Rethinking Global Health: A Social Medicine Approach To International Medical Partnerships

By

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A thesis submitted in partial satisfaction of the

requirements for the degree of

Master of Science

in

Health & Medical Sciences

in the

Graduate Division of the

University of California, Berkeley

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Fall 2020

Acknowledgements

Thesis Committee: Seth M. Holmes, Vincanne Adams, Ndola Prata
Thesis Working Group Instructor and Advisor: Colette Auerswald
Partner Organizations: Equal Health, SocMed, Social Medicine Consortium
Undergraduate Research Apprentices: Sophie Zhang and Francesca McLaren

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Part 1: Literature Review

I. Introduction

a. Overview

Over the last centuries of medical transnationalism—including missionary, colonial and international health—racism, ethnocentrism, economic disparity and political hierarchy have created vast inequalities and health disparities. While medical professionals have been conscripted to rectify these health disparities, they have also at times—unwittingly, or not—reinforced them. This duality has taken different forms across historical periods, but persists none the less. Colonial medical practitioners sought to protect colonials' health, but also the well-being of colonized laborers, thus ensuring the economic productivity of the imperialist enterprise. Missionary physicians strove to save lives in order to save souls and convert. International health experts aimed to distribute health resources, but also set in motion neoliberal agendas that reproduced and hardened inequalities.

As the twenty-first century approached, international health shifted to become global health: a field built upon the promise of a true partnership between the global north and south. This new field has solidified its place in the US nonprofit sector, the health sciences research world, the world of American higher education. The past decade has borne an explosion in global health opportunities for medical students and undergraduates in North America. As the field of global health continues to gain momentum around the world, the potentially conflicted role of medical personnel in alleviating, yet at times perpetuating, vast inequalities and health disparities must be closely examined. Therefore, we must ask: is Global health succeeding? At what?

Social Medicine is a field and set of practices that has offered insights about the cause and cures for social inequality as expressed in and through health and healthcare. For over a century, Social Medicine scholars have proposed that it is the nature of social circumstances, rather than a lack of technology, that produces, perpetuates, and potentially rectifies health inequities. The legacy of Social Medicine flourished in Europe, in Latin America, in South Africa, and has had a resurgence in the US in recent years. As the relatively new field of global health becomes cemented in the world of health sciences practice, research, academia, one can ask, how can Social Medicine guide the field of global health ?

My research explores one particular site of deployment of Social Medicine as an explicit effort to undo social inequalities that undergird global health efforts in many places in the world. Specifically, I explore the use of Social Medicine principles and concepts in medical education. I ask: *Who* is the target with this education? What does this emphasis on Social Medicine mean for students in the 'global south' as opposed to the 'global north'? What does this curriculum aim to accomplish? This study will take the form of an ethnographic case study of a specific NGO: The Social Medicine Consortium. In this paper, I provide a literature review that covers scholarship that will help me to make sense of this set of global health activities.

b. Paper Organization

In this literature review, I will begin with a history of the large scale eras of colonial medicine, international health, and global health , with a specific focus on highlighting themes that persist through out the 19th, 20th and 21st centuries. I will demonstrate how these persisting themes of capitalism, quantitative analysis, and humanitarianism have shaped the modern field of global health. Next I will explore the historical narrative of Social Medicine. I demonstrate that the ideologies of Social Medicine have provided alternate approaches to vertical, disease centered narratives in international health, and show how this approach has gained momentum in different places and times. I highlight a direct relationship between global health and Social Medicine, and discuss the possibilities and challenges for a merging of these two traditions of thought. I will then move towards the more specific focus of this project - medical education. I will explore the rise of global health in medical education as well the current standing of Social Medicine in medical education. I will synthesize this information to support my conclusion that Social Medicine education in global health presents potential as an area of investigation. At this point, I will move on to discussing the specifics of the proposed project by exploring the sites of inquiry for this project. Finally I will conclude with thoughts about the appropriate methodology to explore the proposed research questions.

c. Terminology

Caution must be applied in simplistic framing of a bipolar world with an imagined 'global north' and 'global south'. This bifurcation obscures considerable differences across countries within these two imaginary blocs, and drastically simplifies other aspects of historical, cultural, and linguistic ties (Czaika, de Haas, and Villares-Varela 2018). The use of 'Global North/Global South' language is an attempt to avoid what may now be considered unsavory language: First and Third World; Developed/Un- or Under-developed; colonizer/colonized. However, simply renaming the same categories does not erase the tacit assumptions which make the older verbiage now repugnant(Adams et al. 2019). However, in this paper, I will at times resort to the use of this Global North/South vernacular as a way to critique the long-standing colonial histories of health and development. I acknowledge that this is problematic, and I will continue to search for better ways to express ideas that respect our global diversity of cultural identities and histories with more specificity.

II. Historical Perspectives

a. Tropical Medicine and Colonialism

Global health may be a relatively new concept, but an examination of its ancestor, colonial tropical medicine, can be illuminating. In the 19th and early twentieth centuries, we can understand the practice of western medicine in colonized lands as an instrument of colonization. In this section I will explore the economic, moralistic, quantitative, and dimensions of tropical medicine, as well colonized persons feeling of hostility and ambivalence toward these practices. I will trace these themes as they evolve through these three eras of medical transnationalism.

Nineteenth century colonial health projects[1] revolved around controlling pathogenic, conquered landscapes to make them livable for the bodies of white colonizers, as well as training and disciplining individual black and brown colonized bodies. For example, an 1840 issue of the London Newspaper "The African Colonizer" was intended to be a "source of information useful alike to emigrants, scholars and politicians, merchants, and philanthropists". Any mentions of health are focused on the health of the colonizer, discussing: "sickness and mortality among our troops" (Source of Information Useful Alike to Emigrants, Scholars and Politicians, Merchants, and Philanthropists 1840). Anderson (2000) argues that the turn of the twentieth century marked a transition in the practice of western medicine in many colonial holdings. This shift was mediated by both the growing prominence of germ theory and the increasing incorporation of colonial holdings into the global economy. According to Anderson, these developments marked native bodies simultaneously as dangerous reservoirs for germs fatal to the colonizers, and as valuable resources in the form of manual labor in an increasingly globalized economy. Anderson argues that: "tropical medicine was principally a localized form of industrial hygiene, first for the colonizer, and then for the laboring colonized"(Anderson 2000; Medical and Sanitary Matters in Tropical Africa 1921). In this sense, Anderson is arguing that 20th century colonial medicine represented a change in marking colonized peoples as economic assets, and therefore worthy of medical attention. However, the works of Randall Packard, and Megan Vaughan characterize 19th and 20th century medical regimes as very focused on training and disciplining the African body. Regardless of whether the turn of the 20th century marked a shift in the practice of western medicine in colonized lands or merely a continuation of ongoing practices, western medicine was an instrument of colonial rule in this time period.

Tropical medicine was much more than a tool for upholding colonial economies. Colonial hygiene campaigns were not only a matter of maintaining a healthy work force for resource extraction, but these public health practices were tied with the values and core identities of the colonizer and the colonized. Hygiene quickly became associated with the civic responsibility to uphold a clean, healthful society, as defined by the colonizers. Anderson describes a specific example of this hygienic remaking of Filipino values and self-image. In the first decade of the 20th century, this can be understood as an act of cultural erasure, to be resisted:

> While the Manilla Carnival occurred each year in February, Clean Up Week—the other [Colonial Government Sponsored] alternative to the traditional fiesta, usually took place the week before Christmas. Promising "the sanitation and the beautification of the Philippine towns," it was chiefly a time for the cleaning of private and public premises, the gathering and burning of rubbish… and the construction of toilets,". In the past, it had been "the custom to have a municipal clean- up before town fiestas," but what used to be merely preparation for a festival had become the raison d'etre of community activity. In this sense, it was promoted as a "nation-wide" revival of a "good customs of our grandfathers, only to be done in a more systematic way."[84] The first such celebration of Hygeia took place in 1914—"to a distinct lack of cooperation and interest on the part of everybody"[85](Warwick Anderson 1995:665).

[1] For a clear illustration of colonial geography as it changes over time, please refer to: https://www.youtube.com/watch?v=ihD3__Nm8qA

These hygiene campaigns not only took the form of government sponsored sewage fiestas, but also heavily targeted schools, focusing on retraining Filipino youth:

> […]health experts urged that "the construction of a toilet in his own home or in that of a neighbor be a project for each seventh grade boy". The production of colonial space required that Filipinos confess repeatedly their filthiness […]Filipinos, whatever their misgivings, were compelled from infancy to confess this "putrescence" so that formalizing American institutions would recognize them—if only to retrain them […] a Filipino becoming civilized is abandoned to equipment that "unrelentingly works to prove to him that he is a betrayer, a coward, a pile of shit (Warwick Anderson 1995:661).

Only with the confession of this rottenness could Filipinos be admitted to an American modernity; once fallen, they could help raise themselves up (Warwick Anderson 1995). As demonstrated here, hygiene campaigns not only affected the working life of the colonized, but also sought to reshape their culture, traditions and values according the values of the American colonizers. Anderson asserts that: "By the 1930s, colonial public health and associated hygiene projects such as these became increasingly argued in terms of human rights" (2000:242). Although it might be anachronistic to use the phrase 'human rights' at this time period, an evolving ideology around morality and healthcare played a key role in the rhetoric of the tropical medicine.

Ideas of humanitarianism, existing outside of the theological, trace their origins to nineteenth century Europe. The word "humanitarian" was first used in 19 century England, then referring to a theological position stressing the humanity of Christ (Redfield 2013). However, canonical enlightenment writers such as Voltaire, Kant, and Rousseau began to emphasize the moral significance of arbitrary pain, while rejecting any theological justification. These ideas greatly influenced the ways in which medicine was practice in Europe during the enlightenment period, as can be seen in the establishment of organizations such as the Red Cross in 1859, which melded enlightenment and theological approaches to the alleviation of suffering. While his form of medical humanitarianism was originally contained to Europe, images of David Livingstone, implanted the romantic idea in the minds of many Europeans of a heroic white doctor toiling in the depths of Africa. Despite secular notions of humanitarianism in Europe, medical humanitarianism in colonial holdings in the 19^{tha} and early 20th century largely remained rooted in religion: "Africans encountered Christianity through health care, the European reading public encountered Africa through reports of suffering on the 'sick continent', " (Redfield 2013:45). Tropical medicine and colonial health did include an element of moral weight placed on human life, a theme which evolved over time toward a more secular tenant of human rights. The American hygiene campaigns in the Philippines exemplify this shift toward a secular human rights mentality applied to colonial medicine.

The moralistic nature of tropical medicine is deeply ironic, considering the inherent brutality of colonization. Following the example case of the Philippines, the American hygiene campaigns must be considered in the broader historical context of this time period. After anti-Spanish Filipino revolutionaries fought on behalf of the Americans in the Spanish American War, the Philippines declared independence on June 12, 1898, and Emilio Aguinaldo was named president. In December of 1898, US declined to recognize President Aguinaldo and the Philippine's independence, instead sending US military to the islands, and thereby continuing the legacy of imperialism. In response Aguinaldo wrote his 1899 "Letter to the American People" which includes the lines:

> We Filipinos have all along believed that if the American nation at large knew exactly, as we do, what is daily happening in the Philippine Islands, they would rise *en masse,* and demand that this barbaric war should stop[…] America abandoned her traditions and set up a double standard of government—government by consent in America, government by force in the Philippine Islands[…]You will never conquer the Philippine Islands by force alone. How many soldiers in excess of the regular army do you mean to leave in every town, in every province? How many will the climate claim as its victims, apart from those who may fall in actual warfare? What do the American people who have thousands of acres yet untilled, want with the Philippines (Aguinaldo 1899)?

The legacy of tropical medicine, and its humanitarian aspirations are inextricably linked—directly or indirectly—with the brutality of colonialism.

These ideas of hygiene and morality intersected with a growing European fascination with statistical analysis of health data. In the 1820's, the field of statistics began to play a new role in social and scientific thought due to Adolphe Quetelet, who sought to apply the error-based statistical calculations in the field of celestial physics to the social sphere. Quetelet was ultimately struck by the predictability of man: not only did the numbers of births and deaths remain constant year to year, but also did the number of marriages and suicides. He thus became enchanted with the "homme moyen", the average man, who represented the trajectory of the social body(Porter 1985). Galton also took up Quetelet's ideas on the subject of averages, but instead of focusing on the average, Galton focused on the exceptional. Based on ideas of 19th century scientific and statistical thinking, Galton founded the field of eugenics[2], believing that the human race could be improved through controlled breeding of the more exceptional members of society(Porter 1986). In colonial projects, this expansion of quantitative science manifested as an inclination to count and measure. In *Metrics,* Adams articulates the relationship between this approach to the science of colonial medicine and ideas of morality:

> The creation of these systems of counting in relation to standardized notions of measurement enabled a practical set of tools for colonial rule, working to ensure the smooth transition from mercantilism to direct and indirect systems of colonial governance. Historians of science also note that the metrics were a morally aspirational undertaking: they offered the possibility of shared conversations and shared bases for comparison, for evaluation, for stabilizing the truth around complex assemblages of people, life, and nature, and for creating policies for governing that took ethical questions out of the hands of the priests and colonial rulers and put them into the morally neutral hands of scientifically minded experts(2016:20).

In this way, the transition towards a more secular medical humanitarianism was facilitated by the rise of statistical scientific thought, which all served to stabilize a colonial economy.

[2] I need to stop writing this paper at some point, I will not go into social Darwinism, or the history of race science, though these topics are certainly important in considering this history. Instead, please refer to my classmates' work on the history of biological race in medicine here: https://www.instituteforhealingandjustice.org/

Because Tropical Medicine was practiced in different settings across the globe, over a considerable period of time, there are ofcourse counter examples to this quantitative, statistical, mode of practice. In the 1910's, many tropical medicine practitioners recognized the role of social factors, such as poverty, on health (Packard 2016). In 1915, US physician William Crawford Gorgas, who ran the yellow fever eradication campaign in Panama, gave a speech to the health officers of NY state:

> It's is a health officer's duty to urge forward those measures in his community that will control individual diseases ; but my experience has taught me it is still more his duty to take that broader view of life that gets to the root of bad hygiene, and to do what he can to elevate the general social conditions of his community. This, my experience has taught me, can be best achieved by increasing wages(Packard 2016:25)

Gorgas's statement to this assembly evidences the acknowledgement of the social aspects of medicine during this colonial period. Earlier works by Rudolph Virchow famously acknowledged social causes of illness during this colonial era as well. A tension between quantitative positivist practice of medicine, and a more socially minded approach to medicine stretches across the 20th into the 21st century. This tension will be further explored in later sections, but it is worth noting that tropical medicine, international health, and global health , have all fluctuated between holistic socially minded approaches to health and quantitative, disease specific mindsets.

In the history of tropical medicine there is ample evidence of "scientifically minded experts" wielding the power of statistics and the justification of humanitarianism to rationalize colonial practices. Yet neither beneficent intensions nor epidemiologic improvements necessarily mitigate the suffering inflicted by these practices. In *Medicine and Colonialism*, Franz Fanon illustrates the extent of statistics and tropical medicine as tools of colonial power. In times of peace, Fanon reveals European doctors in mid twentieth century colonial Algeria to not merely be healers, but also to be colonizers, settlers, and symbols of domination and oppression: "Statistics on sanitary improvement are not interpreted by the native as progress in the fight against illness in general, but as fresh proof of the extension of the occupier's hold on the country"(1965:122). Fanon highlights the double bind of Algerians who, in order to get care, had to submit to being subjected to the violence of colonial rule and colonial assumptions about the natives.

Fanon also focuses on how the political economy of colonialism shaped interpersonal experiences with medicine at the doctor-patient level. He describes every interaction between the Algerian and colonial doctor, who was also often a land owner, playing out as a confrontation, which is embodied in the stiffness and reticence of the patient:

> The doctor rather quickly gave up hope of obtaining information from the colonized patient and fell back on the clinical examination, thinking that the body would be more eloquent. But the body proved to be equally rigid. The muscles were contracted. There was no relaxing. Here was the entire man, here was the colonized, facing both a technician and a colonizer(Fanon 1965:126)

The clinical encounter between white settler physician and black patient cannot be separated from the subjugation, cannot be depoliticized, forever resulting in a compromised quality of medical practice.

In reading Fanon's work, one might ask, why then, would the colonized person subject herself to the colonial doctor at all?

> Under these conditions, colonial domination distorts the very relations that the colonized maintains with his own culture. In a great number of cases the practice of tradition is a disturbed practice, the colonized being unable to reject completely the modern discoveries and the arsenal of weapons against diseases possessed by the hospitals, the ambulances, the nurses(Fanon 1965:130).

This is the fundamental conundrum of colonial medicine. While one can recognize instances in which medicine serves as an insidious form of control, it cannot be denied that some of the work of western medicine is desirable. Saving lives, wielding the "arsenal of weapons against disease" is hard to discount as a positive thing. In this way, the colonized, are—at least partially—won over in supporting the colonial agenda of tropical medicine.

Thus far, I have discussed tropical medicine as a tool of colonial empire building. In this era, disparate practices occurred across colonized lands around the globe. However, a few cross-cutting themes—with various exceptions—characterized tropical medicine. Economic extraction of both resources and labor was a key motivation in imperial/colonial projects, and medicine played a direct role in making this possible. The practice of medicine and public health sought to retrain and discipline colonized subjects. Moral arguments, religious motivation, and emerging humanitarian rhetoric were both motivating and justifying forces in the practice of tropical medicine. Statistical analysis of health data was key to the operation of these projects. Finally, the complex double bind of the colonized person in their relationship to western medicine must be acknowledged. Though tropical medicine has evolved in many ways in the subsequent eras of international and global health , these themes of economic extraction, retraining, humanitarianism, quantitative analysis, and a double bind of the colonized persist throughout these periods. I have demonstrated above that the practice of tropical medicine could not be disentangled from the brutality of colonialism. Moving forward we must ask ourselves, how does the practice of Global health relate to this history? In what ways do these elements of colonial medicine persist today?

b. International Health

In this section, I will discuss the chronological transitions from the era of tropical or colonial medicine of the late 19th and early 20th centuries, to the era of international health of the latter half of the 20th century. First, I will discuss the social and economic circumstances that laid the foundations of international health, establishing neoliberalism as the underlying ideology defining this historic block.

