[audio only] Winter School 2025 - day 1 - Anuj Kapilashrami

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Global health, health inequalities, intersectionality, migrant health, mental health, gender violence, structural violence, colonial legacies, health justice, social justice, community organizing, public health, COVID-19 impact, decolonization, global solidarity.

SPEAKERS

Speaker 2, Tanatswa Chineka, Speaker 4, Speaker 3, Becky Walker, Speaker 1, Jo Vearey, Speaker 7, Lydia Moyo, Anuj Kapilashrami, Fadzie Chipato, Stanley Muravhasta, Speaker 5, Speaker 6

B **Becky Walker** 00:00

And let me welcome Professor Kapila sharami from the University of Essex, been working now with ACMs for long time, but it feels like a very long time. But yeah, and primarily through the the gems partnership. So Anuja, I'll pass over to you, and then we will, yeah, open up a discussion afterwards.

Jo Vearey 00:33

You happy for me to share your slides as a PDF?

A **Anuj Kapilashrami** 00:39

Yeah? I mean, the reason I'm sharing it from my it's a complicated system that we finally figured out, but there was some problem with the USB and encryption and all kinds of stuff, which those of you who know me, I would know that I don't understand. But we have crossed those technological challenges, and I'm here and delighted to be speaking to you. It's really exciting to be here, as Jo already mentioned, these are the real perks of being in academia, right? 80% of our time goes in doing stuff that is not what we think academia is about, or not as rewarding, right? It is about interactions like these, and also, not only in one, oh, thank you, not in one institution, but look, but speaking to people who are coming from really very diverse institutional, political, economic context. And I think this kind of classroom spaces is what is most rewarding about academia. So thank you for organizing this. This was, this is we had something very similar last year in Nepal, when we gathered as gems, and I'm really pleased to see that with core and ACMs, we were able to facilitate this. Now I want to just start Becky's already introduced my my day job, right? But I introduced myself as an academic activist who's

trying to work across these very clear epistemic silos. Again, I'll reflect a little bit on that, and you drawing on research and the work in academia in order to bring about the globe the change that we need to bring about to address the global health deficits that we see today. Right? I've I chair med act, an organization of health workers in the UK, which is a sister concern of IPP and W, which is the International Physicians Network for peace and against nuclear armament, and the Ahmed act in the UK has been working quite a lot on some of the issues that we have heard about in the context of migrants. So it leads a number of campaigns, including patients and not passports, which is really trying to extend access to health care for asylum seeking asylum seekers. It also does. It is essentially engaging with a number of different campaigns which together advance health justice and social justice can link to that. I'm also trustee of health Poverty Action which is represented here, and I will draw on some of the analysis that they have presented again, really putting out very hard truths and critically interrogating the evidence and disrupting the evidence that we all often hear, or the discourses that we often hear about, international aid, a dependencies and so on. I forgot to mention uh people's health movement, but I'm going to draw on a phm case study to talk about how health activism, social movements, can bring about the change that we desperately need in times of today and have been a long standing member of people's health movement. So my brief was to really talk about tackling inequalities, actioning change for Health Justice, but in essence, really bringing in the most recent book we have done, I've done with two co authors, Professor Neil Quinn in Scotland, again, a member of people's health movement, and Dr Abhijit Das, based in India and. And I will be introducing that in a bit of what the book is about and what the journey has been, and then talk specifically about key sort of the problem that and the premise for the book, the action for change, and the strategies and pathways that we have identified in the book.

05:22

So

A Anuj Kapilashrami 05:24

but before that, just introducing gems to you. Since Jo mentioned and gems is really now in its third year, like it's a three year old baby which is, which is trying to find feat to run, but in essence, it is a global health research group looking at the syndemics, or the CO occurrence of gender violence and mental health among migrants in precarious contexts. Now the focus itself was driven by an understanding that the definitions and the administrative terminologies or labels that have been ascribed to migrants are problematic and are only giving sort of a partial understandings of migration processes, which you have really heard from both Suraj and Jo we treat political migrants distinct from and economic migrants, even though we know that refugees and asylum seekers significantly contribute to economies, or even undocumented migrants significantly contribute to economies. There are new terminologies being added to this migration health debate, including climate refugees and other terminologies, in order to try and understand the magnitude of the problems. But the this kind of labeling and then putting these categories into these and specifically these administrative categories, and defining these categories around the kinds of migrants, or blurring it with their contribution, often takes us away from really understanding what the problem is. Right? I'll come to that in a bit. So the idea was to really look at five different precarious contexts and look at different kinds of migrant population, and with the starting point of disrupting those migrant categories, because

we also know that in global South, in many contexts, the international migrants often become part of the internal migrant Labor Workforce, whether it is some of the Bangladeshis who are moving in across states within India, or some of the Nepali migrants in India. And we've also seen something similar in the South African Ansem context, where the point of entry might be an international border, but in essence, they're part of that loop within the country. So what does all this mean, and what are the risks that the journey poses? What are the factors that then determine their vulnerabilities or exposure to violence. And here we are conceptualizing violence broadly. We're looking at the gendered basis of not only domestic sphere of violence and or intimate partner violence, but also looking at and looking at how, looking at structural violence, looking at institutional violence, and the gendered basis of that and linked to that we're looking at mental health now, often these two issues and problems are seen in very in silos. There are and that also drives interventions which then focus on either mental health or gender based violence. Some excellent interventions like one stop crisis center, tackling violence, which will do a bit of counseling, but is not really addressing the different aspects of mental health. Likewise, you have mental health interventions that tend to often ignore gendered violence. So we wanted to look at this cycle. We are the context that I was referring to are very diverse, and of course, have changed over the last three years. We initially started with Myanmar amist ward in India and Mumbai, the Messina in Messina in South Africa, and actually Bay Bridge in Zimbabwe. And over the last three years, we've also moved from Myanmar because of the political situation where we could not continue the research objectives that we were had planned and intending to continue with some of the development objectives. And then moving to Cambodia, finding a new context, again, of a very mixed form of migration and associated precarities among migrants. So that's where we are. It is a very eclectic group. It's a very exciting group. We spend 10 days together. We're tired of each other, but we have been. We always love spending more time and having those very enriching discussions with each other. It brings together academics, it brings together development practitioners and NGOs, community based organizations as well, together to generate new knowledge, improved understandings through two work streams. One is the evidence work stream, and looking at existing data, the second aspect of the second evidence work stream is more experiential, so capturing the burden of violence and mental health through surveys but also through lived experience, says of migrants captured in interviews and then through a series of participatory action work, co design some of the public health solutions to in order to disrupt this cycle. We we've just finished our third annual meeting, and had the opportunity to also visit the Messina context and the Messina and Zimbabwe border, which was really enriching for everyone to understand a different context. There were researchers from Cambodia from from India, sorry, the in the Indian researchers weren't able to join with the Cambodia researchers, the Zim researchers and organizations coming and I'm trying to understand the con, the very unique migration context in South Africa. Now that's just a very quick introduction to gems. I'm very happy. And there are lot of gems here, so please feel free to engage with them on what the findings have been so far. But we are in that very interesting space where we're moving from data to making sense of this data and developing solutions with the communities now, now I come to what my brief was about, and just at the outset, I want to give you a context of why this book, this book has been The work of almost four to five years. I know that's been sort of an exceptionally long period, but that's how much time we really get to do, to write. And the context of this was very and it has the last four, last five years have been marked by very significant and distinctive political uncertainties, massive changes in electoral democracies and constituencies across the world. That was just last year, the largest number of countries going through elections and unfortunately voting for some very far right political parties. We had COVID 19 and connected to the 90 that the pandemic not we witnessed not only a public health crisis, but a crisis that was also a crisis of governance, a crisis of solidarity, a crisis of development and a crisis of societies where we saw what we are currently seeing is very high

