze* at the heart of academic global health. It is a difficult problem to name. So I reach for the words of the African-American writer Toni Morrison. Replace the word "white" in the quotes above with the word "foreign", and you may see what I mean. Better still, please read on. Without naming this problem, it is difficult to think clearly and holistically about imbalances in the authorship of academic global health publications – and by extension, the entire knowledge infrastructure of global health. These imbalances are about who gets to speak about and on behalf of the other(ed) across inequity lines, and on which platforms. Again and again, bibliometric analyses of authorship distribution show well-known imbalances (Kelaher et al., 2016; Chersich et al., 2016; Rees et al., 2017; Cash-Gibson et al., 2018; Schneider & Maleka, 2018; Boum Li et al., 2019; Hedt-Gauthier et al., 2019). Patterns that are largely explained by entrenched power asymmetries in global health partnerships – between researchers in high-income countries (often the source of funds and agendas), and those in middle-income and, especially, low-income countries (where the research is often conducted).

It is tempting to proffer specific or direct solutions to imbalances in authorship with initiatives such as mandating journals, funders, universities and their governing bodies to include local authors (based in low- and middle-income countries); to change their academic promotion criteria so that foreign experts (based in high-income countries) can more readily give up choice authorship positions on work done in low- and middle-income countries; to provide resources to academics in low- and middle-income countries to engage more equitably in partnerships; to change the criteria for authorship so that more roles in the global health research process are recognised; and to increase the diversity of journal editorial boards with the expectation that the more diverse the editorial board, the more diverse the published authors (Boum Li et al., 2018, 2019; Hedt-Gauthier et al., 2018, 2019; Carvalho et al., 2018; Lancet Global Health, 2018; Bhaumik & Jagnoor, 2019; Nafade et al., 2019). In my view, these measures are often necessary. But I can't help wondering if, without addressing the problem of gaze, they may result in us granting ourselves moral license. If the self-congratulation that will likely follow having these measures in place might make us excuse ourselves from addressing more fundamental issues.

It took me time to name the problem of gaze. In conversations and in comebacks, I found myself unable to say what I wanted to say without a 15-minute preamble. Naming the problem required finding a language for it. We cannot talk about authorship or inequity in knowledge production without grappling with who we are as authors or the position or standpoint from which we write or produce knowledge (our pose), as well as for whom we imagine we write or produce knowledge (the gaze).

In a field like academic global health that acts at a distance – physical and social – we must strive to distinguish where we stand (pose) and in relation to whom (gaze). I had to find these two interlocked concepts, and the more I thought about them – separate, combine, juggle and stretch them – the clearer it became to me that to proffer solutions to authorship imbalance in academic global health without considering pose and gaze is to fall for the allure of simple solutions.

The concept of *pose* stems from the idea that one's account or analysis of a social system or a social reality is rooted in one's situated knowledge and perspectives (Harding, 1991). But as the German-American historian and philosopher Hannah Arendt argues, we are not prisoners of our pose or standpoint. In her words, it is possible to analyse a given social issue "by making present to my mind the standpoints of those who are absent" such that while doing so, "the more people's standpoints I have present in my mind" and "the better I can imagine how I would feel and think if I were in their place", then "the more valid my final conclusions" (Arendt, 1968). Arendt calls this disciplined practice "representative thinking". The concept of *gaze*, the way I use it, comes from Toni Morrison; it includes the idea that one's primary audience can be local, is ideally local, within one's community, where the soil is fertile, where authenticity is reinforced. It is the sense that one's audience is never inert. We speak differently based on who is listening, who we think is listening, who we wish would or want to listen.

Just as it is possible to imagine oneself occupying a foreign pose – even if rarely done, for example, through Arendt-style "representative thinking" – one can also write for a foreign gaze by imagining what it is like to listen from afar. One can imagine what an outsider is like, what it is they want to hear, and play to it. I have had cause to occupy a local pose and sometimes combine it with a foreign pose. I have also had cause to address myself to a local gaze, and often to a foreign gaze. As an academic, I have had to manage my own shifts in pose and gaze, working as a local researcher and a foreign researcher (Gilmore, 2019).

The structure of this essay is based on a constructed "ideal" (Appiah, 2017) of how things might be if there were no international health research partnerships; how things must have been when (circa late-19th to mid-20th century) many of the places that are now high-income countries experienced significant improvements in health and equity (Cutler et al., 2006); i.e. an "ideal" of *local people writing about local* *issues for a local audience.* It is the kind of ideal that Toni Morrison might prescribe for art and literature. But here I deploy this "ideal" not necessarily as a prescription, but more as a heuristic device. By applying this sense of "ideal", I wrestle, rhetorically, with three questions that give me pause whenever I consider solutions to imbalances in authorship, solutions that require mandates and strictures. These questions are (1) What if the foreign gaze is necessary? (2) What if the foreign gaze is inconsequential? (3) What if the foreign gaze is corrupting?

The first question – What if the foreign gaze is necessary? – stems from the notion that the requirement for balance in authorship in global health research is not self-evident. The research questions addressed in such partnerships may be best posed by foreign experts, and their findings best written for a foreign gaze. Does it matter if the authorship of such a paper is skewed towards foreign experts or entirely by foreign experts? While the local gaze is important, we cannot presume that the "ideal" of *local people writing about local issues for a local audience* always holds. But a situation in which the foreign gaze is necessary should be an exception. And so, such papers should be labelled by the lead author ("written with a foreign pose for a foreign gaze"), with the justification for this exceptional choice of pose and gaze clearly and visibly articulated. Perhaps in a box, just below the list of authors, or as a footnote, or next to the conflicts of interest statement.

Let's explore one such potential scenario. Take, for example, a hypothetical paper written by a foreign expert about burial practices in West Africa. The author was deployed as part of a team of anthropologists to support efforts to address an Ebola outbreak. Through this anthropological work, the academic helped the "foreign-led" team in West Africa to make sense of local practices, thus contributing to more effective strategies for adapting burial practices in the wake of the Ebola outbreak (as the burial of loved ones who died from the infection is often a channel for contracting the virus). The audience for whom the paper is written is likely other anthropologists who perform similar services in other countries while working as foreigners: a role that may not exist if all such response teams were led by local experts – if every country had the capacity (especially, the funds) to respond to their own outbreaks.

In an "ideal" scenario – in which the anthropologist is a local expert who speaks the same language as their fellow locals, with the same burial practices, and works within a team of other local experts – the paper is different. It is "written with a local pose for a local gaze". Here is a worthwhile thought experiment: how does the content, emphasis, style and framing of a paper "with a local pose for a local gaze" differ from one "with a foreign pose for a foreign gaze"? We can extend that question to other deviations from the "ideal" pose and gaze (Figure 1): for example, "written with a local pose for a foreign gaze" and "written with a foreign pose for a local gaze". Typically, these choices are neither consciously made nor explicitly declared. But they should. Such a declaration could function as a short form of authorial reflexivity, helping academics – foreign and local – to be more deliberate in their choices and attitudes, and helping readers to better situate the purpose of a paper.

This authorial reflexivity could give permission to the foreign expert, who, recognising the limits of what they can see or understand, chooses to write primarily for other foreign experts. It can also expose the hubris of a foreign expert who does otherwise. But note that the local versus foreign pose can shift depending on the person and the topic. An anthropologist from the same West African country, but of a different ethnicity to the location of the outbreak, may be a foreigner in relation to burial practices in the location of the outbreak – foreignness could be defined by familiarity, by ethnicity, race, caste, gender, geography, socioeconomic status, or the issue in question. The declared authorial reflexivity could also help readers or bibliographers understand the reasoning behind the pose and gaze. This might be that there is no local capacity available, that the pose and/or gaze does not matter, that the message is best suited for a foreign audience, or that the lead author knows too little to have anything of value to say to local experts.

The longer form of the second question – What if the foreign gaze is inconsequential? – is as follows: What if it is indeed the local (rather than the foreign) gaze that is consequential? To explore its implications, let's return to our foreign anthropologist in West Africa, but one who chooses to write primarily for local experts – i.e. "with a foreign pose for a local gaze" – in an effort to approximate the ideal "with a local pose for a local gaze". Such a paper would be published where our "ideal" paper is published, in local journals, many of which may not be indexed in global databases or published in English (MoChridhe, 2019), but would contain publications addressing research questions and policy issues that exist irrespective of the presence and influence of foreign experts, foreign funds, foreign donors, foreign helpers or foreign collaborators. Just consider the sheer volume of such publications. Indeed, most academic global health papers are local (Sgrò et al., 2019), many of them appearing in outlets that may be deemed non-traditional or "predatory" (Shen & Björk, 2015; Frandsen, 2017).

	Local Gaze	**Foreign Gaze**
Local Pose	"Ideal"	Corrupting?
Foreign Pose	Consequential?	Necessary?

Figure 1 | The authorial reflexivity matrix with potential effects of combinations of local and foreign pose and gaze.

How consequential is the minority of academic global health publications written for the foreign gaze? It is almost certain that local output is much more consequential, if only because sustainable progress in global health is homegrown, because local processes are responsible for many of the historical improvements in health and equity (Szreter, 1988; De Brouwere et al., 1998; Fairchild et al., 2010; Bhatia et al., 2019; Medcalf et al., 2015). For example, there is as yet no association between the density of papers (archived in international databases of academic publications) on universal health coverage from a country and the attainment of universal health coverage by that country (Gheorghe et al., 2019). What gets written for the foreign gaze reflects the appetite of the foreign gaze (Storeng & Béhague, 2017; Chambers, 2017; Roalkvam & McNeill, 2016; Jerven, 2018; Rajkotia, 2018; Bédécarrats et al., 2019; Storeng et al., 2019), which is more attuned, in the words of the 20th-century British writer and literary scholar C.S. Lewis, to "the surgical" than to "the organic" (Lewis, 1943).

In his book, *The Abolition of Man*, C.S. Lewis describes the difference between "alteration from within" (or organic change) and "alteration from without" (or surgical change) (Lewis, 1943). He illustrated surgical change with the example of "a theorist about language" who chooses to "approach his native tongue, as it were from outside, regarding its genius as a thing that has no claim on him and advocating wholesale alterations of its idiom and spelling in the interests of commercial convenience or scientific accuracy".

He juxtaposed this with the example of organic change by "a great poet, who has 'loved, and been well nurtured in, his mother tongue'" whose "great alterations […] of the language are made in the spirit of the language itself" such that "the language which suffers [or undergoes radical changes] has also inspired the changes". In our efforts to achieve health equity, as in other efforts to bring about social change, it is much easier to see and bring about "surgical" change (as the agents of change are tangible, short-term, often external), than it is to see and bring about "organic" change (as the agents of change are diffuse, long-term, typically internal). Yet attaining a goal such as universal health coverage requires an organic process. As people who do academic global health, we must get better at recognising and explaining long-term processes of organic change (Rosling et al., 2018).

Papers written for the foreign gaze represent only a slice of reality; only a subset of publications originating from a country that may advance the cause of global health in that country. In some cases, it is an important slice, but a slice, nonetheless. Too much focus on this subset unduly emphasises discrete, short-term and episodic efforts, often initiated or led from outside – the "surgical". But evidence and insight from several low- and middle-income countries suggest that long-term change is brought about by local organic processes, policies and dynamics: for example, the role of women's empowerment in explaining long-term change in child health outcomes (Keats et al., 2018; Nguyen et al., 2018; Rahman et al., 2019; Dwomoh et al., 2019). It is unfair, and even misleading and colonial, to pay undue attention to the foreign gaze. If the academic literature to which we give priority does not reflect that local experts are at the forefront of addressing local problems, then there is something deeply wrong with that literature, because it does not reflect reality.

We must rethink our attitude to "local" journals and take some responsibility for why many local experts publish in "predatory" journals. If we prioritise the local gaze, we will seek to publish our work in the same journals where local experts exchange ideas, local journals and outlets will have their proper place in our imagination, and perhaps some of the shady entrepreneurs behind predatory journals may found legitimate peer-reviewed journals instead. Why, for example, should it be normal that a trial of strategies to reduce maternal mortality in rural India gets published in a journal based in Boston or London instead of Bangalore? Perhaps we should extend our authorial reflexivity so that it includes the justification for the choice of a foreign journal: e.g. because it is a multi-country study, the findings are irrelevant to a local audience, the funder's expectations, the journal's impact factor, or for promotion, grants and prestige.

The third question – What if the foreign gaze is corrupting? – has particular resonance for me and for many people I know who work primarily from a local pose. To explain what I mean, let's return once again to our anthropologist, but this time it is a local anthropologist who is a local expert that chooses to write primarily for a foreign audience. As pose is often determined by the gaze of the spectator, a foreign gaze can alter the local expert's pose. The choice that a local expert makes about the audience that they want to inform or impress can corrupt their message. The local expert makes a trade-off – between on the one hand, the need to tell it like it is, and on the other, an effort to globalise the use of language, to make the message intelligible to an audience with little background knowledge, to sanitise the reality that they wish to convey, to hide the dirty linen. When the foreign gaze wins over, as it often does, complexity, nuance and meaning (for example, about local burial practices) can be lost, especially for the local audience.

The foreign gaze can make a local expert write like an expatriate. This tendency is often detectable in the language of local experts who work closely with foreign experts, or in post-colonial literary fiction written for the foreign gaze (Adesokan, 2012). This phenomenon can also corrupt the local expert's own sense of reality. In the process of massaging, simplifying and altering reality, the local expert also risks losing their own sense of reality; the sense of complexity and of multidimensional reality that is often necessary to solve problems in global health (Abimbola, 2018). An additional corrupting influence of a preoccupation with the foreign gaze is that it can distract local experts from engaging in the often consequential and often non-academic conversations in their own setting, some of which are not in English. These conversations should be at the centre of academic global health discourse, but unfortunately are often not taken as seriously (Saha et al., 2019).

The most important conversations about health systems in many low- or middle-income countries do not make their way into peer-reviewed journals (whether local or foreign), and, perhaps, neither should they. I glean them from email listservs, local newspapers, local blogs, local radio, WhatsApp groups, and even on X (formerly Twitter). It would be colonial and anachronistic to expect or require that such conversations be had in foreign journals, which many of the participants do not read, and should not be expected to read. But it should also be unacceptable that, like ships in the night, local and global conversations often pass each other by. The challenge is to create channels through which the content of some of these conversations can get into the academic global health literature, channels that can help people who are foreign recognise, amplify and draw insight from local conversations without asking those conversations to move, extractively, to foreign platforms.

To make global health truly global is to make global health truly local. Perhaps what our local anthropologist who seeks to or must, for various reasons, write for a foreign gaze might do is write two versions of the same paper: one written from a foreign pose for a foreign gaze, and another written from a local pose for a local gaze (e.g. a local newspaper, journal or blog, perhaps in a local language) (Saha et al., 2019). In the version written from a foreign pose for a foreign gaze, the local expert might explain the reasoning behind that choice and the impact of the foreign gaze on their pose, on their prose, their language, their style, on what they chose to include and exclude in their paper, on the aspects of reality that they left out, and where the local audience might find the version written for them. The local expert might do this in a statement, as part of the declaration on authorial reflexivity, just below the list of authors, or as an extension of the conflicts of interest statement.

There are times and places in which it may be unwise to be so honest or to even focus on the local gaze. Writing that denounces government violence or human rights violations can better serve their local purpose with a foreign gaze. Publishing such denunciations in a foreign journal for a foreign audience can strategically attack the credibility or image of the government in question. The pressure exerted can be more consequential than a local debate or exchange. When direct criticism of government action or inaction is involved, opting for a foreign gaze can be the opposite of corrupting. Externally directed writing can also trigger strong local debate and denunciation of the silencing and repression of local voices. In either case, the foreign gaze is justified and necessary. There are times and places in which often for colonial reasons, the best way to be locally consequential, to obtain a place in the local conversation where consequential decisions are being made, is to cultivate and sustain strong foreign networks and visibility, including through publications. There are also features of a social system or a social reality that you only see clearly when you have to explain them to an outsider; or when an outsider tries, even if unsuccessfully, to explain them to you or to fellow outsiders.

* * *

Concerns about imbalances in authorship are a tangible proxy for concerns about power asymmetries in the processes involved in – and the benefits of – knowledge making, use, and sharing in global health. In fact, authorship per se is not the fundamental issue. Undoing what those imbalances represent – a continuity of the colonial project in global health – is often the issue. Discussions on authorship in academic global health are an opportunity to have the necessary conversations that go beyond mere representation in lists of authors. We can trigger these conversations by engaging in open self-reflection: that is, reflexivity, a practice about which much can be learned from critical and Indigenous anthropologists (Jacobs-Huey, 2002; Smith, 2012; Harrison, 2011). These self-reflections can be aided by the authorial reflexivity matrix (Figure 1), as we explore and seek to be explicit about the situations that lead us to make less than "ideal" choices about authorship, why those choices are sometimes necessary, how to make our work in less than ideal situations more consequential, and our choices less corrupting.

What makes one's pose or gaze local or foreign is not only defined by a physical place, and it is not static. Although I was born, raised and educated in Nigeria, the meaning of "somewhere else" could include a part of Nigeria that I am unfamiliar with. I grew up in Owo, a peri-urban town in southwestern Nigeria. That may be the only place where I am truly local in a physical, geographical sense. I have moved around a lot since then. In many ways, I am more foreign to many big cities in Nigeria than I am to Sydney in Australia, where I currently live (perhaps more so, the longer I live in Sydney). The distance that makes us local or foreign can also be social. I feel "local" to middle-class Nigeria across much of Nigeria. In many ways, I am "foreign" to the realities of Nigerians living in poverty, except perhaps in Owo because of my mother's pro bono practice as a community midwife. But even then, I saw them in my childhood through a particular lens, and certainly not fully in the same way they see themselves. I am "foreign" to the realities of most women, LGBTQIA+ people, Indigenous Australians, Swedes, upper-class Nigerians, Nigerians raised in Muslim homes, etc.

The awareness of my foreignness is a cautionary stance. It reminds me to tread gently, to be slow to form opinions, to hold my opinions lightly, to defer judgement as long as necessary – or forever. It is a caution against being "colonial", especially towards people in relation to whom I have more power. Not being cautious or humble about the limits of one's pose is at the root of colonial love. There is often a lot of introspection involved in knowing one's status, whether foreign or local in relation to a place or issue. One's pose cannot be easily determined by someone else. Our pose in relation to a place or issue is ours to decide and declare. While it is possible to do "representative thinking" à la Hannah Arendt, to imagine oneself into "the standpoints of those who are absent", and to imagine how one might feel, think, and interpret if one "were in their place", it is a difficult thing to do and often impossible to do well. No matter how expansive one's imagination or self-awareness, it is always limited. Hence the need to carry out reflexivity in the open.

The implications of the three questions explored in this essay are inescapable, just as the foreign gaze is inevitable. In a relentlessly globalising world, our destinies are so interlinked that the reasons for and solutions to problems in global health can be local or foreign. Even within a local space, those who get to be in a position to work towards health equity, to do global health, do it from a place of relative privilege, a foreign place. But in a world of power and knowledge asymmetries, we see differently and understand differently; and too often, the power to act is not directly proportional to the knowledge upon which to act (Abimbola, 2016). There will always be gaps between what local experts see and what foreign experts can possibly see (Gilmore, 2019). But having more and open conversations on the place of the foreign gaze, of local knowledge, and of organic (rather than surgical) change in global health, are – and can help us identify other – strategies to fundamentally undo colonial knowledge practices. The proposed reflexivity statements in publications can be a starting point, in the hope that, in this case, sunlight may well be the best disinfectant.

CHAPTER 3

EVIDENCE AS CLICHÉ

"For […] there are experimental methods and conceptual confusion […]. The existence of the experimental method makes us think we have the means of solving the problems that trouble us; but problem and method pass one another by."

Ludwig Wittgenstein (1958)

In 2018, I was invited by the *Cochrane Database of Systematic Reviews* to review an important manuscript. It was a systematic review on the impact of decentralised governance on health services. That is, on the impact of shifting the governance of health services – or aspects of it – from a higher, more powerful, distant level of government (e.g. a national government) to a lower, less powerful, proximate level of government (e.g. subnational governments). Or a transfer of responsibility from any government to community groups, to health facility managers, or even to private for-profit entities. Or a transfer of responsibility from the headquarters of a large organisation (e.g. a national ministry of health) to subunits of itself (e.g. located in different regions of a country). I was happy to have been asked. The protocol for the review was published in 2013, and I had read it with a mix of excitement and scepticism (Sreeramareddy & Sathyanarayana, 2013).

Cochrane places evidence from randomised controlled trials – or experimental studies more broadly – atop a hierarchy of methods to generate the best evidence for decision-making. The authors had proposed in their protocol to review evidence only from experimental and quasi-experimental studies on decentralised governance. As policies to decentralise the governance of health services are implemented globally, the authors planned to review evidence on its impact anywhere in the world. But knowing that decentralised governance (as a policy intervention) is not readily amenable to such methods of inquiry, I wondered where the authors would find the studies to include in their review. As a policy intervention, decentralisation is typically implemented as part of all-encompassing political reforms within a country, with inevitable flow-on effects in sectors such as health and education (Liwanag & Wyss, 2017).

A randomised controlled trial would require that researchers find a way to deliberately separate decentralised (experimental) from centralised (control) provinces or districts. It was a move that I thought would be unduly intrusive and thus not tolerated within a complex political process; hence, unlikely to occur. It would require high levels of cooperation from politicians and high-level policy actors whose interests and incentives tend to vary too frequently to last the duration of a randomised controlled trial. I was therefore not surprised to note that the authors of the systematic review on the impact of decentralised governance on health services were able to identify only one eligible study. But even that study was not really eligible. As I wrote in my peer-review report (*Cochrane* has an open peer-review process, and I agreed to being acknowledged by name in the final publication):

> […] the authors define decentralisation and centralisation only in relation to governments. The challenge of such a limited definition is twofold. (1) Decisions of governments to (de)centralise the governance of services between levels of government are made in such a way that it is hard, if not impossible, to subject to experimental evaluation – hence it is not surprising that the authors found no such study that meets their inclusion criteria. (2) The only study that meets the authors' inclusion criteria does not really meet their inclusion criteria – this study examined decentralisation within an organisation (and not from one level of government to another). The authors have the option of rewriting or reframing their review and how they define (de)centralisation in a broader sense that goes beyond what happens between [or] among governments, to [include what happens within] the governance structure within organisations.