We can understand the World Wars as a period of crisis that shook the foundations of the twentieth century, marking the beginning of the disintegration of the colonial period. As colonial economies began to transition, the nationalism accompanying the cold war set in. To understand the transition of these colonial economies into the cold war context, the concept of neoliberalism is useful. Wendy Brown characterizes neoliberalism as a rationality:

> Neoliberal rationality, while foregrounding the market, is not or even primarily focused on the economy, rather it involves extending and disseminating market values to all

> institutions and social action even as the market itself remains a distinctive player(Keshavjee 2014:90).

Based on Wendy Brown's understanding of neoliberalism, we can think of this system as not only economic, but social and ideological as well. In the second half of the twentieth century, the influences of neoliberalism shaped the increasingly far reaching American approach in international health.

Brown, Cueto, and Fee describe the evolution from tropical medicine to international health in *The World Health Organization and the Transition from "International" to "Global" Public Health*. The authors describe the 1948 formation of the World Health Organization as the beginning of the era of international health, marked by vertical disease eradication strategies and moving away from the previous title of tropical medicine. The authors point out that early disease control projects of the WHO in the1950's were clearly manipulated by the political and economic motives of member states, evidencing the rise of neoliberalism as a response to communism:

> The United States and its allies believed that global malaria eradication would usher in economic growth and create overseas markets for US technology and manufactured goods. It would build support for local governments and their US supporters and help win "hearts and minds" in the battle against communism (Brown, Cueto, and Fee 2006:65).

From its inception, the field of international health was predicated on the political agenda of protecting and spreading a capitalist economic system. The malaria eradication campaign simultaneously sought to protect globalized economic interests by creating healthy potential consumers, and to create a sense of civic responsibility and loyalty to US aligned powers in response to communism.

International health programs in the 1960s indeed sought to spread market values as well as solutions to ill health. In his 1961 speech, given at the founding of USAID —a US organization that continues to be large player in modern global health —John F. Kennedy explicitly declared the objective of spreading an economic philosophy:

> Its [US foreign aid's] fundamental task is to help make a historical demonstration that in the twentieth century, as in the nineteenth, in the southern half of the globe as in the north—economic growth and political democracy develop hand in hand(Keshavjee 2014:102).

The strongest boost for neoliberalism came in Thatcher/ Regan era of 1980s. Regan founded the National endowment for democracy (NED,) a nonprofit organization whose purpose it is to supply funds to institutions for the purpose of promoting democracy abroad. In the 1980s and 1990s, NGOs funded by the NED, as well as private donations, began to play an increasing large role in international health. In the span of four years, NGO funding rose from $2.8 billion to $5.7 billion USD (Keshavjee 2014). Physician anthropologist Salmaan Keshavejee argues that NGOs became a "transplanting mechanism for neoliberal ideology" in that NGOs are accountable not to the people they serve, but the interests of their funders (Salman Keshavjee 2014, 106).

In the previous section, I discussed the deeply ambiguous nature of the relationship between colonial subject and colonizer. In the struggle for independence and subsequent phase of nascent independence, this relationship evolved, though these ambiguities remained, arguably

deepening. Frantz Fanon describes medicine as a tool in the Algerian Revolution for independence. In times of revolution, European doctors became informants, with holders of life-saving vaccines, administrators of truth serum and electric shock on native bodies(Fanon 1965). In these ways, European doctors violently participated in perpetuating colonial rule. Yet, on the other side of the struggle, Algerians who had been trained in the science of the colonizer suddenly were of incalculable value. They provided otherwise inaccessible care to the Algerian rebels, as a part of the revolution:

> The Algerian doctor, the native doctor, who was looked upon before the national combat as an ambassador of the occupier, was reintegrated into the group. Sleeping on the ground with the men and women of the mechtas, living the drama of the people, the Algerian doctor became a part of the Algerian body. There was no longer the reticence, so constant during the period of unchallenged oppression. He was no longer "the" doctor, but "our" doctor, "our" technician (Fanon 1965).

In these examples, a doctor-patient interaction within a colonial medical system is a recreation of the larger power dynamics of subjugation. However, revolutionary native doctors were able to wield western a medicine in service of the people.

Despite hard won independence, economic systems of many former colonies remained intertwined with their former colonizers. As described above, the US and European nations[3] created neoliberal economic policies with significant implications for many former colonies. On the other hand, many nations in the 'global south' attempted to create economic policies to protect themselves from exploitation. Following the Algerian example, we can see that formerly colonized nations struggled against a global power imbalance that stifled the ability to make economic policy:

> […]This is also shown by the examples of many African countries, which, after independence, imposed visa regimes for citizens of former colonial powers and other foreigners. For instance, after independence in 1962, the left-wing factions in the post-revolutionary, socialist Algerian government tried—but ultimately failed—to impose an emigration ban to France because they saw emigration as a continuation of the colonial exploitation of labor and as detrimental to the long-term interest of workers. Although pragmatist factions—who saw temporary emigration as a way to relieve unemployment, generate remittances, and develop workers' skills abroad— eventually gained the upper hand, the government only accepted this point of view grudgingly (Czaika, de Haas, and Villares-Varela 2018:595).

This ambiguous relationship between France and Algeria presents only one manifestation of the complexity of economic and immigration policy decision between "global south and north".

This era also produced new mechanisms of assessing population health. The QALY, or quality adjusted life year, was invented by two health economists in 1956 and began to play a major role in the practice and evaluation of international health projects, again reinforcing an economic rationality for international health projects(Adams 2016). This new measure captures

[3] I realize that I am omitting many Asian and Middle Eastern nations from this narrative. This is a dangerous simplification, as south Asian, east Asian, and middle eastern nations wield significant economic influence in modern Africa—but I just have to cut off my paper 1 somewhere!

both the quantitative, statistical drive to establish quantifiable metrics for all aspects of life, but also the economic rationality of this period.

Ideals of humanitarianism also evolved dramatically after the world wars, and continued to play a role in international health, though in a more secular fashion than before. In the wake of second world war, the 1946 WHO constitution was the first international instrument to discuss "the right to health"(WHO | Human Rights n.d.). The 1948 establishment of the Declaration of Human Rights further enshrined these ideas. This declaration provided a secular framework for moral language around humanitarianism, affirming the "inherent dignity of all" including members of the human family (Adams 2016). This new understanding of human rights coincided with a reimagining of the global landscape, shifting away from the language of colonialism:

> In 1952, a French economist named Alfred Sauvy introduced the term Third World to describe this new, largely post-colonial terrain […] Both American and soviet ideology focused on the betterment of humanity, and each sought control primarily through forms of aid and improvement rather than direct domination and administration. Discourses of development moved directly into the political spotlight, and new institutions, bureaucracies, and armies of experts maneuvered to spread rival gospels of modernization(Redfield 2013:51).

In this reconfiguration, humanitarian ideals merged with political ideologies, and in many ways, medical intervention remained a tool of empire.

Forged in turbulent post war years, this era of international health can be characterized by neoliberal economics, epidemiologic innovation, emerging human rights rhetoric, and the struggle for independence of many former colonial holdings, resulting in a complex relationship to Western nations. Many of the themes seen in the era of colonial medicine evolve to play a prominent role in this era as well. Here, we see how the legacy of colonial ideologies shaped the subsequent revolutionary era; this legacy manifests as both new forms of resistance, and as new mechanisms of extraction from, and control of, the global south.

C. Global health

In this section, I will discuss the transition from the era of international health of the mid 20th century, to the current era of global health emerging in the late 20th century until today. I will discuss the current state of the field of global health as it relates to the themes discussed in the previous two sections.

Emerging at the turn of the 21st century, global health aspires to be a distinct enterprise from that of tropical medicine and international health by striving for more equitable partnerships. After the first meeting Consortium of Universities for Global health in 2008, the executive board members, led by Jeffery Koplan, published *Towards a Common Definition of Global health* . Here the authors express this desire to create a new, more equitable system.

> The preference for use of the term global health where international health might previously have been used runs parallel to a shift in philosophy and attitude that emphasizes the mutuality of real partnership, a pooling of experience and knowledge, and

> a two-way flow between developed and developing countries. (Brown, Cueto, and Fee 2006, 65).

Despite the goals of the newly imagined field of global health , the economic trends from the period of international health persist in the period of global health , making aspirations or partnership difficult.

The WHO began to lose its purchase and influence as the World Bank rose in prominence in the 1980s and 1990s, and focus in international health shifted to privatization of healthcare systems (Lakoff 2010). The World Bank enforced structural adjustments on low-income-countries' economies, which cut government expenditures, ultimately resulting in marginalization of the state and increased space for NGO service delivery in the global south. In a 1987 decision, later referred to as the "Bamako Initiative", leaders from UNICEF, the IMF and African ministers of health agreed—against the wishes of the WHO—to a new model of health service delivery that shifted the cost of care from cash strapped governments by requiring patients to subsidize the cost of their own care, supplemented by the good will of NGO donations (Keshavjee, Salman 2014:98). In his book *Blind Spot*, Salmaan Keshevjee argues that NGOs are the mechanism through which neoliberalism *infiltrated* global health . While Keshavjee's analysis of the impacts of the Bamako Initiative and role of NGO's in spreading Neoliberal ideology is brilliantly argued, suggesting that neoliberalism *infiltrated* global health may be misleading. As evidenced above, neoliberalism has been a driving force in international health since 1948, and continued to be a core feature of global health programs into the 21st century.

In conversation with the neoliberal trends in global health in this era, the role of quantitative analysis evolved from the basic counting and statistics that defined the era of tropical medicine, and even beyond that of the QALY. The era of global health is the era of big data and the randomized control trial. In this context, Adams argues that data in the era of global health has become a market commodity in itself:

> The marketing of toolkits and patentable data system programs for running algorithms and managing throughput of large amounts of data has become a new target of opportunity for all of us to do our research, and to potentially profit from it at the same time. The metrics of global health are not simply instruments for the production of evidence; they are profitable products themselves (Adams 2016:37).

In this way, research in the era of Global health is often conducted by large US and European based NGOs, and has become thoroughly integrated with market ideologies. It is in this context that the goal of the field of global health to build "genuine partnership" must be examined.

In addition to shifts in global health research and economic structures, humanitarian ideologies also continued to evolve in the final decades of the 20th century, creating what Didier Fassin describes as "A new moral economy centered on humanitarian reason" (Fassin 2012:6). Fassin cites several factors in the solidification of this humanitarian reason in the 1990s: the fall of the Berlin Wall making the neoliberal creed appear to be the only "viable ideology", the United States' employment of moral sentiment in a doctrine of interventionism sanctioned as the "responsibility to protect", and the role of private foundations such as the Gates Foundation redrawing political maps (Fassin 2012:14–15). In this context, the relationship between domination and assistance becomes blurred and obscured by language of equality and solidarity. Fassin's antihumanitarian perspective highlights the impact of this tension on those in the global

south: "Those at the receiving end of humanitarian attention know quite well that they are expected to show the humility of the beholden rather than express demands for rights"(Fassin 2012:3). This lopsided relationship between delivery and recipient of medical intervention textures the practices of global health.

As in the era of international health, global health is plagued by large scale power imbalances, creating high levels of complexity in economic and immigration policy decision between "global south and north". The contemporary 'brain drain' of medical practitioners and researchers from South to North can be understood in relation to this historic extraction of human capital from the global south (Yeboah 2018). This extraction of human capital has created, and continues to create deficits in health systems across the Global South.

The Global health research agenda is driven by funders—such as the U.S. NIH, the Bill & Melinda Gates Foundation, the Wellcome Trust—and major global health agencies—including the WHO, the World Bank, USAID, the Global Fund, the CDC, and universities—each with their own specific interests and agendas (Birn 2014; Pai 2019). These processes lead to inequities in staffing and equipment, research and interventions that fail to attend to local specificities, and geopolitical systems that systematically maintain such inequities in health capacity (Gautier et al., 2018). If the use of the term global health, intended to be indicative of a new "mutuality of real partnership, a pooling of experience and knowledge, and a two-way flow between developed and developing countries", it is then implied that partner institutions must have the capacity to produce knowledge and research to be exchanged in bidirectional information sharing(Koplan et al. 2009:1994). Yet African scientists frequently function as specimen collectors and providers of materials, but more rarely participate in research design, dissemination, or utilization. Iruka Okeke analyzes this skill gap within the world of genomic science. Okeke examined the authorship contributions to all papers published as multi-country genomic studies including at least one African author, from 2000 to 2015:

> All of the papers featured bacterial species that produce a high burden of disease in Africa and/or cause outbreaks. [...] While materials provision was a category that featured significantly in all world regions, only Africa made very little contribution to the other categories. On a country level, my analysis revealed that the materials provision category was the *only* one to which African authors other than those based in South Africa contributed (Okeke 2016:465)

Okeke's analysis powerfully demonstrates the extent of the inequality occurring in transnational research partnerships. Furthermore, only 19% of global health publications include authors from Low and Middle Income Countries (Zicker, Fonseca, and Albuquerque 2019). Okeke is original in using the concept a "little brother effect" to describe the current state of global health research. This effect describes a well-meaning partner, the "older brother", who shares credit with the other partner, the "little brother", who is viewed in need of guidance, and is therefore required to learn by example (Okeke 2016:461). This relationship becomes problematic when the little brother is constantly cast as the beneficiary in the relationship, always relegated specific tasks, and is never permitted to outgrow the title of "little". Clearly, this model of capacity building perpetuates—however unintentionally—an uneven, paternal, rather than fraternal, relationship.

In addition to problematic paternalistic implications, confining African researchers to the tasks of data collection also leads to a lack of investment and ownership in these partnerships. In

Clare Wendland's *Heart for the Work,* an interview with a Malawian medical student reveals his attitude towards research collaborations with NGOs:

> Maybe we need to own these things. Maybe we should feel they are ours. It's for our benefit and not—right now we just think it's for *them.* Our benefit is just the money. And that's where it ends for us, we don't care (Wendland 2010).

While African institutions cannot hope to match the grant funding available to those in the north at the present moment, African scientists are excluded in the design of much of the research conducted in Africa, consigning them to this supporting role. The results of these global health research projects are published in prestigious international journals, which attract further grant funding back to the northern scientists. It is then the transnational body of knowledge that benefits and global guidelines that are established as a result of such projects. Problematically, when local scientists and physicians have no ownership over such projects, the impacts of such studies are rarely felt at the local level from which the specimens were collected. While global health partnerships may strive for mutuality, economic inequality and the pervasive little brother effect prevents this from becoming a reality.

Geissler's *Public Secretes* is extremely useful in thinking about the inequalities in typical research paradigm in Global health . His thesis argues:

> […]As a countercurrent to the scientific project of making the unknown known—rendering a dangerous landscape of disease legible and navigable—certain facts about the world, including vital inequalities, are here "unknown" or, rather, handled— in Michael Taussig's (1999) terms—as "public secrets" (Geissler 2013:14).

Geissler references an anthropological tradition of studying "nonknowledge", and the finding that nonknowledge is intentionally created, serving distinct purposes. Geissler acknowledges that African science has always involved working across material difference, which has been addressed in different ways: imperial reconnaissance justified by scientific racism; colonial welfare by paternalism; socialist internationalism and by solidarity; development aid by charity. Today, scientific collaborations are rationalized as *partnerships* based on freedom and emphasizing autonomy of the involved entities. However material inequities form a striking contrast not only between researcher and subject, but also between research staff, local and foreign scientists, and institutions. These disparities are not openly discussed, but certainly play into mutual perceptions. These topics are uncomfortable to breech, so instead:

> […]conversations about "colonialism" among local staff at times substitute open debates about contemporary inequalities and index the sensitivity of these relations, as colonial has negative connotations for everyone involved in this collaboration (Geissler 2013:25).

Geissler concludes that ultimately, unknowing serves some productive functions, allowing scientists from different backgrounds to work together. However, in this state of unknowing, these injustices are caste as beyond the scope of scientists or as being simply unchangeable.

Global health rhetoric describes partnerships and bilateral flows of ideas and personnel. In this section, I have demonstrated that the structure of global health , inherited from international health and tropical medicine institutions, does not predispose itself to this shift

toward equity. Careful scrutiny of the underlying economic motives, patterns of immigration and authorship, premises of charity-based aid, and the questioned left unanswered by randomized control trails, reveals that true equity and partnership in this field would require drastic structural changes. Yet, these features are masked as "public secrets" which make these structures of oppression taboo topics of discussion in global health partnerships.

III. Social Medicine

The defining themes discussed above—quantitative statistics and biomedicine, neoliberal economic principles, humanitarianism, pubic secrets—are all features of global health, and have evolved over (at least) two centuries. However, these are not the only actors and ideas that have played a role in the field of medicine and global health . Social Medicine has had a rich international history, playing starring roles in medical practice and governance at different times and geographic locations. In this section, I will define Social Medicine, discuss its origins and international nature, and elucidate the relationship between Social Medicine and global health. I will argue that Social Medicine presents an alternative to many of the inequitable practices of global health described above. I will also detail the reasons why this model is distinct from current mainstream US practice of global health , and provide other examples of medical practice that has embraced these principles.

a. What is Social Medicine

Rudolph Virchow, the 19th century German physician and founder of cellular pathology, is often cited as the father of Social Medicine (Porter 2006). His 1848 *Report on the Typhus Epidemic in Upper Silesia* included much of the language and principles that form the basis of Social Medicine as it is understood today. He applied ideas on the social causes of disease which he derived from French and English Sources to conditions he observed in Silesia :

> This population had no idea that the mental and material impoverishment to which it had been allowed to sink, were largely the cause of its hunger and disease, and that the adverse climatic conditions which contributed to the failure of its crops and the sickness of its bodies, would not have caused such terrible ravage it had been free, educated and well to do (Virchow 2006:2102).