burden of mental health resulting from the social isolation. We're seeing economic significant economic impacts, both on national economies, but also on economies of at household economies, how that has impacted, particularly more procurement work, precarious workforce, including migrants. So we are in the context of this poly crisis, and this is a term now even acknowledged and used by the World Economic Forum in the last 2024 report, which really talks about the poly crises being a concept where there are interconnected systems that where one system witnesses a crisis or disruption that impacts on All other crises. And we are talking about the economic systems, we are talking about the political systems, we are talking about the public health systems, the environmental systems and so on. Now the second problematic, what that we saw and why we were compelled, was. How, in this space around health justice, around social participation, and again, social participation, with the new, recent resolution that W World Health was passed at the World Health Assembly,

A Anuj Kapilashrami 15:16

it has prioritized the idea of Nothing about us without us right that that for any sort of health system, any systems development, any program planning, etc, it is important to involve communities. But all these theoretical debates, as well as the evidence collection, continues to happen in very clear silos. So you have and especially this, this is a more troubled space with social justice theorists and where I've been when I've been asked to speak in very in talk, in conferences and seminars at some very prestigious institutions in the global north, where where much of the writings and theories are coming from on social justice, on participation, on health justice, I often realize that it's not coming from those who are actually involved in these social movements, right? So one of the attempts in this book, has been to ground theory in the Praxis. And by praxis, which is distinct from practice, we mean when we engage in practice to also make sense of the world and inform the world by generating theory, right? And I think this is really important, and what we are arguing for is the social movement practice, or participatory practice, should emerge from the actual practice, from organizations, from academics who are involved in these campaigns and health justice movements. The final point that I want to highlight is that in understanding these multiple or the poly crisis, and what is happening with these systems, what happened with COVID 19, we often ignore the colonial legacies of these inequalities of the or of the problems that we are trying to address. And I'll give some examples around this in a bit. So these are the this is the context in which we embarked on this process. We initially it was an idea that Neil Quinn and I started working on, and then we also recognized how we reflected a little bit on our own positionalities, which are which are presented in quite detail in the introductory chapter in the book, and we reflected on the differences in where we are coming from. So Neil Quinn, an academic based in a Scottish academic based in Scotland myself, who is an academic activist. Much of my training in India. Then I came to the UK and started my academic journey in the UK, after doing a PhD there and then we decided to bring in another voice from also the global South, but one that is also of practitioner, right? So both medical doctor, but also have been working in development organizations, and hence the process of writing was really very complicated, very messy, because we were talking across these very different position positions and positionalities We were talking often, even when we talked about the community development, we were seeing it from very different lenses, very different gaze. Neil Quinn was talking more about community development as it was seen in the UK, in the US, civil rights movements, et cetera. And from those of us who have been part of these movements and development sector in India, had a very different and a very critical take on the ways in which community development panned out right so there was a lot of dialog across these three positions which are part of this book. Now just want to begin with and this I'm going to draw on. I can't do justice in summarizing

what the book entails in in whatever time I'm left with, but I want to highlight one of the chapters, which talks about engaging communities at the margins and talk looking at health inequalities. And how do you engage communities at the margins to tackle inequalities and then to bring about change and to advance health justice? So this slide, I mean, I surrosh, has done a great job in talking about how some of those inequalities are most felt the whole healthy migrant effect. And it fascinates some of our students to even think about, you know, how how common sensical it is that only people who are healthy tend to migrate, right apart from those who have experienced a lot of conflict and extremely or natural disasters. But I think it is really important to highlight who are the people who are most affected by the crisis that we are describing. But let us look at the current status of health. I'm not going to go into a lot of data, but just want to show you these these pictures, and pick up one indicator, one marker, of health inequalities, child mortality rate. It's often said that for developed societies, child health becomes a moral compass of developed societies, how well you do with children determines how good you are as a society, right? So if you see the significant disparities in the under five child mortality rate, and you'll see the darker red countries and contexts which have a significant higher mortality, from 75 to 80 per 1000 births. To other contexts, like Australia, like some of the parts of Europe and the US. And in essence, what you also in this particular map, you also see that countries that are with worsened under five mortality rates are all in Sub Saharan Africa. And if you look at the disparities around countries in Sub Saharan Africa, on average, have 18 times higher child mortality rates than countries in such as Australia, right? So this is the difference that we're talking about in child mortality, but this picture really reflects on cross country differences, right? What? What do you think explains these? Why is, why are rates so different 18 times higher? So if you're a child born in Sub Saharan Africa, you're 18 times more likely to die by the time you attend, you become you're five years old, as compared to a child who's born in Australia. What do you think explains these differences?

22:48

Come on. Are people? Yes. Sorry,

A Anuj Kapilashrami 22:55

health sector. Can you expand on that more? I

A Anuj Kapilashrami 23:05

Okay, okay, and what explains that? Why?

23:16

Okay, any other Yes, Chief, thank you. Probably

A Anuj Kapilashrami 23:24

population versus resources and the dependency of external resources in the health facilities in the regions, yeah. Okay, so limited resources, greater like higher population. Melissa

the regions, yeah. Okay, so limited resources, greater like higher population. Melissa,

S Speaker 1 23:46

I think it's also because of the increased migration within the sub Saharan region, which also has impact on access to care. For example, we have most countries in Sub Saharan Africa spending more most of their budget in private sector compared to the public sector, whereas we have a large number of people actually relying on the public sector. In the case of South Africa, for example, we know close to 10% of the GDP goes to the health investment, but that's not what we're seeing on the ground. So which means money is going somewhere where it's not supposed to be going. Okay? So

A Anuj Kapilashrami 24:31

we're talking about poor infrastructure or much less developed health systems. We're talking about more population, less resources. You're talking about investments in health, right? Although it's interesting that this is a very classic trickle down theory in economics that the more wealthier a country becomes, the better. Investments in health, in education, etc. But that's not the case, right? Some of the growing economies of the world currently invest only 3% India is about 3% of or 2.5% or something, of their GDP going in health, right? You had a hand raised, but important question about how much is being invested in these systems? Yes, okay, I

S Speaker 2 25:27

think they are the underlying issues of nutrition health, which are often overlooked or under prioritized in development issues.