When I wrote these open peer-review comments, I felt that most (if not all) experimental studies of decentralised governance would potentially amount to large-scale tampering with health system governance, unaccountably, from a distance. I still think so. However, I have since changed my mind on the potential to find such studies. Over time, I have come to the view that a well-known health policy intervention – "performance-based financing" (e.g. an arrangement in which health service providers are financed by a government or an entity that pays for health services based on how well they achieve pre-set performance targets) – which has repeatedly been subjected to experimental and quasi-experimental inquiry (Witter et al., 2012; Oxman & Fretheim, 2009; Eijkenaar et al., 2013, Suthar et al., 2017; Das et al., 2016), is a misnomer. In fact, it is decentralised governance in disguise, just like interventions such as purchaser–provider split (e.g. when a government or an entity that pays for health services decentralises the responsibility for service delivery to other entities, which may be for-profit entities), and community engagement in governance (e.g. when community groups are assigned or take on some of the responsibility of supporting the demand or supply of health services within their community). As with decentralisation, performance-based financing, purchaser–provider split and community engagement in governance have been used as strategies in efforts to improve health service delivery around the world. Whether or not trials of paying for performance in health care are useful, or should have been conducted, they exist. They should have been considered as eligible for inclusion in the proposed *Cochrane* review on decentralisation. But I did not make the link at the time.

A major appeal of randomised controlled trials is the dubious promise of simplicity; the ability to reimagine a complex social intervention that is emergent and contingent on context as one that is simple, tangible and decontextualised. Randomised controlled trials were designed for such simple interventions. The problem with attempting to simplify complex interventions is that the evidence generated by doing so often at best has the relevance of a cliché, typically appealing to the foreign gaze. A cliché in the sense that the evidence never means what it is claimed to mean, but replaces or obstructs thought in ways that may appeal to someone listening from afar with too little detail to think about it adequately. The further away one is from what is being evaluated, the simpler it seems, and the simpler one's perceived needs concerning evidence appear. This is a tendency at work in the evidence on performance-based financing, an intervention whose name deceptively simplifies a complex intervention that involves extensive decentralisation of health system governance, which is itself an inevitably messy political process. This simplification uncouples performance-based financing from decentralisation, from context and complexity, thus limiting the learning that ought to accumulate on the effects of decentralisation in health systems.

With pilots or full-scale programmes in at least 32 out of the 46 countries in sub-Saharan Africa, performance-based financing is one of the most widely implemented health policy measures in the region (Gautier et al., 2018, 2019). Its spread is backed by a well-nurtured "nexus of strongly dedicated diffusion entrepreneurs", working in, funded by, or supported through bilateral and multilateral development banks and agencies, especially the World Bank (Gautier et al., 2018). Trials have played a central rhetorical role in legitimising performance-based financing initiatives across Africa. Even though the results of those trials are rarely impressive, decisions to scale up the initiative within a country or to spread it to other countries have often been made "before research results were made available, or in spite of them" (Gautier et al., 2019). Even the champions of these performance-based financing initiatives in sub-Saharan Africa seem to be aware of the clichéd use of evidence from trials to supposedly evaluate their impact on health system performance. In any case, the literature on performance-based financing does not position decentralisation as its core feature. Instead, it is framed in terms of a relatively marginal and often adaptable feature – incentives given to health facilities or peripheral governing entities to improve the quantity and quality of their services.

In the implementation science literature, programmes or interventions are sometimes described as having core elements and adaptable elements (Fixsen et al., 2009; Eboreime et al., 2020). Core elements are features that are directly or primarily responsible for programme impact. Adaptable elements are features that are modified to align with contextual nuances. The core feature or element of performance-based financing is often framed as the incentive to improve performance. But at the core of the initiative is the transfer of power, resources and responsibilities from central to peripheral actors. This transfer may occur between national and subnational governments, between a government and health facilities, or between a government and community groups (e.g. community health committees) (Oxman & Fretheim, 2009). Thus, the core feature is decentralisation – performance-based financing is decentralised governance by another name. Without decentralisation reforms, health facilities, subnational governments or community groups cannot receive, use or make decisions based on performance incentives.

I put this conceptual confusion down to the problem of gaze: the foreign gaze. The framing of performance incentives as being at the core of performance-based financing makes it amenable to evaluation through randomised controlled trials. The alternative is much more difficult. Asking directly for the decentralisation of health system governance is tantamount to asking for a – likely unwelcome – wholescale retooling of health systems, involving a complex, contested, threatening and long process of reforms and negotiations. The "simplification" of performance-based financing lends it, in turn, to the generation of simple and apparently compelling evidence on its effectiveness through randomised controlled trials, making it "marketable" to a funder or policy actor at a distance – to the foreign gaze. The language of performance-based financing offers decentralisation through the backdoor; after all, rather than an extensive reform, it is quite a specific intervention. The core element (decentralisation) thus becomes a relatively silent consideration.

Much like decentralisation (Dwicaksono & Fox, 2018; Sumah et al., 2016; Cobos Muñoz et al., 2017; McCoy et al., 2011; Casey, 2018), efforts to quantify the effects of performance-based financing on health system performance have yielded mixed results (Witter et al., 2012; Oxman & Fretheim, 2009; Eijkenaar et al., 2013, Suthar et al., 2017; Das et al., 2016), and inevitably so. It is a non-problem. What would raise concerns is if the results of the evaluation of such complex interventions were *not* mixed. In spite of repeated efforts (including the use of trials in the case of performance-based financing) to demonstrate their effectiveness, or lack thereof, it has proved to be an impossible, and perhaps, unnecessary endeavour. After all, their effectiveness could not possibly be proven one way or another, or proven once and for all. They are complex social (and/or political) interventions with effects resulting from the interacting and varying behaviours and interests of the diverse individuals and groups who design and implement them, and those who are their targets or intended beneficiaries. Their effects also depend on their design: decentralisation or performance-based financing in one place is necessarily different from an intervention that carries the same label elsewhere.

While their effects vary from place to place and from time to time, there may be tendencies and identifiable patterns in how these complex social interventions and phenomena perform over time when introduced or activated in a particular place or setting (Pawson & Tilley, 1997; Pawson et al., 2005). But even those tendencies are always contingent on context. For example, in a setting where X exists, and people have experienced Y and so reason in a particular way Z, favourable outcomes result from decentralised governance or performance-based financing. Hence, for a policymaker, the question is not so much whether to decentralise governance (in settings where they have the power to do so) or to implement performance-based financing, but rather, how will it work in a setting where X does not exist, but rather there is A, and where instead of Y, people have experienced B, and so are likely to reason in way C rather than Z when the policy is introduced.

Understanding the knowledge and evidence needs on complex interventions and phenomena in terms that acknowledge their complexity should be the starting point of inquiry, not the conclusion. Too often, it is the other way around. The studies, often experimental, randomised controlled trials, have been set up and conducted in multiple places, frequently at great cost, only to conclude after their results accumulate over time that the evidence is mixed. Of course, the evidence is mixed. It is a misuse of the experimental method. But the practice persists. The question is why? In the case of performance-based financing, once you see it as decentralised governance, the question becomes even more difficult to answer. Decentralised governance is an ongoing process that involves continual negotiations and learning amid tensions. It is never complete. Any evidence on its effectiveness is at best tentative. Generously interpreted, it is a thought-stopping cliché: "the evidence says yes" or "the evidence says no" – as if the evidence can possibly be definitive, final. At worst, it is a disingenuous, cynical (if sometimes useful) excuse for tampering with health system governance.

If the question is "Should a country adopt performance-based financing?", these randomised controlled trials cannot answer it. Nor can they answer the question "What kind of performance-based financing should a country adopt?" Nor the question "How should a country modify a performance-based financing initiative to suit its context?" So what are they good for? Why does evidence from these trials remain so important even though the results, whether positive or negative, demonstrating effectiveness or not, say little about what is actually an effort to reform a system? Who is the audience of these randomised controlled trials? The foreign gaze? Is saying "the evidence from randomised controlled trials is X" perhaps simply an easier way to convince funders and unsuspecting, distant governments who will accept the evidence as unthinkingly as policy entrepreneurs who have been told and have come to believe that these trials are the arbiters of truth?

Using randomised controlled trials to assess performance-based financing initiatives is like judging a cake by the icing on top of it. The cake is the core, with its underlying layers of decentralisation reforms and processes, on top of which the "performance incentive" rests. In these randomised controlled trials, it is the whole package that is being evaluated, although the evidence is typically presented as if it was about the performance incentives alone. When the evidence is mixed, it is often because the context asserts itself, again and again. To understand why evidence from randomised controlled trials could be considered useful at all, one can only infer from the rhetoric implicit in such trials. This implicit premise is that there are benefits to simplifying a complex intervention, and to wishing away context and complexity, such that even when context is taken seriously, the contextual aspects considered are those that readily lend themselves to simplification.

These wishful assumptions relate, in part, to the origin story of performance-based financing. Early evidence of its use in international development and global health came from post-conflict states undergoing or considering sweeping governance reforms (Bertone et al., 2018; Paul et al., 2018). The first scale-up effort was in the very atypical reformist setting of post-conflict Rwanda. It was evaluated in a randomised controlled trial that showed success in improving health system performance (Basinga et al., 2011), a result that has since been challenged and has hardly been replicated elsewhere despite repeated efforts (Paul et al., 2018). However, outside such atypical settings with ongoing governance reforms onto which performance-based financing can position itself as icing on the cake (for example, in Rwanda, Burundi and Zimbabwe), it is rare for national governments to devote significant domestic funds or local resources to implement or scale up performance-based financing initiatives (Paul et al., 2018; Mayaka Ma-Nitu et al., 2018). Those funds have typically come from outside – notably, as loans from the World Bank (Gautier et al., 2018, 2019; Paul et al., 2018).

In the absence of ongoing reforms or national or subnational governments' willingness to undergo such reforms, efforts to introduce or scale up performance-based financing (usually accompanied with randomised controlled trials), may therefore require unwelcome tampering with health system governance. And given that existing governance arrangements are typically entrenched, context reasserts itself in the (in) effectiveness of such efforts. Tampering may cause unintended consequences. Nonetheless, masquerading a necessarily "organic" reform (that is, decentralised governance) as a "surgical" intervention (that is, performance-based financing) may also work as a deliberate backdoor strategy to introduce an important and desirable reform into a health system that powerful interests in the system would otherwise have resisted. But this coy (if sometimes beneficial) strategy is easily undermined by the appetite of the foreign gaze for simple rather than complex interventions.

I experienced this appetite first-hand in Nigeria in 2013. I was working at the National Primary Health Care Development Agency in Abuja, which was implementing Nigeria's performance-based financing initiative. I had volunteered to help during the fieldwork for a study (thankfully not a randomised controlled trial). There was suboptimal uptake of services in pilot health facilities for the initiative, and the World Bank wanted to know why. In the study, we consistently found that where local decentralised governance structures (community health committees) were active, service uptake was high, and where they were not, service uptake was low (Mabuchi et al., 2017). But this finding was not reflected in the recommendations in the draft report shared with the rest of the team by the lead World Bank consultant. The report focused on the reasonable but much less compelling idea of using transportation vouchers to improve uptake. I raised this glaring omission. The consultant replied that it would be corrected. In the final report, there was hardly a mention of community health committees; the focus remained on transportation vouchers (Mabuchi & McCune, 2015).

The foreign gaze had held on to a tangible, surgical intervention – something simple that could be readily sold to a funder looking or acting at a distance, something that could be proven, once and for all, to have worked. This is how I interpret that experience: when you are looking from a distance, you see "concrete" things, like funds and performance incentives, things that can come from outside, and surgically (or magically) make things better – things like transportation vouchers.

It is harder to see things that are organic, that require on-the-ground retooling, negotiations, fixing, learning – things like community health committees or decentralised governance more broadly. Transportation vouchers are tangible: they can be measured and evaluated, implemented in the same format from place to place replicable, like a travelling model. It is a solution easily imagined as scalable. It is discrete. It can be presented as something "new". It appears attractive at a distance.

Yet interventions should begin from the premise that people are already making efforts and learning how to solve their own problems. At close range, an example of what you may see community health committees and similar entities do is respond in various ways to an unsatisfied demand for health and other social services (Ben-Ner & Van Hoomissen, 1991). In his book, *Exit, Voice and Loyalty* (Hirschman, 1970), the German social scientist Albert Hirschman theorised about the range of conceptual options available to people when they find the cost, quality, quantity or distribution of public goods and services unsatisfactory. He described "exit" as choosing to obtain services elsewhere or under a different arrangement (for example, in a nearby community or in a for-profit health facility); "voice" as choosing to form or use a coalition of users (for example, a community health committee) to advocate for improved provision and oversight of services from government; and "loyalty" as choosing to contribute or generate resources to support their services (for example, through financial donations from high-income community members).

The presumption that people anywhere are waiting with folded arms for a saviour is one that is only easily made and sustained at a distance. People select from among many diverse options available to them (Figure 2). They may use their "voice" to demand improved government financing of existing public sector provision or better regulation of private sector provision. Local actors may come up with new for-profit entities, and coalitions of users may come up with non-profit responses to meet unsatisfied demand in the community, providing channels of "exit". Coalitions of users may "exit" into new arrangements, transforming into a self-provision coalition as they co-produce or augment existing public, for-profit or non-profit services. These efforts – all of which are emergent, deeply contingent on context and involve lots of learning on-the-go – may also fail (Ben-Ner & Van Hoomissen, 1991). But the range of decentralised agency potentially on display is ignored by parachute interventions such as performance-based financing.

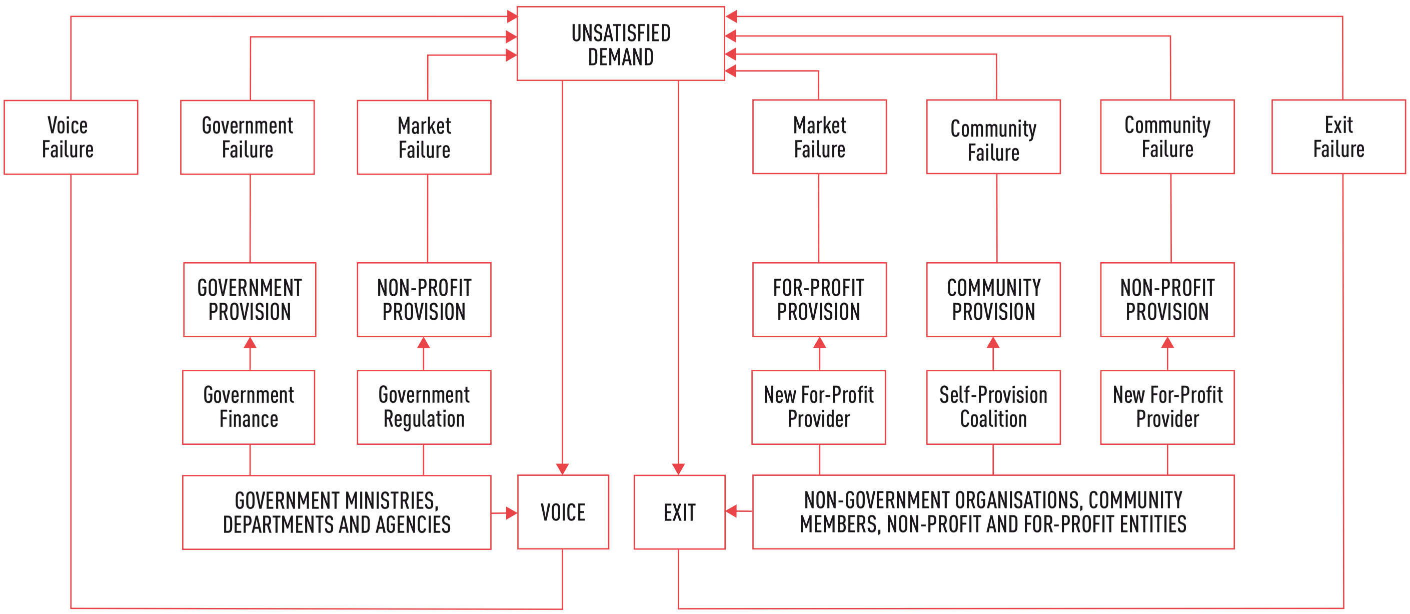

Figure 2 | Potential decentralised responses to unsatisfied demand for primary health care services.

Source: Abimbola (2020), inspired by Ben-Ner & Van Hoomissen (1991).

If performance-based financing were reframed as a form of decentralised governance, how would it be studied? Before I came to this understanding myself, I conducted and published an evidence synthesis on how decentralised governance influences health system performance (Abimbola et al., 2019). But in that review, I left out the literature on performance-based financing. Looking back now, this omission leaves me with deep regret and appreciation for the many such potential opportunities for learning that we so easily miss when we frame interventions or reform efforts in a way that makes their adaptable elements seem like the core elements. As a result, we do not optimise potential learning that may otherwise occur across settings and/or interventions. We fail to draw insights from seemingly different interventions which, on closer examination, belong in the same "core elements" family (Abimbola, 2018). Which does incalculable harm to our ability to solve the problems that trouble us in global health and development.

Nonetheless, the evidence synthesis I conducted on decentralisation began with a premise of complexity. It acknowledged that what is useful evidence is not whether decentralisation "works", but how, for whom, and under what circumstances it works or not (Pawson & Tilley, 1997; Pawson et al., 2005). It also depends on what we mean when we say "works". It acknowledged that what is called "decentralisation" is often limited by a focus on its top-down connotations as an "intervention". That decentralised governance may also be seen as a common phenomenon: as how things are, regardless of a formal policy to enact (de)centralisation as an intervention. There are de facto ways in which health systems are decentralised: for example, regardless of government mandate, community groups may govern their local health system through the exercise of local agency. One cannot study decentralisation only as an "intervention". This conceptualisation of decentralisation as both phenomenon and intervention allowed me to cast a wider net on studies that could be included in the evidence synthesis, enriching the range of potential sources of learning.

While none of the included studies was a randomised controlled trial, in retrospect I realise that trials (of performance-based financing) could have met the inclusion criteria. But such trials are rare, precisely because decentralised governance involves iterative social and political decision-making processes that resist randomisation. Trials assume standardised interventions across sites, while decentralisation involves continuous local learning and adaptation. Unfortunately, the "surgical" appetite of the foreign gaze means that researchers who are inclined to gain understanding from the bottom up, to study, support and engage in long-term organic processes of change, may feel the need to apologise for their choice (although it is the better one), or to even justify why they "have not developed a traditional intervention" (Barasa et al., 2020). These researchers risk being seen as "academic lightweights, producing nothing of substance", who "answer questions which are dull, not novel (little contribution to the scientific literature), or not generalizable (focused on local issues)" (Oliver et al., 2019).

Trials do not entirely preclude asking nuanced questions, but make them much more difficult to ask. In the context of a trial, such questions are an afterthought (when embedded within the trial), are limited (by the assumptions of simplicity which are necessary to conduct a trial), or are wrong (e.g. when asked as a binary, such as whether something is good or bad, or whether it works or not) (Liu et al., 2019; Lewin et al., 2009). Yet what is really important are nuanced questions of process or more fundamental questions of appropriateness, of fairness, of justice, or overarching systems. Or of the ongoing, iterative, long-term effects of health system interventions, processes and reforms (and their outcomes) and day-to-day phenomena (such as feedback, adaptation and learning) that trials are ill-equipped to capture: What does a system need to improve? Are performance incentives (beyond salaries) necessary? Why? Are there locally informed strategies to address these issues? Do they require local political engagement? How do you support ongoing local political process to better generate desirable change?

Much like randomised controlled trials, performance-based financing has generated serious debate (Paul et al., 2018; Mayaka Ma-Nitu et al., 2018). Both debates are linked. The opportunity and transaction costs of implementing performance-based financing are cited by those challenging it. They also cite trials showing its failure, just as the other side cites trials showing its success and makes the case that any failure is due to "context". This is a thought-stopping clichéd debate that shows the limits of trials. Notably, in their defence of performance-based financing initiatives, a group of local health system practitioners across six African countries do not cite evidence from trials. They argue that it is a "reform approach" in "constant evolution" "over time", which builds capacity at different levels of decentralised governance, to improve "coordination, decentralisation, accountability […] including community engagement in […] governance" (Mayaka Ma-Nitu et al., 2018). Viewed from a local pose, performance-based financing is decentralised governance.

In 2020, I visited the *Cochrane* website to check the status of the review on decentralisation. I wanted to see the direction the authors had taken in response to my and others' peer-review comments. Unfortunately, I found a notice, dated 2019, stating that the editors of the *Cochrane Database of Systematic Reviews* had "withdrawn it from publication" because "this protocol has not been successfully converted into a full *Cochrane* review within established timelines due to lack of resources to complete the review" (Sreeramareddy & Sathyanarayana, 2019). The two authors are based in Malaysia, which may explain their limited resources. I thought, what a loss. By broadening the scope and redefining its parameters, their systematic review – preferably one that would not simply ask if decentralisation "works", but how, for whom, and under what circumstances it works or not: a realist review or synthesis – would have been an opportunity to deepen and enrich the literature on the impact of decentralisation on health systems and services.

I am left wondering what the results would look like of a systematic review on decentralisation that includes evidence – both qualitative and quantitative – on performance-based financing initiatives. It could be an extension of the evidence synthesis I conducted, or a revision of the planned systematic review that may never be completed, due to lack of resources and *Cochrane*'s preference for experimental studies. The result would look different, with "performance incentives" featuring as one among many contextual factors that may enable or constrain a range of outcomes, such as quality, equity and efficiency. The literature is poorer for the lack of (and for not normalising) such a complexity-informed realist review or synthesis (Pawson et al., 2005). This is one of the many uncounted costs of randomised controlled trials – they can obscure conceptual connections and therefore limit opportunities for learning. We must find ways to count this cost, the cost of unrealised learning too.