In this excerpt, Virchow articulates the main tenant of Social Medicine as it is widely understood today: that the root of disease is often inequitable social circumstances. One hundred seventy one years later, the UNC Chapel Hill Department of Social Medicine echoes the same ideas, defining Social Medicine as "a focus on the social conditions and characteristics of patients and populations; the social dimensions of illness; the ethical and social contests of medical care, institutes, and professions; and resource allocation and health care policy"(Oberlander et al. 2019). It is worth noting that this 2019 definition has dropped some of the more paternalistic sentiments expressed by Virchow, such as "this population has no idea…".

In addition to the works of Virchow, the field of Social Medicine draws heavily from other 19th century thinkers, notably, Marx and Engels. Engels's earlier 1845 work describes the mechanism of "social murder" in which:

> [...] that it [society in England] has placed the workers under conditions in which they can neither retain health nor live long; that is undermines the vital force of these workers gradually, little by little, and so hurries them to their grave before their time (Engles 1845:107).

Engels frames sexual indulgence and drunkenness as a product of the labor conditions of the working class, describes a lack of access to "skilled physicians" and exposure to dangerous quack medicine as a product of poverty, and discusses the lack of education among the working class as the active mechanism by which bourgeois maintain their status over the poor within the capitalist structure of the economy.

Principles of Social Medicine eventually incorporated a Marxist rationality. In his 1867 work *Capital,* Marx put forth the concept of primitive accumulation as the seizure of land, and resources for capitalism. In this condition, capitalism functions to claim the labor of the dispossessed:

> The process therefore which creates the capital-relation can be nothing other than the process which divorces the worker from the ownership of the conditions of his own labor; it is a process with operates two transformations, whereby the social means of subsistence and production are turned into capital and the immediate producers are turned into wage laborers (Marx 1893:87)

The creation of these two groups of people, the owner of the means of production and the free worker, presents a framework for understanding capitalist systems and its potential for control over workers moving forwards.

Social Medicine rose and fell in popularity in the ensuing decades. In *How did Social Medicine evolve, and Where is it Heading,* Porter describes the rise in popularity of Social Medicine ideas in the interwar period. European universities, as well as American institutions such as Yale,, established departments and institutes according to the principles of Social Medicine during this time:

> At Yale University, the, Institute of Human Relations was created in 1931 under the direction of Milton Winternitz, the dean of the Medical School. The aim of the institute was to integrate medicine into research on social inequalities, which would inform the training of physicians to become, in Winternitz's words, "clinical sociologists," (Porter 2006:1667).

European students of Virchow, such as Renee Sand, established Social Medicine departments in Peru, Brazil, and Chile in the 1920s and 1930s. The League of Nations also prioritized Social Medicine during this period. After the Second World War, students of Social Medicine in Latin America, including physician and Chilean president Salvador Allende, promoted Social Medicine, profoundly impacting Cuban, Chilean, Nicaraguan revolutionary governments' reforms of medical and educational infrastructure (Porter 2006). In contrast, the climate of cold war America led the

US field of public health to shift away from ideas of Social Medicine towards a focus on "individual behavior change" (Porter 2006:1669).

Most Latin American accounts of Social Medicine's history cite European origins, indicating ideas spreading from the global north to the global south, mirroring other north-south knowledge flows from this colonial period(Waitzkin et al. 2001). However, Howard Waitzkin pushes back on the idea that Social Medicine originated from European thinkers whose ideas were then exported to Latin America. While some of the roots of LASM can be traced back to Europe, others, such as the legacy of Che Guevara, are entirely Latin American in origin:

> One might expect that Guevara's views developed partly from knowledge about Allende, Justo, and others who preceded him, but apparently this was not the case. Sources close to Guevara, including an uncle who served as a role model in medicine, claimed that throughout medical training and career Guevara remained unexposed to earlier works in Latin American Social Medicine and that he developed his analysis linking health outcomes with social conditions largely through experiences during his motorcycle trip(Waitzkin et al. 2001:1595)

All of these traditions of Social Medicine share the idea of improving health through a revolutionary agenda of improved conditions for the working class, rather than the US public health model of increasing health to increase the productivity of the work force.

Social Medicine continued to develop as a field in Latin America, yet these advancements were largely ignored in the practice of international medicine and global health by northern actors. Howard Waitzkin proposes an explanation for this phenomenon:

> Although Social Medicine has become a widely respected field of research, teaching, and clinical practice in Latin America, the accomplishments of this field remain little known in the English Speaking world. This gap in knowledge derives partly from the fact that important publications remain untranslated from Spanish or Portuguese into English. In addition, the lack of impact reflects a frequently erroneous assumption that the intellectual and scientific productivity of the Third World manifests a less rigorous and relevant approach to the important questions of our age (Waitzkin et al. 2001:1592)

LASM remains a vibrant academic field, even if Northern scholars of health and social theory do not acknowledge these contributions. While LASM groups historically focused on analyzing the impact of imperialism, extraction of raw materials, and exploitation of labor forces in south and Central America, today, many of these groups direct their attention to international macroeconomic policies. These studies have illustrated the harmful effects of the deterioration of the public sector "safety net" services, and have shown evidence disproving the assumption that market oriented practices improve conditions for the poor (Waitzkin et al. 2001:1594). Specific examples include Asa Cristina Laurel's evaluation of the impact of Social Medicine policies implemented in Mexico City, and Jaime Brail's advocacy for improved international visibility for 'collective health" practices in Latin America (Breilh 2008; Laurell 2003).

It would be an omission to insinuate that the ideas of Social Medicine never penetrated tropical medicine, international health, or global health policy. As mentioned above, in the period prior to World War I, leading American physicians, including US army general William Gorgas, who lead American yellow fever and malaria eradication efforts in Havana and Panama,

articulated the need to address poverty and underlying social causes of disease(Packard 2016). US philanthropic institutions such as the Rockefeller Foundation (RF), founded in 1913, played a large role in providing health and social services. According to Anne Emmanuel Birn, philanthropic players filled a gap in US government policy:

> Domestically in this period, philanthropy played an ambiguous role in struggles around government-guaranteed social protections by promoting "voluntary" efforts in place of citizen entitlements; since then, compared to most European and many Latin American countries, the private and philanthropic sectors in the United States have played a large part in the provision of social services—both curbing the size and scope of the U.S. welfare state and giving private interests undemocratic purview over social welfare (Birn 2014:3).

The international efforts of the RF sought to generate good will and promised social advancement instead of colonial repression. In the later international health era, US policy did at times focus on social improvements for newly independent nations, as an element of cold war foreign policy:

> Many countries also learned to play the rivals against one another, sometimes stimulating improved social conditions, other times exacerbating unequal power and control over resources72-74. Under Indira Gandhi, for example, India received as much or more aid from Washington as from Moscow, with both superpowers eager to accede to New Delhi's requests for foreign developmentassistance75(Birn 2014:8).

By the 1970s the WHO adopted an intersectional approach to health improvements:

> But in the 1970s, the WHO's disease-focused, donor-driven approach began to be challenged both by member countries—especially G-77 countries, which were seeking cooperative efforts that addressed health in an intersectoral fashion—and from within headquarters, under the visionary leadership of its Danish Director-General Halfdan Mahler (first elected in 1973, holding this office until 1988). The primary health care movement, as enshrined in the seminal 1978 WHO UNICEF Conference and Declaration of Alma-Ata82 and WHO's accompanying "Health for All" policy, called for health to be addressed as a fundamental human right—through integrated social and public health measures that recognize the economic, political, and social context of health, rather than through top down, techno-biological campaigns83,84 (Birn 2014:8).

However, this resurrection of Social Medicine ideas in the 1970s created bitter divisions amongst international health institutions and actors, and the RF reemerged to promote "primary selective health care —a reduced, technical (and highly contested) counterpart to Alma-Ata's broad social justice agenda for primary health care,"(Birn 2014:8). However, neoliberal political ideology was on the rise in the US, and after his 1980 election, Regan froze the US contributions to the WHO as a reprimand for its essential drug program(Birn 2014:10). In the 21st century, the Gates Foundation came to occupy the center stage of global health actors, and unlike the RF foundation, largely ignored leftist alternatives in favor a political-scientific-business alliance approach to health policy(Birn 2014:11).

Social Medicine presents itself as an alternative approach to many of the tactics pervasive in Global health, and particularly those global health policies practiced by US institutions. This field stems from a rich international history and remains a vibrant area of practice in many parts of the world today. This field remains somewhat invisible in the US today due to historical and modern neoliberal influences on health care policy and practice; language hierarchies; and an underlying assumption of inferiority with respect to research and theory from the global south, rooted in racialized capitalism.

b. Social Medicine and Global health

Global health as it is practiced today, by the US and some other countries in the 'global north,' does not often follow the principles laid out above. As I have demonstrated in the preceding section, there have been moments historically where this was not the case, and there are examples of other movements practicing similar principles with or without the title of Social Medicine.

Social Medicine can also be understood outside of the domain of academia, as a grassroots application of medical principles to meet the immediate needs of those who's suffering stems from social injustices. This tradition is perhaps more closely aligned with the Social Medicine tradition tied with Che Guevara. As discussed previously, Fanon, a physician and activist, described ways of Algerian health practitioners trained in western medicine played an integral role in the revolution, given the need for speed in addressing wounds during this violent period: "There was no longer the reticence, so constant during the period of unchallenged oppression. He was no longer "the" doctor, but "our" doctor, "our" technician," (Fanon 1965). A parallel can be drawn with the transformative narrative put forward by Alondra Nelson in *Body and Soul*. She explores the health related activities of the Black Panther party, which included "social health" free clinics and push back on racialized research. Nelson shows how African American communities have responded to the racial formations and subjugations of the American medical system. Nelson begins her piece by discussing ramifications of the historical abuse experienced by African Americans in the American medical system: " some black are reticent about or even resistant to seeing necessary healthcare or participating in research studies"(Nelson 2011:34). She eventually moves to the conclusion that

> [...] the Panthers' own foray into providing healthcare and health advocacy reveals that the group, while skeptical of mainstream medicine, was not antimedicine. The activists appreciated that biomedicine was necessary and could be put to useful purposes if it was loosed from market imperatives and carrries out by trusted experts(Nelson 2011:20).

Both Fanon and Nelson illustrate how medicine can both perpetuate domination and racial subjugation, yet also become a tool of revolution and liberation. The key to this transformation is the practice of medicine *in tune with the social needs* of the formerly dominated. I argue that the field of Social Medicine has mixed roots, both in colonial and revolutionary practice, and that this legacy must be continually grappled with as the field moves forward. The questions of *who* can practice Social Medicine, and *how* it will vary across context remains an area of exploration.

Recently, some academics have called for the integration of Social Medicine principles into the new field of global health as it develops. Holmes, Stonington and Green argue that as the field of global health struggles to establish itself as a new discipline, the long legacy of Social

Medicine would provide a necessary framework (2014). The authors suggest specific characteristics and methodologies for this incorporation:

> As such, Social Medicine can be defined by four primary characteristics: multidisciplinary methodologies, roots in social theory, critically interpretive stance and proclivity to engage with social aspects of clinical and scientific problems. Crucial to all of this work is a commitment to rigorous empirical research in the social world: ethnographic engagement, historical analysis, sociological and social epidemiological analyses and contextual ethics(Holmes, Greene, and Stonington 2014:477).

The request to locate global health within Social Medicine, should not be taken as a directive to merely include a limited reference to "social determinants of health" in existing frameworks. Adams et al. argue that in order to be located in Social Medicine, global health needs to "to resist the use of facile notions of the social, but also facile methods of apprehending the social"(Adams et al. 2019). This would mean grappling with the ways in which the social is currently understood in social science: engaging with the implications of the para-state for health care delivery; understanding the role of philanthrocapitalism in global health policy; or reconceptualizing the geopolitics of a "global north" and "global south" (Adams et al. 2019:3). However, Adams et al. point out that many actors are practicing principles of Social Medicine without recognizing it as such:

> One can find scholars and activists relying on what are clearly identifiable Social Medicine genealogies across a wide array of social scientific and humanities disciplines (from history to global surgery) and yet they do not claim to be doing Social Medicine. Indeed, rather than being seen as foundational to emerging fields that offer approaches to the 'social', social epidemiology, social psychology, population health, health economics, etc. (Bell,2018), these fields often ignore the fact that they are actually doing Social Medicine at all(Adams et al. 2019:2).

Ultimately, incorporating Social Medicine (in name or not) into global health will require a deep engagement with the diverse and evolving ways in which 'the social' is currently understood across disciplines and by local communities.

These calls to action with regard to global health have led to some attention to this nexus in the US. The NEJM's recent Social Medicine series published several articles related to global health (Stonington et al. 2018). Despite this example, which remains constrained within the restrictive requirements of a biomedical journal, the vast majority of global health literature produced in the US does not adopt this lens. In this section, I have discussed the origins of Social Medicine, and the possibilities it presents for a form of medicine attuned and equipped to address a complex, dynamic social world. However, Social Medicine is an elusive goal for global health: the questions of who can practice Social Medicine, and what that looks across diverse contexts remain unclear. Furthermore, a deep engagement with social theory and methodologies would require a re-imagination of what is currently understood as global health , rather than a mere addition of another variable or increased use of surveys. Meaningful incorporation of Social Medicine into global health remains an area for growth. In the realm of global health and medical education, this gap is particularly pronounced.

IV. Intersections with Medical Education

a. Global health and Medical Education

The increasing interest in global health in the 21st century has led to changes in higher education, which largely originate in North American universities and impact institutions in the global south. The increasing interest in global health has led to an ever-larger demand for short-term international experiences for undergraduate and medical students. There is a dearth of research about these short-term international programs in the current literature. In evaluating the shift from previous iterations of international health to modern global health , the role of these short-term programs, particularly on institutions and peoples as to host global health visitors remains unclear.

In The Dramatic Expansion of University Engagement in Global health , Merson and Page identify three root causes for the growth of global health in American universities:

> 1. Significant changes in American higher education that places greater emphasis on and resources for internationalization, in response to students' greater awareness of the world starting at an early age and facilitated by the global media.
> 2. Heightened public visibility of the global health agenda, as a matter of U.S. foreign policy, and as part of a larger movement for greater global equity.
> 3. Expansion of resource flows: U.S. government, foundations, corporate and private philanthropy have generated new opportunities for universities, and potential career paths for students (Merson, and Chapman, 2009).

All of these causes reflect changes in American media, politics, and resources. These changes reflect several key characteristics of global health that I have identified earlier including neoliberalism and moral or humanitarian ideologies. The authors do not cite any causes for the expansion of global health programs in the United States related to the needs or interests of institutions or peoples in the global south.

Other authors have noted an imbalance between northern and southern institutions in the use of 'global health ' as the preferred terminology. MacFarlane points out that the shift from tropical or international health to global health may be almost exclusively North American in its geographic academic reach (Macfarlane, Jacobs, and Kaaya 2008). In a search for authors affiliated with 'Global health Institutions,' 87 percent were from North American institutions. Evidently, academic institutions labeling themselves as 'Global health Institutions' are much less widely geographically manifest than 'international health' or 'tropical health' labels. The authors provide a possible explanation for this trend:

> We suggest that the term global health has become a means to brand the global prestige of an academic institution, and to strengthen its capacity to work globally by facilitating disciplines to organize across campuses, providing education that fulfills the expectations of students, offering research opportunities that meet the international interests of faculty, and by accessing new and large sources of funding for global health (Macfarlane, Jacobs, and Kaaya 2008:122).

These purposes for use of the term global health to "brand the global prestige of a university" are markedly juxtaposed to the proclaimed motivation to establish "real partnerships" for the terminological shift put forth by Koplan. This evidence points to the continuity in the hegemonic characteristics of tropical/colonial medicine, international health, and global health .
While the proliferation of global health in northern universities has been a relatively well-researched phenomenon, the impact of this proliferation of global health partnerships on southern institutions remains a black box. In "Gaps in Studies of Global health Education: An Empirical Literature Review", authors also identified this distinct imbalance in the evaluation of education programs. Of the articles written on global health education programs, authors found that, "94.6% were conducted in North American and European countries" and that "No study has been done in African countries as yet,"(Liu et al. 2015) The authors note that this imbalance in the geographic distribution of global health education research is a gap in the literature. In an attempt to address this imbalance, Crump and Sugarman discuss ethical considerations and potential issues and benefits for host institutions in global health partnerships. In addition to the sentiment that formal ethical guidance should be developed, the authors assert that: "collection of systematic data within the context of existing short-term global health experience programs is urgently needed to inform host and sending institutions about the true costs of these programs so that they can be addressed." This imbalance in research is unsettling, but it can be remedied through focusing more research on the subject of academic global health on southern institutions.

Johanna Crane points out the unequal aspects of these north-south partnerships fall into two categories: those that have clear remedies, and those that are inherent in the field of global health. Examples of inequalities that have potential solutions include situations in which northern institutions often set curricula, control lab spaces, undermine local bureaucracies, fail to credit southern scientists in publications, or fail to adequately compensate host institution for hosting students. In nearly all of these examples, it is conceivably possible to achieve a more equal partnership. Crane also points to more deeply rooted issues of unequal partnership:

> …Within academic global health in North America, the availability of patient bodies—lots of them—suffering from high levels of illness (especially infectious disease) and low levels of pharmaceutical, surgical, and other forms of treatment is both an inequality to be redressed and an opportunity to be taken advantage of (2013:148).

That the existence of the field of global health requires ample access to the kinds of suffering it aims to end reveals a deeply conflicted model**.** The strictly biomedical, pharmacological, molecular, and genetic basis of disease and intervention central to global health education in the US, often fail to acknowledge this paradox, or the fundamental causes for the existence of this high burden of disease amongst a treatment naive population (Adams et al. 2019). Ultimately, there is a lack of structural or social framing in current formulations of global health education, as well as a lack of research on the impact of these experiences on Southern students.

b. Domestic Medical Education: The Argument for a Social Medicine Approach

The need for explicit training and framing for medical trainees interacting with vulnerable populations has been studied in the US context. This literature points to many themes likely

applicable to similar programs on the global scale. Ultimately, these works point to a tension between the clinical gaze of biomedicine and the large structural forces which the create health inequalities which students hope to treat in these settings.