A Anuj Kapilashrami 25:36

Okay? And where do these stem from? I want you to go into causes of causes of causes, right? Why less infrastructure? Why under nourished mothers or babies? Why the Natsu and then Fauci? Yeah,

T Tanatswa Chineka 25:56

I think it also relates to the systems that define the lives where these people live that stem from historical inequalities around how health systems were designed, where you find most of the population being located in the types of jobs, the types of foods, just for aspirations that they have access to, but these are very historically situated in others having more access to certain things, like resources, besides others. It's, it's not something that happens by chance or because people can't or don't have ambitions. It's, it's historically situated in how these systems define the actual lives that they live by day by day that creates health for them.

A Anuj Kapilashrami 26:44

Thank you. So it is how these systems were developed, and important to go back into the history, it is no surprise that all countries with these high child mortality rates were former colonies who have witnessed centuries of colonial extractivism, complete, but also, not only through colonial history, but subsequently through aid, structural adjustment, economic programs also impacted on The debt that these countries have, and the ability to build these systems. Fauci,

F Fadzie Chipato 27:26

thank you. I was going to talk about also how we are losing the healthcare professionals, how they are migrating. For example, in Zimbabwe, we are experiencing a lot of brain drain, and yet the government sometimes actually invest in healthcare professionals. And also the healthcare system is heavily dependent on aid. So in terms of how the government invests, they know that we normally get foreign aid. Most of the successful programs in the health sector, they actually depend on donor funds,

A Anuj Kapilashrami 28:01

absolutely so the a dependency, but also the coloniality of eight structures, how? And I will come to that very shortly. But I now want you to take move away from the idea of looking at Cross Country differences, and I want you to take, want to take you to a specific country context. Now this is a map, a special map, of Scotland's most populous city, Glasgow. How many of you have been heard of Glasgow? Yes. Have you heard of the Glasgow effect? Okay, so I'm introducing you to the Glasgow effect of on inequalities, or the Scottish Scotland effect of inequalities. This is a map of Glasgow City and Jerry McCartney and colleagues in the Glasgow University. And forget I'm confusing with the two universities, Strathclyde, Glasgow, but yeah, in Glasgow University have done a very interesting spatial patterning of inequalities. If you take a train from Jordan Hill, which is northwest of Glasgow City, to Bridgeton the southeast, every stop signals a drop in life expectancy of almost two years for men and 1.2 years for women. So the end result is, in the same city, there are people in Jordan Hill who can expect to live up to 78 or 83 years, if they were men or women. And in Bridgeton, it's only 63.7 years, which is actually less than many national averages in other poorer countries. Right? What explains this?

29:59

Yes.

T Tanatswa Chineka 30:01

I think part of it is city, city making, if I may call it, how neighborhoods come into being, how they progress, the movement of certain classes of people across the spaces so like through processes such as gentrification, which is very determined and influenced by, by by, I'm trying to find the word it's it's not. It's very deliberate how these neighborhoods came into being, how some processes for certain classes of people, because they can access or cannot access certain

services, to move into certain spaces, and then they conglomerate in these spaces, having certain access to certain resources and classes. And for me, that's part of the story of how that came to being.

A Anuj Kapilashrami 30:49

So you're absolutely right. It is some of the policies that have been taken. I call it a combination these toxic policies that have been taken and the kind of neoliberal development that we're seeing in cities today, which have segregated populations and resulted in areas that have highly deprived and other areas that are far more affluent or less deprived, that impacts on how the health systems in those areas are what kinds of resources or job opportunities, etc, exist for young people there the schools and the quality of education among these in these areas as well, right? So you see within country, and this is it says south we are in South Africa, and I am not very well, very well versed with the ways in which this patterning exists, but I am always fascinated when I hear, because we were in Ponte city, for example, and how I was hearing about the different sort of crime rates, the different job opportunities, the racial segregation, all these impact on how developed a particular neighborhood is, or how deprived a neighborhood is. And I'm sure you can share a lot of these experiences with regards to South Africa. So the main point I'm trying to highlight is inequalities. These are the inequalities and the differences that we are seeing are not just random or by chance, right? These are systematic. They result from a combination of historical as well as contemporary, current processes, the historical being and current being colonialism, the economic globalization that clearly was serving interests of the rich nations. Linked to that were these structural adjustment programs of the 80s and 90s that we saw in in Africa, in South Asia, in South America, and what we are now seeing in many parts of the of Europe, the austerity agenda being applied selectively to on certain pop that is impacting disproportionately certain populations, including migrants, including refugees, asylum seekers. There are also these other macro processes that we see, the policy making, the kind of policies that are being introduced, and these forces are really stratifying societies, creating these very clearly unequal positions in society, which then determines who has access to health care, who doesn't who has access to good quality education. Are food secure, are housing secure. Have employment, which is they have secure jobs and not procured employment. And these are resulting in the kinds of unfair and preventable differences in child health that we saw, or in life expectancies right now. These not random, unfair preventable and systematic differences that we see in health of people is termed as health inequalities. Right? There are very many different definitions that have been put forward. I'm using Hillary Graham's here, but in essence, these are not simply differences because of my BMR or my weight and height, these are differences that are not simply biological or genetic, but they are created and are complete. And are differences that are that are completely avoidable, right? But. Yeah, so now that's the context again that we were talking about there are several explanations for health inequalities. I do not want to make it a master class on health inequalities. Please attend my module for that, but I just want to flag there have been different explanations provided for health inequalities. There are arguments around cultural, culture and behavior. A lot of a lot of attention has been paid in public health to thinking about how behavior of individuals or their cultural practices impact on their poorer health. Right? There are material explanations which are talking about the area based deprivation, the resource deprivation, not having enough access to tangible resources that are enabling your health. There are psychosocial explanations as well around stress, anxiety and how that impacts on bodies, the whole connection between mind and bodies, and how that affects health. And then finally, the social production of disease that we talked a bit about, many of the conventional explanations around why people's different people have different

health outcomes and health access often focuses on those sort of meta theories, right? What we fail and this, I'm going to give very concrete example with COVID 19, what it often fails to identify that how this health is distributed in society based on people's unequal positions, right? So like the we were, like Suraj, for example, was giving the example of TB and the TB rates among migrants and non migrants, right? Or host populations. There is a lot of work that has happened only in the last, I would say, two decades, which is now beginning to look at how in order to understand inequalities, we need to better understand societies and how it is divided, how it is structured, right? And some of these social stratifiers have a very clear relationship between the people, individual person's identity, my ethnicity, my race, my education levels, my where I live, what I work in, how I get paid, to our social environments, the social economic structures in these societies, right? Please tell me where you're getting lost and you want sort of more concrete examples. Now, a lot of studies have also focused on those specific positions, like gender based inequalities, right? Why do women fare worse in many of these health conditions, right? Or why do men so interesting puzzle with mental health is more women report depression and anxiety, but when you look at suicide rates, there are more men committing suicide, right? That that's a very simple thing. But why do you think that would be

38:27

yes? Lydia,

L Lydia Moyo 38:30

I think for men, it's the responsibilities that they carry for their families, like trying to provide and sometimes not meeting those much needed resources for their families.