What are the costs of randomised controlled trials in health systems, global health, and international development research? In the example that I have presented here, in part due to the rhetorical, if clichéd, advantage of these randomised controlled trials in feeding the appetite of the foreign gaze, a policy measure that was designed to strengthen decentralised governance is largely misnamed (as performance-based financing), misvalued (using evidence from randomised controlled trials), and mismarketed (like a Trojan horse) to governments as an excuse to tamper with health system governance (although sometimes desirably). The literature on performance-based financing in health systems should be part of the literature on decentralised health system governance. The fact that it is not, limits the learning that could have taken place between them. The cost of simplification – aided by randomised controlled trials – is that it, perhaps unwittingly, limits learning.

CHAPTER 4

THINKING IN TWO TRIANGLES

"I have made no innovations in high theory. My contribution to economics has been to urge the inclusion in our analysis of features of the economic system [i.e. 'the institutional arrangements which govern the process of exchange'] so obvious that […] they have tended to be overlooked. Nonetheless, once included in the analysis, they will, as I believe, bring about a complete change in […] the way we analyse the working of the economic system and in the way we think about economic policy."

Ronald H. Coase (1994)

"Elinor Ostrom's […] methodology of empirical inquiry required on-the-ground knowledge and historical specificity (including not just recognition of cultural beliefs in practice, but detailed knowledge of the physical realities of the situation as well). Methodologically, and as a matter of normative principle, [she] gave priority to the people that were on-the-ground solving social dilemmas in their unique way, rather than the usual one-size-fits-all solutions offered by experts from afar."

Peter Boettke, Jayme Lemke and Liya Palagashvili (2013)

Efforts to bring about health equity require knowing how health systems work from the perspective of the people within them. When you approach a health system – local or foreign – the intangible forces at work are often not readily apparent, even to a local analyst. Or they may seem so apparent that you take them for granted. The more distant you are, physically or socially, the more difficult it is to see those intangible forces or take them seriously. I think of these intangible forces in terms of rules: the formal rules (e.g. government regulations and policies) and the informal rules (e.g. social norms and conventions) that govern a system.

A challenge of working in multidisciplinary fields such as global health or international development is finding a language that is recognisable, understandable and useable by people from different disciplinary backgrounds. Without such language to talk about how systems are governed (Abimbola et al., 2017a), it is hard to think clearly about what it means to act or analyse at a distance (Poteete et al., 2010). A framework that is often used to analyse governance (Bigdeli et al., 2020) presents something of a "triangle of persons". Each of its three nodes is occupied by a category of persons: policymakers, providers and people (people being citizens or service users). This triangle began its life in the 2004 World Development Report (World Bank, 2004) to map persons involved in accountability relations. It has since gone through several iterations, interpretations and applications (Brinkerhoff & Bossert, 2014; Pyone et al., 2017; Cleary et al., 2013).

But a focus on persons is insufficient. I am drawn to the definition of governance as "making, changing, monitoring and enforcing the formal and informal rules" (Abimbola et al., 2017a) that shape "collective action and decision-making in a system" (Meessen, 2020). That is, a way of thinking about governance that is concrete and shifts the focus away from governments as the singular governing entities. It focuses instead on the rules that shape and stem from the collective agency of constituted authorities and informal groups. It is a way of considering how a system is governed that lends itself to thinking in two triangles – the first, a triangle of persons, and the second, a triangle of rules.

The expression "triangle of persons" was first used by the British psychotherapist David Malan (Malan, 1979), who put together two triangles (Figure 3) as a simple framework for psychoanalytic psychotherapy. The first depicts relations between a patient and three sets of persons – past "significant persons" (e.g. parents), the therapist, and current "significant persons" (e.g. spouse). The second, the "triangle of conflicts", is less tangible, but no less consequential. It depicts what animates relations between persons: defences (e.g. changing or minimising the subject), anxieties (e.g. worry and panic) and feelings (e.g. anger and grief). The "triangle of conflicts" shows how defences and anxieties can block the expression of feelings. The "triangle of persons" shows how this pattern

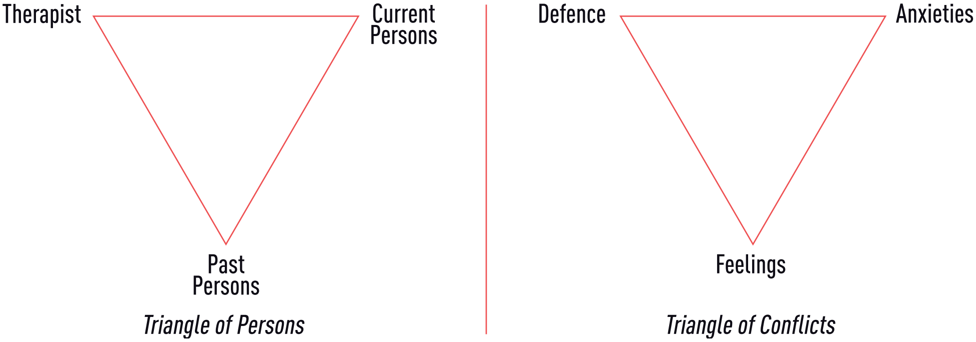

Figure 3 | Two triangles representing what happens in psychoanalytic (or psychodynamic) psychotherapy: defences and anxieties can block the expression of true feelings. These patterns began with past persons, are maintained with current persons, and are often enacted with the therapist (Malan, 1979).

of behaviour began with past significant persons, is maintained with current significant persons, and gets played out with the therapist.

The point of having frameworks is to simplify, to clarify. Triangles do the "simple but not too simple" job well, in line with Occam's razor, or the principle of parsimony, which prioritises explanations that use the smallest possible set of elements. Two elements, a single line, are too few, with space for only one two-way interaction. Four elements, a rectangle, are too many. Unlike a triangle, all the elements in a rectangle are not in direct interaction with one another. Triangles are complex, but just enough. Malan did not develop the two triangles, he only put them together. But by doing so, he achieved a framework with explanatory power that far surpasses that of each single triangle used separately (Osimo & Stein, 2012), while maintaining relative simplicity. They are still in use (Lilliengren et al., 2016; Johansson et al., 2013). You can criticise them for their tendency to oversimplify, but if two triangles simplify, one triangle is even more reductive. One triangle is insufficient to capture the necessary complexity involved in psychotherapy. The same is the case when the "triangle of persons" is used to analyse how health systems are governed. Like psychotherapy, health system governance requires a second triangle.

The distinction between the triangle of persons and the triangle of rules is subtle. Like Malan's triangles, one represents persons, and the other what governs their actions, decisions and relations (Figure 4). The triangle of rules is about the rules that they make, change, monitor and

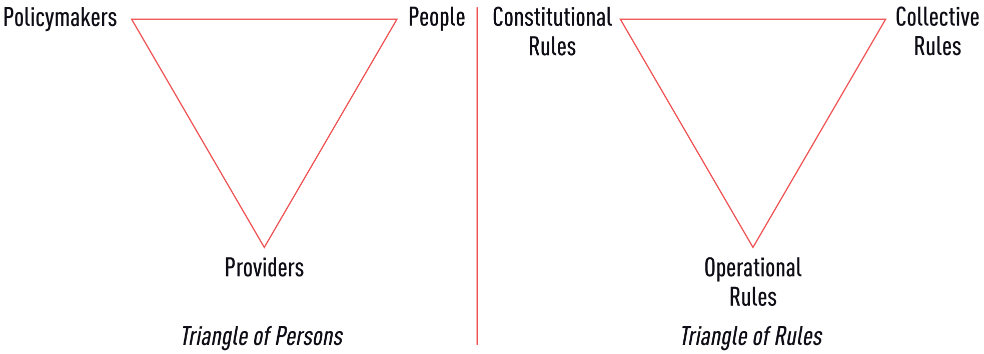

Figure 4 | The two triangles that represent what happens in health system governance: policymakers, people and providers make, change, monitor and enforce formal and informal rules, which may be constitutional, collective and operational, and these rules in turn influence their actions, decisions and relations.

enforce: the rules that govern their actions, decisions and relations; and the rules that emanate from those actions, decisions and relations (Figure 5). This was inspired by the Institutional Analysis and Development framework developed by the American political scientist and economist Elinor Ostrom (Ostrom et al., 1994; McGinnis, 2011), although she and her colleagues did not explicitly conceive of the framework as a triangle, but rather as "three worlds of action" (Kiser & Ostrom, 1982) or "three levels of rules" (Polski & Ostrom, 2017).

The rules-in-use (de facto rules) at the operational node may diverge significantly from the rules-in-form (de jure rules) from the constitutional node. An important mediator of that gap are actors at the collective node (McGinnis, 2011; Bushouse, 2011). For example, consider the operational rule that shapes the opening hours for outpatient services in a public sector health facility. Constitutional rule-making entities (say, policymakers in the headquarters or capital city) may decide that the operational rule should be 9:00 am to 5:00 pm. Or they may decide that such a rule should be made at the collective node (say, by the council of chiefs or the governing board of a health facility, or by the health committee in each community). The council of chiefs may, in turn, decide that this rule should instead be made by operational actors (say, the manager or health worker in charge of the facility).

If such a rule is only made, changed, monitored and enforced at the constitutional node, problems may arise. Because of where they are

	Who makes them	What they shape	What shapes them
Operational rules	Individual choices	How individual actors make day-to-day decisions	Constitutional rules and collective rules
	Market forces of demand and supply	How market rules (as prices), informal rules (as social norms) and formal rules (as government policies) shape how people in a community use (i.e. demand) and provide (i.e. supply) health and other social services	Constitutional rules may influence operational rules directly and indirectly through their influence on collective rules
Collective rules	"Close-to-ground" governing entities that may be informally constituted (e.g. women's groups or community health committees) or formally constituted (e.g. a small-scale district government or local council)	How, by whom, and on what terms rules at the constitutional node and at the operational node are made, changed, monitored and enforced The operational node may be the day-to-day operational activities on the demand side or on the supply side	Constitutional rules Feedback, pressures and demands from the operational node
Constitutional rules	"At-a-distance" governments (e.g. national or subnational governments with large jurisdictions) or government-like entities (e.g. headquarters of large NGOs with subnational, national or supranational reach)	How, by whom, and on what terms rules at the collective and operational nodes are made, changed, monitored and enforced To shape the rules that are in use at the operational node, constitutional rules may pass through – and be modified at – the collective node	Social norms Feedback, pressures and demands from the collective and operational nodes

Figure 5 | The types and attributes of the rules that make up the "triangle of rules".
(McGinnis, 2011; Kiser & Ostrom, 1982; Polski & Ostrom, 2017; Bushouse, 2011; Abimbola et al., 2014).

located, the constitutional actors are distant from this health facility, and may not be able to monitor and enforce this 9:00 am to 5:00 pm rule. Distant constitutional actors may also be unable to access information and feedback from the community to make and change rules in a way that is responsive to people locally. Women may be dissatisfied with the 9:00 am to 5:00 pm rule if on market days they are unable to take their children in for immunisation during those hours. On those days, they may want the heath facility to open earlier, at say 7:00 am, so that they can go to the immunisation clinic before heading to the market.

If the constitutional actors are distant and ineffective, collective node actors may play the role of changing this rule, whether or not they have the constitutional mandate to do so. But what if the collective actors are also absent or too disengaged; say, a council of chiefs that does not care? What you then have is a situation in which the de facto rules (rules-in-use) that govern opening hours may depend only on relations between demand and supply operational actors. At the operational node, workers may do what the women want because their income, sense of fulfilment, or social standing depends on it; or in exchange for a bribe or informal fees; or because it is convenient for them to open early and close early on market days, so that they too can shop at the market.

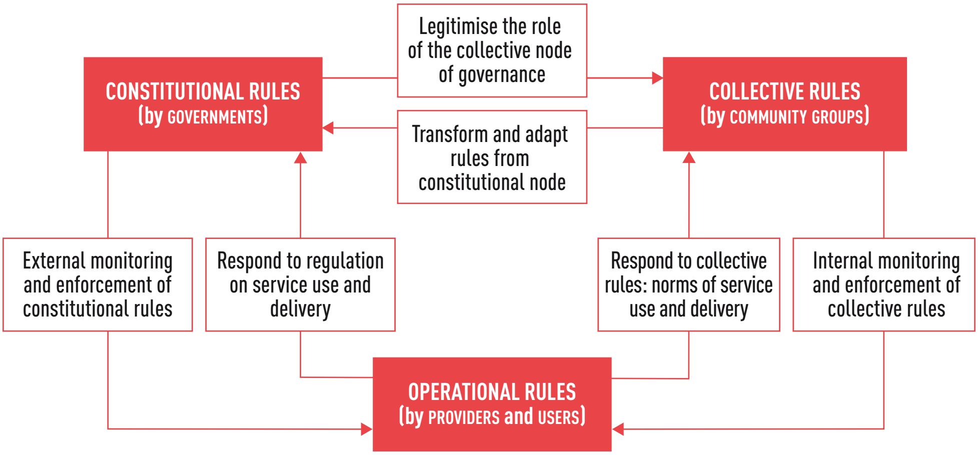

Figure 6 | The "triangle of rules" showing examples of bidirectional relations between each of the nodes of the triangle, using the example of rules that may govern service delivery within a community.

I use this triangle of rules, often implicitly, in my own work and to reinterpret others' work. But I bear in mind four starting points for doing the Arendt-style kind of "representative thinking" (Arendt, 1968) that I want to do and wish others would do, for thinking from a local standpoint, for taking on a local pose. First, I remind myself to analyse the rules from the bottom up – to start the inquiry from the operational node. After all, this is where individuals make choices and where rules-in-form become rules-in-use. I ask myself: what are the rules-in-use at the operational node? Are they rules from the operational node (e.g. the interplay of demand and supply), or from the constitutional or collective node? Or did they result from a combination of processes at two nodes or all the three nodes? Bottom-up questions shine a light on informality, on how rules-in-use diverge from rules-in-form. I find myself asking: why are people in a community seeking care from unlicensed drug sellers, or from traditional birth attendants, healers, or bone setters? Why do they ignore or take too long to reach regulated or non-traditional service providers (Abimbola et al., 2015a, 2016; Godlonton & Okeke, 2016; Reid, 2012)?

The answer may be found in context. It may be *socioeconomic* – e.g. the inability to afford formal providers may lead people to "shop around" at informal providers. It may be *geographical* – e.g. if a village is large there may be many informal providers, and for many in the community, it may be difficult to physically access a single formal provider. Or it may be *institutional*, i.e. the rules-in-use in the local health care market (for example, the constitutional rules to regulate informal providers) are neither monitored nor enforced (McGinnis, 2011; Kiser & Ostrom, 1982; Polski & Ostrom, 2017; Bushouse, 2011; Abimbola, 2020). Interacting with one another, these factors combine to shape trust, power and accountability relations, which also strongly influence the choice of provider. When constitutional rules are not monitored and enforced, the rules of the marketplace may dominate at the operational node. Or collective rules may dominate. The collective rules that dominate may be the "professional code" of informal providers that shape their practice, and perhaps makes them the preferred providers, even if constitutional rules (that would otherwise regulate their practice) are neither monitored nor enforced.

You may try to change existing rules that govern informal providers so that they refer their clients to formal providers or work alongside formal providers. You may spread information about the costs of inappropriate care in the community so that people can change their care-seeking behaviour. But these strategies require changing local norms (i.e. informal rules), which can take decades to shift (Abimbola et al., 2016; Reid, 2012). You may also try to change constitutional rules to enable the supply of more formal providers or reduce out-of-pocket costs of care at formal providers. But this requires political engagement strong enough to alter those constitutional rules. Or you may seek to improve the monitoring and enforcement of the constitutional rules that limit informal providers' practice. But entrenched local norms and informal practices are hard to know or regulate at a distance (Godlonton & Okeke, 2016; Reid, 2012). If there is a large distance between the constitutional and operational nodes, it may be more effective to strengthen the hand of collective actors (including through constitutional rules that legitimise their role) to make new rules or change existing ones in ways they can monitor and enforce.

The second thing I remind myself is that rules function in a dynamic balance as they shape social action (Abimbola et al., 2017a; Abimbola, 2020; Dixit, 2009) to *provide public goods* (e.g. rules on using taxes and other collective resources to provide a social safety net and health infrastructure); to *define and protect rights* (e.g. rules on the rights and conditions under which individuals and communities benefit from a resource, including the right to access, use and manage public or quasi-public goods such as health facilities and services); and to *facilitate social exchange* (e.g. by ensuring that information, regulation and coordination work to align demand with supply and vice versa).

Each set of rules may originate from any of the three nodes, functioning in a dynamic balance to shape social action (Bushouse, 2011; Dixit, 2009; Abimbola, 2020). The rules for facilitating transactions, and thus promoting the use of formal providers may be made at any of the nodes. But when rules are effectively made, changed, monitored and enforced from the constitutional node, there is less role for collective rules, and so constitutional rules would often prevail at the operational node (Bushouse, 2011; Abimbola et al., 2014; Abimbola, 2020). The weaker the constitutional node, the stronger the roles of actors at the collective and operational nodes. But constitutional actors may deliberately configure the rules so that some are made, changed, monitored and enforced at the collective node, and others at the operational node.

Let's look at another example: health worker absenteeism. One set of rules shape how many health workers are available in a health system or within a country (*rules that provide public goods*). Another set of rules shape who has access to those health workers (*rules that define and protect rights*, e.g. the rules governing the posting and transfer of health workers to rural communities, which can then shape the access of these communities to health workers). Yet another set of rules shape how, once health workers are in a community, people access the services they provide – are people aware that health workers are available, what time of day are they available, are they available when the community is able to access them, do they provide high quality services, are they respectful, are they responsive to the people (*rules that facilitate social exchange*) (Abimbola et al., 2015a, 2016a, 2016b; Abimbola, 2020)?

To understand high levels of rural health worker absenteeism, you may ask: Are there no rules governing operating hours? (Unlikely.) Are the constitutional rules not monitored or enforced? (More likely.) Are there collective rules crafted to govern operating hours in ways that allow health workers to be present only when the community needs them most? Are health workers absent because the rules protecting the rights of rural communities to have access to them are inadequate? Are health workers left to sort out their accommodation when transferred to rural communities? Are they without a travel allowance? Is the collective node so absent that health workers at the operational node make their own rules (Abimbola et al., 2015b, 2016a, 2016b, 2017b; Onwujekwe et al., 2019, 2020)? The triangle of rules helps to explore how absenteeism (like other actions, decisions and relations that reflect how a system is governed) is a complex and adaptive phenomenon. When one node of governance fails, the extent of the failure can be assuaged or compensated for by governance at or from another node (Bushouse, 2011; Abimbola et al., 2014).

The third thing I keep in mind is that rules have a distance and scale effect. As a governing entity, the number of units you have to govern can determine how effective you are able to govern, just as the distance from the units you govern can determine how effective you are able to govern. An important consideration here is that this distance and scale effect can be about knowledge. Rules have epistemic properties. Health systems are, after all, knowledge systems. How rules are made, changed, monitored and enforced (mediated by distance and scale) can lead to varying capacities to generate the knowledge to wield rules effectively, equitably and responsively (Bushouse, 2011; Boettke, 2018; Lewis, 2020). It is important to consider the distance that may exist between the constitutional or collective node and the operational node, and the scale or number of operational units that are the subject of rules. Distance and scale, themselves mediated by power, resources and technology, also influence how governance actors use local knowledge and feedback to make, change, monitor and enforce rules.

Let's say there was a major constitutional reform in country X, which meant that the governance of tertiary hospitals in X becomes decentralised from a national ministry of health to regional (that is, subnational) governments (Barasa et al., 2017). Pre-decentralisation, there were 50 tertiary hospitals, run from the "distant" national ministry of health of country X, the constitutional node. Each hospital had a governing board, i.e. the collective node. Pre-decentralisation, the "proximate" boards exercised power and discretion in the day-to-day activities of each hospital, i.e. the operational node. This was in part because the centre was far away from most of the 50 hospitals, thus diminishing the national ministry's ability to make, change, monitor and enforce rules for all 50 hospitals across X. By default, much of this responsibility fell to each hospital's governing board. But with decentralisation, constitutional governance shifted to 50 locations across the country, which are now much less "distant" to each hospital. Previously influential, each of the 50 hospital boards (collective node) become much less powerful, as the operational day-to-day rules are made, changed, monitored and enforced more directly at (newly decentralised) constitutional nodes – by regional governments – leading to "recentralisation" and poorer hospital performance, as in their responsiveness to communities (Bushouse, 2011; Barasa et al., 2017; Lipunga et al., 2019).

Now consider an alternative, almost opposite, scenario in region Y, the largest region in country X, five years after the nationwide reforms in X. As part of the reforms in region Y (carried out independent of the national government), aspects of the governance of primary health care facilities become decentralised from the government of region Y (that is, a subnational government) to community health committees (Mabuchi et al., 2017; Loevinsohn et al., 2019). Pre-decentralisation, day-to-day operational decisions were shaped by constitutional rules made by the ministry of health or region Y for, the 75 primary health care facilities in region Y. Pre-decentralisation, there was little or no formal role for collective governance by community health committees. With decentralisation, the "proximate" community health committees (one for each of the 75 primary health care facilities) make, change, monitor and enforce the rules governing the finances of their own health facility. The performance of these health facilities improves (as in their responsiveness to communities) compared to when decisions were made predominantly or exclusively at the constitutional node which is located in the capital city of region Y (Bushouse, 2011; Mabuchi et al., 2017; Loevinsohn et al., 2019).

What is at play here is not just proximity. There is also a scale effect. Pre-decentralisation, the national ministry of health of country X looked after 50 operational units (that is, tertiary hospitals) and the subnational ministry of health of region Y looked after 75 operational units (that is, primary health care facilities) diluting their effectiveness to make, change, monitor and enforce rules. Post-decentralisation, each governing entity (that is, each regional ministry of health across country X, and each community health committee across region Y) oversees only one operational unit. With decentralisation to regional governments, stronger constitutional governance can reduce the influence previously exercised by default or delegation at the collective node (that is, the governing board of each tertiary hospital). But with decentralisation to community health committees, stronger collective governance can promote local community autonomy and health facility performance (Bushouse, 2011).