Michele Rivkin Fish's ethnographic analysis of a dental-student-run rural outreach clinic raises questions about the effects of medical training in resource poor settings in America. Rivikin-Fish argues that social justice in health care should not be about promoting altruism, but about educating new practitioners about the lives of poor people, the systems that perpetuate poverty, and the structure of health care. Rivkin-Fish claims that, in the context of our commodified health care system, these students learn to free clinic patients as failed consumers who cannot afford dental care, which allows for the acceptance of a different quality of care in the free clinic. As one student put it "You get what you pay for" (Nelson 2011:34). This attitude presented direct risk to the patients, due to a lack of supervision in this setting, student saw this work as "… a chance to seek independence and not have the supervision they have at the dental school clinic. They want to try things out and see what they can do" (Rivkin-Fish 2011:193). Without recognizing the underlying structures—namely the influence of capitalism in American health care—students can find their stereotypes about poverty and poor health reaffirmed. From this ethnographic account, Rivkin-Fish argues that educational outreach programs would be best served not by teaching students to ask, "how can we help these people?" but by teaching them to think "why are conditions this way?" (2011:188). This analysis raises questions about what short-term global health experiences are teaching students, and the additional risk vulnerable patients may experience as a result of the presence of these inexperienced students.

Other studies have further complicated the work of medical students with vulnerable populations, not by pointing to ways in which students overstep their bounds, but by highlighting the tension between the objectification of the medical gaze, and the compassionate act of bearing witness to suffering. The Foucault's term "medical (clinical) gaze" can be understood as denoting the dehumanizing medical separation of the patient's body from the patient's person, or identity(Foucault 1975). Beverly Davenport's ethnography of a student run clinic for the homeless points to challenges that remain when many of the issues Rivkin-Fisch takes issue with are remedied. These students were trained by their coursework and mentors to see circumstances producing poverty and illness for the patients at this clinic. In many ways, Davenport observed students struggling to balance this desire to understand their patients' life and bear witness to suffering, with the demands of medical practice, the confines of the SOAP note, and the conflicting messages that they learned at the clinic in comparison to the rest of their medical school classes (Beverly Ann Davenport 2000). In this case, we see that Foucault's concept of the medical gaze cannot fully explain what occurs as medical students interact with vulnerable populations, particularly when they are given the tools to see the systems that have produced suffering. Further research is required to understand how medical training can successfully impart this structural understanding upon students, and what the long term impact of these experiences, viewed through a structural lens, is on new practitioners: do they continue to work with vulnerable populations, do they experience less burn out, do they practice with greater compassion?

The work of medical students with vulnerable populations domestically points to the need for contextualization of the lives of these patients and an understanding of the systems that contribute to poor health. The works above do not necessarily indicate that students should not interact with these patients, but that without the proper supervision and framing, these interactions put patients at increased risk, and have the potential to reaffirm stereotypes held by

students about their patients. In instances where this framing is provided, the effects on students, and the type of care they provide is mixed, and requires further investigation. In applying these ideas to global health experiences for medical students, one would hope that training programs would contextualize patient care in the historical legacies of tropical and international medicine, neoliberalism, and the specific local systems, and work to understand how this can benefit vulnerable populations.

c. Social Medicine and Structural Competency in Medical Education

Efforts to build this contextualization and systems-level understanding exist in spaces associated with, at the margins of, and tangential to US medical education today. US training programs in Social Medicine, and more recently, "structural competency" attempt to show the "direct and indirect ties between social inequality and ill health"(Adams et al. 2019:2). This trend is mirrored in increasingly central conversations for provider training in principles of Social Medicine, as evidenced by the recent New England Journal of Medicine series on Social Medicine(Stonington et al. 2018).

This trend is decades old, structural competency being the most recent formulation, acting as an increasingly popular conduit for the ideas of Social Medicine in US education. Metzel and Hansen, credited with formulating the concept of structural competency, emphasize how attention to the structure of the medical system itself rather than culture of the patient can illuminate upstream origins in treatment injustice and disparity:

> Approaches that attempt to address issues- such as the misdiagnosis of schizophrenia in black men, perceived diet "noncompliance" in minority populations, or the punishment of "crack mothers- through a heuristic aimed solely at enhancing cross cultural communication between doctors and patients… will overlook the potentially pathologizing impact of structural factors(Metzl and Roberts 2014:681)

Metzel's practical prescriptions suggest teaching structural approaches rather than focusing on culture and individuals, including multidisciplinary alliances.

In *Teaching Structure*, the authors we able to demonstrate that structural training left residents feeling that this had "a positive impact on their clinical practice and relationships with patients"(Neff et al. 2017). Residents also reported a feeling overwhelmed by their nascent understanding of structural impacts on patient health. This emphasizes the idea that a multidisciplinary approach is truly necessary, as physicians alone are not equipped to address structural issues.

Predating, the US based structural competency trend, alternative ideas to pedagogy built upon a theoretical framework of dismantling oppressive structures. Brazilian educator Paulo Freire's 1970 work *Pedagogy of the Oppressed,* moves beyond pondering how to train upper and middle students to think about structure and understand vulnerable populations. Instead, Freire's work is about ensuring that this critical consciousness is brought out in oppressed populations themselves: that education itself should do the work of freedom and liberation for the oppressed.

> A deepened consciousness of their situation leads people to apprehend that situation as an historical reality susceptible of transformation. Resignation gives way to the drive for

> transformation and inquiry, over which [wo]men feel themselves to be in control[...] Problem posing education, as a humanist and liberating praxis posits as fundamental that the people subjected to domination must fight for their emancipation. To that end, it enables teachers and students to become Subjects of the educational process by overcoming authoritarianism and an alienation intellectualism; it also enables people to overcome their false perceptions of reality. The world—no longer something to be described with deceptive words—becomes the object of that transforming action by men and women which results in their humanization(Freire, Bergman Ramos, and Ramos 2014:86).

Freire's ideas about liberatory education focus on raising this structural consciousness for the oppressed. He argues that educating oppressed peoples in very systems, which created their suffering, does not solve the oppression. This practice has the potential to generate even harsher forms of domination, as these marginalized figures attempt to prove themselves in the inherently violent order(Freire, Bergman Ramos, and Ramos 2014). This work pushes us to question not only the nature of global health medical education, but also who the target of that education should be.

The application of these ideas to global health education is a phenomenon that has yet to be researched. The Social Medicine Consortium, a US based NGO with strong ties to Haiti and Uganda seeks to apply these principles to its global health activities. This organization seeks to educate medical providers according to the principles of Social Medicine, structural competency, and following the Freirean tradition. Furthermore, this education is targeted at medical trainees from both the global north and the global south learning together (Westerhaus et al. 2015). This educational approach is the subject of the proposed research project.

V. Geographical Context

a. Mobility and Fluidity

The geographic context for this project is scattered, fluid, and unpredictable. In that way, the project is representative of the larger field of global health, the world of NGO's, and the identities of many of those who occupy this space. The methods for this project will follow the example of Tianna Paschel in her work *Becoming Black Poltical Subjects.* Paschel describes her ethnography and particularly her field site as "nontraditional":

> At times I had to sacrifice local culturally and political specificities for the sake of crafting a more macro narrative and the making of black political subject in two countries [...] I prefer to think of it as a political ethnography in which I chose a substantive, rather than a geographic space as my "field site"(Paschel 2018:245)

In this work, Paschel follows the actors and organizations that are part of a movement, rather ran focusing on a specific place. In my work, I am trying to understand the place of Social Medicine within global health . I will follow the aforementioned organization, The Social Medicine Consortium. This organization has members in 19 countries, with staff located in bases in the US, Haiti, and Uganda, Spain, and Zimbabwe. During the designated period of my ethnography, the organization will have hosted conferences in Chiapas, Mexico; Gulu, Uganda; and Port au

Prince, Haiti. The organization hosts summer training courses twice a year: once in Northern Haiti, and once beginning in Gulu, Uganda and traveling to Rwanda. The organization hosts monthly webinar calls open to the public. A subbranch of the organization, its "Campaign Against Racism" has chapters in 10 countries, and also convenes via monthly phone call. As of March 2020, the consortium has hosted weekly COVID-19 organizing calls. Teams for planning the conferences, campaign, and courses meet virtually on monthly, or sometimes weekly bases. The purpose of this study is to understand the successes and challenges of this approach. Therefore the site of analysis will be at the level of the organization and actors, rather than the localized place.

The concept of international mobility is key to the conceptual framework of this project and to understand the dynamics of global health . Johana Crane uses the theory of "sedentarist metaphysics" to understand the concept of mobility in global health partnerships: "Global health relies upon a very strong notion of bodies in place in which certain kinds of patient bodies are linked to certain kinds of places, and by extension, certain kinds of biomedical learning opportunities," (Crane 2013:148). Crane is referring to the fact that black and brown bodies in the global south are expected to remain in place, allowing mobile northern students to travel and capitalize on the educational opportunities presented by high rates of disease in these populations.

This requirement, of bodies rooted in place, calls into question, how students and faculty of southern host institutions can "do" global health . For southern students and researchers, does global health simply mean staying at home and continuing to practice medicine and conduct biological research as usual, or does global health means traveling abroad to access populations with even higher rates of poverty and disease? Currently, global health for southern students almost never means traveling to the north. Crane points out that laws and regulations largely prevent a south to north flow:

> A representative from the University of Minnesota told me that his attempts to host foreign medical residents were thwarted by the university's teaching hospital, which put up "so many hurdles it's impossible," including forbidding foreign medical students from seeing patients (Crane 2013:158).

In this way, it appears that short-term international learning opportunities are a feature of US academic global health that is exclusive to these students. However, the courses offered by the Social Medicine consortium often promote south-to-south travel (although south to north travel remains elusive).

The unequal mobility of northern versus southern bodies is a theme also explored by Claire Wendland, through the theory of 'moral mapping'(Wendland 2010) Wendland examines the effect of visiting northern 'clinical tourists' on Malawian-host medical students for whom the possibility of practicing medicine in another country is slim. As described by Wendland, this one-way travel creates for Malawian physicians a 'moral imaginary' of medicine 'out there' in the countries from which the clinical tourists come. Wendland focuses on the effect of that moral imaginary on the Malawian physicians' self-perceptions, noting two main responses, the first response being: "A richer and more cosmopolitan world imagined as 'out there' can serve as cruel reminder of one's abjection— or forcible disconnection—from modernity's promises"(Wendland 2012:113). Wendland also documents a second drastically different response: "Some also fashioned there an image of themselves as more flexible and creative, as

more committed and empathetic, and sometimes as better able to see the big picture of health and disease: that is, as practitioners of a better medicine" (Wendland 2012:113). Wendland ultimately emphasizes that these unequal partnerships have significant consequences for "people's picture of the world and their own place in it," (Wendland 2012:118). Wendland qualifies her analysis as preliminary, because this topic arose naturally in many of her interviews and the ethnography was a byproduct of a larger study. Thus, the need for examination of the impacts of global health upon southern host students is an area for further research.

In contrast, medical education in Cuba follows the legacy of Social Medicine, and is marked by different patterns of mobility. Robert Huish's *Where Do Doctor Has Gone Before-Cuba's Place in the Global health Landscape"* details an alternative narrative. Graduates from Cuba's Escuela Latino Americana de Medicine (ELAM) come from diverse international backgrounds, largely in the global south and serve communities internationally. The anticapitalistic approach to public and global health described by Huish provides an interesting counterpart to the larger conversation of mobility in global health .

The dynamics of mobility rights is a complex thing, and I do not want to minimize this topic into a simple north south dualism. Mau et al.(2016) provide insights into the evolution and nature of global migration regimes:

> In their analysis of visa waiver policies of over 150 countries for 1969 and 2010, those researchers found that while, at a global level, visa-free mobility has increased, the inequality in visa waivers has also increased. They argue that, while citizens of wealthy countries, often members of the industrial-country Organization for Economic Cooperation and Development (OECD) have gained mobility rights, those rights for other regions have stagnated or even diminished— in particular for citizens from African countries. They referred to this global bifurcation in mobility rights as the global mobility divide(Czaika, de Haas, and Villares-Varela 2018:590).

Other authors, including Czaika et al. imply that a "bifurcation in mobility rights" is an over simplification: "Instead of a global mobility divide, it is therefore perhaps more ap- propriate to speak of multiple regional mobility divides in an increasingly multi-polar world(Czaika, de Haas, and Villares-Varela 2018:618). Ultimately, caution must be applied in simplistic framing of a bifurcation of mobility rights between an imagined global north and global south, because this erases the nuances of global migration.

However, the practice of restricting freedom of movement along racial lines has been an evolving feature of our increasingly globalized economy, and an important mediator in inequitable disease spread and mortality. This restriction of mobility can be understood as a mechanism of oppression, a tool of white supremacy. In "Chocolate Cities" Hunter and Robinson provide an alternative to traditional attempts of understanding the geography of black bodies claiming "the South is everywhere Black people find themselves" (Hunter and Robinson 2018:159). The authors follow the stories of black public figures including artist Yasiin Bey (Mos Def) and internationalist, sociologist, activist W.E. DuBois. In both instances, the authors demonstrate how the movements of these black (American) bodies are constricted. The authors conclude:

> There is power in movement and restricting the movements of black people is a central feature of anti-black racism globally. From physical confines of slave ship-cargo holds to

> fugitive salve laws to “whites-only” signs to ghettoization and gentrification, keeping black people in a designated place is essential to White supremacy. Black people, chocolate city traveling folk, have none the less pushed and moved and resisted (Choc Cities 171(Hunter and Robinson 2018:171).

Understanding restriction of black mobility as a tool of structural racism, as a key feature of hegemonic mainstream global health practices, helps to highlight the subversive nature of Social Medicine approaches such as that of ELAM to facilitate movement of southern bodies.

The literature on mobility and migration highlights another component of global health practice that perpetuates inequity. When it comes to global health education, this literature encourages us to rethink the structure of global health programs. It pushes us to question who is doing the traveling, and from where. We know that 96% of US medical schools offer international electives to students (Medical Schools Offering International Elective Courses n.d.)How often are students from the ‘south’ traveling to the ‘north’; south to south; what about other regions of the world? This study seeks to pursue this question of mobility, and how a Social Medicine education approach may impact these practices, through the case study of The Social Medicine Consortium.

VI. Conclusion

This literature review has sought to illustrate the historical origins of the inequities within the nascent field of global health . I have south to demonstrate the ways in which economic policy (colonialism and later neoliberalism), quantitative approaches to health sciences (QALY to DALY to RTC), and humanitarian ideologies, though divergent over time, have also in some way or another formed cross-cutting themes throughout three distinct time periods. I have argued that these three eras—tropical medicine, international health, and global health —have seen a relatively continuous hierarchy of power, resources and privilege in which the ‘north’ holds domination over the ‘south’. I have also highlighted historical and present narratives that offer an alternative to this reductionist approach, unified by themes of Social Medicine. I have demonstrated the need for a Social Medicine approach in medical education, and the ways in which this is a complex undertaking, requiring serious engagement with multiple social science methodologies. I have discussed the relationship between global health approaches to medical education and Social Medicine. After a thorough review of the literature, I have concluded that Social Medicine approaches to global health education remains an area of active research, and will form the site of inquiry for this project.

The proposed thesis project will analyze the activities of Social Medicine Consortium, a US based NGO. The proposed method of data collection and analysis is an ethnographic investigation of a substantive rather than geographical site. This means that ethnographic methods will be used to collect data in physical locations such as Uganda, Boston, and Haiti, as well as nonphysical spaces including monthly video chat meetings amongst the organization, email chains, shared articles, and WhatsApp groups. Through this investigation, I will aim to learn: 1) How actors in this organization understand the current state healthcare and global health , and its associated problems 2) How these actors seek to approach these problems and the nature of solutions posed 3) The ways in which these approaches are successful, and the barriers that diminish potential for success. This project seeks to answer the following research questions:

1. How do education and coalition building practices grounded in Social Medicine principles disrupt or reproduce structural inequalities in transnational medical partnerships?
    a. Who takes part in defining Social Medicine, the nature of the educational interventions, and movements built around this concept?
    b. Which aspects of legacies of colonialism, international health, and current global health activities are discussed, and which remain "public secrets" in the context of the Social Medicine activities of the NGO?
2. How does bringing students from North and South together succeed (or not) in its goal of reducing inequalities, sharing insights, and stabilizing or leveling power between the groups in global health medical education?
    a. What forms of knowledge and perspectives are exchanged in the context of this Social Medicine course?
    b. What are the differences between what medical students from Haiti and Uganda learn and medical students from the US learn in the context of this Social Medicine course?
    c. How do distinct cultural perspectives on gender and sexuality inform interactions between students with different backgrounds? how race and racism are understood differently and similarly?
3. How can this Social Medicine framework strengthen responses in global crises, including COVID 19?

By answering these questions, this project seeks to engage with the current trend of global health in medical education by attempting to elucidate the outcomes of a Social Medicine approach.

Part 2: Ethnography of Social Medicine Education

I. Introduction

Social Medicine is a field and set of practices that has offered insights about the cause and cures for social inequality as expressed in and through health and healthcare. For over a century, Social Medicine scholars have proposed that it is the nature of social circumstances, rather than a lack of technology, that produces, perpetuates, and potentially rectifies health inequities (Oberlander et al. 2019). The legacy of Social Medicine flourished in Europe, in Latin America, in South Africa, and has had a resurgence in the US in recent years(Porter 2006). As the relatively new field of global health becomes cemented in the world of health sciences practice, research, and academia, Social Medicine has the potential to guide the field of global health (Holmes, Greene, and Stonington 2014; Adams et al. 2019).