A Anuj Kapilashrami 38:46

So you say that again, the last sentence Lydia,

L Lydia Moyo 38:49

I'm saying for them trying to provide for their families and not being able to meet whatever that the family needs.

A Anuj Kapilashrami 38:57

Okay, that can be one explanation. Any others. Yes,

S Speaker 3 39:04

I would say maybe the social norms also in that men are socialized in a way that we they don't speak up. And also, when they commit Sue, when they commit suicide, usually they use deadly way points as compared to maybe women.

A Anuj Kapilashrami 39:26

Yeah, absolutely. So a combination of these we there are social norms, there are gender norms, and in patriarchal structures, where which prevent men to go to the GPS or the health providers to report depression and therefore seek early interventions. I'm not suggesting that it is a very rosy picture for women. Women are also not doing that, but if we just look at evidence right, there are more women who are reporting early on as common mental health conditions where. As men reported at much later or do not seek support in this process, and therefore most suicides. So gender inequalities literature really systematically looking at what explains these differences. Is it to do with gender norms? It is it? Is it to do with gender power relations in household, within communities or across institutions is research gender blind. For example, what kind of conditions are being researched, what kind of solutions and drugs and products are being researched? And you see a very clear gender disparity there as well, right? A classic example is contraceptives. Much of the research in contraceptives goes into more hazardous contraceptives that are targeting women, when the safest contraceptives, there are very limited research which is done around how to improve the uptake of, say, condoms, which is non invasive, but the research that continues to happen around products, around nor plant injectables and other contraceptive we see are mostly targeted at women. So there are several big questions to be asked around that now the other so similarly, there is also now studies around race and ethnicity which are pointing to a disproportionate burden being on minority ethnic communities in all sort of all health conditions and what prevents them from seeking health care in these contexts. In other contexts, you can think of indigenous status, right in First Nations, or even in countries in India, in South Asia, you can also think of particular ethnicities and religion. So there are lot of research that is now happening on what are these social positions in society? What are these stratifiers that are placing people at a disadvantage and that impacts on their health? Right? However these continue to look at, is this okay? However this continues to look at individual access of disadvantage my gender or my caste or my race, right? Not look at the interconnections of all these and how that impacts on our health status. We experience our health not because simply we are a woman, but my experience of health is because I'm a woman from a particular community, raised in a country as a minority or as a migrant in the UK, right with a particular level of job security. So it is the combination of all these that are impacting on our health. However, research, and a lot of epidemiological research continues to treat these inequalities in single dimension of disadvantage. So this particular paper that I've highlighted here, and I'll be happy to share these talks about why these looking at only these single dimensions is not enough to understand and then address health inequalities, problem that we see in our society, and what we need is an intersectional gaze. I'll give examples of COVID 19. Can I check how much? How am I doing with time? I

43:43

Yeah, okay, cool, great,

A Anuj Kapilashrami 43:47

right? So I'm going to give examples of COVID, 19 pandemic. Now, how many of you remember the slogan of the virus doesn't discriminate that everyone across different countries, context, was impacted by COVID 19. Yes. Do you remember every one get being affected, all countries

being affected, and sometimes it really didn't matter if it was a high income country in fact, that had a higher rate of deaths and also infections as compared to countries like low income countries, right? Did you think everyone was equally affected by COVID 19? So? Did it discriminate? What were the differences? Did you observe?

L Lydia Moyo 44:45

Yes, Lydia, I think most of the people were equally affected. For instance, when we were asked to stay indoors, everybody except those healthcare workers. So in my opinion, I think we equal. Affected when it comes to that right

A Anuj Kapilashrami 45:04

debate. I want disagreements. Yes, Sally,

S Stanley Muravhasta 45:14

I would say, I think we're not equally affected poor people, including people living in Township, it was difficult to to stay indoor. You know, staying in a shack, for example, with three members of family as like, maybe there's one person who have to wake up every morning going to work. You know, maybe that person is a security guard. You know, that person can come back with the COVID and COVID 919, and then we are staying in a one room. So it is, it was kind of difficult, you know, compared to people who are staying in in a Sabbath where there's a large yard, where they can sit outdoor, but inside their yard, you know, for us, I mean, for us it was, it was difficult. You know, we need to contain ourselves inside because of the soldiers. So the moment the soldiers passed, we need to go to the street.

A Anuj Kapilashrami 46:09

Yes, the virus was there, but how many? There were different protection levels, different exposure levels, among different people doing different kinds of jobs. You had frontline jobs. There were so they were who were differently affected and more exposed to the virus. Right? Domestic workers, we saw a lot of migrant workers in informal economies that were clearly exposed, but the responses to COVID 19 also put them at a different advantage disadvantage, because the lockdown, for example, did it affect us equally? Right? What? Yes, no. I think there were a few hands raised there, yes. Sorry. I can't see the names, but I just

S Speaker 4 47:01

wanted to say for me, what stood out during COVID was, particularly for migrants, how access to social security, for example, from government, and even within migrant communities, they were also affected differently, whether they are documented or undocumented, as well as where you were during the COVID the particular geographic space, whether you had access to all the services that were necessary.

47:28

Thank you. Others, yes,

T Tanatswa Chineka 47:32

it was also quite evident. There's a case in point in Zim where, like Stanley said, Some communities could not afford the lockdown. They leave from hand to mouth. You lock them up, they're not going to work. They have nothing to eat. So essentially, in some spaces around some communities where lockdown did not actually happen unless somebody complained and it becomes visible, then they send in the army, but virtually, people could not afford that, and then they actually built a hospital for the elites called Arundel. Access to that hospital was very restricted. Mm, it now made public. Now everyone can go and access that hospital for free to get just basic attention now, but that hospital was created specifically because the wealthy could not go out of the country. They had to. So a few rich people got together, built the hospital, but still, access to that was very restricted. You had to know someone. So you had

A Anuj Kapilashrami 48:30

differences in access to hospitals, difference in access to oxygen supply. I recall one of the peak. I think it was a third peak in India where there were very high number of deaths that happened during COVID, oxygen was very much. There was a massive shortage in oxygen supply, but only those who were playing that extra money could afford those or had political connections or could pay money for those extra beds. So we saw very clearly that even though the virus doesn't discriminate, but there were very clear implicate differential implications of policies that were put in place on people who are already in the margins or already experiencing precarity in these right this. I mean, we saw that in the case of migrants. And we've written, I'm drawing examples of South Asia in particular, where we saw lockdown of factories, etc, most affected migrants who were working there, who had to make journey journeys back to their villages almost 100 to 1000 kilometers away, and then were making these journeys on foot or swimming across the river channels to go, to say, back to Nepal or other places where their homes were. We also saw that the provisions that were introduced in these factories subsequently the. Relief measures that were introduced in the factories did not take into account that often the informal and most precarious migrant is not on a contract or a payroll in these factories, so therefore do not get these social protection systems or any relief measures right. So that's one end of the differential impact. The other example I want to give is in from in the UK, because and the example of health providers. Now, we knew that because health workers was the frontline force working during COVID lockdowns, that we found a disproportionate number of health workers dying during this during COVID 19 pandemic, right? But if you closely observed, and much of the earlier data on COVID 19 was only coming around, three variables, if you remember, male, elderly and CO morbidities, these were the three risk factors, big risk factors that were identified. But of course, the different strains of COVID 19 was changing, but the three risk factors that were identified, being male, being elderly and having co morbidities, were not investigated for how these co morbidities are distributed in the society. Comorbidities cannot be the cause, right? It's a yes, it is a biological risk factor. But if you look at what explains these co morbidities, who are co morbid in this population, you would see where the vulnerabilities lie, right? So when we started looking at there were, this was whole interesting discussion about health work more, when they started seeing that more