The fourth thing I keep in mind is that the power to make, change, monitor and enforce rules can be diffuse or concentrated. The power is concentrated, for example, in the case of a private sector provider who makes and changes rules without consulting another authority (where the constitutional node, that is, the government responsible for its oversight, is weak and there is no governing board of community members). Or it can be diffuse, say, where a board of governors or a coalition of users is responsible for collective governance, and there are effective, well-resourced and technologically advanced (even if distant) constitutional actors (Munthopa et al., 2019). The rules governing a system are diffuse when rules are made, changed, monitored and enforced at more than one node, and when there is space for contestation between actors across the three nodes (Bushouse, 2011).

Now let's say you are in a place where the government is distant or weak. There is a private sector health facility without a governing board of community members (Bushouse, 2011; Bloom et al., 2014; Champion et al., 2012). In that health facility, you may describe the situation as a collapsing – or folding into one – of rules; a concentration of the power to make, change, monitor and enforce rules. The operational rules may reflect whatever the owner decides the constitutional rules are, especially when it is an "on-site" owner who is also the lead service provider. When off-site, the gap between constitutional rules (as made by the owner) and operational rules may depend on the proximity of the owner (Bushouse, 2011). Or imagine you are in a health facility that is owned by a religious or ethnic organisation, with a governing board of community members who are also members of that same religion or ethnicity, with constitutional rules made by the national leader of the religion or ethnic group, supported by subnational deputies. Health workers in that facility are also mostly members of the religion or ethnicity. Here, although the three nodes of governance are present, the lack of diversity within and across the nodes means, in effect, that the power to make, change, monitor and enforce rules is concentrated (Bushouse, 2011).

Concentrated power – alongside socioeconomic and geographical context – can shape how well operational rules align with local needs and realities. An on-site owner of a private health facility who is governed at the operational node only by the rules of the marketplace, may prioritise only the segment of the community that is able to afford high service charges. On the other hand, an ethnic or religious service provider that is governed by the dominant values of a religion or ethnic group, may be responsive to local needs and realities if the community that relies on it aligns with its values. Where there is a diversity of values and identities, such concentrated power may be mediated by collective node actors, say, a governing board that is representative of that diversity. But the presence of collective node actors (e.g. on the demand side in the form of a governing board of community members or a professional, norm-setting association of health workers) is not enough to guarantee that they will be able to make, change, monitor and enforce rules. Their management rights to do so need to be well defined and protected (Lodenstein et al., 2016; George et al., 2015). They need to have the capabilities to govern and sufficiently favourable geographical circumstances (Abimbola, 2020; Falisse et al., 2012).

The triangle of rules can expose you to how little you know, and it can compel you to take the standpoint of "others" in your analyses, to practice "representative thinking" (Arendt, 1968). Your positionality (pose) as an analyst matters (Gilmore, 2019; Harding, 1991). The triangle of rules can make you ask yourself, seriously: How well can I see the granularity of rules – their interractions, what they do, and how they are made, changed, monitored and enforced – at a distance (Poteete et al., 2010; Stiglitz, 2001)? The triangle of rules reminds you of the limits to your perception when you are trying to see at a distance, or when you have limited knowledge of the granular details of context.

The triangle of rules also asks that you take knowledge as seriously as you take accountability (Ostrom et al., 2017; Pennington, 2013). Given its origins, the triangle of persons focuses on accountability (World Bank, 2004). Accountability requires rules, as it requires knowledge. But knowledge can do its work without accountability – simply by actors knowing the right thing to do and how (Abimbola et al., 2019). So the triangle can also make you ask yourself: What is the optimal strategy to improve governance in this particular setting, for these functions, or at this scale – knowledge, accountability or both? What is the role of technology, which can alter the epistemic properties of the relations between the nodes of the triangle of rules, which can change the meaning of proximity and can make monitoring and enforcing rules at a distance less costly (Polski & Ostrom, 2017; Bloom et al., 2014; Champion et al., 2012; Ostrom et al., 2017)? But if and when that is the case, such technology can lead to less flexibility and freedom to shape rules-in-use locally.

The triangle of persons focuses on human agency, while the triangle of rules focuses on the rules that constrain and enable such agency. It asks you to think again about the debate on the relative importance of structure versus agency (Harris et al., 2020; Porter, 2015). You may think that it is easier to change people's choices than it is to change the rules that constrain or enable those choices. But trying to change people (by appealing to "the better angels of their nature") may be less effective than aiming to change the rules that govern them or who should be in a position to make, change, monitor and enforce those rules, especially when you are at a distance. Global health involves acting "at a distance" (Abimbola, 2018), with less than optimal knowledge, agency and stake ("skin in the game").

Often, the only things of value you can offer at a distance are design features, based on bottom-up syntheses and abstractions of learning and based on insight from comparative analyses across settings (Stiglitz, 2001; Taleb, 2017; Ostrom, 2005).

What can a distant (or foreign) analyst really say about governance? What are our/their limits? What are the limits of the foreign pose? The triangle of rules sheds light on potential strategies to alter structure – for example, on how to decentralise governance in ways that facilitate community engagement (Topp et al., 2018). But the closer governing entities are to the ground, the more prone to, say, nepotism, and the lower the ability of central governing bodies to impose beneficial equalising measures top down. The triangle of rules may inform comparative analyses to identify "optimal" points for decentralised governance that minimise its negative consequences – a design feature (i.e. structure) that may be understood in the abstract or influenced at a distance, but not prescriptively, so that features unique to the context can shape the redesign of the system (Ostrom, 2005).

Thinking in two triangles means you can move persons between nodes, based on the rules they influence or the rules that influence them (Abimbola et al., 2014). The same person who functions as a service provider or user (operational node) in a setting, may simultaneously function as a community leader (collective node) in the same setting and also as a legislator with an even broader jurisdiction (constitutional node). The same governing entity may function at different nodes depending on size and distance: a council of chiefs in a town of 2,000 people may function at the collective node. If the town grows to a population of 200,000, the council of chiefs may become so distant from the operational node that it functions, essentially, at the constitutional node (Bushouse, 2011).

The actor who functions at each node may also vary depending on the scale or size of the system you are analysing: a district or regional health system, a national health system, or even the dynamics of global health governance. Imagine a pandemic during which the supply and demand of personal protective equipment came under the governance of global markets (operational rules), but also collective rules (groups of countries that came together – or not – to govern the market for a collective good), and the constitutional node (through the World Health Organization, or the "constitutional" rules contained in its

International Health Regulations) (Ferhani & Rushton, 2020). The district or regional government may act at the constitutional node when you are analysing dynamics within a district or region, but if you are thinking nationally, depending on its size, the district or region may function, essentially, at the collective node.

What is said of models is also true of frameworks; all frameworks are wrong, but some are useful. Combining frameworks – without blunting Occam's razor, i.e. while maintaining the principle of parsimony – adds great value. When used together with the triangle of rules, the triangle of persons is more useful. As for Malan's two triangles, the need for a second triangle is not unusual. There are other instances of a multi-triangle framework (Bauer & Gaskell, 2008; Andreouli et al., 2015). One of the most widely used triangles in health systems and global health analyses deserves homage for its parsimony – Gill Walt and Lucy Gilson's policy analysis triangle (Walt & Gilson, 1994). This triangle explicitly spells out three interacting nodes to consider during policy analysis: context, content and process. Yet Walt and Gilson included actors ("persons") in their various roles – as individuals, groups and organisations (Buse et al., 2007) – which they could easily have called a "triangle of persons" (Figure 7).

The triangle of rules highlights often ignored features of health systems which are worth keeping in mind when trying to understand or improve

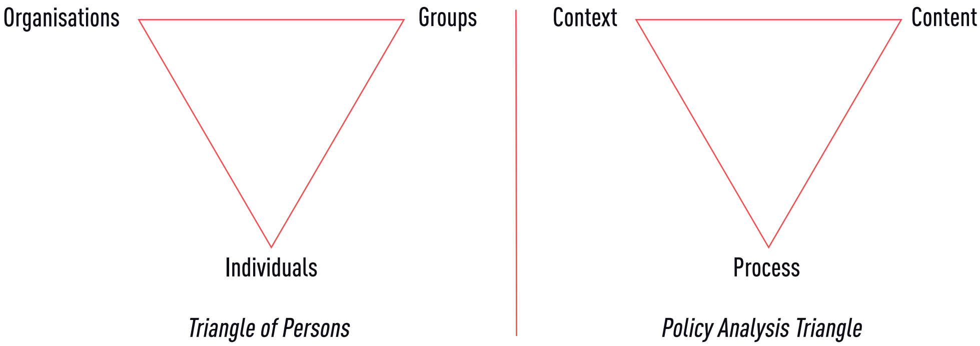

Figure 7 | Policy analysis triangle(s) showing the factors (context, content and process) affecting policy and the relations between these factors, and the "persons" interacting as individuals, as groups or as organisations to influence the policy context, content and process.

their governance and performance from a distance; features that are easily missed if the triangle of persons is used alone. What I have tried to do in this essay, to paraphrase the American economist Ronald H. Coase, has been “to urge the inclusion in our analysis, of features of the [health] system so obvious that […] they have tended to be overlooked” (Coase, 1994). The language of rules (or institutions) and their configurations, the lines of inquiry, the transferable insights and middle-range theories they suggest (Ridde, 2016; Van Belle et al., 2017; Ridde et al., 2020), and the analytical stance they require, can improve our analysis of health system governance – especially analyses done at a distance and on which the foreign gaze exerts its powerful pull.

CHAPTER 5

THE USES OF KNOWLEDGE

"If […] the problem of society is mainly one of rapid adaptation to changes in the particular circumstances of time and place [then] the ultimate decisions must be left to the people who are familiar with these circumstances, who know directly of the relevant changes and of the resources immediately available to meet them. We cannot expect that this problem will be solved by first communicating all this knowledge to a central board which, after integrating all knowledge, issues its orders. We must solve [the problem] by some form of decentralisation […].

But the '[people] on the spot' cannot decide solely on the basis of [their] limited but intimate knowledge of the facts of [their] immediate surroundings. There still remains the problem of communicating to [them] such further information as [they need] to fit [their] decisions into the whole pattern of changes of the larger […] system. How much knowledge [do they] need to do so successfully? Which of the events which happen beyond the horizon of [their] immediate knowledge are of relevance to [their] immediate decision, and how much of them need [they] know?"

Friedrich Hayek (1945)

Like many academics involved in global health, I am frequently called upon to make judgements on research papers (Abimbola, 2018). To assess their value, I rely on their declared aim, which is usually stated at the end of the "Introduction" or "Background" section. The declared aim can reveal for whom we imagine we write (i.e. gaze or audience) and the standpoint from which we write (i.e. pose or positionality). But much too often, it reads like an afterthought, as though it was written in pretence or in tenuous hope, like an item thrown into deep space in the hope that it might hit a target called "equity" or "improving the lives of people in need". The declared aim of research papers in global health often betrays our lack of a collective sense, or *theory*, as to how knowledge leads to equity – a theory with which we may align how we value, produce and use knowledge. Such a sense of how knowledge does its work exists in the basic and biomedical sciences, but not in global health – or in a more prosaic rendering – not in our efforts to achieve health equity.

Much of the edifice of academic global health is built on the assumption that the goal of inquiry is to identify universal truths: to add to a central pool of knowledge (Rutter et al., 2017; Greenhalgh, 2020; Ogilvie et al., 2020), e.g. on the biology of a virus, or the quest for a vaccine. The propensity to value the universal in global health – often apparent in the declared aim of research papers – stems partly from its biomedical and colonial origins (Affun-Adegbulu & Adegbulu, 2020; Biehl & Petryna, 2013, 2014; Richardson, 2020). In biomedicine, you search for universal truths insofar as biology, chemistry and physics are essentially the same everywhere. In colonial relations, you look from a distance, and you are unable to see or value what is unique to a place. You see whatever you deem universal or value what you see insofar as it aligns with your foreign, external worldview. You conflate what it means to be "rigorous" with a thought-stopping cliché that demands universal truths and external validity, a randomised controlled trial and approximations of it, or a default to uniform and standardised methods, metrics, indicators and measures around the world. But truth, in such a centralised or universal sense, is typically not the goal in the quest for equity within and across social spaces and systems (Rutter et al., 2017; Greenhalgh, 2020; Ogilvie et al., 2020). What often matters much more is finding contingent, circumstantial or particular truths about what it takes to achieve equity at a particular place and time, and subsequently, finding regularities; finding the universal in the particular. After all is said and done, eventually, ultimately, you can go looking for regularities across places and times. But only after finding the specific, and then abstracting across multiple specifics.

If all you read are research papers in elite academic journals, the impression you get from the literature is very likely that equity in global health comes about primarily through "surgical" change brought about through discrete, episodic, one-off events or efforts. That is, macro-innovations or (often externally introduced) measurable, tangible, time-bound interventions, which function independently of one another and of context, and whose effects can be seen from a distance (Biehl & Petryna, 2013, 2014; Richardson, 2020; Storeng & Béhague, 2014; Weick, 1984). You may also get the impression that large or multi-site studies are inherently more valuable than small or single-site studies; or that there is virtue in adopting methods and measures whose primary purpose is to simplify complex realities. The literature is a misleading tip of an iceberg. What remains hidden beneath the surface are the day-to-day uses of knowledge by actors working within systems at different scales of organisation to bring about change: that is, "organic" change. The literature thus reads like a conversation to which the primary participants, those working for change day to day, were not invited.

The academic global health literature marginalises many conversations that should be primary. Conversations on the role that social learning plays in how knowledge is used to achieve health equity (Sheikh et al., 2020; Ellerman, 2001; Schon, 1994). Conversations within and between countries on the organic processes that underpin equity in health and its determinants, which, even when local, would often have international resonance. It is time to look again at our assumptions of the primary purpose of our literature, and to consider what a reordering of those assumptions might mean for how this literature is put together. The status quo reflects a pervasive misordering of value (Richardson, 2020). We need to reorder our working assumptions so that they begin with a (rebuttable) presumption that there are primary uses, users and producers of knowledge that our literature must serve first and foremost. The construction of such a different order for our literature – for how (or how not) to use knowledge for equity – could be based on the principle of subsidiarity.

* * *

"Subsidiarity" comes from *subsidium*, a Latin term that originated in the Roman military. It was used to describe the third line of soldiers, "who would only join in a battle if the powers of the two front lines were insufficient" (Gosepath, 2005). The military connotation of *subsidium* has faded over time. The term now refers to help, assistance, support or aid – the kind that one would not need under ideal conditions, or the kind only offered on request (Gosepath, 2005; Cahill, 2017; Höffe, 1996). In its modern usage in social and political philosophy, "subsidiarity" is used in relation to an ethical principle: the *principle of subsidiarity*. This principle holds that decisions about efforts to help others and to attain the common good (for example, by using knowledge to achieve equity in global health or within a social space or system) should, by default, take place at the smallest or most proximate level/scale of organisation possible, and only when necessary at a larger or more distant level/scale of organisation (Gosepath, 2005; Cahill, 2017; Höffe, 1996; Chaplin, 1997).

Evoked as a safeguard against (over)centralisation, subsidiarity is a priority principle for relations between governing entities. Subsidiarity means (until proven otherwise) that smaller/proximate units take precedence over larger/distant units – individual nations over supranational entities to which they belong, subnational over national governments, communities over governments, and families over communities. The principle of subsidiarity predates its modern, explicit usage. For example, subsidiarity was implicit in the formation and relations within and between loose confederations of historical Greek and Yorùbá city states (Usman & Falola, 2019; Adelusi-Adeluyi & Bigon, 2008; Rufus Davis, 2021; Roy, 2007). In global health, there is a multiplicity of proximate–distant (or primary–subsidiary) relations (between social, technical and political entities within and beyond jurisdictional boundaries). Subsidiarity provides a practical basis for governing aspects of these relations; especially those that pertain to the uses of knowledge.

The case for adopting the principle of subsidiarity to reorder our assumptions about the uses of knowledge can be made on two inseparable grounds: on the practical (e.g. effectiveness and efficiency) and moral (e.g. equity and justice) benefits of acting close to the ground, close to the issues, and close to the people. Among the practical benefits are that this principle allows proximate actors with optimal knowledge of the problems to take initiative, to experience the consequences of their actions, to revise their theories, and to inform subsequent iterations of action based on local information, feedback and observed regularities (Gosepath, 2005; Cahill, 2017; Höffe, 1996; Chaplin, 1997; Drew & Grant, 2017; Abimbola et al., 2019). By promoting proximate initiative and action at or by diverse smaller scales/entities, this principle also promotes plurality and multiplicity of forms, which in turn increases opportunities for learning (within and across such small units) and for resilience to shocks (given network effects across small units) (Höffe, 1996; Drew & Grant, 2017; Abimbola et al., 2019).

The moral benefits of the principle of subsidiarity mirror its practical benefits, as moral proximity tends to follow physical proximity. Moral proximity implies accountability to oneself and to one's community, with a high stake ("skin in the game") in ensuring the success of collective efforts or initiatives. Putting one's own proximate (often tacit and informal) knowledge to use can inspire one's confidence in its value. And with proximate action and use of knowledge, actors see how their (often collective) efforts help to promote the common good. This experience can then help them achieve the deeply human and existential need to be useful, to avoid social alienation and dependency, to exercise agency, and to gain the sense of dignity and meaning that comes with shaping one's own destiny (Drew & Grant, 2017). Indeed, the moral necessity of the principle of subsidiarity is such that assigning to a distant or subsidiary entity what a proximate or primary entity can do has been described as "a grave evil" and "an injustice" (Pope Pius XI, 1931).

On the road to equity, knowledge is primarily produced or used by proximate actors to generate small wins – continuous day-to-day "organic" micro-innovations (Weick, 1984; Ellerman, 2001). On the other hand, subsidiary production or use of knowledge is often about large wins, typically episodic, "surgical" or major innovations, designed or enacted at a distance. Proximity focuses attention on small wins. Large wins are really a cumulation of these small wins, of minor changes that result from ongoing learning. Small wins require less coordination to implement, and they are more structurally resilient compared to single large wins. Each small step inspires confidence in the possibility of success in the next step. These steps can be assembled in endlessly varied combinations from place to place and from time to time. But what may appear to a distant subsidiary actor as the "next logical step" or "next solvable problem" typically diverges significantly from that of a proximate primary actor (Weick, 1984; Ellerman, 2001).

The Irish legal scholar Maria Cahill has distilled the principle of subsidiarity into four precepts (Cahill, 2017). These four precepts may be applied to the uses of knowledge along the following lines (Gosepath, 2005; Cahill, 2017; Höffe, 1996; Chaplin, 1997). (1) Primary units must have the freedom, opportunity and responsibility to produce, use and rely on their own knowledge, and to indicate when they need the help of subsidiary units. (2) Subsidiary units must only provide help when requested, respecting the presumptive authority of primary units in relation to knowledge, unless primary units are evidently so weak that they are unable to seek help. (3) Subsidiary units must direct requested or offered help towards the goals of primary units and not their own goals. (4) There must exist built-in structures to govern the engagement of subsidiary units with primary units, e.g. to decide when to modify or (dis)continue help or what to do with knowledge that is produced, so that subsidiary units do not undermine primary units and primary units do not become overly dependent on subsidiary units.

How then may we distinguish primary from subsidiary uses (or units of users or producers) of knowledge? The principle suggests that academic research is subsidiary to knowledge from the arena of practice; policy designers are subsidiary to implementers; what is episodic is subsidiary to what is day to day; and distant decision-making is subsidiary to proximate decision-making. These distinctions suggest four uses (or units) of knowledge (Figure 8) (Dekker, 2020). Two uses/units are primary: *emancipators* (people using knowledge to transform the structural determinants of their own health) and *plumbers* (implementers using knowledge for change). Two uses/units are subsidiary: *engineers* (policy designers using knowledge from primary units) and *professors* (knowledge-mongers). Each use/unit may exist in an individual, group or organisation. Quite like fractals, the units of four form a knowledge ecosystem that is present at different scales of organisation (Figure 9).

“Emancipators” are activists – individual activists, teams of campaigners, women’s groups, civil society organisations, etc. They use knowledge in their efforts to construct a new reality for themselves, to demand and create ideal conditions (economic, social, political, gender) for themselves, and to alter the social structures and rules that disadvantage them (Galtung, 1969), regardless of whether those structures and rules are made locally or at a distance. In the process, as they work to transform social systems and realities, they also produce knowledge.

	Activist/Constructive Attitude	Accepting/Corrective Attitude
Proximate/Local/Primary Position	“Emancipator”	“Plumber”
Distant/Foreign/Subsidiary Position	“Engineer”	“Professor”

Figure 8 | Units of uses/users of knowledge in global health.
The distinctions drawn here are partly inspired by Dekker (2020) and Abimbola (2019).

On the other hand, broadly accepting of the status quo, "plumbers" work within existing systems. They use and produce knowledge day to day, bringing about incremental change through service delivery as individual bureaucrats, teams of service providers, NGOs, or ministries of health. As primary units, plumbers and emancipators are together responsible

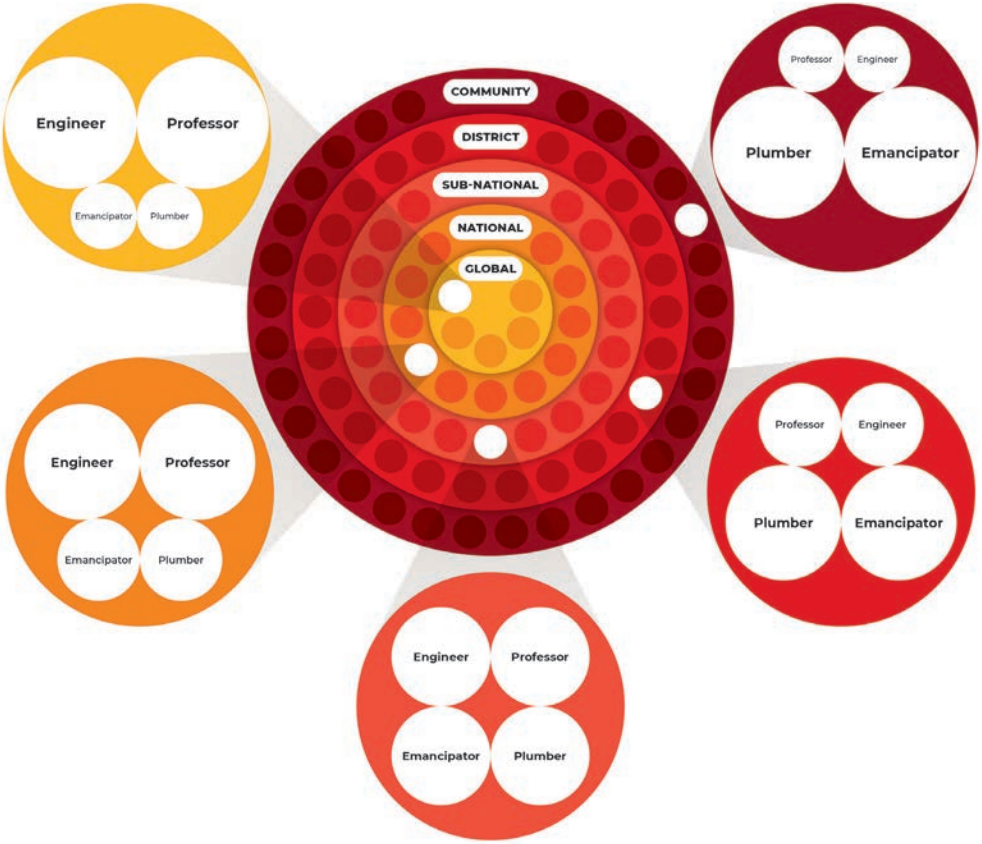

Figure 9 | Concentric rings of knowledge uses/users in global health.