This field of global health is rooted in a history of two centuries of medical transnationalism, including missionary, colonial and international health projects. Racism, ethnocentrism, economic disparity and political hierarchy have created vast inequalities and health disparities across borders. While medical professionals have been conscripted to rectify these health disparities, they have also at times—unwittingly, or not—reinforced them. Missionary physicians strove to save lives in order to save souls and convert (Redfield 2013). Colonial medical practitioners sought to protect colonials' health, but also the well-being of colonized laborers, thus ensuring the economic productivity of the imperialist enterprise (Packard 2016; Vaughan 1991). International health experts aimed to distribute health resources, but also set in motion neoliberal agendas that reproduced and hardened inequalities (Keshavjee 2014). Emerging at the turn of the 21st century, global health aspires to be a distinct enterprise from that of colonial medicine and international health by striving for more equitable partnerships, including bilateral flows of ideas and personnel (Brown, Cueto, and Fee 2006). However, the structure of global health, inherited from international health and tropical medicine institutions, does not predispose itself to this shift toward equity. Careful scrutiny of the underlying economic motives, patterns of immigration and authorship, premises of charity-based aid, and the questions left unanswered by randomized controled trials, reveal that true equity and partnership in this field would require drastic structural changes. As the field of global health continues to gain momentum, the potentially conflicted role of medical personnel in alleviating, yet at times perpetuating, vast inequalities and health disparities must be closely examined.

The past decade has borne an explosion in global health opportunities for medical students and undergraduates in North America: one in five medical students complete an international rotation, the majority of which are in the Global South (Medical Schools Offering International Elective Courses n.d.). Global health in medical education is no exception to the issues raised above. There is a deficit of structural and social framing in current formulations of global health education. While qualitative research on global health experiences for students coming from the Global North is beginning to emerge, there remains a paucity of research on the impact of these experiences on students from the Global South, on successful pedagogical structures, and on the application of social medicine principles and structural analysis in Global Health (Eichbaum et al. 2020; Adams et al. 2019; Liu et al. 2015; Crane 2010; Myser et al. 2018).

This research explores one particular site of deployment of Social Medicine as the basis for international medical partnerships and education. This model seeks to explicitly name and dismantle structures of oppression in medicine through the formation of decolonized[4] international partnerships. In this context, a decolonized approach can be understood as an effort in 'repoliticizing and rehistoricizing health through a paradigm shift, a leadership shift and a knowledge shift,' (Büyüm et al. 2020). The need to decolonize global health is a response to the exploitative histories of medical transnationalism. Decolonization requires solidarity and partnership that, in the words of Unangax̂ scholar Eve Tuck, is an "uneasy, reserved, and unsettled matter that neither reconciles present grievances nor forecloses future conflict," (Tuck and Yang 2012).

Through a close examination of the activities of a group of organizations together called The Social Medicine Consortium (SMC), this work explores the successes and frictions of the deployment of a Social Medicine approach to this end, in local and global healthcare spaces. The SMC describes itself as "a collective of committed individuals, universities and organizations fighting for health equity through education, training, service and advocacy, with Social Medicine at its core,"(Social Medicine Consortium n.d.).

a. Background

The consortium defines Social Medicine as:

> Social Medicine is the practice of medicine that integrates: understanding and applying the social determinants of health, social epidemiology, and social science approaches to patient care; an advocacy and equity agenda that treats health as a human right; An approach that is both interdisciplinary and multi-sectoral across the health system; A deep understanding of local and global contexts ensuring that the local context informs and leads the global movement, and vice versa; Voice and vote of patient, families, and communities (Social Medicine Consortium n.d.).

The SMC is a global coalition of over 700 people representing over 50 universities and organizations in twelve countries. It seeks to use activism and disruptive pedagogy rooted in the practice and teaching of Social Medicine to address the miseducation of health professionals on the root causes of illness (Social Medicine Consortium n.d.). This research project in particular focuses on the educational and advocacy aspects of the consortium's activities.

The SMC was launched by two collaborating NGOs, SocMed, and Equal Health. SocMed is a 501(c)3 non-profit organization with roots in Minnesota, USA and Gulu, Uganda, with members of the board of directors from both countries. The organization hosts two

[4] Decolonizing medicine can broadly be defined as: developing strategic mental, conceptual and structural resistance to the infiltration of real or foreseen hierarchies that tend (or may tend) to continue legacies of colonial hegemony whether implicitly or explicitly in every aspects of medicine (Fayemi and Macaulay-Adeyelure 2016).

immersive educational courses titled “Beyond the Biologic Basis of Disease” in Uganda and in Minnesota. The course in Uganda has half of its seats reserved for students from Uganda, while the other half of its seats are open to students internationally. This course seeks to create local and international connections between course alumni with the objective of spurring systemic change in healthcare systems. To accomplish this goal, the organization educates medical providers following the Freirean tradition. Equal Health hosts a similar course in Haiti each year.

Other activities of the SMC include monthly zoom calls, in which members of the consortium—including social scientists, practicing clinicians and educators, students and alumni from the courses—from across the world discuss organizing activities. The SMC also sponsors an international “Campaign Against Racism,” with 23 chapters globally, which coordinate via monthly zoom calls. Finally, the SMC hosts annual conferences, which many course alumni attend. I was a participant observer in the regular zoom meetings, 2019 Social Medicine conference, as well as the immersive “Beyond the Biologic Basis of Disease” course in Uganda. Through participant observation in multiple settings and by conversing with and interviewing course participants, alumni, and staff, I assessed the process of creating shared vision and goals amongst a diversity of social positions within differentials of power, the successes and frictions of the organizational goal of creating a Social Medicine global health experience, and the impacts of Freirean epistemology and consciousness raising.

b. Terminology

Caution must be applied in simplistic framing of a bipolar world with an imagined ‘global north’ and ‘global south’. This bifurcation obscures considerable differences across countries within these two imaginary blocs, and drastically simplifies other aspects of historical, cultural, and linguistic ties (Czaika, de Haas, and Villares-Varela 2018). The use of ‘Global North/Global South’ language is an attempt to avoid what may now be considered unsavory language: First and Third World; Developed/Un- or Under-developed; colonizer/colonized. Simply renaming the same categories does not erase the tacit assumptions which make the older verbiage now repugnant (Adams et al. 2019). This paper will makes use of this Global North/South vernacular as a way to critique the long-standing colonial histories of health and development, and make sense of current dynamics. With the acknowledgment that this is problematic, I will continue to search for better ways to express ideas that respect our global diversity of cultural identities and histories with more specificity.

The use of designations based on World Bank income groups divides World Health Organization (WHO) member states into four income groups: low, lower-middle, upper-middle, and high). WHO member states are then grouped into low and middle-income countries (LMIC) by WHO region (the 6 WHO regions are used), separating out high-income countries (HIC) within each of these regions into a 7th group (WHO | Definition of Regional Groupings n.d.). These LMIC and HIC designations are now commonly used in global health literature. Yet, while this LMIC/ HIC terminology further obscures historical and political context, perhaps even more so than the Global North/South language. It treats income as a characteristic, and not a structural outcome of global power relations. This LMIC/HIC terminology does not address the problematic nature of ‘Global North/ Global South’ vernacular, and potentially introduces further obfuscating complexity to the milieu. Given this, I will only occasionally use this LMIC/HIC

language it does serve to put this work in direct conversation with other new global health literature. I will make use of both of these designations as appropriate, simultaneously noting that these designations decontextualize the historical circumstances creating such economic imbalances.

II. Research Questions

1. How can a Social Medicine framework disrupt inequities in transnational health partnerships, global health organizing, and education?

2. How can we imagine and work toward a decolonized partnership for health equity across borders?

3. Which structures support or obstruct this goal?

III. Methods:

In order to address these research questions, this study employs the anthropological technique of participant observation, supplemented by tape-recorded, semi-structured, in-depth interviews (Hammersley and Atkinson 1995).This methodology was deemed most appropriate for the exploration of the power dynamics of the practice of Social Medicine, and the impacts of this practice on identities, capacity, and careers of people in the global north and global south.

Participant observation data collection was based in a substantive rather than geographical 'field site,' by tracing the activities of the group of NGOs identified as the Social Medicine Consortium across physical locations--including Uganda and Mexico--as well as nonphysical spaces including video chat meetings, email chains, shared articles, and WhatsApp groups (Paschel 2018). Triangulation of results was guided by collecting several kinds of data from these various sources, in order to verify the validity of research findings.

Ethnographic participant observation data was collected for 17 months from February 2019 to June 2020 in several capacities. The researcher attended monthly Social Medicine Consortium video calls throughout this time period, as well as intermittent attendance at Campaign Against Racism monthly calls. From February to June 2019, the researcher participated in video planning meetings with 3-4 key NGO staff in preparation for the Social Medicine course planned to take place in Haiti in June 2019. The researcher participated in a virtual Social Medicine course for students from the US and Haiti in June 2019. Data collection occurred at the four day Social Medicine Consortium conference in Jaltenango de la Paz, Mexico in June 2019. From October to January 2020, the researcher participated in planning meetings for the Social Medicine Course in Uganda. From December 25, 2019 through January 28, 2020 the researcher participated in an immersive Social Medicine course in Gulu, Uganda which involved travel to Rwinkwavu, Rwanda. This immersive course included 23 students from Uganda, Rwanda, Tanzania, Zimbabwe, Liberia, Norway, Canada, and the US. Participants were all health professionals, including physicians, dentists, medical students, nurses, a psychologist, pharmacist, medical illustrator, and an x-ray technician. Ages ranged from 21 to 68. Course staff included the US based and Uganda based SocMed NGO directors, staff from other organizations

part of the Social Medicine consortium including Partners in Health Rwanda, UCSF's HEAL initiative, as well as ten volunteering local course alumni from previous years.

Tape-recorded, semi-structured, in-depth interviews were conducted throughout the Social Medicine course in Gulu, Uganda and Rwinkwavu, Rwanda.

a. Recruitment of Interviewees

Interviewees were recruited from course participants in the immersive Social Medicine Course in Gulu, Uganda and Rwinkwavu, Rwanda. Study participants were recruited for interviews through opportunistic sampling, a common practice in ethnographic research. Recruitment subjects for interviews was based on relationships created over the course of this time period.

The researcher recruited subjects with a diversity of positionalities including course participants from various stages of training, course alumni, and course organizers (n=19)[5]. Interviews were conducted until thematic saturation was achieved.

b. Data Collection and Analysis

For all participant observation data collection, field notes were recorded in a small field notebook in real time, and later typed as field notes the subsequent evening or within two days. Memoing took place as field notes were produced. Memoing from field notes was used to guide and adjust semi-structured interview guides. In this way, preliminary theories from earlier interviews were tested and, in some cases, elaborated more fully in later interviews. Memoing and altering subsequent questionnaires to pursue theories are common components of qualitative methodologies(Emerson, Fretz, and Shaw 1995). Interview data was collected in private locations in one on one tape recorded interviews lasting from thirty minutes to one hour.

Interviews were transcribed by two undergraduate research assistants. The author checked transcripts for accuracy by comparing them to original recordings. Thematic Analysis guided the transcript coding and data analysis process. Group coding conducted with two research assistants, and faculty input triangulated analysis.

IV. Ethnographic Findings

Overview of Results:

Participant observation and interview data highlighted several thematic areas of interest, described in the following sections. The consortium activities--the creation of a Social Medicine international course and broader antiracist social movement--are analyzed along the axis of points of success and frictions raised through these activities. Areas of success include pedagogical innovation, conscientizing course participants as politically activated members of the consortium, decentralizing global health practice, and promoting reflexivity on positionality among participants. Accompanying these successes, there were also points of friction that impeded this work. These frictions, both acknowledged and unsaid, include: relative risk and

[5] Table 1 in appendix

mobility limitations among course participants and complexities in reproducing hierarchies of knowledge. Successes and points of friction are explored below at both the intra and interpersonal levels. First, however, I will provide an overview of the organizations' complex visions for its practices.

a. Complex Visions:

In this section I will begin with findings from the Social Medicine course *Beyond the Biological Basis of Disease,* and then briefly discuss other observations from the Social Medicine Consortium including conferences and virtual coordination of activities and movement organizing.

Intentions behind the formation and the goals of the immersive Social Medicine course differed amongst organizers from distinct positionalities. These subtle differences reveal successes and tensions in educating students of diverse international, professional, and career stage backgrounds in an integrated setting. The founder of the course, a US based physician, describes problems he noticed in the field of global health:

> I spent time here [Gulu, Uganda], a few months, as a medical student in 2003, and then again in 2005 as an anthropology student, as well as 2005-2009 during residency […]during that time, talking with colleagues in Uganda and the US, I noticed four things that were problematic: That global Health rotations were unstructured and under supervised, both for US students and for Ugandan students. Ugandan students would go out into the villages in the clinic, and sometimes everyone would be on vacation, and they would be responsible for everything. With me, I definitely had times where I did not have supervision. Sometimes unethical things happen because of this lack of structure. Next, there was a lack of training in the social, a divorce between clinical care and social forces. Third, I noticed that I was learning in parallel with Ugandan students and residents, we were both here, but there were missed opportunities to learn with Ugandan students. Finally, I thought about my role as an outsider, and asked why are we here?

These four issues were the motivations behind the formation of the "Beyond the Biologic Basis of Disease" course and founding of the NGO SocMed. For the 2020 course, another US based staff emphasizes the importance of learning structural and social analysis in a diverse cohort as the key objective:

> Okay so my experience is to bring together a very thoughtfully designed transnational cohort of […] early career learners to… really compliment their training with like Social Medicine framework…with social/structural framework to balance like this heavy biomedical kind of weighting which is coming through their pre-service training and to give them some frameworks to start to imagine and understand the worlds that they are going to be in and to make meaning of what they are going to experience because many

> of them only have formally the clinical toolkit and don't have any social or structural tool kit. I think that probably a secondary objective would be the transnational community and to really get people to shift their own goal in social change.

In addition to educating medical providers with the tools for social analysis of health inequalities, this staff member hints at the intention of international coalition building for social change. Throughout the course, consciousness raising formed an implicit, and at times, explicit goal.

The Ugandan course director emphasizes the problems he sees in global health along axes of racism, problematic charity models, and unidirectional flows of people:

> Well I think global health really has taken an interesting twist. It's tagged more as a racial process where its attributed to being white or being brown, you know and so people are really like, like black and African of my nature and even of the U.S, I'm not really seen as a global health practitioner, I'm seen as an African who has come to the U.S. I'm not really seen as a global health expert and even in Uganda itself or in Africa itself where it will be people from America or people of white color coming in to do some bit of clinical practice, or really experience the field, and even then where actually I'm supervising them clearly as a global health expert, they're viewed as global health practitioners… not me. So for me I'm seen as a clinician in the world, who might have... so global health is not attributed to me just because of my color and really for me I feel like that's a gap. That is a myth for global health to deconstruct. Also for me, what I have actually seen at the moment is that global health is often seen as a charity model.

In his vision for the course, he explains that the goals involve pushing back on the racist characteristics of the field; the assumptions of who can 'do global health.' He also emphasizes going beyond the "charity model" and creating international partnerships across nationality and race as key goals of the project:

> And I feel maybe for us as a team, or as Social Medicine practitioners and having been running this class for over this period we are trying to really say how do you move beyond the charity model in global health and the racial … global health lenses. That is why you try to see us saying 'Hey, it is good to see an African and white man sitting together in a class and sitting together and dialoguing on issues which are actually cross-cutting in their local context and even far beyond their local contexts. That's why you see we have students from the U.S, from Norway, from Zimbabwe, from Rwanda, from Uganda all sitting in the same class, respective of their experience but contributing to the body of knowledge that we actually want to bring out clear and explicit within the different frameworks

By defining all students as 'social medicine practitioners', the question of who gets to practice global health is foregone, instead calling on all providers to be able to consider and act on structural causes of health inequities at a global and local scale.

At the level of the broader consortium, the political nature of the mission is far more explicit, as listed in the unified Campaign Against Racism organizing statement:

> The Campaign Against Racism is organized to uncover the historical connections between racism and capitalism to radically imagine a future in which sociocultural, political and economic systems work towards health equity, rather than against it. We employ tactics of formalized reflection on the role of racial capitalism in each chapter's work and experience (CAMPAIGN AGAINST RACISM n.d.)

The Campaign Against Racism is organized as a network of chapters, in which each chapter declares a strategic goal for their direct community and commits to be a part of the collective campaign. Many of these chapters' mission statements specifically name and define decolonization as it pertains to their contexts. The Zimbabwe chapter defines the action of decolonization as such:

> […] achieving an awareness on the intersectionality between racialized capitalism and other forms of discrimination like tribalism, classism, sexism , xenophobia, homophobia and sexualism as social and structural determinants of health by educating and creating collective dialogue amongst health students and professionals on the manifestation and persistent effects of structural racism, colonial structures and impact of racialized capitalism, neoliberal policies , structural adjustments on equitable access to healthcare in postcolonial Zimbabwe (Chikwenhere 2019).

The contrast between the objectives of the course, and that of the broader consortium, allows for a pathway to more radical action in achieving the organizational goal of a decolonized global health. This process of conscientizing participants will be discussed in later sections.

The goals of the consortium members and course staff from varying positionalities have different but related foci. From the perspective of the US based course staff, the goals are about providing tools for internal reflection and a potential path to political action. From the perspective of the Ugandan course staff, the main goals relate to disrupting structural racism in global health practice. For most students, the immersive course is an introduction to the ideas of social medicine. Many subsequently become active members of the consortium, staying involved for years to come, forming local action groups of alumni, and participating in SMC activities such as the campaign against racism. The goals of the broader consortium are to explicitly name structural racism as it relates to a capitalist economic system and to health, and to provide an organizing structure for conscientized members to act on a political axis, and to 'correct the miseducation of health professionals on the root causes of illness'(Social Medicine Consortium n.d.). These goals provide a pathway for members to work at increasingly structural levels for

change towards decolonizing global health. At the same time, some internal frictions borne of structural impediments complicate this vision, as I will explore next.

b. Successes

The innovative practices of the Social Medicine Consortium, and its component organizations, including SocMed, succeeded in disrupting inequities in transnational health partnerships, global health organizing and education in several ways. The successes described below provide examples of strategies for working towards a decolonized partnership for health equity across borders.

1. Pedagogy

One of the successes of the educational activities of the consortium was an effort to take a decolonized approach to pedagogy. Data collected in planning meetings, monthly consortium video meetings, conferences, and the immersive course itself demonstrated the emphasis placed on diversifying pedagogical techniques. NGO founders and staff sought to decolonize global health practice not only by using techniques developed by thinkers outside the US, but also by challenging participants to reimagine their realities.