black, Asian, minority ethnic health workforce was dying, there were all kinds of explanations that started coming into play, including some people arguing, saying or hypothesizing that these are different cultures and of care. So Black, Asian, minority health professionals come closer to patients and therefore get more great, more exposure, right? So there were all kinds of these theories and hypotheses that were coming up. We started looking at data, we conducted a survey, and there was an icope study. This is just one paper, but there is a another paper where we started looking. We threw a survey and some open ended questions and interviews. We looked at the protection exposure of these health professionals in the NHS, and what we clearly saw was a very clear pattern. We only did this in about 570 health workers. We could not really disaggregate to each ethnic constituency, but what patterns very clearly imaged emerged were that nurses, and in particular those who were from minority ethnic backgrounds, were three times more likely to be redeployed to COVID wards and in patient facing roles. Right? We also saw a clustering of people in the front line, like porters, like cleaners, et cetera, or even for those who are doing catering work, who were more there was a clustering of racial, ethnic minorities in these jobs, and these were the jobs that were most exposed. We also looked at did an intersection analysis to see whether this changes, if there are more senior people, so like, if you are a consultant, but from a minority ethnic and while it reduced, but we still saw an excess exposure among minority ethnic doctors in the NHS. So when there was there were few PPEs, for example, right protection gear for COVID 19 who had access and what kinds of jobs, which were they or what kinds of roles were they given during that time, there was a very clear systematic discrimination and racism underpinning that. So what then we argue in this paper? I mean, it is not the virus that is racist, but it is our responses and the institutional responses that are clearly discriminating people of color. These are two examples that I've given which really talks about the inequalities that we are seeing in the world, and how decisions, policies and actions can impact on COVID 19 now as a result. And what then it argue, what we are arguing in the book is researching and actioning on inequal. Qualities, therefore, demands us to go back to a political analysis of these oppressions. Right of this discrimination it allow. It demands us to look at the role of power, how power is distributed in society, within institutions, institutionalized discrimination, like racism and the practice that I gave an example of, and then looking at the need for organizing beyond single issue or single axis of oppression. So not alone gender or not alone, race and ethnicity, but a combination of these, when we started looking at evidence and intersection, it was very clear women nurses in who were from minority ethnic backgrounds were three times more likely to be redeployed, greater exposure, but less protection from PPE. We saw that in other countries as well. There were hospitals built for, I mean, India, I can give another example, because I was doing a lot of comparative analysis around the policy change, etc. That we were seeing, there were hotels which were cleared up for doctors to stay back in hospital, for hospitals, but nurses weren't given that kind of accommodation, there were nurses were clustered in institute like hostels with no support for laundry change of their What do you Call it scrubs? Yes, no laundry services cleaning scrubs, or the kind of PPE gear that the doctors enjoyed. So we are really talking about multiple access of disadvantage and oppression that we systematically need to examine. Now these little infographics are from the book. We have three parts to the book, and the first really talks about what I have shared with you around power, participation, and why we are talking about and why the need for engage communities engaging to change what we are seeing in society today, what we here, we very Clearly argue that this kind of organizing requires an intersectionality approach, which does not talk about one single disadvantage, but looks at the connections of disadvantages, looks at these larger processes together of colonialism, patriarchy, ableism, racism, sexism together, right? And intersectionality, really, it's a How many of you have heard of intersectionality? And, okay, can I quickly get some responsive what

is intersectionality? But without looking at No, don't this. The slide gives away. Don't look at the slide, but don't use the term prism. But yes, what? What do you mean by intersectionality? I'm not going to ask those who have attended my intersectionality module, yes, Stanley,

S Stanley Muravhasta 58:14

okay, for me, intersectionality as a theory or a framework aid how people are disadvantaged differently by can be by gender, race, sex, ethnicity, how those things intersect and contribute to their disadvantages? For example, if we are speaking about race, maybe African race and black man is not as disadvantages as as black women, ja, something like that. And also, also in white, a white man is not as advantage, as advantage as in advantages position as white women, yeah, something like that.

A Anuj Kapilashrami 58:58

Two points to it completely, wholly agree with the first part, right, looking at the interactions of those multiple disadvantages, or seeing different disadvantages and advantages. The second part, I want to, again, pick up what people feel about this frame of, sorry, a black man is not as disadvantaged as a black woman, right?

59:28

Do people agree?

A Anuj Kapilashrami 59:32

Okay, why? Yes. Please tell me. I think it hotel Stanley. Yes. I

S Speaker 3 59:39

think it depends with the context, you know, when it comes maybe to job opportunities, we find that nowadays, women are more preferred as compared to men. You know, if you are a woman, you are likely, maybe to be employed as compared to men.

59:59

No. Yes. LELO,

S Speaker 5 1:00:08

I think it depends with the context. I think in some spaces, women are still disadvantaged compared to men, so I think it just depends with the context. That's my thing.

S Speaker 6 1:00:22

How many would agree? Okay, okay, so I said job sector, they just classify that we also need female workers. It doesn't mean that they are not employing male workers. So I don't think men are disadvantaged in

A Anuj Kapilashrami 1:00:39

that way. Okay, so you don't think that serves as a basis of an advantage or a disadvantage, right? Because the men already working there are what we call as positive of affirmative strategies and positive discrimination, where you are improving the status of women by identifying, okay? Show me.