This figure shows (a) examples of the scales of organisation at which knowledge is used for equity (the five concentric rings); (b) the spaces in which the knowledge is used (the small circles that line the concentric rings); and (c) the four uses/users or units of knowledge, which are represented as four labelled circles within each small circle. The size of the primary uses/users or units (emancipators and plumbers) is larger closer to the community "ring", while the size of subsidiary uses/users or units (engineers and professors) is larger closer to the global "ring".

for the vast bulk of change in global health (Weick, 1984; Sheikh et al., 2020; Ellerman, 2001; Schon, 1994; Dekker, 2020; Galtung, 1969; Gumbonzvanda et al., 2021; Levitt et al., 2013; Hendel & Spiegel, 2014; Askew et al., 2020). They make progress in small wins. They learn from these small wins, and from small losses too. They learn by doing.

"Engineers" design policies, programmes and systems, or they create the overarching framework within which plumbers perform these and their own roles (Dekker, 2020; Erasmus, 2014). "Emancipators" seek to alter the designs of engineers. Engineers have power or align with power. They are considered "activists" insofar as they can use their power to construct emancipatory realities, especially when emancipators push engineers to transform unjust social systems and realities. Engineers are visible. They attract the attention of "professors". Too much of our literature is aimed at engineers, as if change emanates primarily from the intercourse between the political and academic elite – as if the literature is just an instrument of power. The knowledge needs of (and the knowledge produced or held by) emancipators and plumbers go unacknowledged, as if they do not exist. Yet the vast bulk of the literature should be written for and by emancipators and plumbers. If this claim appears farfetched, it is because the status quo is not fit for the purpose.

"Professors" can be individual academics, journalists or reporters, town criers or village announcers, research or data teams or groups, think tanks, academic institutes, or universities. Or the research or data team within an organisation of engineers, emancipators or plumbers. Professors share knowledge through publications and teaching and activities that help to connect a system, any system, "to more of itself" (Wheatley & Kellner-Rogers, 1998; Wheatley, 2001; Wheatley & Frieze, 2015). Disconnection is the source of many inequities. To connect a system "to more of itself" is to make unavoidably known – elsewhere or by others – what was already known or has been experienced by a part of a system, or a set of actors or knowledge users. It is to connect one voice to another voice, and many voices to many ears. Professors also repackage and reframe existing knowledge, and sometimes make new knowledge. To contribute to equity, professors might seek to undo assumptions that hold it back or develop analytical tools to better define and solve problems (Whyle & Olivier, 2020). Some, in an ivory tower sense, may be uninterested in equity, curating seemingly useless knowledge, some of which may nonetheless become useful for equity. But perhaps the most direct – and primary – way in which professors can use knowledge for equity is by helping to connect a system to more of itself; by moving knowledge within and across time and place.

The academic global health literature has predominantly been a space for professors. It is time for that to change. What engages the attention of professors is not necessarily what advances equity in global health. Professors are party to equity when they are part of the learning processes of and between plumbers and emancipators (with or without engineers), purposefully helping to connect units to one another. They may be professor–emancipators (scholar–activists) (Gumbonzvanda et al., 2020; Eschle & Maiguashca, 2006; Musolino et al., 2020; Campbell & Burgess, 2012) or professor–plumbers (scholar–implementers) (Irimu et al., 2018; Ropa et al., 2019; Young et al., 2018). They may work directly with engineers to make sure that their designs are based on knowledge produced or held by plumbers and emancipators (Barasa et al., 2020; Montilla et al., 2020; McAteer et al., 2019; Uzochukwu et al., 2016). Even then, engineers need to aggregate a plurality of interests and knowledge (Belghiti Alaoui et al., 2020; Bonvin & Laruffa, 2018; Salais, 2008). Professors may help to connect different interests and knowledge by facilitating platforms for deliberation among groups of emancipators or groups of plumbers, or between emancipators and plumbers (Bryant, 2002).

Equity is political. Engineers and emancipators are inevitably political. Even plumbers will sometimes have to be emancipators (Schaaf et al., 2020; Abers, 2019; O'Sullivan, 2015; Brown & Fee, 2006). Professors will often need to be political. Uses and users of knowledge can also be fluid. An emancipator for one cause can be a plumber or an engineer for another. An engineer for one design may be a plumber or an emancipator for another. But the use of knowledge by engineers for "big wins" is so visible that it is far too often the focus of professors' attention (Biehl & Petryna, 2013, 2014; Richardson, 2020; Storeng & Béhague, 2014; Weick, 1984). The use of knowledge by plumbers gets a lot of professors' attention too, but nowhere near enough. Emancipators get even less attention. The primary uses of knowledge (by plumbers and emancipators) often go unseen, in part because despite small wins and the learning that results from them, day by day nothing appears to change (Weick, 1984). Change is more apparent in hindsight. Much more visible is the episodic work of professors (aimed at engineers) and of engineers (reported by professors).

There are countless spaces within which knowledge may be used to connect a system to "more of itself". Such spaces exist at different scales of organisation – communities, districts, subnational or national entities, the globe (Figure 9). Inside each space, actors produce and use knowledge as primary units, sometimes with the help of subsidiary units. Knowledge from small wins may get shared within the space in which it is produced, or shared between spaces at the same scale of organisation (e.g. between districts or countries) or at different scales of organisation (e.g. between a community and a district, or a country and a global entity). The principle of subsidiarity suggests that the flow of knowledge should circulate within spaces, serving proximate spaces and primary units before it is put to subsidiary uses. Maria Cahill's four precepts of the principle of subsidiarity (Cahill, 2017) suggest how we might make sense of and limit injustices in the uses of knowledge.

First, injustice occurs when subsidiary units fail to default to primary units as primary producers and holders of knowledge. Or when subsidiary units do not allow primary units to make the most of the knowledge that they produce and hold. It manifests when subsidiary units default to a deficit-based approach to knowledge rather than asset-based or strengths-based approaches to knowledge (e.g. reckoning with existing knowledge, efforts, and small wins) (Morgan, 2014). It manifests in failure to minimise the need for subsidiary units, by not investing in platforms that allow primary units to learn for themselves, to circulate learning from small wins, and to connect to more of themselves (e.g. through routine data, deliberation or after-action review) (Ghaffar et al., 2020). To limit such injustices, it may be necessary to mandate that any help provided by subsidiary units should be provided in a way that does not take away from (but instead reinforces) the capacity and opportunity of primary units to learn for and by themselves.

Second, injustice occurs when subsidiary units presume to have the right to help primary units to produce or use knowledge when there is no explicit request to do so and no evident lack of capacity to make such a request. The effect may be to usurp the ability of primary units to learn for themselves and develop their own learning structures as they iteratively produce and use knowledge to generate small wins. Or it may manifest in the failure to see that the only help worth offering without explicit request is to offer platforms that facilitate the flow of existing knowledge, which then connect a system, first to more of itself, then its neighbours and similar entities elsewhere (Bailie et al., 2018). To limit these injustices, perhaps ethics approval for any help provided by subsidiary units should require evidence of a request from primary units (e.g. through a representative process), or evidence of an inability to request help, or that the help being offered is only subsidiary.

Third, injustice occurs when subsidiary units prioritise or privilege their own perspectives, concerns or needs (for example, what is “innovative” or “new knowledge” to the foreign gaze) over helping to connect a system to more of itself. This may manifest in a tendency to focus energy on subsidiary activities even when primary units request help: for example, acting as if publication is a primary goal of such an effort, even though the knowledge in publications pales in comparison to whatever knowledge is produced while assisting plumbers and emancipators, or even engineers. Perhaps academic journals, institutions and funders should insist that knowledge ought to have achieved its primary work in the world before it is allowed to be published or used for other subsidiary purposes. This way, as much about “new findings”, research papers would be about the lessons learned during the primary work – that is, while being used to connect a system to more of itself.

Fourth, injustice occurs when there are no effective structures to govern the terms of engagement between subsidiary and primary units to avoid subsidiary units undermining primary units or primary units becoming overly dependent on subsidiary units. This governance could involve, for example, a committee to review, modify or discontinue engagement, to ensure that subsidiary units do not unilaterally disengage, and to guide what to do with any knowledge generated as part of the engagement, and what gets published, how and where. The committee might recommend that knowledge intended for primary uses should be presented concretely, while knowledge intended for subsidiary uses should be presented in an abstract way that allows insights to travel (Abimbola, 2018). The committee might be responsible for approving publications, their authorship and intended audience. It may insist on local outlets and forms that are readily accessible to the relevant primary units. It may insist on serving primary units and uses first and foremost.

The academic global health literature needs to develop more just and inclusive ways of reckoning with knowledge of all kinds – especially from and for plumbers and emancipators. The literature must be more open to different ways of sharing knowledge. It must seek to approximate available knowledge. Ongoing concerns about lack of representativeness of authorship must also be understood in terms of lack of representativeness of the knowledge available in the literature, or lack of representativeness in whom or whose purpose the literature serves primarily. The literature needs to begin from a set of premises that defaults and defers to the practice-based knowledge produced and held by plumbers and emancipators and at proximate scales of organisation. Professors will need to invest as much time, energy and resources in plumbing and emancipation, in helping to better connect systems and in making routine data systems strong, as they do in initiating research. With such strong connections and data systems much research will become redundant.

The assumptions that underpin our system of prestige and value in academic global health are essentially extractive, and thus colonial. These assumptions make the literature read like subsidiary actors speaking to one another in echoes about subsidiary actions. They lead us down paths of injustice. In placing the value of a study on publication, and considering that what is not published is not known, we have been unjust. In choosing to focus on the episodic at the expense of the day to day, we have been unjust. In failing to prioritise what is primary over what is subsidiary in our uses of knowledge, we have been unjust. In failing to see, share and publicise small wins, we have been unjust. In reinforcing the notion that external validity and standardised measures come before local use and local relevance, we have been unjust. In thinking that our primary role is "new" knowledge rather than helping to connect a system, any system, to more of itself, we have been unjust.

This is not to pitch one use of knowledge against another. The principle of subsidiarity is not so much about what should be done or not done as it is about what should be prioritised. It is a call to rethink our relative focus, emphasis, priority, gaze. It is a call to default to the local gaze; to take the imaginative leap that allows a foreign (or subsidiary) actor to assume, speak or write from a local (or primary) pose. It is a call to reorder the hierarchy of rigour and value that shapes our assumptions about knowledge; to recognise where the vast bulk of knowledge used to advance equity in global health is to be found. It speaks to an intellectual deficit in academic global health (Abimbola & Pai, 2020). This deficit overlaps with the problem of colonisation, but not completely. The principle of subsidiarity shows us how we default to injustice – it also points to an alternative vision of academic global health, and its literature.

CHAPTER 6

THE DIGNITY OF THE SPECTATOR

"Every narration places the spectator in a position of agency."

Manthia Diawara (1990)

When I was a child, I was taught by Nigerian teachers, who were teaching a Nigerian curriculum, endorsed by the Nigerian government, in Nigeran public schools, that the River Niger, the largest river in West Africa, was discovered in 1796 by Mungo Park, a Scottish explorer. I did not know that this could not possibly be true. I did not know that it is not possible for an outsider to discover something that has always belonged to another people; that the concept of discovery does not apply in this context. I began to understand this lie in my teenage years, alongside much else that I was taught in school – things calculated to erase the knowledge and agency of my ancestors. The Nigerian educational system proselytised on behalf of the British empire.

But there is a sense in which British schoolchildren may be taught that their ancestor discovered a river in faraway West Africa. After all, people in Britain did not know the river existed until Mungo Park brought back the news. The claim to have "discovered" such a river can be valid when addressing an audience that did not know about it, an audience far away, an audience on behalf of whom the discovery was made: "Hey, look what I found over there!" The audience for a claim of discovery is an important determinant of what makes the claim make sense. As in the quote by the Malian filmmaker and scholar Manthia Diawara in the epigraph to this essay, "every narration places the spectator in a position of agency" (Diawara, 1990). Yet what I was taught as a child did not place me and my ancestors in that position of agency. It denied our dignity as knowers, as people whose knowledge of the river mattered. We are all entitled to dignity because we possess certain ethically important features. One of those human features is that we are knowers.

As an academic who studies health systems, I see this denial of people's *dignity as knowers* at the heart of how much of academic research works. Especially in fields such as mine, where claims about what is true or new require a primary audience of people where (or from whom) the knowledge was made (Bhakuni & Abimbola, 2021). Denial of dignity manifests, for example, in the acceptance without question that an academic journal in Britain can do for Nigeria what it does for Britain. A researcher studying how to improve the health systems in Nigeria considers a British journal as a choice platform for publication; a choice that stems from colonial conditioning; from being educated and socialised in a way that places Europe at the centre of the world.

Philosophical Transactions of the Royal Society is the oldest scientific journal (Andrade, 1965; Fyfe et al., 2015; Dolby, 1977). It is still in circulation. It was first published in 1665, just as the printing press, a revolutionary invention, started to be put to mass secular (non-religious) use, and magazines and periodicals began to enter mass circulation (Dolby, 1977; Eisenstein, 1979, 2005). The establishment of such scientific journals made it easier to share ideas and discoveries among scholars with common interests. Groups of scholars had started to grow so large that physical meetings were no longer sufficient. Enabled by advances in printing technology, scientific journals helped to drive a scientific revolution in Europe in the late 1600s (Dolby, 1977; Eisenstein, 1979, 2005; Cohen, 1994; Mokyr, 2005). Scientific journals quickly became a platform around which communities of scientists emerged, organised themselves and networked to critique, correct, test, transform and spread one another's ideas and discoveries. Today, we continue to rely on journals for the crucial function of connecting us, scientists, to one another; a connection that generates the intellectual sparks which are often necessary to advance science in all its forms.

The original full title of *Philosophical Transactions of the Royal Society* was "*Philosophical Transactions, Giving some Account of the present Undertakings, Studies, and Labours of the Ingenious in many considerable parts of the World*". But it belonged to England (Andrade, 1965). The "World" was

Europe and places it had invaded or claimed for itself. "Ingenious" people were Europeans, including Europeans far from home. Dedicated to natural philosophy (that is, the physical and life sciences), *Philosophical Transactions* was the kind of journal where the discovery of the River Niger or any other such natural occurrence could be reported. The field of natural philosophy generated knowledge that may be deemed universal or generalisable – that is, natural sciences, which one might expect to thrive and serve their purpose regardless of the location of their audience. Knowledge such as: What is the refractive index of a lens? How does volume change with pressure? What is a new virus made of?

Yet even authors in the natural sciences choose their idiom, use frames of reference, or assume prior knowledge based on their audience. Early scientific journals did not just connect people who shared a common purpose: authors and audience also often shared a common worldview. The community that *Philosophical Transactions of the Royal Society* connected was European. In the 1800s, if a team of European "tropical medicine" researchers working in a West African town "discovered" a disease that was new to Europeans (but well known to West Africans local to that region), they would publish their paper in a journal where their European peers would read their findings and be fascinated, but the paper would be written in a way that ignored existing local knowledge and interpretations of the disease by West Africans. What was known locally would not have been the starting point of inquiry.

But that is only part of the story. The *content of what is shared* is one thing – that is, the nuances that get left out because the audience in Europe lacks knowledge, or what is mistaken or not fully known by the researchers because there were no local West African interlocutors. The *effects of how it is shared* is another – the lost opportunities to connect knowledge and interpretations about the disease in parts of West Africa to one another. A discovery in Europe by European researchers would have lead to such a connection. Instead of building on knowledge and interpretations in West Africa about the disease, whatever is "discovered" gets extracted to Europe where it lands on a blank slate, generating falsehoods and misinterpretations. What gets published is mistaken; a result of the failure to respect the dignity of West Africans as knowers.

The discovery of a disease is a middle point along a spectrum. The point where the natural world meets the social world; where the aspect of the natural world being figured out has social meaning. On one end of the spectrum is the natural world untouched by the social – say, how does volume change with pressure? On the other end is the social world hardly touched by the natural – say, how do gifts work as a means of exchange? But in the middle, you have questions such as: How does a new disease manifest? How do people respond to it? The audience matters greatly, and even much more at the social end of the spectrum. Inquiry is about social systems. Connection is the point. What is being connected are communities of people: scientists, activists, policymakers, practitioners, ordinary people. As the American systems theorist Margaret Wheatley said, "To create a healthier system, connect it to more of itself […] so that it can learn more about itself from itself" (Wheatley, 2001).

In the 1900s, if a team of US researchers conducted a study on the social organisation of sanitation, or the political prioritisation of women's health in Lagos, Nigeria, and they chose to publish their findings in a US journal, we may ask which system they were trying to connect to "more of itself". If they published a study on sanitation and women's health in Michigan or Alabama in a US journal, then the answer is obvious – but not so much for the Nigeria study. What if the Nigeria study has lessons for the United States? Both countries are, after all, large and federally governed. If that is the case, useful as it might be for the United States, the article could not serve to connect Nigeria to more of itself in the same way or to the same extent. The article written for a US audience will not be the same as the one for Nigerians. The difference is not just in terms of where it is published, but also how it is written, the assumed prior knowledge that frames the research question, and the purpose that informs the data analysis and interpretation.

What then is the point of academic papers if they so often fail this basic test of connection? They fail because passing the test has not been their primary goal, although it should be. There is a deeply held but unspoken assumption that the location or nature of the audience does not matter; that where an article is published matters mostly for prestige and visibility. That assumption can only be sustained if one believes that the *British Medical Journal* can possibly do for Nigeria what it does for Britain. Since the 1800s, the *British Medical Journal* has helped to connect scholars, activists, policymakers, practitioners (within and across these categories) to improve health and equity in Britain (Smith, 2006; Frampton, 2020a, 2020b). Something else did the same thing in 1800s Britain: the regular publication of death rates disaggregated by districts, which led to comparisons and learning within and across districts and over time; and also led to debates about causes of deaths and differences in rates, and efforts to reduce death rates to match those of better performing districts (Crook, 2016). The rates "pointed to those spaces that were ahead and those that were behind; or as it was sometimes expressed, those that were winning and those that were losing" such that "ultimately, civic pride was at stake" (Crook, 2016). From the late 1800s to the mid-1900s, local and national newspapers in Britain and medical journals including the *British Medical Journal* actively published death rates and commentaries interpreting them for the public and politicians, and for health practitioners and policymakers. This contributed to a period of significant improvements in health and equity in Britain, with similar dynamics elsewhere in Western Europe and in North America (Cutler et al., 2006; Costa & Khan, 2017).

In the 2000s, if a team of Nigerian researchers conducts a study on the organisation of the health systems in Nigeria, they might publish their work in a US journal, an outcome that Nigerian researchers see as desirable for prestige and visibility outside Nigeria. But by their choice of question (will it appeal to a US audience?), method (will US scholars consider it cutting edge?), framing (will it contribute to a conversation US scholars want to have?), idiom (will a US audience understand it?) or recommendations (will a US audience find them palatable or feasible?) the researchers de-optimise their work for Nigeria. A study of great value for Nigeria may be irrelevant for the United States or inscrutable for US audiences. Where a researcher plans to publish their work can therefore corrupt the choices that they make about what they study, on what basis, how it is studied and how it is presented.

We have created or been handed a knowledge infrastructure built on a premise that ignores what may be its most fundamental function – to connect a system to more of itself. Whether this is done by West African or European scholars, Nigerian or US scholars, or whether in the 1800s, 1900s or the 2000s, the effect is the same. It has never been right. It was never right anywhere, or at any time in history. When the dignity of the audience or people it should be connecting is not respected – especially their dignity as knowers – as we make, use and share knowledge, we will perpetuate falsehoods and promote wrong interventions.