Pedagogical principles and techniques developed by Paulo Freire and Augusto Boal, two Brazilian revolutionary scholars, were centered in the organization's works. Paulo Freire challenged educational conventions by engaging students in reflective action through a problem-posing model, based on themes generated by the material conditions of the students (Caldas 2020; Freire, Bergman Ramos, and Ramos 2014). Inspired by his contemporary's work, Augusto Boal used his background in playwriting and directing to developed techniques designed to give the people a stage to discuss and rehearse ideas of revolution (Caldas 2020; Boal 1985). While Freire asked, for whom is education? Boal asked, for whom is the theatre? In Freire's work *Pedagogy of the Oppressed*, and Boal's *Theater of the Oppressed (TOTO)*, both scholars answered these questions with a preference for the poor and oppressed and against the exploiters. Equally important, each hit upon a similar methodology for accomplishing their work: the engagement of the oppressed (Zwerling 2008). The SMC utilized this pedagogical approach as a core element of a Social Medicine approach to global health practice.

Two Brazilian scholars of Freire and Boal's approach, were invited to the four day SMC conference in Jaltenango. They facilitated the implementation of elements from TOTO, demonstrating the transformation of participants from spectator into actor. Boal's concept of 'making the body expressive' includes "a series of games by which one begins to express one's self through the body, abandoning other, more common and habitual forms of expression"(Boal 1985:126). The 150 conference attendees engaged with enthusiasm in several games: Boal's "African mosquito", and "Columbian hypnosis", and participants suggested and altered the games as they were played, embodying Boal's idea that participants should not simply be

"passive recipients of entertainment from the outside," (Boal 1985:131). The Brazilian scholars then employed the TOTO technique of Simultaneous Dramaturgy, in which volunteers improvised a scene depicting abstract concepts, and, as they watched scenes of oppression carried out, audience members were encouraged to halt and reenact the scenes to 'liberate' the oppressed. Participants acted out the concept of "machismo" as volunteered by a US campaign member, and, at the urging of a Ugandan participant "US aid coming into Africa thinking it can fix everyone". Subsequently, the trainers and several volunteers ran a TOTO workshop allowing local Jaltenango grade school children to enact their chosen concept of 'abuse'. This mode of pedagogy was successfully conveyed, and enacted throughout the conference, with lots of participation and enthusiasm from participants, who offered their own ideas about how to characterize and disrupt structural oppression.

During the immersive three week course, other elements of TOTO were utilized, including the principle of image theater (Boal 1985:135). A participant was asked to reflect on a theme discussed in the course, and without speaking, use the bodies of the other participants to "sculpt' a scene portraying the idea. Concepts represented included 'colonialism,' 'charity,' and 'neoliberalism'. Course participants had varied, but largely positive reactions to employment to this technique. Following the several constructions of human sculptures concretizing the concept of colonialism, one Ugandan medical student noted:

> After this I am asking myself, is there anything good about colonialism? Based on all the sculptures, it seems like no, so now I am asking myself this question. (course participant)

This student's reaction exhibits the consciousness raising potential of this approach. A course participant form Rwanda noted:

> The purpose was to show it [colonialism], you don't have a chance to saw it in that time, but it was like this, you think how it can change. That was his purpose. (course participant)

This response exemplifies another goal of the approach, creating concrete representations of the abstract to allow for a reimagined reality. This pedagogical technique evoked strong responses in participants, with greater discomfort occurring along lines of race and gender: as noted by one US student speaking to the sculpture activity:

> I do feel like the physical nature of things, is something that, as a white man I have the least insight into. I feel like everybody that's not a white man probably has some kind of visceral/ physical relationship to a lot of the concepts we were talking about *(course participant)*

This US based participant displayed some reflexivity, while also not quite acknowledging the connection or complicity he has in relationship to the effects of colonialism. Indeed, not all reactions were as positive. Some participants explicitly named this pedagogical practice as traumatizing. A Ugandan medical illustrator recalled:

> Sometimes you feel like.. sometimes you are doing the sculpture, and someone was trying to say with how he used the students in Europe, and then the Black students. When you reflect upon that psychologically, to me I see someone who still has a mentality. Why would you want to use such a kind of thing, you are trying to make someone think that you are the colonial masters. That's how I took it. You are the colonial masters, and we were like this. [...] I think to learning is touching topics that are really sensitive… was a big challenge because it's kinda traumatizing, it creates shame...discomfort to people (course participant).

In this case, the participant found the exercise degrading. Multiple Canadian students noted feeling uncomfortable portrayed as colonizers, one of them stating 'We are not our ancestors.'

This pedagogical practice, born from the Brazilian school of thought with the intention to create awareness of oppression and empower the oppressed, succeeded in eliciting strong responses in participants. The discomfort experienced by some members may have been an intended or productive part of the project, though the risk of inflicting or triggering trauma for students of color makes the success of the practice somewhat ambivalent. Still, this may be considered part of the process of conscientization, as described by Freire, in which difficult emotional and experiential moments are meant to alter consciousness about one's position in relation to power: to make one aware of the hierarchies at work in one's social milieu and to be aware enough of them to try to address or redress them.

In addition to utilizing these theory-based techniques generated outside the global north, a pedagogical design pioneered by a consortium member, a Rwandan physician educator, was featured heavily by the NGOs. One of the monthly consortium-wide zoom meetings was dedicated to an exploration of this technique. This physician titled her approach: "Walk the talk" and described her inspiration as follows:

> I didn't have a framework when I started, it came from frustration with international students who come for one week, it's like a window into where we are, but not the whole picture. I began walking with the students to give them a more complete picture of Rwanda outside of the clinic settings, I never thought of it as a methodology [...] originally this technique was for foreign students but now we do it for the Rwandan students. They are Rwandans, but they don't have experience of the rural area, Seeing the agriculture, topography, seeing where patients walk was key (consortium member/course instructor)

This pedagogical technique arose out of what this educator saw as a problematic global health practice. Later she decided that contextualization through this practice was needed for both domestic and international trainees. She explains "the key to Social Medicine is observation, so we wanted to have students see more, and reflect on what happens when they walk". Through this effort to turn careful attention to surroundings, students were asked to conceptualize the specific health implications for the individual, as well as the contributing social and structural factors.

During the immersive course, the class of diverse learners were taken for such walks in both Gulu, Uganda and Rwinkwavu, Rwanda. During my participant observation of this practice in Rwanda, the educator brought students up a hill, and asked what we saw. A student noted large piles of dirt in the distance. This prompted conversation about the local economy of the nearby town, which was largely based on the tungsten mining industry. The physician educator explained how the mining practices led to the local epidemic silicosis, and irreversible lung disease. This prompted further discussion on a resource extraction economy, elucidating how structural forces directly impact individual health outcomes.

Overall, participant reflections on pedagogy were positive. An US medical student with a background in teaching noted:

> I think pedagogy is just this… criminally ignored part of, at least in medical training, and there's some-some teachers really took it apart in this course. And I thought it was awesome. And I think you could really see how you could break down walls of like how cultural differences, professional differences with things like the sculpting- you know the human sculpting, community walks. Um, yeah. Just some really cool pedagogical practices, so I think that is the strength, and I think that is something that… I think I have been very critical of pedagogy and I think the people that I've been talking to understand that it's a sign of respect (course participant).

This positive response highlights the successes of a Social Medicine approach predicated on teaching techniques pushing not only beyond the biomedical, but also outside the didactic. Practices based on Brazilian pedagogy effectively represented abstract concepts, illustrating how structural barriers underlie health inequities and create unequal footing for international partnerships. Visually representing these ideas with active participation allowed consortium members and course participants to reimagine their realities. These techniques also forced an at times uncomfortable reconciliation with positionality for participants. Though this may have been a goal, it ran the risk of potential harm and alienation for students of color. In addition to the theoretically informed practices, teaching modalities arising from a grassroots effort by a Rwandan educator played a key role in the organizations' practices. The "walk the talk" approach created an opportunity to visualize the manifestation of structural forces at the community level and tie these concepts into the health of individual patients. These innovations represent some of the organization's points of success in efforts to decolonize global health.

2. Political Activation

An implicit goal of the educational course, and explicit goal of the larger organization—with its Campaign Against Racism—was raising political consciousness. This success may be in part credited to the innovations in pedagogy described above. In other words, the organization gave permission to talk about political ideas by framing them through the lens of health. This is not to say that the organization assumed students were not politically aware before, but in providing specific language, toolsets and space, the organization directed and organized this energy towards a confrontation of structural problems at both the very local and international levels. In this way, this Social Medicine approach to global health sought to disrupt inequity in these partnerships.

On the first night of the immersive course, an OBGYN and Ugandan course alumnus used a military metaphor to inspire an ideology of activism among the participants. Based on my ethnographic notes:

> He raises up his right hand, curling it into a fist, he tells us that we are now part of a movement, 'repeat after me: I am a soldier' Fists rise up, and the class repeats 'I am a soldier'.

At the outset of the course, this unadvertised, as of yet unstated, objective became central to the operation. Students were made aware that here, Social Medicine should be understood as coalition and movement building for change, rather than a purely academic, or even strictly clinical work. Another alumnus uses a similar military metaphor:

> Because, I think Social Medicine should be amplified, this particular program that we are doing, should be amplified. Um, why should it be amplified? Because we need **to recruit more soldiers for the war** (emphasis added) that we mentioned about and recruiting more soldiers means we are going to have the solutions quicker then. And remember soc-med is directly education, education and empowerment 'cause this education will distribute power to actually think that they can do some- know that they can do something and so the more people we give these tools to, is going increase the possibility of more people we are going to have causing change (course alumni).

The pedagogical techniques used in the course, described in the previous section, resulted in a sense of empowerment, and students came to see education as means of conscientizing others.

One member of the course in previous years described an inspiration to act at a national level based on the principles and activities of the class. In the words of this Ugandan physician and course alumnus :

> […] when I was a medical student. Just a medical student. And there were issues around the country… doctors were not happy, junior and senior doctors went on strike. Uh. They were not happy…. I was part of a leadership… media station who went to speak to national TV about the policies at the time… and for some reason … So I think I take my pride because it was Social Medicine that empowered me, and through the network of Social Medicine it made it possible because …. Made a strategy plan for that movement… and for some reason it has always given me that boldness, that courage, that confidence to face whatever situation. Irrespective of looking at how small I could be, so it has opened so many new ways of thinking (course alumni).

This participant describes having applied the organizing principles taught in the course to national politics, joining in with existing activism to advocate for better working conditions for physicians in Uganda. He explained that the medical student effort to speak on national TV were initiated by members of the 2015 social medicine course, supported by fund raising efforts from course classmates in the US. The overall efforts of this movement succeeded, resulting in legislation limiting shift hours. This is a significant achievement in a country with the charged political atmosphere of Uganda. The Social Medicine approach allowed students to desegregate politics and health, using their authority as medical personnel to effect change.

The achievements in consciousness-raising extended beyond empowerment to act at the national level. The larger organization's Campaign Against Racism has 23 chapters in 10 countries, providing the opportunity to act at the international level. In both Haiti and Uganda, chapters of this campaign were founded by course alumni. Over the period of the immersive course, students already involved in this campaign used tactics taught—such as SMART goals and asset mapping—to collaboratively plan activities for their respective chapters in Uganda, Zimbabwe, Minnesota. The larger organization approached political action from a structural lens: the chapters of this campaign agreed upon a mission statement specifically targeting racialized capitalism as a source of health inequity. Actions included campaigning and calling on the World Bank and IMF to cancel all LMIC debt, advocating for abolition in the US, and lobbying for racism to be declared a public health crisis by city governments and universities.

In the immersive course, examples of effective radical political action based in the realm of health was often taught based on examples from the US. Referencing the free clinics established by the Black Panther movement, or even Obama care, the US based course participants led many of the discussions related to political activism. In asking Ugandan students how this affected learning, and what it would be like to use Ugandan examples, I was told by a participant : "[the US course director] would be thrown in jail, there are spies everywhere," While using examples from the US initially appeared to recreate the global health trope of knowledge flowing from north to south, it served to allow conversations about the political nature of health in a safe way, permitting Ugandan students to determine and lead in any actions undertaken without putting participants at political or bodily risk.

Not all course participants were interested in engaging with explicit political action. Some held on to the narrative medicine elements and humanistic interviewing techniques also taught in the course, preferring to focus on the individual level, rather than engage politically: As described by one Tanzanian course participant:

> Yeah so, in terms of racism… um… I will not talk much about that because you know, I am more into the medical practices and I am not a politician [laughs]...and at least for now I don't want to be one! But what I wanted is the little power that I have in my room, my consultation room, to make sure that I use to reach out to many people because I am a primary care physician. So I believe with my position I can, even you know infuse these ideas of you know, health literacy, you know.. racism. Though, I don't see we have much of it, maybe because I didn't dig out and find out, though I know it is there. But I feel now my priority is to make sure that people first are well aware of their health, their responsible for their health and seek the health, you know, behaviors and things like that. That is my priority, for now. Yeah (course participant)

This course offered opportunities for political activation that were not universally embraced less politically inclined students maintained their focus at the individual patient level. Some participants continued to draw sharp lines between medical practice within the clinic space and upstream causes of ill health. By including instruction in elements of narrative health, storytelling, and interviewing techniques, the organization offered widely appealing content, as well as providing an entry point to political conversations that students may have otherwise not engaged with, as well as an avenue to continue to opt out of these conversations.

This Social Medicine approach to global health partnership enabled a practice of consciousness raising among participants, allowing for connections to be made between global politics and health inequalities. Course students, alumni, and organization members explicitly sought out political means of disrupting inequities on local and global scales. Pedagogical practices helped participants to reimagine their reality, teaching specific organizing tools gave participants means to fight for these ideals, and the organization's structure provided a pathway for course graduates to join an international movement.

3. Decentralizing Global Health

The activities of the consortium also sought to disrupt the typical flows of information in global health, where resources, knowledge, and legitimacy often flow from north to south. In highlighting the social and structural causes of ill health, the locus of expertise was shifted away from technomedicine practiced in the US, allowing for other types of healthcare knowledge to lead the conversation. The NGO made efforts to create opportunities for knowledge sharing and production that specifically promoted collaboration between learners from different locations in the global south. This created valuable opportunities for exchange of knowledge between

participants working in low and middle income settings, while simultaneously displacing the idea that the north is the source for ideas about what constitutes appropriate interventionary medicine.

The activities of the course included several visits to rural clinics and villages, evoking drastically different responses in participants based on background and positionality. While students coming from the global north were made to question their place in rural settings, learners from other parts of the global south found direct applicability from these activities. One student, a nurse from Liberia who works as a supervisor for community health workers in outreach to remote villages, found such visits extremely productive. Visiting community health clinics allowed comparison and collaboration between supervisors of community health workers from Uganda and Libera on such topics as the content and regularity of training for community health works, defining scope of practice for these workers, and supervision structures. In accompanying the community health workers to a family home, she further describes:

> So, visiting the family in their homes in the community, I just—it was just a repeated experience for me. As I told you earlier I'm always doing community work,[…] I value it so much, yes, because I always want to be with the poor people..[..]Yeah, so it was a good experience for me. I was just happy to go and see how it is on that side, apart from my country, I was fortunate to see the villages in Uganda (course participant).

The opportunity for comparison across resource limited settings allowed for collaboration and knowledge co-production, for these practitioners. This decentralized not only northern knowledge hierarchies, but also hierarchies within the health profession: nurses and community health workers led these conversations, and physicians were put in the position of trying to understand how these conversations fit into their practice, rather than the reverse.

The organization held its 2019 annual conference in the city of Jaltenango in Chiapas, Mx, another example of an effort to decentralize the site of knowledge production and legitimacy. The site was chosen in part due to the proximity to heart of the Zapatista revolutionary movement, a leftist activist group with strong Mayan and mestizo roots. The organization sent out materials before the conference educating participants on the Zapatista Chiapas Rebellion, which occurred throughout this state twenty years previously partially in protest of NAFTA and in support of a democratic socialist regime (La Botz 2014). The first day of the conference involved a tour of a Zapatista University, as a model of free and communal knowledge production. These efforts sought to uplift local knowledge and emphasize grassroots understandings of Social Medicine as an organic force arising all over the world in response to social inequity.

In addition to connecting the Social Medicine work of the organization with that of grass roots movements, Chiapas was selected because this location allowed for greater participation from organization members throughout the global south. The organization's 2018 conference had been held in Church Rock NM, on Navajo Nation land, centering Navajo knowledge and healing

as yet another approach to Social Medicine. However, the conference held within the US limited attendance to those who could easily obtain visas, making attendance from Haitian, Ugandan, and other international partners difficult or impossible. By moving the conference to Mexico, these structural travel barriers were lessened, and a wider attendance was possible. Attempts to decenter the US and create a common ground for communication amongst diverse attendees faced the structural limitation of language. Despite being physically held in Mexico, the conference was held almost entirely in English and a Spanish translator was broadcast via headsets to Spanish speaking participants. Although English was used as lingua franca, which could be seen as reinforcing global north and neocolonial relations, the participants felt that the benefits of displacement by hosting in non-global north locales largely outweighed the issues around language.

The organizations' efforts to establish Social Medicine as a grass roots approach rooted in knowledge produced in communities throughout the world, instead of merely in US hospitals, was largely successful. This approach provided learning opportunities that decentered US physicians, paving the path for other interprofessional and international collaborations. Highlighting diverse political social movements such as the Zapatistas continued to emphasize the aspect of political activation discussed in the last section.

4. Reflexivity

In creating an immersive Social Medicine course with diverse participants, the organization succeeded in creating space for reflexivity. So often in global health work, the material inequities that form a striking contrast between research staff, local and foreign scientists, and institutions are not openly discussed, though they certainly play into mutual perceptions. As Wenzel Geissler describes: "conversations about colonialism among local staff at times substitute open debates about contemporary inequalities"(Geissler 2013:25). Actively unknowing and ignoring these inequities may serve the productive function of allowing medical personnel from different backgrounds to work together. However, in this state of unknowing, these injustices are cast as beyond the scope of scientists and health practitioners and as simply unchangeable.