S Speaker 7 1:01:05

No, but, yeah, let me try and get it back. I don't know. I kind of feel like maybe that's not the question that we should be asking, because there's so many different issues that come into play, like we're talking about intersectionality, right? That's not something that's how can I put this? Rather, we shouldn't be comparing, basically, is what I'm trying to say, because the intersection intersectionality is present themselves in such different ways. And for me, the moment that we start saying, oh, this person is not as disadvantaged, while there are many other contexts that make up their life. So, yeah, I'm like, should, should we be concerned? Very

A Anuj Kapilashrami 1:01:48

interesting point, and I think this is what where I was getting. But again, you have only so many, so much money in for to spend on this municipality. How, where would you move that money? Who would you? Where would you? How would you target that money to reach those who are most disadvantaged, right? So we do need an assessment and analysis of disadvantages, but you're absolutely right. What intersectionality is asking you to avoid is homogenizing an experience like universalizing an experience like all women are disadvantaged. Yes, we know there are gendered disadvantages that women face, but women from a particular class versus or or a caste or an ethnicity or an indigenous status, right? These collectively and cumulatively, will impact on their position in society. So it is important to reflect and to capture data to understand on the all the different bases of disadvantage that we can see. So agree with Stanley, but when we're talking even breaking it down further, which black man are we talking about? Which black women are we talking about? What are they coming from? A more deprived areas, less deprived areas, education that they have been, they've had access to health care, they've had access to and we've seen now migrant status being another stratifier or qualifier for these experiences, because if it's a migrant, black man who has moved from a conflict affected area, separated by the family at the border, Right, are we equating that black man to all black men? So I think it's that context, and this the prism is important. So essentially, intersectionality is being referred to as a theoretical framework, as a methodological approach, as an analytical approach, but essentially how my own journey with intersectionality has been one of thinking of, okay, this is a useful theory to now thinking of it as a prism to understand society and understand the social problems that we have, but also as

a political tool to bring about that social change, right? So this infographic is based on a talk that I gave with Kiara Bodin for international people's health University, and they drew what how they see health, how they see what factors, macro processes, determine health for individuals, and how These issues are connected. Oh, okay, okay, so right, the Q and A, I'll take a mud. Yeah, yeah, okay, okay, so just want to bring back to the point about colonialism I made and what we argue in this book. So one is the intersectionality as the prism, but also decolonization. Generation and decoloniality as an important tool to affect and even understand those kind of problems that we are trying to address. But in terms of colonialism, I do want to emphasize Just two very quick points. One, it's not a historical process. Often it is considered as how land, how states accorded sovereignty to other state, like those who were ruling one state, they physically withdrew from their land, and those nations became sovereign, free, independent nation states, right? This is the classic understanding of colonial, colonialism or colonization, but it's important to really reflect on to what extent colonialism is a historical phenomenon versus a contemporary phenomenon. There is a very interesting interview by Kwame Nkrumah, who talks about how the extraction of land, of resources continues to date, through a NEO Imperial, Neo colonial expansion, extractivism, that we are saying, right? So then decolonization is not simply about doing the historic righting, the historic wrongs. Right? It is also about looking at how the current systems structures that were developed in the colonial period and by colonial powers, right, how those are continuing to marginalize the PEEP communities at the margins, right, continuing to extract. I mean, there are several examples what we are looking at in the context of Palestine, the levels of hunger and starvation in Gaza, among children, the stopping of aid by colonial forces, the con the conversations that are happening around us, deploying their army in in Ukraine to to prevent further accession in exchange of minerals and ores, right? So there is continued extraction and development through, especially through developmental aid that we see today that is continues to be the the former colonial colonization that we are seeing in more contemporary times. The second aspect that I want to highlight here is that the current, the current global system, that is, and I think Suraj, you also alluded to the changing power dynamics and relations in the state today, that colonialism and the Neo colonialism cannot be seen simply as The Global North versus global South, right, even in free, independent states, we are seeing colonization. We are seeing of more marginalized communities, like indigenous populations, like removal, extraction of land resources. Of those communities, we are also it's not only a matter of across borders, it is also what is happening within borders, and that's also part of the story that we see in Scotland. That's also part of the story that we see in First Nations and in other contexts where we are seeing settler colonialism, right, including the Israel and Palestine example. The other point with regards to neocolonialism is this very interesting graphic that health Poverty Action did in one of its briefs, which I really like, of how the aid discourse is seen as these rich countries, people who are taxpayer from taxpayers money, rich countries supporting poor countries and their development, right? But the way in which international aid system is structured, you see, there is more money going out of Africa each year than into Africa through aid.

A Anuj Kapilashrami 1:09:19

Right? This is through interests. This is to loan conditionalities. It is through access to minerals, trade and other economic development opportunities, right? So what we are seeing, we can we are continuing to see that kinds of colonialism to date. So what do we need to do about it? We are seeing as a result of what we we're talking about cross widening inequalities. We're talking talking about oppression within states, within borders, as well as across borders, and a growing anger, frustration, disenfranchisement of people, but also divided societies. We are so divided. It today, and we've more divided than we have ever been before. You see the kinds of riots that

have happened in very harmonious states. We see anti immigrant attacks, we see xenophobia, we see homophobia. We're seeing this kind of divisions at every level. So the really the book is saying that why that is happening is because that people are feeling a loss of social, economic and political power, and in order to fight that loss, it is important to have be to develop a countervailing power from below. So all that is happening from the top on communities and societies, requires action from below, more global solidarity movement building and resistance from below and such countervailing power also requires very different kinds of activism and community Organizing, which is not simply about one single issue, struggles. It is about looking at the connections between these struggles and this kind of connections is being a long stand. Has been a long standing priority. We have had Dalit feminist movements. We have had indigenous struggles around water, around deforestation, around toxic wastes dumping by corporate actors. And what is really essential is how these come together in an environment which is becoming very nationalistic, very anti immigrant, anti gender and anti rights movements, as we have seen from the Trump diktats. So what we what decolonization and what intersectional practice really requires is really a multi dimensional strategy. I'm going to skip this. Here's some examples of what we have done, and these five pathways that the book explores, sorry, four pathways to health justice. Are you able to sorry, see the next slide. Yeah. So these four pathways is very much about engaging those communities that are at the margins in ways that is empowering, not just an individual, but empowering a collective, and the collective becoming part of the movement. The second is addressing the political, social, environmentally, as well as commercial determinants of health, what the corporations, together with states, are doing in the kind of extraction we are seeing. The third is strengthening accountability from below. We give plenty of examples where communities have come together in formal systems of accountability, demanding states to provide, say, for example, maternal health service services or essential medicines, and they have enabled the change, both at legislative level, right by trips. Relaxations to trade. And, I mean, I'm just thinking of a word for simplifying. Trips, trade, no, no simplifying. So, yeah, so the kind of taxation that happens, or the kind of export restrictions that happen on essential medicines, including in Vax vaccines for COVID, so communities have also done advocacy to resist that, to demand that there be a COVID fact facility, which is providing poor states and people who are more deprived free access to medicines. But there are also more localized interventions, where communities have come together to monitor local health services of what kinds of drugs, what kinds of services they are providing, and engage them in very powerful like citizens, tribunals, like public hearings, like truth commissions, where the authorities are made to hear the kinds of evidence that they have collected on the ground and seek compensation for these so there are plenty of examples that We do talk about, it's not all story of doom and gloom. I'm not going to go into deep into the people's health movement, but just want to introduce there'll be, there are a lot of references to that and written in fairly simplistic way, but the people's health movement really came about in 2000 right to celebrate the failures of the international community in not addressing the goal of Alma Ata conference. If you remember 1978 was this historic Alma Ata Conference, which said, by 2000 we will have health for all. So when we were nearing 2000 across the. Countries, a lot of health professionals, advocates, human rights practitioners, activists, came together across 70 countries. I'm talking about to demand that health for all now. So instead of health for all 2000 I was part of the Indian people's health movement. Then I was very fortunate to be at the first people's health assembly in Dhaka, where almost 70 countries participated, and they embraced through very ground level, community based dialog, a whole health manifesto, people's health manifesto, that they then began to use with their political parties to demand the kind of change, including, for example, in India, there was a long standing advocacy and campaign around increasing the GDP invest percentage going into health, which was at the time, 1.6% which is now subsequently come to about 2.6 or 3% so there's been a number of I'm going to skip the Scottish example, but through a number of