In 1911, the German philosopher Hans Vaihinger published his magnum opus, which would later be translated in English as *The Philosophy of "As If": a System of the Theoretical, Practical and Religious Fictions of Mankind* (Vaihinger, 1924). In it, he argued that we willingly accept things we know to be false or fictitious in order to function in a complex world. We construct fictional explanations of how the social world works and proceed "as if" those explanations reflect reality. Our inherent cognitive limitations as humans hardly allow us to function otherwise. We think of the world in stories. We make sense of the world with metaphors. These stories and metaphors are socially produced, used, reinforced and transmitted. When we set out to describe a social reality or change it, we draw on this stock of stories. The ancient Indian parable of the blind people and the elephant is an enduring example of such a process (Figure 10). In this parable, the elephant is a metaphor. It represents complexity; that which is difficult to grasp – a social system or a social reality. As the largest living land animal, the elephant is often used in metaphors around the world. When Yorùbá people want to remind you to acknowledge a significant thing, person or event, or chide you for not doing so, they say: *T'abá r'érin, ká sọ pé a r'érin, àjànàkú kọjá mo rí nkan fìrí* ("When you see an elephant, there is no other way to describe what you've seen than

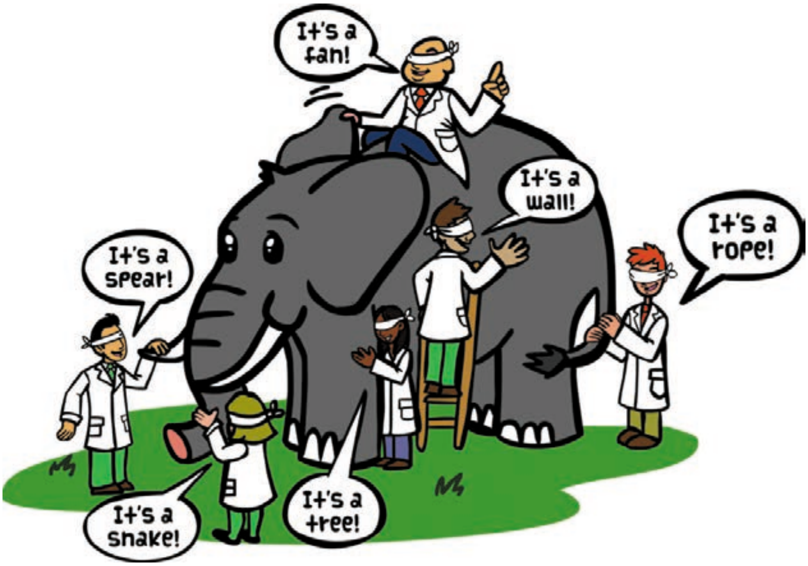

Figure 10 | Six blindfolded people and an elephant.

Source: Directional Church Board Members (2019).

to say you've seen an elephant – you cannot say you saw something just pass by in a jiffy"). An elephant is too big, too unique to mistake for or be described as anything else. But what if you cannot actually see it?

In the Indian parable, six blind people who had never seen an elephant try to describe what it is like, limited to their sense of touch and positioned next to different parts of the animal. The blind people rely on metaphors to describe the elephant based on what they perceive. The person standing next to its tail thinks the elephant is like a rope; the person next to the trunk thinks it is like a snake; the person next to its ear thinks it is like a fan; the person next to the leg thinks it is like a tree trunk; the person next to its side thinks it is like a wall; and the person next to the tusk thinks it is like a spear. Each person's assessment is partly right, but also wrong. An elephant is more than whatever metaphors its individual parts might suggest. In a popular telling of this parable (Saxe, 1873), there is the suggestion that if they do not get a chance to exchange notes or shift positions, the six blind people would disagree furiously among themselves. But that if they do speak to each other and move around and feel different parts of the animal, together they might figure out what an elephant is really like (Thatamanil, 2020).

Your account of a social system or a social reality says a lot about your audience. But as the parable shows, it also says a lot about where you stand. Indeed, your account says more about where you stand (pose) and who your assumed audience (gaze) is, than it says about the system or reality you seek to describe. The audience needs to know the metaphors beforehand – needs to recognise, in Vaihinger's words, the *useful fictions*. What is often left out in the telling of the parable is the audience of the six blind people's conjectures. The audience must know what a rope, snake, fan, tree trunk, wall and spear are. Each object must mean the same thing to each metaphor-making blind person and their audience. Without having "useful fictions" in common, their effort at connection fails. We humans grow up learning through daily interactions to frame our messages with the useful fictions we have in common with our audience. We learn to respect our audience's dignity as knowers.

Even then, there is another sense in which useful fictions are at work in the parable. There is an assumption in its popular telling that blind people rush to conclusions and are overly confident about what they can glean by touching an object at a single position. But the Australian writer and theologist John M. Hull, who became blind in his 40s, argues that "this is precisely what the blind do not and cannot afford to do […] the blind know better" (Thatamanil, 2020). He explains that tactile knowing is deliberately slow, gradual, patient and incremental (Hull, 2013). The presumably sighted storytellers must have made assumptions about blind people; assumptions they could only make without blind people in their audience, or without respecting the dignity of blind people as knowers. This metaphor – as with other useful fictions – reflects the pose and gaze of the people who crafted it in ways that risk perpetuating a falsehood that blind people are either rash or not credible knowers.

Revisiting Hans Vaihinger's work more than 100 years later, the Ghanian-British-American philosopher and writer Kwame Anthony Appiah draws out some of the implications of Vaihinger's ideas in his book *As If: Idealisation and Ideals* (Appiah, 2017). Appiah reminds us that the "elegant simplicity" of useful fictions – a line illustration, a mathematical equation, a chemical formula, or a conceptual abstraction – brings into sharp relief certain features of what they describe. We need useful fictions sometimes because what we want to describe, its feature that we want to see, focus on, analyse or make sense of "becomes legible", Appiah wrote, "only through a loss of exactitude." But that legibility, partial and incomplete as it is, can be seductive. We get carried away, thinking that these fictions are true, and that they are complete representations of reality. We are misled by the fictions we create. But when useful fictions work, Appiah argues, they do because "We use them in two steps – first by ignoring a range of phenomena in order to build a model of a world without them, and then, once we have grasped how that model works, by adding more and more of the world gradually back in." Much too often, we forget the second step.

Seduced by our models, we blissfully ignore that our conceptions of the world are incomplete. Our useful fictions are reinforced, projected back at us by an audience that is (like) us, an audience whose dignity as knowers we respect. But what happens when our model is about other people's worlds, people who are excluded from our audience? It is the kind of exclusion that makes claims like "discovering" the River Niger or the parable of the blind people and the elephant possible. It is what happens if one of the blind people, say the one standing next to its side, is physically restrained, and can only talk to other blind people who have only ever stood next to its side. They all might be fully certain that the elephant is a wall. It may be difficult to convince them otherwise. But if the other five blind people could move around and talk among themselves, they would quickly have a better grasp of what the elephant is like, even if none among them has ever stood next to its side. We researchers are often that one restrained blind person, or category of blind people – only in our case, we are self-restrained – while the other five blind people are people with direct expertise and lived experience as activists, policymakers, practitioners or ordinary people. That one self-restrained blind person can also be foreign in other ways – as someone working at a distance marked by space, power, gender, class, caste or status – while the other five blind people occupy proximate positions.

If where you stand limits what you can grasp, and if useful fictions are socially constructed based on where you stand and who is within earshot, then the task of connecting a system to more of itself imposes certain responsibilities. Respecting your audience grounds you. If you speak in the same register as your audience, you modify your useful fictions to align with or include theirs, and yours is richer for it. You are reminded to repopulate your models of the world with a broad range of useful fictions: yours, theirs, others'. But you must first acknowledge that other useful fictions exist, and that yours is not complete. As Appiah argues, "Our best chance of understanding the world must be to have a plurality of ways of thinking about it" (Appiah, 2017). Then, we must connect the plurality of ways to one another. But each way of thinking about the world must have the chance to flourish in its own right and place. Otherwise, the useful fictions being connected are unequally yoked.

In a documentary film about her life and writing titled *The Pieces I Am*, the African-American writer Toni Morrison describes how she went about her work: "I wanted to speak to [Black people] […]. The first thing I had to do was to eliminate the white gaze… that little white man that sits on your shoulder and checks out everything you do and say. I wanted to knock him off" (Greenfield-Sanders, 2019). A writer or scientist's choice of gaze or audience – to the extent that they get to choose – is about connection, responsiveness, transparency, accountability, feedback, collective self-knowledge, and other relational qualities that make a system healthy. But a writer or a natural scientist or a social scientist is not stuck with just one type of "local" audience. Anywhere, the audience may include scientists, activists, practitioners, policymakers and ordinary people. Connecting a place or system to "more of itself" means all these actors can speak, hear and respond to one another. Each place must get the chance to build its own connections – and after that, to connect with others.

Serving and being accountable to a local audience does not mean you are not relevant outside that space. It is, in fact, what *makes* you relevant outside that space. In Toni Morrison's words, "I never asked Tolstoy to write for me, a little coloured girl in Lorain, Ohio […]. If I tried to write a universal novel, it would be water" (Morrison, 1994). That need for specificity, and finding the universal in the specific, was what the African-American writer James Baldwin meant when he said in an interview, "It was Dostoevsky and Dickens who taught me that the things that tormented me most were the very things that connected me with all the people who were alive, or who ever had been alive" (Howard, 1963). What you offer the world as a writer, as a person who studies and interprets social systems and realities, what the world benefits from your perspective on a subject, is greatly enriched by addressing yourself primarily to an audience of people who know about, are local to, and are intimately connected with that subject, that system, or that reality.

* * *

Our idea of scientific communication is stuck in a past in which the "world" was just Europe and its outposts. That idea needs updating, especially in fields of research that require a local audience of knowers to serve their purpose. What we have come to accept as the structure of a research paper is itself a tool for building useful fictions. A research paper is necessarily a constructed narrative. By design, it selectively emphasises some features of science and leaves out others. The features of science that get excluded are often the ones that have the potential to link it to a local audience of knowers. If we are keen to fulfil the responsibility of science to connect a system to more of itself, and to respect the dignity of people in that system as knowers, then we would need to modify the structure of research papers. What the traditional structure of research papers leaves out is often far more important than what it includes. The useful fictions we craft based on that form must be enriched by reinstating some of what we traditionally exclude.

In the typical "Introduction" or "Background" section of a research paper, we make claims that we are filling gaps in the literature, and we proceed *as if* the literature is a storehouse of all available knowledge (note: "as if" signals a useful fiction). Yet people often know what the literature does not. While gaps sometimes do exist in the literature, the bigger need is to fill real gaps in the knowledge of real people and real gaps in the connections between real people in a real place. When we respect the dignity of the people in that place as knowers, our inquiry starts with what they already know, what they are doing with that knowledge, and what their learning needs are – not with gaps in a vaguely defined global literature. If we start with what is known or unknown in a place, the learning needs to be served become different, and we become aware of the real gaps in the knowledge of real people that need to be filled or the connections between them that need to be made or made stronger.

The interpretive tools, framings or useful fictions that shape the knowledge and connection gaps in a place are central in deciding the methods we use to investigate a problem or answer a research question in that place. Writing the "Methods" section should therefore be an exercise in juxtaposing useful fictions. The method should not be chosen based on an arbitrary yardstick of rigour or the researcher's preference, but on what contributes to an ongoing conversation about connection and learning in that place. The experience of conducting the inquiry changes the researchers as much as it generates knowledge and facilitates connections. The "Results" section then should not just be what researchers found, but also what researchers learned; how we and our methods changed, how we modified and repopulated our useful fictions, and how new knowledge or stronger connections helped to solve real problems of real people in that particular place.

In the "Discussion" section, the results should not just be put in conversation with the literature, but much more in conversation with the place, with where the knowledge was made. The discussion should be about how the results helped local learning and action. The recommendations should be what people in the place (and not the researchers) want to do or want done, systematically sourced and documented. A study is not yet ready for publication until this cycle of connection is complete. What we have done up to this stage may be written up and published in a temporary, work-in-progress form as pre-print, but the full manuscript should not be deemed ready to be sent for peer review or published in its final form until it completes the cycle of connecting a system to more of itself.

Beyond repurposing the form we use in constructing our useful fictions about what happens during research, we must call into question the delivery platform. The design of the traditional platform for scientific communication – scientific journals – is also partial and incomplete in its conception of how the world works. It was designed for another time, place and purpose. By seeing the role of journals differently, we can reinstate what we have excluded so far. It is time to let go of the idea that local journals – which allow local connections and respect for the dignity of local audiences as knowers – are inferior. European and North American journals are local journals too. They primarily serve their local audiences. Even when a journal is not defined by a place in its name or scope but serves a field or discipline, it still carries the intellectual imprints – the useful fictions – of where that field or discipline originated or is local. Local journals strengthen local systems. By establishing, nourishing and supporting local journals, we can put them in the service of making local systems stronger outside Europe and its outposts. But perhaps it is time to imagine new platforms that are altogether more fit for purpose than journals.

Scientific communication has not changed much in the almost 400 years since the first scientific journals were published. Not even with the internet's potential for new forms and platforms that could democratise and decentralise knowledge systems. It is an endlessly remarkable stubborn anachronism that research papers and scientific journals are the default mode of scientific communication in academic global health. It is time to let go of designs made on behalf of non-social natural sciences that knowledge must aggregate in a universal sense first and foremost. That design is not fit for knowledge that is socially constructed, locally used and circulated; when novelty, relevance and resonance are locally determined; when, to avoid false conclusions or wrong assumptions, we must respect the dignity of local audiences as knowers.

In scientific communities that are not solely European, or that are not European at all, we must examine which of our traditional useful fictions need updating. Our choices of the forms and platforms to use for scientific communication are not just about science, they are also about ethics; about what is morally right or wrong. In any field where we write about others, decisions about gaze or audience are at the same time decisions about ethics. They are never neutral. When we carry on as if they are not choices about ethics, we risk gaslighting local audiences of knowers – like the parable of the six blind people and the elephant when told to a blind person. Or like the misguided Nigerian school teacher, teaching Nigerian children that what was always known to their ancestors was discovered by a European explorer. We gaslight knowers, whether we know it or not, when we fail to respect their dignity as knowers.

CHAPTER 7

TO BE WRONGED AS A KNOWER

"In shaping the experience to make it palatable to those who were in a position to alleviate it, they were silent about many things."

Toni Morrison (2008)

"The victim who is able to articulate the situation of the victim has ceased to be a victim: he, or she, has become a threat."

James Baldwin (1998)

There is a special category of injustices: the ones that constrain you as a knower. It is not easy to talk about being wronged as a knower. The nature of that wrong means that you are unable to name it, or you are not listened to or taken seriously when you do. Injustice done to you as a knower comes along with injustice on things more tangible than knowledge: physical violence, material dispossession, denial of access to public goods. Tangible wrongs find easier expression in words, and take less effort to explain. You can easily take pictures or videos. Even then, you are constrained in your ability to fight those other forms of injustice without addressing the wrong done to you as a knower. It is why many injustices last so long. To be wronged as a knower is to be wronged in every other way. If there is one way to fight for yourself, it is by breaking the hold of that constraint; by finding ways to articulate the situation of being wronged as a knower.

To speak of such wrongs, I tend to pick a story that my global health audience might care about. I sometimes talk about my longstanding interest in group antenatal care. I start by saying if you were raised by a nurse-midwife as I was, your earliest exposure to health and care systems where you grew up is likely linked to childbirth. That this is even more likely if, like my mother, S.O., the nurse-midwife had a community practice. The exposure is second-hand – another woman's, another child's. But you learn a lot if you keep a keen eye on events, eavesdrop on conversations, ask for the meaning of words and phrases; even when you are told or sense that it is inappropriate to watch, listen or ask. The group antenatal care sessions I witnessed in Owo, the peri-urban town in southwestern Nigeria where I grew up, were conducted by midwives. Pregnant women would meet in a semi-open space, often just before a one-on-one session with a midwife or doctor in private rooms nearby. The group sessions were so loud a child sitting on the edge could listen in. The pregnant women would share stories and lessons and inspire one another. There was peer bonding and learning. Midwives would lead the songs. It felt like church. Singing was at the heart of the sessions. These were among the most joyous scenes I have ever seen.

Growing up, I witnessed group antenatal care sessions at church and in the hospital. At church, S.O. organised two sets of fortnightly sessions. With each set of sessions held in alternating weeks, there were weekly sessions. One set of sessions was devoted to antenatal care, the sessions in which the sharing and the singing happened. The other set of sessions was prayer meetings with pregnant women. The prayer points were given at about 5-minute intervals, and the women would pray for about 30 minutes, on their knees, except when the pregnancy was so advanced they had to sit on the floor or a bench. The prayers were not silent. You could figure out what they were asking or thanking God for, or hear some of the stories you heard during sharing and singing. In the group antenatal care sessions, a church midwife would intervene to bring out the lesson in a story. The songs too contained lessons or messages the midwives wanted to pass along to the pregnant women. At the hospital, the sessions were held in much the same way. But there was never a doctor at the church we attended, the Apostolic Faith Church, with its doctrine of divine healing, and the one-on-one antenatal care sessions were typically held with each pregnant woman during home visits by church midwives.

So you can imagine my surprise when a researcher told me she wanted to do a randomised controlled trial to know if group antenatal care sessions work. I could not wrap my head around what she was seeking to know or prove. This researcher grew up in Nigeria. We were in medical school at the same time, in Ile-Ife, a town in southwestern Nigeria. As a medical student and junior doctor, she had witnessed group antenatal care. She told me her plan in 2018, two years after she finished her PhD at the London School of Hygiene and Tropical Medicine. She had tried to convince her colleagues in London, who only knew of individual antenatal care, that group sessions worked well as a platform for education and emotional support. But she could not win them over, and so she thought evidence from a randomised controlled trial would be compelling. She knew there was hardly anything new that such evidence could say to people for whom group antenatal care was a norm that emerged long ago and is refined through learning. If a trial found that "it" did not "work", this would not alter the prior judgement of its value among Nigerians with intimate knowledge of it. There was no equipoise – a state of not knowing if something is good or bad, works or not – an ethical precondition for randomised controlled trials (Lilford & Jackson, 1995; Ravallion, 2020; Abramowicz & Szafarz, 2020).

Any piece of useful evidence must take its cue from where learning is today; in this case, the knowledge needs of people in Nigeria about group antenatal care. How might one find out the state of ongoing learning or the knowledge needs of people involved in group antenatal care sessions in Nigeria – pregnant women (and their families), researchers (academic and otherwise), practitioners (health and care workers), policymakers (governments and churches) and advocates (for access to care)? I did what a researcher might do – I searched the literature. This took my surprise to a new level. A "comprehensive" review of evidence on group antenatal care published in 2015 in the *Cochrane Database of Systematic Reviews* stated that:

> Group antenatal care is a relatively recent model of antenatal care that is being implemented in many settings; it is important to assess the evidence base for such an intervention. It is also important to determine the acceptability of new models of care for care providers, if longevity of the model is to be assured. (Catling et al., 2015).

That statement is an unsettling affront to anyone who grew up with group antenatal care all around. The *Cochrane* review further stated that "group antenatal or pregnancy care has been developed in the United States in a model known as 'Centering Pregnancy'" and that it "has been adapted for use in several countries including Australia, England, Sweden, Iran, Canada, Malawi and Tanzania". The impression you get reading the paper is that group antenatal care was a US invention developed in the 1990s (Rising, 1998), which has since spread to the rest of the world. The review included data from four randomised controlled trials: two in the United States, one in Sweden and one in Iran. These trials showed that "available evidence suggests that group antenatal care is acceptable to women and is associated with no adverse outcomes for them or for their babies". But the authors still called for additional studies "to determine whether group antenatal care is associated with significant benefit in terms of preterm birth or birthweight" – as if such benefits could or should predictably result from a single intervention or even a vehicle for interventions, no matter how comprehensive.

Another review on group antenatal care was published in 2018 (Sharma et al., 2018). The authors wanted to identify existing "models of group antenatal care in low- and middle-income countries" through a review of published studies and through interviews with members of "a global research consortium on group antenatal care in low- and middle-income countries formed at the Global Maternal Newborn Health Conference", which was held in Mexico City, Mexico in 2015. They wanted to "identify attributes that may increase the relevance, acceptability and effectiveness of group antenatal care in such settings". The rationale for the review was that "given its success in high-income countries, it is reasonable to hypothesise that group antenatal care may optimise health outcomes and experiences of care for pregnant women in low- and middle-income countries as well". The review included 19 models from 18 low- and middle-income countries across Africa (11 countries), Asia (4 countries) and the Americas (3 countries). Not once did the article mention that there were any existing Indigenous approaches to group antenatal care – or even the possibility of the existence of such models. Only Centering Pregnancy and similar models initiated in high-income countries were described as the "existing group format" that had informed the models they found.

The call to see if group sessions work in low- and middle-income countries was taken up by researchers in the United States. A team conducted a trial of group versus individual antenatal care in Kenya and Nigeria, and published the protocol (Kabue et al., 2019) and subsequently two research papers (Grenier et al., 2019; Noguchi et al., 2020). It is not clear what they did in the control arms of the study – did they discontinue preexisting group antenatal care activities? The authors said “the original model of group antenatal care as an intervention was designed for high-income country settings” (Noguchi et al., 2020), and that “the meeting framework [for the group sessions] was informed by previous group antenatal care models” from high-income countries (Grenier et al., 2019). Both found that the intervention increased the number of women who chose to deliver in health facilities and the quality of care they received. But we were not told why. What happened in the control arm? Was the intervention just a version of Indigenous approaches to group antenatal care? The authors were based in the United States, Nigeria and Kenya. But the Nigerians and Kenyans did not lead the work. The first, second, corresponding and last authors were all based in the United States (except in one paper with a Nigerian last author based at the Nigerian subsidiary of the US organisation where the lead authors were based). Even so, it is remarkable that the Nigerian or Kenyan authors and partners did not say anywhere in the three papers that group antenatal care is not a US invention; that it is a longstanding practice in Nigeria.

Later, I found a published article that mentioned that group antenatal care is a widespread practice in Nigeria (Eluwa et al., 2018). In this cohort study conducted between 2012 and 2014 on the impact of Centering Pregnancy in northwestern Nigeria, the authors found that it had “a positive effect on the use of antenatal services, facility delivery and postnatal services”. But they presented Centering Pregnancy as “a promising innovation which challenges the standard model of one-on-one counselling of prenatal care”. The authors took this “promising innovation” through “a community-validated facilitative” process “which incorporates locally-rooted cultural concepts, language and practice” as if it was absolutely foreign. All authors were based in West Africa, although the first, second and corresponding authors were from Nigerian subsidiaries of US organisations, and the last author was from the University of Ghana. The authors responsible for localising the “innovation” were based at Ahmadu Bello University, Zaria, in northwestern Nigeria. While elsewhere in their article the authors described one-on-one sessions as “the standard” model of antenatal care, they had also noted in the same article that group antenatal care was not foreign to Nigeria; in fact, that there was a version of it that was “the standard… at most Nigerian health facilities”:

> The Centering Pregnancy model used in this intervention differed from the standard group antenatal care approach used at most Nigerian health facilities in the following key respects: (i) an educational format is followed that uses a facilitative leadership style with didactic discussion format; (ii) each session has an overall plan; (iii) attention is given to core content although emphasis may vary; (iv) there is stability of group leadership and the composition of the group is stable, but not rigid; (v) participants are involved in self-care activities and opportunities for socialisation are provided and there is ongoing evaluation of outcomes. (Eluwa et al., 2018).