Throughout the activities and pedagogical practices described above, a level of consciousness and self-commentary was promoted among participants, in an effort to challenge such injustices. This process was intended to foster an ability to see one's self and the other in relation to the global power dynamics discussed. This aspect of the Social Medicine approach made meaningful steps to make power inequities visible, though it also created friction as these tensions were brought to the fore. From the perspective of a medical student from a large institution in the US, I was very aware of how my own identities impacted these conversations about self and other. I found these conversations particularly challenging with those from different international and training backgrounds. It was precisely the practice of steering into this discomfort, that made the Social Medicine approach successful.

The curriculum of the course strove to make formal space for reflexivity through activities such as a privilege walk, asking all participants to share a story of self, and periodically holding space for debriefing after tense moments. I discussed this topic with each in each of my interviews, and found that the most profound experiences of participants came in the moments after these spaces were created. When asked about reflection in an interview, a Rwandan course educator shared her own process in making sense of these complex relationships, reading me a poem she had written after a group reflection session:

> Who are you? I see you, but who are you? Who formed you? What do you need to undress, to put on, to be able to put aside for me to be able to see you? What do you need to put on to be acceptable for me? For me to see you and frame you, to know who you are. You grate against my sensibilities. Why? Or, or who do you represent? Why do you do that? Is it because of who you represent? What trauma did you, you are like, your people, your type, your color, your education, your trade, your country, your continent, your age, your gender, your history, your geography, your language, your understanding, your sexual orientation. What trauma? Effect, support and many other words. What did they cause me, mine, and theirs and other groups? Did you realize that you are a summation of more parts from around before, after, that you represent. Why does your face cringe as you talk? Your smile. Rudiment. Condensation. Anger. Puzzlement. Politeness. Why do you refuse to be present to me? Is it because of who you are? Or who I am? Who they were? What is around? And what all this means…. What do I threaten to your tribe? What hope do I bring? How do you place me in your universe? Do I maybe connect, evoke, light, subconscious stakes even you are not aware of? Do I connect? Do I evoke? Do I have a history, hopes, that we are not aware of? For all this and that is unknown partially or partially known, I need your forgiveness. And I need to forgive you. So as to create a garden where we can plant new seeds, grow new plants, see new blooms, weed out, collect harvest and allow creativity to continue so that we are co-creators with god… that is how I debriefed.

In her poem, this educator makes clear the magnitude of the struggle she faces in reconciling the concept of partnership in the context of such deep differences and disconnect. She imagines how the other might see her and describes her own limitations in seeing the other. In acknowledging the vastness of this disconnect, she can begin to honestly express the amount of work needed to reach a genuinely productive relationship. Ultimately, she retains faith that co-creation across these differences is a worthy objective. Decolonizing practice is an uneasy process, and cannot be expected to resolve all present grievances or prevent future conflict. Grappling honestly with these tensions was key.

The Social Medicine approach sought to make evident the role of not only histories of colonialism, but also the present geopolitical forces and modern economic practices in creating current health inequities. Beyond discussing these macro elements, the course organizers were able to foster reflection at the interpersonal level between participants from different backgrounds. However, it was likely the resulting intrapersonal work that was most important. This level of honesty and metacognition brought tensions to the fore, at times making

relationships between diverse participants more difficult. However, it is precisely the ability to steer into this discomfort that makes this approach strong. The organization seeks not only to disrupt structural inequities in global health through political action, but to begin to unpack the obstacles to partnership at the intra and interpersonal level.

c. Frictions:

In discussing points of friction, I analyze the structural forces that challenged the organization's goals to approach global health with a decolonized practice. These critiques are not failures, but areas for further growth and analysis in efforts to create equitable international partnerships. I discuss these points in the two sections below.

1. Risk and Mobility

The SMC faced structural limitations in disrupting the longstanding problem of unidirectional flow of global health learners from HIC to LMIC. These limitations in mobility are a well-documented phenomenon and source of inequity in global health partnerships. In some important ways, the organization sought to push back against this colonial model. Bringing learners from Zimbabwe, Rwanda, Nigeria, and Liberia (as well as from the US, Canada, and Norway) to learn in Uganda represents a different type of flow than seen in previous eras of tropical medicine, international health, and many current global health practices. However, the levels of risk and potential reward undertaken by students traveling from other places in the global south remained relatively greater than that of their colleagues coming from the US, Canada, or Norway.

Students coming to take the immersive course from the US, Canada, or Norway frequently framed the experience as a way to travel or as a vacation destination. These students described little difficulty in obtaining plane tickets, vaccinations, or visas to Uganda and Rwanda. These expenses were often covered by their universities, and many students spent time before or after attending safaris or otherwise exploring. The immersive class involved driving from Rwanda to Uganda, and during the journey, antelope and zebra were spotted, to the delight of all course participants, particularly those from the global north. One Canadian participant stated: “Did you ever think you would be seeing animals like this” adding “it’s the real reason I came to Africa!”. While this comment was facetious, the lightness of this undertaking for these students underscores a structural imbalance well known in the field of global health.

For some students coming from other places in the global south, the sacrifice of attending was far higher. During the period of the immersive Social Medicine course, tensions between Uganda and Rwanda were particularly high, and travel between the countries represented a large problem. Namely, crossing the border on land had become impossible, but travel by air via an intermediate destination allowed for safe crossing. The NGO sponsored one student and two educators from Rwanda to fly in via this circuitous pattern. The student from Rwanda describes landing in Uganda:

> Fear. From Rwanda to Uganda, you cannot cross the border easily...I felt a lot of fear coming to the class. Some of my family understands, but whether they accept or not, I have to come. It is better to die doing something that can help your society, than just staying at home thinking (course participant)

Similarly, one of the Rwandan educators explains to me that her colleague had lost cell phone service for a day, prompting his wife to enter a state of panic, call the human resources department of the university at which they both worked, and procure the other educator's number, leaving her several extremely panicked voicemail messages. These quotes and anecdotes indicate that the risk is larger, but also underlines the importance and relative gain from attending such a course.

One participant coming from Zimbabwe similarly described assuming a high level of risk to attend the immersive course:

> […]my Human Resources was a different story (laughing). She didn't think it was important for me to do it now, you know. And she was, she was actually saying "you can just cancel it now and you can just go next year." And I was like, no (laughs), I can't wait for next year…yeah. And they couldn't give me off days—even if I take off days for that thing, they could not give me. And they told me like, "if you go we'll dismiss you" (laughs). And I figured—you know what, these guys aren't going to help me, and I don't think I want to miss it this time around, I'm so like—really excited about this and I'd like to have this, you know, global health immersion into like, different areas. So I thought I would just go in you know and get it out (course participant*)*.

This participant risked her employment in order to come to the course. In later communications, she confirmed that she was indeed dismissed from her job. Again, while this level of risk was higher, the potential benefit was also larger. Based on connections made over the educational course, she was able to obtain a scholarship to do a Master's degree at the new University for Global Health Equity.

Staff members had varying responses to differences in assumed risk. The Uganda course director took an equality lens in addressing the concept, advocating that all course members be treated similarly:

> And everyone is exposed to that risk. Financially can also be a risk, but one thing, one thing we do not want to think of is that there are more privileged persons that other in our class. So we do not want to privilege any community over others of the class, over the overs, and we want to take everyone as human (Ugandan Course Director)

On the other hand, one US staff member, was deeply concerned by the topic, and broadened the idea to include not only students, but support staff of the educational course:

> I think that even outside of us learners like… our Ugandan drivers are here with us and there can actually be stakes for them being in this country [Rwanda] given their nationality, given their class position we don't even understand like there were some things that happened with our group that caused even stakes on other people…So both within the learner groups and then even broadly and I think it is hard because privilege protects, right that's its very nature so how do you even create the space to have those conversations? You know because people won't necessarily share the 'Oh I'm facing extra risk here' or 'the stakes are higher for me for many x, y, z many reasons' that most of us probably won't understand because they aren't part of our lived experience. (course staff)

These statements show varying degrees of acknowledgement of this structural inequity, but neither approach actually advocated for addressing the conversation directly with course participants or support staff.

These organizations also sponsor an immersive course in Haiti each summer. In 2019, political instability in Haiti, in the form of protest against the corruption of Moise's regime, resulted in the NGO leaders cancelling the learning opportunity in Haiti. Based on institutional connections, an alternate plan arose to host the learning opportunity in Chicago. As Haitian medical students applied for visas to the US, the potential of this prospect lead the potential students to risk bodily harm, as explained by the Haitian course director:

> … [Haitian medical] Students are super excited: they have been looking forward to this [the prospect of a course in Chicago], feels like an important time to leave. In fact most of them came downtown for the [visa] interview even though it was dangerous. They want to go so badly that I have to be careful of what I ask them to do to get the visa process going. I don't want them to take that level of risk (Haitian Course co-director)

Although this plan sought to disrupt (and arguable decolonize) global health dynamics, the potential for bodily harm for the Haitian participants once again demonstrates an extremely high level of assumed risk. Doreen Massey's concept of "Power Geometry" can be used to make sense of the personal risks and challenges assumed due the geographical distribution of power. She explains that "there are relations of power which are intrinsic to neoliberal globalization and which tie different places together, subordinating some to the dictates of others,"(Massey 2009:1) Among the 10 students, two teaching assistants and one staff member who eventually managed to apply for visas, only one application was approved. Ultimately, though these medical students may have been part of an elite class, they faced limitations in their ability to travel due to institutionalized racism.

The opportunities created by these NGOs, while striving towards a decolonized practice, were severely limited by geopolitical power dynamics beyond their control. In creating opportunities to expose these large scale inequities by teaching historical context and advocating for structural change, some of these very power dynamics were inescapably reproduced at the individual level, and went unacknowledged. Race and nationality continued to dictate mobility, and the legitimacy associated with interacting with an American NGO led global south participants to accept the possibility of damage to livelihood, or even bodily harm. The decision to assume this higher level of risk was in some cases rational and smart, affording important opportunities for career advancement. The lack of open discussion around the direct impact of these power dynamics on the NGO staff, consortium members, and course participants emphasizes the complexity and magnitude of this friction.

2. Reproduction of Hierarchies of Knowledge

As described above, the organizations made significant efforts to place value on health and healing knowledge produced outside the US as defining elements of Social Medicine. Yet the organizers of the immersive course still felt pressure to include elements of social theory produced in the US and Europe in the curriculum to make graduates 'legitimate' in an international context. As strictly biomedical practices in global health often involve the flow of technology from north to south; Social Medicine similarly must contend with the flow of ideas from north to south as a product of structural racism in the academic social sciences.

Early in the immersive course, a lesson was taught on social theory. This included concepts credited to Robert K Merton, Thomas Luckman, Peter Berger, and Michel Foucault: all American and European social scientists. At the outset of the lecture, the educator explained that one of the reasons to teach these theories: 'It also gives us "street credibility" (use of air quotes here) or legitimacy as a scientific field'. The idea of credibility as defined by that coming from northern centers of production, is a structural challenge difficult for the organizations to overcome in its attempts to establish Social Medicine as a rigorous practice. This is not to say that staff are unaware of these dynamics. In fact, there was some dissent about even the utility of the term 'Social Medicine' and pressure it carries to fit into elite academic spaces, as described by one staff member:

> I can think of three of the colleagues here, are all registered nurses by training, who are community health workers who work outside of health facilities, who often feel very structurally disempowered by some of the same systems that the Social Medicine word come out of…. have been practicing Social Medicine their entire lives and have a very deep understanding especially working outside facilities and working as non-physicians, working as women, working as community members, have a very deep understanding of

> the social and structural forces affecting health and well-being, and the power of naming those and centering a more holistic sense of health and well-being beyond…. You know it's almost like, I feel like Social Medicine is trying to sometimes, my perception of it personally, walk into a space where it has never been allowed because it has always been like biomedical centric/ U.S physician training space and just trying to like wedge itself in (course staff).

This tension speaks to the positionality of these organizations—the Social Medicine Consortium, Equal Health, SocMed—as bodies affiliated with US based medical institutions. This staff member points out that many practitioners in the global south are already very aware of the impact of social circumstances on health. For many practitioners in the immersive course, it is a daily reality. In fact, even the scholarly tradition of social medicine practice has strong roots in Latin America, Algeria, Eastern Europe and Central Asia (Keshavjee 2014; Breilh 2008; Fanon 1965; Weinerman 1969). However, in the technomedicine focused academic medical centers in the US, Social Medicine is fighting to reestablish itself as a central part of health training. So the idea that a set of concepts from the north is needed to explain this phenomenon may be inherently flawed and disempowering for the creation of partnerships.

Reactions to this set of ideas were varied among participants from different locations, not divided equally based on country of origin. One course alumni from Nigeria returned to Uganda the following year to assist in teaching the segment of the course on social theory. He described his reaction the theory portion of the course as conflicted.

> I do feel disadvantaged. I, I think the average African who would be very sincere to themselves would tell you that they feel disadvantaged but like I said earlier before we started the interview, that should be a motivation for us to do something so the fact that most of the- like when I was reading and preparing to teach, I felt like I should write about this. Yeah. That was what I was feeling like. I should collaborate, I should also write, I should- I should teach people, you know I should teach people about the social theories of health. So right now I am so challenged than ever to become a teacher in medical sociology, and um just.. even if it is just something like write a book, and make sure my book is used in teaching material. So um, it is great that I feel disadvantaged, because feeling disadvantaged makes me want to do something. I am not- and I think anybody who is like me um, we are done crying about how the Americans and the Europeans are ahead of us. We can't do anything about it. We can't do anything about that you are more exposed. We can't do anything about that, what we can do is try to that make sure that we are matching up with you. So that is what I wanted to do. So yeah, I was very challenged, very challenged. An example is like reading Foucault? F- Foucault? Michel Foucault? [claps] What is that guy! I had no idea, no idea! [laughing] I have never felt so stupid in my life! And this man wrote a whole book. So, how am I going to read this whole book? I mean like the book had been on two pages, I took the time reading like I really wanted to comprehend what I was reading. I wasn't able to read it like it was a story, I want to be able to comprehend. So, I think, maybe it might be a longer road for me, yeah. But I am walking the road. Yes. I am walking the road. I want to be Kleinman

> someday. Yeah. I already told you about my love for medical anthropology (course participant).

This participant's experience captures many of the frictions in this Social Medicine approach to global health. While he describes the ways in which social theory texts from the US and Europe made him feel 'behind' or 'disadvantaged', he doesn't see this as disempowering, but instead motivating. The exposure to sociology and anthropology concepts was inspiring and influential on his career direction. While in many ways this quote exemplifies the reproduction of knowledge hierarchies, it also alludes the possibility of broadening the social science conversation to include more voices from outside the US and Europe, allowing people to prove themselves on whatever stage they want. Perhaps future iterations of this social medicine cannon (as taught by these organizations) can move to include more theorists from the global south such as Breilh and Fanon.

The idea that Social Medicine can be a means to rethink global health depends on the various deployments and definitions of Social Medicine. Teaching social theory concepts originating in the US and Europe may represent a point of friction in the overall objective in creating more equitable, decolonized partnerships. Yet at the same time, making these ideas accessible to a wider, more diverse audience could be framed as a means of democratizing these academic concepts.

V. Discussion

As global health continues to play a large role in medical education, research, and practice around the world, lessons from the field of Social Medicine can provide necessary guidance towards an equitable practice. Global health is a direct descendent of international and colonial health projects. In global health education, institutional partnerships carry forward these power dynamics. In many ways, the work of the Social Medicine Consortium presents a radical shift in attitude and praxis from standard practices in global health. At the same time, even this organization can't escape from the structural problems disrupting the decolonization of global health.

The goals of the consortium are carried out across multiple practices, including immersive courses, conferences, and international organizing efforts, which provide a pathway to an increasingly political practice of Social Medicine. Recent calls to decolonize global health remain largely aspirational, recognizing the vast amount of work to be done (Büyüm et al. 2020; Eichbaum et al. 2020). While resources such as the 'Competency Toolkit' produced by the Consortium of Universities for Global Health indicate a need for fluency in the 'social determinants of health,' no mention is made of the historical, or contemporary economic or political structures contributing to health inequities (Jogerst et al. 2015). Grounded in historical analysis as well as contemporary economic and political perspectives on health inequities, this

Social Medicine approach provides an example of a potential avenue towards a decolonized practice.

The successes and points of friction of the Social Medicine Consortium's project were often intertwined, indicating the complexities of untangling obstacles to partnership in a reality dictated by racial capitalism.

At the level of the immersive Social Medicine education course, the objectives push back on many of the existing paradigms of the field of global health. This involves challenging the racist norms of the field, specifically in that the title of global health practitioner is seemingly limited to (white) medical personnel from the global north. The immersive course seeks to ensure that students from diverse backgrounds are learning together, specifically discussing histories of colonialism, neocolonial practices, and racism in medicine to counter a 'charity' model of global health. These intentions largely emphasize the programmatic forcing of a reflection on global power inequalities by studying health systems in the way they are impacted by structural forces.

The SMC Campaign Against Racism provides another opportunity for alumni and other members of the consortium to work towards exposing the historical connections between racism and capitalism. The Campaign encourages a reimagining of sociocultural, political and economic systems that will work towards health equity. Through its decentralized structure, the SCM's global campaign against racism supported chapters in ten countries to create goals for an antiracist medicine specific to their local contexts. The Zimbabwe chapter explicitly named raising awareness of and deconstructing internalized racism as a means of decolonization. Allowing space for mobilization at the national level strengthened the global efforts of the organization. As stated by Franz Fanon: "It is at the heart of national consciousness that international consciousness lives and grows(1959)". In these ways, the actions of the SMC align with the concept of decolonizing medicine, as it can be broadly be understood as a development of strategic mental, conceptual and structural resistance to the infiltration of real or foreseen hierarchies that tend to continue legacies of colonial hegemony (Fayemi and Macaulay-Adeyelure 2016).