different ways, in Scotland, in Europe, in southern in Latin America, movements in Mexico and Brazil, as well as parts of Africa and South Asia, we've seen grassroots movements come together to demand and ensure accountability from local planners, municipalities, councils, but also at the global level, international actors. So we have a big constituency represented at the who, which is now part of the CSO Commission, the civil society commission, and it was phm efforts, and there'll be papers written about it, which was responsible for the first Commission on Social Determinants of Health at the WHO level, they argued that health is not simply a matter of disease. We need a commission which talks about social determinants of health, and that should be part of the development goals and millenniums or or at the Sustainable Development Goals. This is a process that we embarked on in Scotland, developing a people's health manifesto, and the process has continued. This is around every election, and we have utilized that and the set of demands with each political parties to affect change. And in many cases, there were some political parties, not unfortunately, SNP, but labor and green that really adopted the manifesto that we developed in Scotland. And what the book presents is several examples from across the world for these kind of cases. But in essence, what we are arguing is that this ground the movement from below to address the power imbalances, the oppressions from the top, really requires us to connect the different issues, it also requires us to build Glocal solidarity, not just global solidarity, connecting with different countries and movements, but also connecting those movements to localized actions and campaigns right and develop more critically conscious communities of actions. So there's grassroots organizing and countervailing force. It also requires us to

A Anuj Kapilashrami 1:18:32

think about and sensitize professionals in demanding some of this change. There are number of different, very powerful, very stimulating and inspiring approaches that have been adopted in people's health movement, as well as members like med act there are, there's a people's health tribunal, again, this is, this is something you will see from med act and phm page that was that have been conducted, where we listen to people's stories of neglect, of oppression, discrimination, and then that informs the advocacy I already mentioned patients, not passports, but also training and sensitizing health providers in the UK who are beginning to extend the state monitoring of migrants. So there is a whole prevent program where teachers, doctors, etc, are asked to identify the radicalized people in the community and report them to the services. So we are now working with health professionals to really talk about how we counter this kind of anti immigrant and which is fourth framed around terrorism, security threats, etc, but in essence, is just anti human rights and anti immigrant discourse. And there's several examples which are also now, I'm sorry I'm not able to look at are you able to see? Yeah, which is also looking attempting to reset the global order. Now, these demands are global demands. These demands are happening at through advocacy at global level. For Yes, sorry, I didn't know what's happening with the slides. For example, I can see this slide.

A Anuj Kapilashrami 1:20:26

Okay, it's not changing in Yes, okay, so these are examples of who pays for recovery after COVID. 19 should be should it be taxed from individuals by increasing taxes, or should we also charge corporations attacks, especially the corporations that have benefited from COVID 19 right by selling by the private providers who are selling test kits, some often erroneous, problematic test kits or selling drugs. How do we ensure that it is people who have benefited

and profited from this pandemic, are paying into it. There are a number of other very promising examples, and I'll leave you with on this note, the one that is happening right now around the International Conference on Financing for Development, where a big contingency is talking about decolonized approaches and the idea of circular cooperation, which is being led by the global south advocates. And that's what is really essential at this time, where we are all in this together. This is the only time I will use David Cameron's words that we are all experiencing these multiple oppressions in different ways, where in our own localities, at in our countries, but also globally, and we need to resist that change. I'll stop there. Thank you for listening, and this is a little code which will give you some discount, which the publishers create for events like these. But thank you.

S Speaker 6 1:22:07

We can help With online people, okay, sorry, just

B Becky Walker 1:22:50

uh huh, okay, yeah. Thank you so much. For me, it was such a fascinating journey through shifting that lens to health as a site of or a systemic site of inequalities, and sort of really teasing that out, and both, sort of, yeah, providing hope amidst a very, generally, very depressing picture of where things are going. There's a lot I would love to ask, but I'm going to open up the discussion and allow open up for everybody here to ask questions or comments or reflections. Please keep your comment to reflection fairly brief. We don't have that long, but it would be great for as many people as possible to have the opportunity to provide some input, as well as the people online as well? So does anybody want to kick us off? Is

B Becky Walker 1:23:50

there anyone online? Jo, just

 Jo Vearey 1:23:58

to feedback a couple of comments that came somebody online sees way says we are still in awe, so has not yet had time to process. But thanks, and we will be sharing a new slides as a PDF just shortly. So there was some comments here about back into the COVID times with differences around access, infrastructure and governance. Importantly, looking at refugee communities, issues around infrastructure or lack of infrastructure, meaning where people could or couldn't. You know somebody here was mentioning about being able to stay home, but obviously also about safety and space, people who are living in congested vicinities, migrants, frontline workers, and I think we could expand that to something that will be being discussed tomorrow afternoon when blessing shares his PhD work thinking about sort of like truck drivers and the movement of goods and services, where. People were being contained, as it were, and we were protecting people, I did, you know, sort of in some way, but not protecting people involved in the movement of goods and services. And pascalia had a very nice question, which maybe is where we could start off. Hi, Anuj, I like how you highlighted activism as a key level lever, lever for change. My question is, how can early career researchers, particularly from the

Global South, strategically align our research with activist movements to invite to advance health justice without compromising institutional or academic legitimacy? And pascalia is a long standing friend of acmesh. Did her masters with us, and is based in School of Public Health. So thanks, pascalia. Over to you, Anish, what are those very simple questions? So there's easy and fast,