In this way, the authors were keen to distance Centering Pregnancy from "the standard group antenatal care approach used at most Nigerian health facilities". Another group sought to do the same. In a 2020 article, a group of predominantly North American authors writing as the Global Group Antenatal Care Collaborative distanced what they called "group antenatal care" (that is, models such as Centering Pregnancy) from "group health talks" (that is, the standard practice in Nigeria), which they then described as "a common practice providing didactic health promotion lectures in antenatal waiting areas" (Grenier et al., 2020). But the noted differences were not true to my experience. What both groups claimed were absent from the Nigerian approach were, to a varying extent, features of the group sessions I witnessed in various settings across southwestern Nigeria as a child, as a medical student, and as a junior doctor. If anything, the sessions offered more. There was sharing and singing and dancing. Even if the standard Nigerian approach had defects, why was the intervention not framed as an improvement on the existing model? Why was the US version not framed as belonging in the same family of interventions as the Nigerian version, which would have facilitated learning between both places and both versions? Why does Nigeria need a foreign innovation when there is a remarkably similar Indigenous innovation doing the same job? Why was the study not about comparing approaches to group antenatal care across Nigeria given the country's diversity, to learn from the differences or similarities? I grew up, studied and worked in southwestern Nigeria, where things may be different to northwestern Nigeria (Fadeyi, 2022). I wanted to see that rich diversity explored. I did not.

So I searched the literature for the feature of group antenatal care in Nigeria I had not seen in any of these studies – the singing. The

Yorùbá people of southwestern Nigeria hold mothers and motherhood in very high regard. There is a saying: *Òrìsà bí ìyá kò sí; ìyá là bá má a bọ* ("There is no deity like the mother; the mother is worthy of being worshipped") (Makinde, 2004; Olusegun, 2020). Yorùbá people have developed, over time, many social practices to safeguard women during pregnancy (Fadeyi, 2022; Makinde, 2004; Olusegun, 2017, 2020; Orimogunje, 2003; Ogunyombo & Bello, 2020). Pregnancy is seen as so fraught with danger that the placenta is named *ibi*, which means "evil" or "danger", because its retention is associated with death. The child is referred to as *ire*, the "good" (Balogun, 2014). There is a prayer often said for and on behalf of pregnant women: *K'ábí t'ibi t'ire* ("May we/you deliver both the evil and the good"). To greet a new mother, you say:*Ẹkú ewu ọmọ* ("Congratulations on surviving the dangers of childbirth"). In a highly musical culture that reveres motherhood and recognises that pregnancy is fraught, it is inevitable that there will be natal songs – songs performed in the community and as part of the practice of traditional midwives. The songs persist in both traditional and non-traditional midwifery. The songs used today in group antenatal care sessions are based on well-known traditional songs with the original lyrics replaced or, given colonisation, they are sometimes repurposed Christian songs and tunes (Olusegun, 2020; Vidal, 1986).

The songs often contain words of prayer and affirmation (all songs included here are from Olusegun, 2020):

Wéré lewé mbọ́ kúrò lára igi,	The leaf leaves the tree without catastrophe,
Ọjọ́ ìkúnlẹ̀ mi ò wéré ni kó jé,	May my day of delivery be without catastrophe,
Wéré lewé mbọ́ kúrò lára igi	The leaf leaves the tree without catastrophe.

and

Lọ́jọ́ ìkómọ jáde,	On the day of the naming ceremony,
Kórí mi má kọ gèlè,	May I live long to tie my head wrap,
Kára mi má kọ aṣọ,	May I live long to wear my clothes,
Kẹ́sẹ̀ mi má kọ bàtà,	May I live long to wear my shoes,
Lọ́jọ́ ìkómọ jáde	On the day of the naming ceremony.

Other group of antenatal care songs contain health-related messages:

Màá f'ọmọ mi ló yàn mu l'ásìkò,	I will breastfeed my child on time,
Èmi nfẹ́ àláfià f'ọmọ mi,	I want good health for my child,
Màá f'ọmọ mi lọ́yàn mu l'ásìkò	I will breastfeed my child on time.

and

Ma foyún mi lẹ́wà jẹ àkàrà,	I will feed my pregnancy with bean cake,
Ma foyún mí lẹ́wà jẹ ọ̀lẹ̀lè,	I will feed my pregnancy with moimoi,
Èmi fálạ̀fíà fún ọmọ mi,	I want good health for my child,
Ma foyún mi lẹ́wà jẹ àkàrà	I will feed my pregnancy with bean cake.

But often, the songs are just playful, for fun, to raise one's spirits:

Ẹ bá mi gbé gbòsà fún ọkọ mi,	Help me hail my husband,
Ọkọ olórí ire, tó fúnmi lóyún,	The lucky husband who got me pregnant,
Gbòsà gbòsà gbòsà gbòsà,	Hail hail hail hail,
Èmi á gbé gbòsà fún ara mi o,	I too will hail myself,
Èmi aya olórí ire tó mára dúró,	I the lucky wife who slept so well with my husband,
Gbòsà gbòsà gbòsà gbòsà	Hail hail hail hail.

In a study conducted in southwestern Nigeria, women reflected on their experience and the function of singing – and associated dancing – during group antenatal care sessions (Olusegun, 2017). First, there was a theme on its emotional function, with words such as: "the songs are basically songs of courage", "the songs restore and strengthen our faith that we will deliver safely", "the songs increase our joy, our hope and confidence that we will have safe delivery", "[we] use the songs to entertain ourselves [and] make us free from evil thoughts and minds", "some of us may be sad from home, but getting to antenatal [sessions] and singing, such sadness will just disappear; so it [the singing] brings a kind of relief from depression and stress", "some of the songs are songs of request and petitions for ourselves and our baby", "the songs are to thank God first, because many are looking for this kind of a gift and could not get it" and "because we sing and dance during the training, it relieves us of fear of the unseen and unknown". Second, there was a theme on the physical function of singing, with women saying "we feel the baby too moving in our tummy during the singing and dancing; it seems the babies in the womb are also enjoying the songs and the dance" and that "it helps our body system, especially the dance is a form of helping us to keep fit". Third, there was a theme on the cognitive function of singing: "the songs we sing are educative, it [the singing] reduces fears", the songs "teach us how to care for our children, their health, our own health, our surroundings and handling of [nappies]" and "when the baby is sick, we remember some of the songs; the text of some of the songs reminds us how to go about helping the weak come back to health".

Here, the story I have chosen to tell ends; a story to help me speak of being wronged as a knower. Next, during the talk, I will draw out the specific wrongs done to certain knowers in this story. But before I do so, I note that the richness of these antenatal sessions is absent from the public health literature on group antenatal care. The study showcasing women's voices was conducted by Titus Olusegun, a Nigerian musicologist at Obafemi Awolowo University in Ile-Ife and published in an African journal (OLUSEGUN, 2017). The articles focusing on group antenatal care in Nigeria were mostly written by non-health researchers and largely published in African and other journals that some may label as "predatory" (MILLS et al., 2021). There is a world of scholars who are attentive to local dynamics, and there is another world of scholars who look from afar and only see what they are primed to see. Like ships that pass in the night, the two worlds speak past each other. If they ever connect, it is transitory, without lasting effect. And the ships are not equal. One ship is bigger than the other, can easily ignore the other, has the weight of centrality behind it. The other ship is peripheral, on the edge, unheard, even when within earshot. The journals where people in the United States or people in public health have their conversations about group antenatal care can be so central in their imagination that they ignore or shun conversations that are outside this hermetically sealed space. The centre ignores the knowledge held at or by the periphery (ABIMBOLA, 2023a; ABIMBOLA et al., 2024). It is erasure by disregard.

* * *

How does one speak of an erasure that is not really an erasure? The knowledge is there; the practice exists. It is just not reckoned with as what should form the basis of inquiry or research, learning or understanding, reform or intervention. It is more akin to a disregard for people's dignity as knowers (ABIMBOLA, 2023b). The story of group antenatal care is not unusual. There are many more like it that remain untold in part because it is hard to do without shared concepts to name or frame what is actually wrong. You must find the right language; one that the perpetrator understands. You may have to speak in a way that the perpetrator will hear. But if they have already violated your dignity as a knower, will they listen to you? If they listen to you, will they understand? If they understand, will they acknowledge that you are right and atone? It is an injustice that places the burden on you – the harmed, the wronged, the violated – to conduct yourself in a way that the perpetrator might find acceptable: credible, relatable, non-threatening, non-confronting. It is an injustice that contains within it the conditions that keep it in place – the inability of the wronged to articulate the injustice, or the need to articulate the injustice, defanged, on the perpetrator's terms.

The British feminist philosopher Miranda Fricker came up with language to talk about this injustice. She called it epistemic injustice (Fricker, 2007), and worked out two ways in which it manifests itself. First, as a credibility deficit, leading to testimonial injustice, which goes like this: I don't trust your account or your ability to give an account now or in the future. I've reached this conclusion based on who you are, what you look like, where you come from, where you live, and not on any assessment of what you know or can know. Second, as interpretive (or hermeneutical) marginalisation, leading to interpretive (or hermeneutical) injustice: You cannot make sense of your experience as there are no concepts or frameworks available to you to make sense of them. Or you cannot communicate your experience or your sensemaking of it because you do not share common interpretive tools – that is, frameworks, concepts, language (in the metaphorical sense) or worldview – as your audience. Or someone else makes sense of your experience in isolation from you or in ways that misrepresent or are unrecognisable to you, or in ways that are simply false. You are confused or locked in. The interpretive tools that may serve your needs are unused, underdeveloped, disregarded, discounted, or not present – and not by accident – in the pool of shared and legitimised tools for collective sensemaking (Bhakuni & Abimbola, 2021; Abimbola et al., 2024).

To be understood when you speak of being wronged as a knower, you may have to tell a story – as I have just done on group antenatal care. If you suffer from interpretive marginalisation, you may need to first seek out shared frameworks or concepts to be understood or even heard at all. The story may need to be very compelling if you also suffer from a credibility deficit: if your audience is inclined to doubt, discount or disregard what you have to say. In telling the group antenatal care story, the weight on me (of credibility deficit and interpretive marginalisation) comes from my audience. The people I want to influence. People involved in designing, conducting, funding or approving studies like those in my story. People who have been trained and role-modelled to see the knowledge practices I consider to be unfair as, instead, best practice and markers of career and intellectual achievement. People to whom the story poses an intellectual and a moral challenge. It says to them: your efforts to do good are plagued by epistemic injustice, by unfair knowledge practices; you are harming the people you set out to support in how you have set out to make, use or share knowledge. Before I finish the story, their minds have, quietly, interrupted me with alternate accounts, or they have misheard or misinterpreted me. They do not have to speak up, the mind wanders. Even if the mind does not wander, my account is easily dismissed. After all, it is an intangible harm.

We may never know for sure what makes a person wrong another as a knower. But we can speculate. It may be something the person does as an individual, interpersonally, or it may be something the person does because the rules that govern their choices default them to wronging "other(ed)" people as knowers (Abimbola et al., 2024). Two factors at play in the credibility deficit and interpretive marginalisation may help explain why (Figure 11). The first is the relative position (or pose) of the actor – the more peripheral an actor is within a social space or system, the more likely it is that individuals who are more centrally located will wrong them as knowers; or that the institutions that govern relations within that space or system will create conditions that make it likely for central actors to wrong them as knowers. The second is the gaze on the actor: the spectator for whom knowledge-making or sharing is primarily enacted; the agency your real or intended audience exerts on you as a speaker, writer or researcher. I like the word "pose" in relation to gaze. It evokes striking a pose: performing. After all, knowledge production is a performance. The gaze – that is, how our primary audience gets to exert power over us – may be individually chosen or decided for us by the rules that govern us, with the same centre-periphery dynamics that lead to more peripheral actors being wronged as knowers.

A credibility deficit may be ascribed to cultural knowledge holders: say, people who know the origin of the songs, the role that singing has played in antenatal care over time, how it has evolved, how they want it to evolve in the future, all reflecting their learning over time. The credibility deficit related to pose says: Do cultural knowledge holders even exist? If they do, does the knowledge they hold matter? Its answer is no. What about technical knowledge holders – midwives, other carers, women or researchers involved in group antenatal care in Nigeria – does their knowledge matter? Or what about the knowledge in the literature produced by health and non-health researchers on group antenatal care in Nigeria – does their knowledge matter? Again, the answer is no. To limit the credibility deficit related to pose, perhaps there should be rules to make researchers studying a topic such as group antenatal care in Nigeria start by finding out what people in that space already know, are learning, are doing with this knowledge, are seeking to know, and seeking to do better. The rules that shape how we researchers work default us to assume that such knowledge does not exist or that such learning processes do not occur; that knowledge comes in certain recognisable forms only. That we can pluck research questions from everywhere else (including from the vaguely defined global literature) but the people concerned, on whose behalf and in whose service we ask the questions.

The credibility deficit related to gaze can be noticed in whose learning needs drive the choice of question being asked or the study design used to answer it. If the primary driver of research on group antenatal care in Nigeria is the learning needs of people involved in it across Nigeria – culturally, technically, academically – then the research question and study design will be different compared to if the primary driver is the learning needs of people elsewhere; say, those seeking to spread a model of group antenatal care developed in the United States. The audience

	Perspective	
Unfair Knowledge Practice	Pose	Gaze
Credibility deficit	1. "The periphery's cultural knowledge does not matter"	1. "The centre's learning needs must drive collective knowledge-making"
	2. "The periphery's technical knowledge does not matter"	2. "The centre's knowledge platforms must drive collective knowledge-making"
	3. "The periphery's 'articulation' of knowledge does not matter"	3. "The centre's scholarly standards must drive collective knowledge-making"
Interpretive marginalisation	1. "The periphery's sensemaking of partnerships does not matter"	1. "The centre's learning needs must drive collective sensemaking"
	2. "The periphery's sensemaking of problems does not matter"	2. "The centre's social sensitivities must drive collective sensemaking"
	3. "The periphery's sensemaking of social reality does not matter"	3. "The centre's status preservation must drive collective sensemaking"

Figure 11 | The mechanisms (individuals' reasoning and institutions' rationale) that may underpin the manifestations of unfair knowledge practices.

Source: From Abimbola et al. (2024).

of our research also exerts agency on us though the knowledge platforms (e.g. academic journals) in which we seek to publish our work. Their editors and their primary readers exert on us the agency of gaze. Knowledge platforms connect the system or space within which they are located to more of itself. The knowledge platform on which a conversation is taking place matters. To speak or contribute to a conversation on a Nigerian platform, you sound different to when seeking an audience on a US platform. You can see the difference in the choice of study design. A randomised controlled trial may be chosen over an in-depth embedded learning or participatory action analysis to appease a false hierarchy that places randomised controlled trials on top; a hierarchy to which our most prominent academic journals subscribe.

Interpretive marginalisation works in even less tangible ways. When related to pose, it shapes the terms of engagement between researchers and other people involved in group antenatal care. The party who shapes the collective understanding of what such a partnership should entail also shapes its initiation, processes, purposes, duration and outcomes. Who crafts the terms of engagement shapes what follows. The framing of a problem or its solution is not given; it is constructed based on one's interpretation of reality. Who decides that group antenatal care is a problem or the solution? Are there other ways of making sense of what may be responsible for the quality of antenatal care? Who gets to make sense of it, and how has it changed over time? How do the actors at the periphery of any space or system understand the social reality within which they function, their place in it, and how to make things better for themselves? What do women want, what do traditional and non-traditional midwives want? If the engagement between researchers and people involved in group antenatal care in Nigeria began with these considerations, the researchers who sought to introduce a US model to Nigeria may not have initiated the studies they conducted in the first place. The resources spent would likely have been put to better use.

When related to gaze, interpretive marginalisation arises from the fact that whom you seek to communicate with, impress or be validated by shapes how you, as a researcher, interpret or analyse a situation. The audience may be funders who get to decide how the problem is framed or which solution is selected. The audience may be fellow researchers who have a preferred way of framing a problem, even if it is very different to how people who use the health and care system frame the problem.

The audience may be powerful people who would rather frame issues in a way that places the problem or its solution at the feet of people who are least responsible for the problem. The real problem may be that midwives are very poorly and irregularly paid. But that framing of the problem would make the study's real subject the government officials responsible for salaries, or the foreign entity responsible for extracting resources from a country such that its government spends more on debt servicing than on health (Richardson, 2020). When such powerful entities make up the primary audience of one's research, they create a situation in which only a certain kind of problem can be studied, and only a certain kind of solution can be investigated: those that affirm the moral certainty (Lichtenberg, 1994; Hermann, 2018; Fourie, 2017), or the sense of innocence, benevolence, ultimate goodness or superiority of people with or in power – including us researchers.

It is that status-preserving sensitivity that I am often up against anytime I explain erasure by disregard. Whenever I use these four mechanisms – a credibility deficit or interpretive marginalisation related to pose or to gaze – to suggest what might make a person wrong another as a knower, or how those wrongs may manifest themselves. It the kind of thing many in my primary audience would rather not hear. It may unsettle their sense of self. It may trigger moral distress (Fourie, 2017; Lützén & Kvist, 2012; Morley et al., 2019, 2021), which then shuts down my message. I am inviting them to make a moral judgement: that they have been, and perhaps will continue to be, involved in a moral wrong. If they go along with that moral judgement, if they agree with me, they may be unable to accept the moral wrong (doing so may undermine their academic credibility) or to change what they might do in the future (the moral wrong is such a well-rewarded, otherwise accepted practice that turning away from it may be too costly). Hence, the moral distress: a state of psychological disequilibrium, a displacement of one's hard-won sense of moral certainty. To accept that you have wronged others, that you cannot or will not right or stop the wrong, is psychologically unbearable. It undermines your sense of self. The psychologically safe option may be to reason away the supposed moral wrong, refuse to accept the moral judgement, or shut down the bearer of the message.

The researchers who conducted the studies on bringing the foreign model of group antenatal care to Nigeria must believe, along with their partners, that they are doing right by Nigerian women and babies. It is the kind of effort that stems, at least in part, from a place of moral certainty. They must have convinced funders and ethics committees and their colleagues of the virtues of the project; that the knowledge they would produce would be of great value in improving maternal and infant health in Nigeria and elsewhere. But nowhere in the publications from these various studies did the researchers show that this was the case; that Nigerian health practitioners or policymakers or women or activists wanted to know if group antenatal care works. Instead, the studies were based on the premise that group antenatal care was foreign to Nigeria, an innovation to be introduced from the United States. What led to such an assumption? Perhaps the researchers had limited access to the literature about Indigenous practices in Nigeria. Or because these practices are only in the literature in a limited way, and not in the health literature. Perhaps Nigerians have not felt the need to write much about group antenatal care because it is so taken for granted as a cultural practice, so part of the fabric of social life that they/we do not need to prove to anyone that it works.

Let's assume that the most important cause of maternal mortality is low quality antenatal care, and that the main reason for this is how midwives and others deliver antenatal care. Then let's go one more step to assume that the most important solution is group antenatal care, the model developed in the United States and brought to Nigeria and elsewhere. Even granting those assumptions, the researchers opted to study group antenatal care with methods – randomised controlled trial and cohort study designs – that limit the possibilities of what could be learned from and about group antenatal care. Those methods do one thing well: answer whether group antenatal care works or not. But that may be the least important question to ask about a practice as entrenched, long-standing and complex as group antenatal care. To ask whether such a practice works is at best to resort to a thought-stopping clichéd use of the idea of evidence. It works, so scale it up; it doesn't work, so abandon it. At worst it is a distraction, an obstacle to learning, a waste of time and money, and a violation of the dignity of many people as knowers. People who are intimately involved in group antenatal care, who cannot see what they know in the knowledge produced "for" them, effectively gaslighting them by suggesting they do not know what they know.

Each set of people involved in group antenatal care is positioned differently in relation to it: mothers, midwives, musicologists, fathers, nurses, activists, traditional midwives, health policymakers, health researchers, etc. Any inquiry that does not begin from what have they learned over time – what they are doing with that knowledge, what their knowledge or learning needs are, what must be done differently in different situations or for different individuals or groups – is misguided. Those are the questions that matter. To not primarily focus on such questions is to fail to respect all those people as knowers, to violate their dignity as knowers. But then, the researchers interacted with Nigerians who must have known that the studies were based on shaky premises. Did those Nigerians speak up and were not heard or listened to? Maybe they suffered a credibility deficit. Or was it interpretive marginalisation? If they had tried to say "this is not new at all", would they have had the language to say it? What if their US partners responded: "Show me the literature that says you have been doing it forever." Would they find it? If they did, would their US partners believe it? Even then, the Nigerian partners may not have had the chance to voice their views, given the vulnerability imposed by their own marginal, peripheral position in the studies.

The Nigerian co-authors of these group antenatal care studies initiated in the United States were "stuck in the middle" (HEDT-GAUTHIER et al., 2019). The position of the first and last author denotes ownership and leadership, which decrease as you go from either end of the byline towards the middle. Even if the Nigerians had wanted to say something and had the language to say it, they might have needed to avoid making their US partners uncomfortable. Speaking up might threaten an already marginal position within the partnership. Being careful not to offend is even more important if the Nigerian partners' livelihood or career prospects depend, no matter how indirectly, on participating in such a study. Those who speak up may even be punished for doing so by senior Nigerian colleagues keen to preserve their position or income. They may be mindful of not triggering moral distress among their US partners. They may recognise that moral distress would make for a difficult working relationship, which may not serve the Nigerians involved well. Or they may perceive that the self-preservation, moral-distress-avoiding needs of their US partners will ensure that no matter how clearly they speak, they will not be heard, their voices will be discounted. They may also suffer a credibility deficit. The risks of speaking up may be too great and the benefits so uncertain that they choose silence.