The work of these organizations emphasizes the importance of a carefully cultivated pedagogical approach in international educational partnerships. Using Freirean techniques and interactive elements from the Theater of the Oppressed allowed participants to enact and embody abstract aspects of power inequities, and grapple with reimagining these ideas in a liberatory way. This approach engendered discomfort for students both from the global north and south. The consequences for some students from the global south included revelations around the far reaching, modern, destructive impacts of colonialism, often bringing forward strong emotional reactions, even anger. As described by Freire, these emotional and experiential moments are key to the process of conscientization. They alter consciousness at the intrapersonal level about one's position in relationship to power. This may be considered as a successful example of decolonized practice: engendering a conceptual resistance to legacies of colonial hegemony. On behalf of students participating in these activities from the global north, any discomfort

experienced could also be considered part of a conscientizing practice. Genuine solidarity in decolonization is an unsettled matter that cannot easily reconcile present grievances (Tuck and Yang 2012). Educational practices involving community walks allowed for connections to be made between these more abstract concepts, the physical environment, and the impact on an individual's health. This approach goes beyond the calls for cultural competency and cultural humility in global health education, instead providing an mechanism to engage with structures of oppression at the intra, inter, and global level (Ablah et al. 2014).

The activities of the SMC took on an explicitly political tone. By giving participants the tools for community and international organizing, the SMC directed its energy towards a confrontation of structural problems at both the very local and international levels. Military metaphors were used to capture this spirit of mobilization. In this way, Social Medicine involved enacting decolonization medicine and global health as a political project (Green 2019).

The efforts to center the needs and work of practitioners outside of the global north in the immersive course represents another element of the Social Medicine approach aligning with a decolonization—understood as structural resistance to foreign hierarchies—of the field. By facilitating exchanges for practitioners between LMIC, knowledge produced outside HIC is legitimizing and valued as a key part of medical transnationalism. Holding large scale conferences in locations accessible to providers from LMIC, while not an entirely new practice, provides further evidence of the organization's efforts to prioritize voices that have been historically marginalized in global health practices and education. Through promoting a practice of reflexivity, participants in the immersive course were made to confront their own challenges to partnership. While this practice produced discomfort, friction between participants from different backgrounds emphasizes how far there is to come in the struggle, and the hard work needed to decolonize, and that this is a serious engagement and long term practice (Tuck and Yang 2012).

While the Social Medicine approach provides a productive model for global health education and advocacy in many ways, a number of points of growth remain. These largely reflect the structural barriers to genuine partnership and paradigm shift, and the difficult work still to be done to decolonize.

Among these barriers, the SMC faced structural limitations in disrupting the longstanding problem of unidirectional flow of global health learners from HIC to LMIC. Despite being part of a relatively elite social class, medical students and personnel from the global south faced limitations in their ability to travel due to institutionalized racism. Limitations in mobility are a well-documented phenomenon and source of inequity in global health partnerships. Johanna Crane uses the theory of "sedentarist metaphysics" to understand the concept of mobility in global health partnerships: "Global health relies upon a very strong notion of bodies in place in which certain kinds of patient bodies are linked to certain kinds of places, and by extension, certain kinds of biomedical learning opportunities," (Crane 2013:148). Crane is referring to the fact that black and brown bodies in the global south are expected to remain in place, allowing mobile northern students to travel and capitalize on the educational opportunities presented by

high rates of disease in these populations, with the trope of helping those in the global south. The organization sought to push back on these dynamics, as described above, but were unable to dispel oppression perpetuated by racialized global economic structures. Doreen Massey's concept of power geometry may also be useful in understanding these dynamics:

> Equally, these power-geometries exist at all spatial levels. The unequal geographies of power that underpin the chasms of economic inequality that are a product of neoliberal globalization are only the most obvious example at the level of the international. The idea of «power-geometries», then, is simply an attempt to capture both the fact that space is imbued with power and the fact that power in its turn always has a spatiality[…] What global cities have are the resources, the economic weight, often backed up by political and cultural influence. Their power is exercised relationally, in interaction with other places(Massey 2009:19)

This concept of power geometry is useful in thinking about the types of power associated with, and perhaps legitimacy of, geographic spaces in relationship to one another. She describes how the power associated with a space may be as much a product of its relationship to other spaces as it is a product of local resources. In the stories of SMC students, we can understand the impacts of this concept of power geometry at the level of the individual: the desire, means, and ability of an individual to cross from one space into another is dictated by this relationality.

While the Social Medicine approach attempted to disband concepts of 'white savior complex' and the idea that learner from HIC were 'helping' those in LMIC, it can be argued that the presence of visitors from HIC inevitably stretches already sparse resources (Eichbaum et al. 2020). Additionally, the ease of travel in terms of expense and obtaining visas for students coming from HIC as well as the sense of adventure or vacation, contrasts sharply with the risks taken by some of the learners from other LMIC. Risking employment or bodily safety to attend the Uganda course, or to obtain a visa to attend a US course, indicates that these LMIC learners saw the immersive course not as a vacation, but as a vital opportunity. This insinuates that the potential rewards from attending is greater for students from other LMIC, pointing to the imbalance of educational opportunity, and at times, inescapable trope that knowledge and resources flow from the HIC to LMIC. Additionally, the lack of open discussion around the direct impact of these mobility dynamics on the NGO staff, consortium members, and course participants emphasizes the complexity of this friction. While the organization promoted and created explicit space for reflexivity with regard to many of the interpersonal challenges of partnership, this element of inequity in mobility went largely unacknowledged. This challenge in mobility remained one of the few public secrets in the SMC partnerships (Geissler 2013).

Other points of friction in the Social Medicine approach included assumptions that social theory from scholars in HIC was necessary to legitimate the title of Social Medicine. This assumption is ambiguous. On one hand, the idea that practitioners from LMIC countries need an understanding of theory—often written in a second, third or fourth language for these

practitioners—to practice a form of medicine informed by the social, may exclude some from the conversation, and undo the work in decentering knowledge from the HIC. On the other hand, excluding learners from LMIC from sociology and anthropology conversations would be counterproductive. This tension points to the larger problem of white supremacist logics forming the basis of these academic fields. The utility of teaching this theory remains a source of debate and ambiguity among those in the organization, as a definition of Social Medicine continues to shift.

Practicing a decolonizing global health is an incredibly ambitious goal. The Social Medicine Consortium made significant efforts to engender mental, conceptual, and structural resistance to hierarchies perpetuating colonial (and neocolonial) logics in transnational medical partnerships and practice. Fanon writes on the struggle of decolonization as a manifestation and formative element of national culture (Franz Fanon 1959). The SMC's practices demonstrate the potential for a paradigm shift in the culture of global health: uplifting existing local knowledge, promoting reflexivity, focusing on conscientizing pedagogy and political activation of health care providers.

a. Limitations

This project had several limitations. Ethnographic data was collected from extended participation in the activities of one organization: the Social Medicine Consortium. I did not carry out a comparison with another global health education course. This lack of comparison may make the findings here less broadly applicable. Assertions regarding the success of this Social Medicine approach are not grounded in an equally thorough comparison of any other approach, but a literature review of standard practices and my previous personal experiences. Other limitations include a failure to obtain one-on-one interview data with either of the SMC founders. This limited my analysis of the organization's goals to my participant observation and informal conversation with these figures, interviews with other consortium staff and students, as well as written documentation. Interview data with either founder would have been useful in comparing the expectations and collected data on the objectives and points of growth for the organization. These interviews were not possible due to impacted scheduling and added strains on these physicians from SARS-COVID2.

1. Positionality

As a white medical student and native English speaker studying at two elite US universities, I in many ways participated in the activities and power structures this project seeks to examine and critique. White supremacist logics do not constitute a psychological attitude that I could simply choose to abandon through a heightened level of awareness as I carried out this project; white supremacy represents an "entrenched material infrastructure which reproduces race at key sites across society,"(CROATOAN 2012). My positionality—as a manifestation of these racialized economic forces—had concrete and material impacts on the data collection process. For

example, in attending the monthly SMC zoom call meetings, Campaign Against Racism zoom calls, and zoom planning meetings for the immersive courses, I had the benefit of excellent Wi-Fi connection, making my voice easy to hear. Consortium members zooming in from lower resource settings, largely in the global south, often struggled with unstable or intermittent internet connection and were often silenced by this structural technological limitation. Traveling to Mexico, Uganda, and Rwanda for this project was made financially feasible due to funding available to me as a medical student at elite institutions. As a US citizen, I took on relatively little risk in terms if my physical safety or security in this traveling or in participating in the politicized consortium activities (which was not the case for participants from other nationalities, as described above).

As a native English speaker, I had the advantage of listening and participating in all activities in my native language, which was not the case for the majority of members and participants coming from outside the US. Language barriers made interviewing course participants who were less comfortable with English an inherently unequal power dynamic. As with any ethnographic project, my findings were influenced by the relationships I was able to build and foster with participants, which were in part influenced by the characteristics described above. This was also a strength of the project. My affinity for the work done by the SMC, and my volunteering, participating, and helping to facilitate activities run by the organization played a large role in forming these connections. This mutual feeling of solidarity meant that many members of the consortium and other students were eager to speak with me to share their views.

VI. Conclusion

The organization studied in this research—the Social Medicine Consortium—sought to redefine the practice of global health and create genuine partnerships between health professionals to combat forces of racialized capitalism as they contribute to health inequities around the globe. This effort to create a movement through education and coalition building around the principles of Social Medicine represents an innovative, laudable, and in some ways transformative, approach towards a decolonized practice of global health. The work of these organizations comes at a moment when global health is striving to find ways to establish more equitable partnerships, and provides concrete examples of how to do so. This study of Social Medicine points to several recommendations and implications for the field of global health in medical education and transnational partnership building:

(1) In educational practices, careful consideration of antiracist structure and decolonized pedagogical approaches to course work and training opportunities is paramount. The study demonstrates the richness afforded by educating a diverse cohort of students from LMIC and HIC countries, and the importance of this structure in disrupting racial norms in the field by challenging the idea of *who* can practice global health. Utilizing a decolonized pedagogical approach, such as elements from TOTO, which force intra and interpersonal reflections about one's position in relationship to power, enables students to conceptualize and reimagine the underlying structures creating health inequities.

(2) Global health inequities should be contextualized, according to the principles of social medicine, as a product of historical circumstances as well as modern economic and political policies; strategies in community, national, and international organizing, as well as direct pathways to political engagement should be considered a part of global health education.

(3) Ongoing Social Medicine practices outside the global north should be uplifted, decentering HIC as the site of production of health knowledge. Opportunities for cross-collaboration among practitioners from diverse LMIC should be prioritized. Conferences related to global health should be held in locations most easily accessible to practitioners from LMIC.

(4) Promoting reflexivity and awareness among all participants in transnational medical education and coalition building is a key process. This should include inherent discomfort in reconciling the challenges to partnership, as opposed to leaving these inequities to remain as 'public secretes.'

(5) Incorporating social theory—particularly that generated in North America and Europe—into global health education may provide useful framing and may provide the potential to broaden conversations in social science fields. Simultaneously, the production of theory should be framed as a bidirectional flow: the vast body of knowledge social medicine traditions developed in the Global South—including the Latin American practice, Indian traditions, and practices originating in South Africa, must be included in teaching social theory.

As global health continues to evolve as a field, practices from social medicine may hold potential to redirect and decolonize transnational medical partnerships. In the hopeful words of one of the SMC founders: "Global health may one day look like reparations for colonialism".

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VIII. Appendix

Table 1: Interviewee characteristics:

TOTAL	19
ROLE:	
STAFF	3(16%)
STUDENT	12 (63%)
ALUMNI	4 (21%)
COUNTRY OF ORIGIN	
US	3 (16%)
UGANDA	9 (47%)
NORWAY	1 (5%)
RWANDA	2 (11%)
LIBERIA	1 (5%)
ZIMBABWE	1 (5%)
NIGERIA	1 (5%)
TANZANIA	1 (5%)
PROFESSIONAL BACKGROUND	
MEDICAL STUDENT	7 (37%)
PHYSICIAN	3 (16%)
DENTIST	1 (5%)
PHARMACIST	1 (5%)
PSYCHOLOGIST	1 (5%)
MEDICAL ILLUSTRATOR	1 (5%)
NURSE	4 (22%)
FELLOWSHIP ADMINISTRATOR	1 (5%)
GENDER	
MALE	8 (42%)
FEMALE	11 (58%)
NONBINARY	0
AGE	
20-30	9 (47%)
30-40	7 (37%)
40-50	1 (5%)
50-60	2 (11%)

Item 1: Example IRB consent form[6]:

CONSENT TO PARTICIPATE IN RESEARCH
Ethnographic Exploration of Novel Approaches to Global Health Education (Interview for Course Participants)

Introduction

My name is Elyse Katz. I am Graduate Student working with Professor Seth Holmes in the Department of Environmental Science, Policy, and Management, Environment and Society Division at the University of California, Berkeley. We are planning to conduct a research study, which I invite you to take part in.
We are inviting you to participate in this study because you are or were a participant in or staff member involved in a Social Medicine education course for students from diverse international backgrounds.

Purpose

The purpose of this research study is to understand how Social Medicine education can serve as an alternative to traditional approaches in global health and development.

Procedures

If you agree to be in this study, you will be asked to do the following:
I will conduct an interview with you at a time and location of your choice within the first five days of the course. The interview will involve questions about your motivations and expectations for participating in this course, your relationships with people from other parts of the world, your experiences with discrimination or racism, and your future career goals. It should last between 45 minutes and one hour.
I expect to conduct a follow up interview near the end of the course, and I will be asking similar questions in a similar amount of time to see if anything has changed.
If you were formerly a student in the Social Medicine education course, I will ask you to participate in one interview only, which will last approximately 45 minutes to 1 hour and will take place over the phone.
With your permission, I will make an audio recording and take notes during the interview. This is to accurately record information you provide, and will be used for transcription purposes only.

[6] Additional IRB consent forms were drawn up and approved for interviews for staff, for participant observation of virtual events, and participant observation of in-person events

If you choose not to be recorded, I will take notes instead. If you agree to being recorded but feel uncomfortable at any time during the interview, I can turn off the recorder at your request. Or if you don't wish to continue, you can stop the interview at any time.

Study Time

Participation in this study will involve between one and a half and two hours of your time for interviews, if you are a current course participant. For past participants, participation in this study will last approximately 45 minutes to 1 hour.
Study location
All study procedures will take place on site at the course location in Gulu, Uganda and Rwinkwavu, Rwanda.

Benefits

We hope that the information gained from the study will help contribute to knowledge about how equitable global health partnerships can be formed for students and health professionals. There will be no direct benefit to you from participating in this study.

Risks/Discomforts

You are free to decline to answer any questions you don't wish to, or to stop the interview at any time.
Breach of confidentiality: As with all research, there is a chance that confidentiality could be compromised; however, we are taking precautions to minimize this risk.

Confidentiality

Your study data will be handled as confidentially as possible. If results of this study are published or presented, individual names and other personally identifiable information will not be used.
To minimize the risks to confidentiality, we will do the following:
Personal identifiers will be removed immediately after audio recordings have been transcribed.
My research records, including audio recordings, transcripts, and field notes will be stored in an encrypted format.
Only I will have access to your study records.

Future use of study data:
The audio recordings will be transcribed and the tapes will be erased at the end of the study.

Identifiers will be removed from the identifiable private information. After such removal, the information could be used for future research studies or distributed to other investigators for future research studies without additional informed consent from the subject or the legally authorized representative.

Compensation/Payment/ Costs

You will not be compensated for your participation in this study.You will not be charged for any of the study activities.

Rights

Participation in research is completely voluntary.
You have the right to decline to participate or to withdraw at any point in this study without penalty or loss of benefits to which you are otherwise entitled.

Questions

If you have any questions or concerns about this study, you may contact me at 631-902-9087 or elyse_katz@berkeley.edu.

If you have any questions or concerns about your rights and treatment as a research subject, you may contact the office of UC Berkeley's Committee for the Protection of Human Subjects, at 510-642-7461 or subjects@berkeley.edu.

Consent
You will be given a copy of this consent form to keep.

If you wish to participate in this study, please sign and date below.

Participant's Name *(please print)*	Date
Participant's Signature	Date
Person Obtaining consent	Date

Item 2 : Sample Interview Guides

Leadership/ Staff

Introductory Questions:

1. How did you come to be interested and involved with global health work?
2. Can you describe your current work with Equal Health?

Relationships between intuitions in the global north and the global south:

3. How did you build relationships for your work in Haiti?
4. How experiences for people in your program from the global north differ from the experiences of those from the south?

Social Theory and Historical legacies

5. How did Equal Health come to use a Social Medicine framework?
6. Can you think of any examples of how historical legacies of colonialism and tropical medicine have affect your relationships with partners international(other doctors, students, or even patients)?
7. How do you see your organization fitting into the larger field of global health?
8. In a scenario where you were not limited by funding opportunities, where you were not held accountable to the expectations of various funders, universities, or pressures to publish, where barriers to international travel were reduced for people in the global south, how would you want global health to look?

Alumni from previous course years

Introductory Questions:

1. How did you decide to take part in this Social Medicine course?
2. What is global health?

Identity/ Goals

3. What are your career goals in health, and how were they influenced by this course?
4. How did spending time with students from other countries influence the way you see yourself? Your career goals?

Social Theory and Historical legacies

5. Can you think of any examples of how historical legacies of colonialism and tropical medicine have affected your relationships with students from other countries?
6. How do you use the principles of Social Medicine in your work now?
7. In a scenario where you were not limited by funding opportunities, where you were not held accountable to the expectations of various funders, universities, or pressures to publish, where barriers to international travel were reduced for people in the global south, how would you want global health to look?

Current participants in Social Medicine course:

Introductory Questions:

1. How did you decide to take part in this Social Medicine course?
2. What are you hoping to learn? (what did you learn?)

Identity

3. What do you think you will learn (what did you learn) from spending time with students from other countries?
4. What challenges do you think might come (came) up?

Social Theory and Historical legacies

5. How would you explain Social Medicine, how would you use these ideas in your work?
6. In a scenario where you were not limited by funding opportunities, where you were not held accountable to the expectations of various funders, universities, or pressures to publish, where barriers to international travel were reduced for people in the global south, how would you want global health to look?