A Anuj Kapilashrami 1:25:59

right? It's, this is a very tough question, which is also probably something we're going to pick up on in the next session, where we are talking about what it means, working across sectors, across the epistemic silos that I was talking about. I've written on this previously, because there and I'll share some of these literature. The first paper was done in around public health advocacy and activism, which makes a case about, or rather challenges the assumption of the need for these two academia and how the world sees the academia quite separate from the activist world, right? There is often this whole assumption that academia and the ivory tower is just about thinking, and the work that organizations, campaigns, movements do is about action, as though they are not thinking, right? Sometimes, yes, because the kinds of the kinds of challenges that we are confronting with are just demand constant action. There may be some less thought through actions than others, but we I disrupt that idea and ask the people's health movement in Scotland that we have done a piece together with, not just academics who were involved in the phm, but also organizations and activists who are continuing to lead the phm Scotland. And I now have moved to the UK and Essex part of more phm, more broadly, but not involved with phm Scotland anymore. It's continuing, and it's continuing by a combination of these dialogs across these different sectors. I think that paper really argues and challenges the idea that we compromise on evidence if we engage in activism, right? I think what we really trying to do is the evidence based or evidence less led, policies and programs that is quite dominant feature of public health, right? In public health, in global health, we keep talking about this policy and programs need to be evidence led. What activist, activism informed, evidence generation is trying to do is shed light on the gaps in evidence. What kinds of data are being collected or being reported, and trying to also move away from valuing what we measure, but measuring what we value right now, these are two different things. We often measure some things, and we do need to understand the burden of depression and anxiety or mental health conditions, suicides, among others, right? But if we value equity, if we value rights, we asking slight other questions. I think you also talked about that the question is not whether a black man is more vulnerable to then or less vulnerable and more at an advantage to a black woman. So I think what activism is allowing us to do, or advocacy, depending on what you're engaging in, is also informing evidence and getting evidence to focus on and research to focus on, the right sky, right kinds of questions that will aid in closing the equity gap. The argument made in that piece is that we are really talking about public health and social. Justice. Each having public health has a normative intent. It is an aspirational goal. We're talking about improving health for everyone. That's not a non normative goal. It is underpinned by the idea of everyone should have a particular quality of health. So it is already a goal and aspiration that is underpinned by these norms. So what we are saying is that it's not, I mean, an advocacy in public health is also demanding that change what where we can come together. And I think so the academic legitimacy point is what I wanted to highlight or respond to. But the second bit is, we are this is it's the reality that we're all working in very, very atomized institutions. By atomized institutions, I mean very fragmented, insular institutions that do not encourage this cross sectoral work. And I can be very shamefully admitting that the number of times my bosses as I was climbing up the academic ladder told me that you shouldn't be doing health movement, health advocacy and stuff focus on the career sort of objectives that

academics need to focus on. I didn't do that badly, so you can all see that it I think the the the both the energy, but also the ideas and the experiences that we got in connecting with this kind of activism also informed my research and the kind of questions I wanted to ask, right? I could not go through the Scotland example, because I think that would have been a good example. In response to, how do we early career researchers engage with this? We started power process, participatory action research to build this and extend the people's health movement in Scotland. That was part of the objective that bring people together while understanding how austerity is impacting on people's health. That was my research question when I started that project. Right? But the also, the underlying objective was, could we bring people who are experiencing the effects of austerity and facing those oppressions daily into a movement that can also respond to these challenges? So that was the intention. And there are different ways. There are phms in different countries that you may want to involve in, depending on where you are. I think South Africa has a very strong people's health movement getting attached to to movements like medac, like IPP and w if you're a medic and want to be part of this wider community of physicians who really care for health equity and health justice, and are attaching themselves to either very localized or very like global and international campaigns. It could be access to essential medicine advocacy with who and the other like pharmaceuticals, or it could be a localized campaign against fracking in your locality or the patients, not passports campaign where you're you know, fighting for extending the right to health care for asylum seekers. So those are ways in which you you can do that. But I do acknowledge it's not a process that is very easy or smooth and requires time in building these connections and being part of these moments.

T Tanatswa Chineka 1:33:54

Thank you. Anish, could you give us a few pointers around how to use intersectionality as a methodological approach or two, that ensures that what you end up doing is actually mapping intersections, and what are some of the issues that one has to look out for

A Anuj Kapilashrami 1:34:19

that's very unfair To nuts for you asking me to summarize that whole module you took on intersectionality, 101 in a response to your question. So I will not give all the because there are different ways to do intersectionality. There are different ways in which you implement intersectionality. You could be asking a question, which is not looking at categories at all. That's an anti categorical approach, and I do not want to use and confuse you with all these terminologies. But you could also be doing intersectionality. So by not looking at categories means not looking at differences between very fixed. Set of populations like men or women or migrants or non migrants, or indigenous communities versus non Indigenous communities, right? So those are fixed categories. So you could be asking a question and then beginning to see how the impacts of to some extent, we located our study in migrants, but we did not define categories to compare the status at the start. So we were not, for example, looking at international migrant mental health status or refugees mental health status versus internal the framing of gems project, for example, has been a broad framing that will allow us to get to who are the most disadvantaged or communities or communities who are have limited access, or who are more precarious. But so our starting point you could do intersectionality by just asking more generic questions and then get to understand the commute society that you are studying or trying to understand of, what are the differential access, how it is distributed, how the

society is structured. I think the approach in GEMS was more of that. Or you could start off by saying, develop if you are well informed by which categories we are most disadvantaged, or least, then you can also look at two, three sets of categories. A lot of intersectional studies are, for example, looked at the crime where, like the three axes in particular, gender, race and class, right? So women of BAME, women and deprived neighborhoods versus non deprived neighborhoods, right? So you could also look at categories and do that kind of analysis, but read the book and do a little bit more reading on this. I do talk a lot about intersectionality in this. I hope that answers, yeah. Sorry.

Jo Vearey 1:36:58

One last question from online Chavi, I'll read it on your behalf, if you don't mind. In your talk, you touched on how coloniality continues to influence migration systems today, building on that, how can we plan intersectional lens to understand how caste, class, gender and race shape the live realities of migrants, especially women in post colonial societies like India and South Africa. Studies by Mala and PESA emphasize how migrant women navigate structural barriers by asserting agency through informal networks and community organizing. However, Indian migrant women are still often portrayed as portrayed as tied migrants or trailing spouses, invisible, muted and without agency. How do colonial legacies continue to reinforce these silences, and what can migration governance systems do to challenge them? This is an incredible PhD project,

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Anuj Kapilashrami 1:37:59

I would agree, and I would encourage you to connect with gems, because this is exactly the kind of questions we're trying to answer. I think the only thing I would say so this, I can't answer the whole question, but I do want to add that one strength of intersectionality, if it is applied well, is that it allows you to connect the individual experiences of what we saw, for example, among farm workers in Musina, right with the structural, institutional, systemic processes of discrimination that we are seeing in the world. Right, without that, intersectional analysis is incomplete, if I just explain which is unfortunate. A lot of quantitative studies on intersectionality do just explain the burden, the differential burden based on different communities, right? So it could be the mic, the examples that you were giving chubby it could it could be the specific excess burden that migrant woman from a particular for particular nationality, moving to South Africa is is faced with, right? So you're talking about excess burden. But this beauty and the strength of intersectionality is trying to explain, why not just describe the burden, an explanation of why, which I was telling you go back to causes of causes, right? Takes you back into the historical process of discrimination. There's a paper that I did on Tanzania and looking at women's access to reproductive information and contraceptives, and that does try to talk a bit about the colonial places, the disadvantage of particular indigenous communities there, and how that is was historically determined. I'd be very happy to share that example. Example as well. But thank you for that very thought provoking question. Great.

Jo Vearey 1:40:04

Huge. Thanks to Anuj and to colleagues for fantastic questions, comments and thoughts and it. It's a very nice link. It makes my job a bit easier tomorrow morning, when we're going to be

talking a bit more about legacies of the sort of you know, histories of global health and immigration and epistemic injustice. So it's a very nice kind of link there. So thank you, Anuj, you've made things easier for me.