The self-preservation gaze that I contend with as I explain what it is to be wronged as a knower is, I suspect, similar to the one faced by Nigerian partners in international studies, although it is less risky for me to speak up. We may have something to say, struggle to say it, struggle to be heard and understood, or choose silence. When I do speak, I tread gently. When I am addressing a room of people leading international studies such as those on group antenatal care in Nigeria, or who have led or hope to lead such studies elsewhere, I reassure them that they are not bad individuals. I note that they likely wrong others as knowers without realising, because they function within a system governed by rules that are unjust; a system that wantonly violates people's dignity as knowers. But I am mindful that my words may trigger internal, unspoken pushback. I try to address those unspoken counterarguments. In the rare instance that a counterargument is actually voiced, it is disguised as a question or comment. I listen carefully for the hidden pushback and I find a non-threatening way to respond. People do not want to be seen to be defending colonial, patronising, self-serving love, no matter how certain they are that the actions – their actions – being described are, in fact, morally wrong.

There is a sense in which research is seen as an elevated enterprise, disconnected from ordinary people: something academics do, a conversation between scholars in an arcane, deliberately obscure register. The kind of research that wrongs people as knowers is more likely to get funded than those I might suggest instead. It is more likely to get published in prominent journals, to attract grants and awards, to make secure otherwise precarious academic careers. It is the kind of research that gives a definite answer to a specific question. Does X work? Yes or no. Then the issue is settled once and for all. It is one reason why this type of research attracts so much attention and support, even if it turns complex social issues and social realities into simple yes or no questions. I know my audience thinks that what I am saying flies in the face of accepted standards. I remind them that our norms in health and related fields let powerful people off the hook, which is another reason why such research attracts so much attention and support. In letting powerful people – including us researchers – off the hook, it disregards not-so-powerful people as knowers. I add that I prefer to think of what we do as learning instead of research; that there is something uncomfortably distant, inert, ivory tower, foreign to the daily realities of non-elite ordinary people about calling what we do "research". Everybody learns. Framing what we do as supporting learning can free us.

As I wrap up, I want whatever moral distress, the internal questioning of colonial love I may have triggered, to last longer than the time the audience is with me. I know that moral distress can be generative. It can lead to systemic action. Many of the wrongs done to people as knowers are conditioned by the rules that govern our engagement with them. But those rules are made, changed, monitored and enforced by people often acting as individuals. Moral distress can trigger individual and collective action (Lützén & Kvist, 2012) to change bad rules, to refuse to monitor and enforce bad rules, or to make new rules that default our engagement to respectful knowledge practices, practices that uphold the dignity of marginalised people as knowers. I tell them that I am hopeful, that I have no other option – but that hope is unstable, that I often despair. Our efforts to achieve health equity are easily led astray by our unfair knowledge practices (Bhakuni & Abimbola, 2021). We labour in vain, in rabbit holes, looking for solutions to problems that do not exist, ignoring those right in front of us. We need self-awareness to get out. But how does a person even know they are in a rabbit hole? How do you let someone know, if you are wronged as a knower? You are in a bind. You want to be truthful in speaking out, but you want to be effective too. You want to help that person achieve self-awareness.

When I think of what it might take to help another person achieve self-awareness, what often comes to mind is the final stanza of the poem "To a Louse" written by the 18th-century Scottish poet Robert Burns (Burns, 2009 [1786]). The narrator is in a church congregation during a service and is positioned close to, maybe behind, a "proper" upper-class lady. The poem starts with the narrator rebuking a wayward louse that had made its way onto the lady's bonnet:

> Hey! Where're you going, you crawling hair-fly?
> Your impudence protects you, barely…
> You ugly, creeping, blasted wonder,
> Detested, shunned by both saint and sinner,
> How dare you set your feet upon her –
> So fine a lady!

The narrator tells the louse to "go somewhere else to seek [its] dinner", suggesting "some poor body" or "around some beggar's temple" or "some housewife's flannel tie" or "some ragged boy's pale undervest" instead of perching on "so fine a lady!" Then, in a sudden shift of attention away from the louse, the narrator addresses the lady by name:

> Oh Jenny, do not toss your head,
> And lash your lovely braids abroad!
> You hardly know what cursed speed
> The creature's making!

Jenny had vainly tossed her hair in response to winks and stares from people in the congregation who were apparently admiring her "gauze and lace" bonnet. Her vanity appears misplaced, as the narrator could see something else – the louse – and that sight was no cause for admiration. The poem ends with a prayer:

> O would some Power with gift give us
> To see ourselves as others see us!
> It would from many a blunder free us,
> And foolish notions:
> What airs in dress and carriage would leave us,
> And even devotion!

To see ourselves as others see us. To see ourselves in others. To see others in ourselves. To see others as they see themselves. To see the world through others' eyes. To see ourselves through others' eyes. To be self-aware is to save ourselves from "many a blunder", from "foolish notions", from "airs" of vanity, and from "devotion" to self. It takes special and continuous self-discipline. But we need institutional discipline too; rules to constrain and default us to upholding the dignity of marginalised people as knowers. To craft and uphold such institutions, we need collective action. For that, we may need widespread moral distress.

We should be able to speak of being wronged as knowers in ways that are palatable, easy to digest, to those who are in a position to alleviate it, but also to articulate the situation so that when we are done, we have ceased to be a victim and have become a threat. Perhaps that is what Robert Burns was trying to do in "To a Louse". Perhaps the poem was actually "To a Lady". He pulls the lady close, he takes her side, speaks up for her, only to offer his message of self-awareness at the end. Even then, he does so obliquely. He does not address the upper class – whom the lady stands for – too directly. He offers his message as a prayer to "some Power" – to God. He sweetens the pill. Perhaps he was effective. But he should not have had to go through so much trouble.

CONCLUSION

"But you don't need statistics or outside experts to know the truth. You just need to look at us. I want to tell these people [who say there is no hunger, malnutrition and starvation in Gaza] to come to Gaza and try to spread these lies to our faces. They will see what we know… If that fact isn't enough to end this nightmare – if we can't even have our suffering acknowledged – then we should all stop pretending that we are humans who care for each other equally."

Mohammed R. Mhawish (2024)

If I was asked to suggest an alternative title to this book, it would be *To Connect a System to More of Itself*. In all the essays collected here, I have refrained from being too prescriptive. I have instead sought to point out lines along which our efforts to transform academic global health may focus, to show fault lines and leverage points at which we may aim our collective hammer. If I were asked to state the one prescription that stems from this book, it would be that equity requires us to connect a system to more of itself. The obverse is also true: inequity thrives when a system is fractured within, when it is not connected to all of itself, when it marginalises parts of itself, when channels that move knowledge around – and, by extension, channels of accountability – are obstructed, occluded, ignored, starved of resources, or even absent.

To connect a system to more of itself is the subtext, the golden thread, the conclusion to these essays. It is an explanation for inequity and a prescription for equity. It is at the same time conceptual and concrete. At first it sounds vague, abstract. But the essays here are put to the service of making this conceptual claim concrete. At the end of this book, I hope you can easily grasp how striving to connect a system to more of itself solves problems – or how problems themselves are caused by weak, limited, inactive or ignored channels to connect a system to parts of itself. The more you consider the claim, the more concrete it becomes. But if this is still not what first comes to mind when you try to explain or solve inequities, here is one more way to think about it.

There are claims you read or hear that immediately invite a rebuttal, or an instinctive impulse to disprove, even if only for the sheer pleasure of doing so. For example, this claim by the Indian economist and philosopher Amartya Sen: "In the terrible history of famines in the world, no substantial famine has ever occurred in any independent and democratic country with a relatively free press" (Sen, 1999a). He adds, with remarkable certainty, that "we cannot find exceptions to this rule, no matter where we look". He says that this is true "even when the country is very poor and in a seriously adverse food situation" (Sen, 2009). It is a bold, audacious claim. To make his case, he lists famines under authoritarian regimes across the 20th century (Sudan, North Korea, Ethiopia, Somalia, China, the Soviet Union) and in 19th-century Ireland under authoritarian British colonial rule. He also reanalyses what he saw others go through as a 9-year-old boy growing up in Bengal during World War II when India was under authoritarian British colonial rule.

Elegant in its simplicity, this claim, this useful fiction, although compelling, has always left me unsatisfied. Not because I think it is wrong or more wrong than any other useful fiction, but because it stops short of naming the mechanism at work, which for me, is the need to connect a system to more of itself. This mechanism is present, but only implicitly so, in Sen's explanation of why the Bengal famine of 1943 occured:

> The Bengal famine of 1943, which I witnessed as a child, was made viable not only by the lack of democracy in colonial India, but also by severe restrictions on reporting and criticism imposed on the Indian press, and the voluntary practice of "silence" on the famine that the British-owned media chose to follow (as a part of the alleged "war effort", for fear of aiding the Japanese military forces that were at the door of India, in Burma). The combined effect of imposed and voluntary media silence was to prevent substantial public discussion on the famine in metropolitan Britain, including in Parliament in London, which neither discussed the famine, nor considered the policy needs

> of dealing with it (that is, not until October 1943 when *The Statesman* forced its hand). There was of course no parliament in India under the British colonial administration (Sen, 2009).

The famine had several causes (Sen, 1983). It was a rural famine brought about by inflationary pressures that pushed the price of food beyond the reach of landless rural labourers. There was a booming wartime economy (with significant military construction work in Bengal), raising the price of food. There were colonial distribution policies (such as food subsidies for people in urban areas, which further drove up prices, and restrictions on food importation and trade between Indian provinces, which made food prices stay up). But what draws me to this famous claim is that it is fundamentally epistemic; a feature that is unfortunately obscured by not stating the mechanism clearly as part of the claim. A choice that would have made the claim much more readily transferable – through abstraction – to other issues or spaces. Spaces such as academia or academic global health. Or relations between a researcher and the researched. Or relations between one sovereign country and another. Here is how Sen framed the epistemic aspect of the claim:

> The rulers of a country are often insulated, in their own lives, from the misery of common people. They can live through a national calamity, such as a famine or some other disaster, without sharing the fate of its victims. If, however, they have to face public criticism in the media and confront elections with an uncensored press, the rulers have to pay a price too, and this gives them a strong incentive to take timely action to avert such crises (Sen, 2009).

This is a claim about distance. It is about being in the world, but not of it. It is a claim about the disconnection of people with power from people with less power. It is about how distance dulls us to the suffering of others. In Sen's claim, the press is the agent of connection, and rulers are incentivised to be responsive because of elections. This need for responsibility-triggering connection applies elsewhere. As between privileged leaders and the least privileged people on the margins, so it is between those who do global health and those upon whom global health is done. But who (like the press) is the agent of connection in that space, and what (like elections) might compel those who do global health to be responsible? Every distance needs a channel of connection and a cloud of witnesses to hold the powerful at one end of the distance to account in their relations with the less powerful at the other end. It may be a code of conduct or a set of norms; rules that the powerful can and will want to hold one another to, and the less powerful – through their own or others' agents of connection – can hold the powerful to. How we make, change, monitor and enforce those rules of engagement should be an ever-present topic of collective deliberation among all of us who work across a distance; who do global health.

Take, for example, the distance between Amartya Sen and the people who suffer famines – during the 1943 Bengal famine, "no one among his family or friends, anywhere in Bengal, ever had to worry about food" (Dabhoiwala, 2022). His self-acknowledged privileged status (pose), and the privileged status of his fellow academics or the policy elite for whom he crafted his claim (gaze) may have influenced its structure. The foreign gaze. After all, what democracy prevents is the extreme situation in which thousands of people die from starvation within a short period: the Bengal famine of 1943 claimed an estimated three million lives (Sen, 1983). A famine is declared when at least 20% of households are affected by extreme food shortages, 30% of children are acutely malnourished, and two in 10,000 people are dying per day from starvation or diseases linked to malnutrition (IPC Global Partners, 2021). But the resting state of hunger, malnutrition and starvation – which is responsible for far more deaths than famines – is present in both democracies and non-democracies. In this sense, what democracy does is almost unremarkable. What is remarkable is that even with a free press and elections, democracies tolerate large-scale hunger, malnutrition and starvation. This seems a more fruitful thesis. Perhaps the structure of Sen's claim would have been different were it made from a different pose and for a different gaze. Those of us who do global health must be willing to reckon openly with what our pose and gaze do to how we structure our claims, analyses and interpretations, and to go where our default positions lead us to avoid. Otherwise we will take for granted our failures to connect.

Sen's claim stops at the "intervention" – democracy, with a sprinkle of free press. It does not go far enough to state the active ingredient – the mechanism – within that intervention, which is *to connect a system to more of itself*. Stated in that form, Sen's claim can travel, taking on endlessly different forms in different settings. It would be wrongheaded to simply offer democracy and free press as recommendations everywhere, if only because whatever claims are made on their behalf, democracy and free press do not apply in every space or at every scale of organisation. If our goal is to learn across time and place, an intervention must be understood, promoted and studied primarily in terms of its active ingredient. The same is true for decentralisation (i.e. a mechanism) versus performance-based financing (i.e. an intervention). The active ingredient takes us closer to reality, allows us to see what is really going on, with insight that is useful beyond evidence presented as thought-stopping cliché for the foreign gaze. In the case of famine, it directs our attention to people who are hungry, malnourished and starving, away from the powerful; from the distant, foreign gaze. Listening from afar, we hear or pick out sounds we can easily recognise. Speaking to someone afar, we are inclined to say what we suspect is familiar to them. But we must reject a field in which the default is one in which the powerful speak to the powerful about the less powerful. It is the kind of default arrangement that breeds a disconnected world; a world in which inequities thrive.

To connect a system to more of itself also requires focusing on all its axes of connection, thinking along the three axes of the triangle of rules or of persons. First, the axis that links the authoritarian British colonial government and marginalised communities at risk of famine in rural Bengal to each other. Second, the axis that links that government and the food market to each other. Third, the axis that links those marginalised communities and the food market to each other. Sen chose the first axis as the primary focus of intervention: in democracies, "famines are easy to prevent", "affect only a small proportion of the population", and can be solved through "emergency employment" (Sen, 2009). This is because famines are not caused by supply shortage, but a sudden drop in relative income, such that already marginalised people are then unable to buy food (Sen, 1983). But what about the second and third axes: the links by which governments or marginalised communities can put pressure on the food market to lower food prices or function differently? After all, the authoritarian British colonial government already provided food subsidies to the relatively more powerful people in urban Bengal, which contributed to raising food prices, which then led to the rural famine. But who would be the agents of connection for such ends? The press? Academics? Activists? No matter, we must be suspicious whenever the powerful insist on their preferred solution to or interpretation of a problem. Even more so when this leaves out a view of the system from the inside, through the eyes of the marginalised people in it, addressed to their gaze. Or when it leaves out the need to connect the system to more of itself.

The triangles give us three sets of actors. But there is one more set of actors to consider: actors who serve as knowledge-mongers; actors who help to move knowledge around within a system; actors without whom our picture of the uses of knowledge within any system is incomplete. In Sen's claim, the press are knowledge-mongers, who (alongside activists and academics) may function at global, national or subnational scales of social organisation. At smaller scales of social organisation, knowledge-mongers and the platforms they use may take different forms. In a small community, the marketplace, town square, or the health data system are knowledge platforms. The town crier or head market woman are the knowledge-mongers who use those platforms: the "professors" in our fuller picture of actors involved in the uses of knowledge in a system. "Emancipators" are women's and youth groups and activists in the community. "Engineers" are the community leaders or local councillors. "Plumbers" are practitioners such as health, nutrition, education or sanitation workers. Analogous actors and platforms occupy each of these four positions at larger scales of organisation. External academics, activists and the press can help to connect these actors to others, helping, if needed, community professors and emancipators to function optimally. This may include building community knowledge platforms or making them stronger. We must be willing to hold ourselves to rules (as in the principle of subsidiarity) that compel us to act accordingly.

To see our primary role as helping to connect a system to more of itself is to accept that marginalised knowers are the primary audience of our work. It means respecting their dignity as knowers, as the spectators for whom we perform. Sen's claim featured two non-existent knowledge platforms. First, parliaments: there was "no parliament in India under the British colonial administration", but only the "Parliament in London" (Sen, 2009). Second, the press: there were "severe restrictions […] imposed on the Indian press" by the authoritarian British colonial government and a "voluntary practice of 'silence' on the famine" by the British press in deference to their owners and their primary audience. This explanation of the famine shows why you must own your own knowledge platforms if they are to serve you well. It shows the primacy of building and making your own knowledge platforms stronger (Abimbola, 2023a). It shows what happens when you are obliged to use others' platforms. It is why an academic journal in Britain cannot serve India well. The knowledge platforms that should have served marginalised people in Bengal were British-owned, British-controlled or British-located. The gaze to which knowledge-mongers on the platforms deferred was British. Hence, the famine. Hence, the hunger, malnutrition and starvation that preceded the famine.

The essays collected in this book are an exercise in finding ways to articulate the situation of being wronged as a knower: to say what it means to be wronged as a knower. The instrumental claim that democracy and a free press prevent famines is not good enough – if only because they do not prevent hunger, malnutrition and starvation. Even to say that what is wrong about being wronged as a knower is the failure to connect a system to more of itself is not good enough, especially if our argument is that the primary goal of this connection is to ensure equity. It remains an instrumental argument. The right argument stems from why we should care about equity in the first place. To which I say: because we respect the dignity of each person – not only, but in this case, especially – as a knower. This is not necessarily fulfilled by democracy and a free press, which – as they currently function – coexist with marginalisation and tolerate hunger, malnutrition and starvation, but can swing into action in the more extreme case of imminent famine. To respect the dignity of everyone as a knower is to constantly check which crises or "slow deaths" (Berlant, 2007) we who are privileged enough to do global health have accepted as normal on behalf of people who suffer. This requires that people who are marginalised are well served by their own and others' knowledge platforms and knowledge-mongers.

* * *

In his essay, *First and Second Things,* the 20th-century British writer and literary scholar C.S. Lewis made a case for putting first things first. He saw first things and second things as primary things and subsidiary things (Lewis, 1970). He identified "dignity" and "justice" as examples of a "first thing". First things provide the rationale and ethical commitments that should drive how and why we do second things. In this vision, efforts to achieve health equity are second things. We connect a system to more of itself because of first things: a commitment to respecting the dignity of each person, especially as a knower (epistemic dignity), and to justice (including epistemic justice). "Put first things first", C.S. Lewis said, “and we get second things thrown in: put second things first and we lose both first and second things” (Lewis, in *The Collected Letters of C.S. Lewis*, 2007). Achieving health equity can only be a byproduct of striving for dignity and justice. If we go about our second things in ways that are not underpinned by a commitment to first things, we will achieve neither equity nor dignity and justice. This idea of first things and second things is well captured in the Yorùbá saying: *Ikú yá j’ẹ̀sín lọ* (“Rather death than violated dignity”) (Abimbola, 2023b), which we could paraphrase as “Let me die, rather than violate my dignity in the name of saving my life or in your quest for equity on my behalf.”

In our quest for health equity, nothing is more foundational than epistemic dignity and epistemic justice. In how we choose our gaze and knowledge platforms, how we build and make knowledge platforms stronger, how we right the credibility deficit and interpretive marginalisation inflicted on people in their role as speakers (pose) or hearers (gaze), and how we connect a system to more of itself, whether we are connecting ourselves to the gaze of the marginalised people or whether we are helping to connect a social space to more of itself – the margins to the centre; emancipator to plumber; emancipator to engineer; engineer to plumber. All inequities have an epistemic foundation. In academic global health, we often seek to redress inequity in health without first attending to – and seriously considering – what lies beneath it and gives it life. When we do so, we inflict additional indignity and injustice. Our interpretations are wrong, our efforts ill-informed, our interventions misbegotten. We are ineffective. To be effective, we must think as Amartya Sen encouraged us to think about famine (to which he could have added hunger, malnutrition and starvation): that, simply providing food is not the real solution. The real solution lies in improving the purchasing power of marginalised people, “since income does give one entitlement to food in a market economy” (Sen, 1983). But even that is not the ultimate goal of our efforts, which goes beyond preventing famines. As Sen argues, a commitment to dignity compels us to work and fight to ensure that everyone has the capabilities and freedoms to flourish (Sen, 1999b). That is the ultimate goal.

This conclusion was written in April 2024, as the world began to reckon with the imminent reality of famine in Gaza (IPC Global Famine Review Committee, 2024), after weeks of bombardment and blockade by the authoritarian Israeli colonial government, which had led to tens of thousands of deaths and tens of thousands of people suffering from hunger, malnutrition and starvation. At this point, more than 100 journalists and media workers had been killed, the vast majority of them Palestinian, some of them killed along with their family (Committee to Protect Journalists, 2024; International Federation of Journalists, 2024). To date, videos showing the intent and effects of Israel's actions have had limited impact on the course of events, despite the fact that the International Court of Justice had made a preliminary ruling in a case brought by South Africa, finding it necessary to put in place urgent measures to protect "the Palestinians in Gaza" given the "real and imminent risk" posed by the authoritarian Israeli colonial government to their rights "to be protected from acts of genocide" (International Court of Justice, 2024). Yet again, the imminent famine in Gaza is consistent with Sen's claim, as is the widespread hunger, malnutrition and starvation leading up to it. Eighty years later, it bears several striking resonances with the Bengal famine of 1943. The resonances are chilling, distressing, enraging.

In an article written from Gaza in April 2024, Mohammed R. Mhawish, a Palestinian journalist, described how he and his family were suffering from hunger, malnutrition and starvation caused by Israel's bombardment and blockade. He trusted the power of his, his family's, and his people's gaze to compel truth-telling: "You just need to look at us", at "our faces", and "see what we know" (Mhawish, 2024). His fervent plea to reorient our focus to the local gaze resonates strongly with the core contention of this book. If we cannot compel deference to the local gaze, and by so doing discipline would-be obfuscators of the truth, obstructors of connection, destroyers of knowledge-mongers and knowledge platforms, and "professors" of all kinds, then what else is there?

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The field of research known as academic global health is in the midst of a scientific debate that is questioning its epistemological foundations. This book contributes to that questioning. Through a series of essays that weave together personal narratives and conceptual reflections, it shows how as researchers in academic global health, we defer to a distant, powerful, foreign gaze, whose power shapes our pose and what we can see or say. Many of our accepted knowledge practices – how we make, use, share and value knowledge – are steeped in structural prejudice and heavily peppered by epistemic injustice. To transform academic global health, we need a critical mass of people who can articulate why many of our accepted knowledge practices are unfair, people who know where to aim their efforts to entrench just practices, people who can get others to join in those efforts. This book was written to help build that critical mass.

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